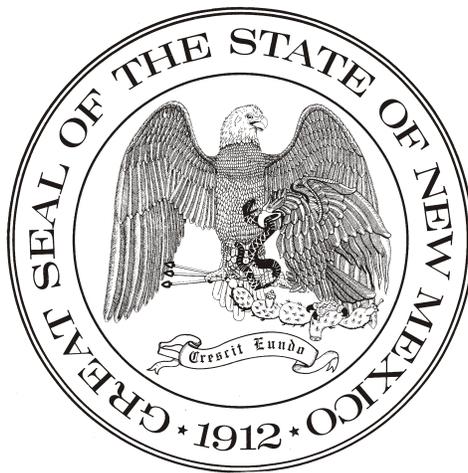


# **Legislative Health and Human Services Committee**

## **2009 INTERIM REPORT**



**New Mexico State Legislature**  
*Legislative Council Service*  
*411 State Capitol*  
*Santa Fe, New Mexico*

# **2009 INTERIM REPORT LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

## **CONTENTS**

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- **Executive Summary and Legislative Proposals**
- **Work Plan and Meeting Schedule**
- **Agendas**
- **Minutes**

## **EXECUTIVE SUMMARY AND LEGISLATIVE PROPOSALS**

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## Summary

This interim, the Legislative Health and Human Services Committee (LHHS) met with constituents at areas throughout the state, including a joint session with the Legislative Finance Committee (LFC) in Gallup on July 8, and meetings in the Pueblo of Laguna, Ruidoso, Rio Rancho, Albuquerque, the Pueblo of Pojoaque and Santa Fe. In addition to the meetings of the entire LHHS, a health care reform subcommittee of the LHHS met in conjunction with the LFC in Angel Fire on August 7, and the Disabilities Subcommittee of the LHHS met in Santa Fe for two days in October 2009. In addition to the six regular meetings and two subcommittee meetings scheduled in the LHHS' 2009 work plan, the committee requested and was granted one additional meeting date, on December 18, 2009, at the State Capitol.

Medical assistance was a major topic of concern for the LHHS, as the latest figures indicate that approximately 500,000 New Mexicans are enrolled in one of the state's medical assistance programs, including Medicaid, the Children's Health Insurance Program, State Coverage Insurance, Premium Assistance for Kids and Premium Assistance for Maternity. The LHHS was greatly concerned with the enormous impact of budget shortfalls reported by the LFC during the interim, and the Human Services Department's (HSD) statements that the HSD wished to restructure medical assistance programs in light of the budget shortfalls and federal health care reform efforts. The LHHS heard a day's worth of public comment and testimony from experts and from the HSD on how to meet the budgetary challenges to medical assistance while continuing to serve the neediest New Mexicans and to receive the federal matching dollars vital to the state's budget. The committee considered whether there was a need to cut benefits or services or whether instead revenue increases in lieu of budget cuts might address the HSD's budgetary shortfalls. The committee also heard testimony and discussed at length the most frequently used services, the impact of provider cuts on provider participation in the program, other states' cost-containment measures and the potential for developing systems of care to address high costs. The concept of the medical home integrated health care delivery model, including the HSD's implementation of the new statutory medical home pilot project, received over a day's worth of testimony and discussion among LHHS members.

The LHHS heard extensive testimony on the issue of building the health care work force, including testimony on expanding the supply of primary care practitioners, nurses and nursing faculty, and dental health practitioners. It heard testimony from the University of New Mexico (UNM) Health Sciences Center on its efforts to expand the Bachelor of Arts/Medical Doctor (BA/MD) program, to implement a medical home model and to expand the reach of health practitioners through the use of telehealth, such as through Project ECHO and its many other telehealth programs. The UNM Health Sciences Center president, Dr. Paul Roth, suggested that a way to address the unmet dental services needs would be to send New Mexico dental students to slots allocated to them in a nearby state's dental school. The committee discussed this possibility as well as the prospects for establishing an in-state dental school.

In testimony by the Con Alma and Kellogg foundations, the LHHS heard a proposal to implement an advance-practice oral health provider program. In places such as Alaska and New Zealand, high school graduates have been trained in providing basic dental services to underserved communities. Other testimony included a proposal to expand the scope of practice for dental hygienists to include some of the practices currently performed only by dentists.

New Mexico State University, UNM and the Center for Nursing Excellence provided testimony on ways to increase the number of nurses and faculty to train nurses in the state. The LHHS also heard testimony from representatives of several programs operating at high schools and colleges that recruit students into health careers. It also heard about the use of the federal Workforce Investment Act (WIA), including WIA funds included in the federal American Recovery and Reinvestment Act of 2009 (ARRA) "stimulus package" to channel unemployed individuals into health careers.

The LHHS heard extensive testimony regarding the Interagency Behavioral Health Purchasing Collaborative (IBHPC) and the new statewide entity (SE) with which the IBHPC has contracted to provide behavioral health services throughout the state. Members of the LHHS have received numerous complaints reporting that the new SE, OptumHealth New Mexico, a subsidiary of United Healthcare, failed to timely process and pay provider claims. The provider community has characterized this as a threat to the continued existence of behavioral health services in many parts of the state. LHHS members took a great interest in this matter this interim and, in fact, conducted an informal, nonscientific survey of behavioral health providers regarding their experiences under the new SE. The survey reported overwhelmingly that providers were frustrated and their resources stressed due to challenges arising from the SE losing claims, the SE's failure to timely pay claims, allegations of the SE's unfair recoupment of emergency payments, the SE's extremely cumbersome paperwork requirements using faulty and illogical software programming, its failure to provide adequate channels of communication, its failure to provide effective channels of dispute resolution and alleged retaliation against providers who complained about the SE's performance. LHHS members repeatedly demanded that the IBHPC take effective action to address these problems. The IBHPC reviewed the contract with the SE and inquired as to whether sanctions would be assessed upon the SE and, after review, issued a notice of sanctions and a directed corrective action plan for addressing the SE's failure to perform. On October 29, the IBHPC entered into a directed corrective action plan with the SE, and sanctions are being collected. The IBHPC appointed a state monitor to ensure compliance with the directed corrective action plan.

In its oversight role, the LHHS and the Disabilities Subcommittee of the LHHS heard comprehensive testimony regarding home- and community-based waiver services, including the new Coordinated Long-Term Services Program (CoLTS) implementation. LHHS members have received repeated complaints about the new CoLTS system implemented since July 2008, including the HSD's and the Aging and Long-Term Services Department's (ALTSD) oversight of the managed care organization's (MCO) implementation of the contract provisions. Evercare, a subsidiary of United Healthcare, and Amerigroup are the two MCOs providing primary, acute and long-term services under CoLTS for enrollees of the disabled and elderly, Mi Via and

HIV/AIDS waivers programs and the personal care option Medicaid benefit. Providers, such as hospitals, nursing homes, pharmacies and home care workers, have complained of slow payment and administrative difficulties in dealing with the MCOs. At its December 18 meeting — called especially to address these issues — the LHHS reviewed these complaints, through testimony and by examining the results of the LHHS' informal, nonscientific provider survey, at length. Committee members directed the ALTSD, the HSD and the Department of Health (DOH) to ensure that money appropriated to reduce waiver waiting lists be used for this reason and to hold the CoLTS vendors, Amerigroup and Evercare, accountable for any failure to live up to program goals.

The LHHS heard extensive testimony regarding the size and length of time spent on waiting lists for the developmental disabilities (D/D) waiver administered by the DOH. As with the CoLTS waiver, concern was expressed regarding the HSD's failure to use money that the legislature had appropriated to reduce the D/D waiting lists. The LHHS also heard testimony by the HSD and the DOH as to budgetary concerns.

The LHHS examined at greater length delivery system reform options, including the implementation of the new Medicaid medical home pilot program pursuant to Section 27-2-12.15 NMSA 1978, enacted in 2009, and the conclusions as to the feasibility of implementing this model in private practice offered in testimony by the New Mexico Medical Society's medical home working group. The LHHS also heard testimony regarding different models of medical homes, including those operated by specialists, nurse practitioners and other mid-level professionals. It learned of care coordination efforts by entities such as Salud! vendor Molina Healthcare, which reported substantial cost savings as the result of less utilization and better health outcomes achieved pursuant to its contract with southwestern New Mexico's Hidalgo Medical Services for patient-centered care coordination.

The committee also examined:

- the prospects for federal health care reform and its potential effects upon New Mexico;
- health- and human-service-related programs that received ARRA funding;
- programs by the Children, Youth and Families Department and private agencies for innovative juvenile justice, domestic violence and interventions for prevention in these matters;
- nutrition programs such as those operated by the New Mexico Collaboration to End Hunger; the federal Women, Infants and Children (WIC) Program and Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps);
- Temporary Assistance for Needy Families (TANF) and efforts to promote family self-sufficiency;

- programs to promote self-sufficiency, including work force, transportation and housing supports for people aging in place and people with disabilities, including brain injuries and developmental disabilities;
- options for ensuring adequate funding for emergency medical services and trauma services throughout the state;
- reporting pursuant to town halls and research coordinated by the DOH pursuant to the Healthy New Mexico Task Force bill passed in 2008, including recommendations for promoting healthy behaviors and managing chronic disease and case management; and
- reporting by the interim study panel on memorials concerning pediatric cancer clinical trials; joint health care purchasing; prescription drug reimportation; a study on the supply of social workers; substance abuse; and a health insurance exchange, among others.

#### Endorsements

The matrix that follows describes the endorsements that the LHHS made in two separate meetings on November 6 and on December 18.

Legislative Health and Human Services Committee: Proposed 2010 Legislation

#	Proposer	Bill or Memorial	Short Title	Description
<b>Bills and Memorials — Endorsed</b>				
1	HSD	Bill 179439.1SA	Exclusion of gender as a premium rating factor	Amends sections of the New Mexico Insurance Code to prohibit using gender as a factor in setting premium rates.
2	HSD	Bill 180153.1SA	Redefining small employer	Amends the Small Group Rate and Renewability Act to permit a small group to be one person.
3	HSD	Bill 179442.1SA	Direct services expenditures at 85%	Mandates that health insurers utilize at least 85% of premiums collected for direct services for those covered.
4	HSD	Bill 179441.1SA	Guaranteed issue for individuals	Mandates that insurance companies offer coverage to any individual requesting it, without exclusion of preexisting medical conditions.
5	HSD	Bill 179440.1SA	Small group rating reduction	Amends the Small Group Rate and Renewability Act to require premium rate limits for all health benefit plans subject to the act to have a graduated reduction over a five-year period from 20% to 10%.
6	HSD	Bill 179482.1SA	Counseling and therapy licensure requirements	Amends the Counseling and Therapy Practice Act to extend the period of time for a certified alcohol and drug abuse counselor to become a licensed alcohol and drug abuse counselor.
7	DOH	Bill 179405.3SA	HIV partner notification	Amends the Human Immunodeficiency Virus (HIV) Test Act to permit the Department of Health to notify partners of the potential risk of contracting HIV from an infected partner.

#	Proposer	Bill or Memorial	Short Title	Description
8	GR	Bill 179403.2GR	Rural health care practitioner tax credit expansion	Amends the Income Tax Act to extend the rural health care practitioner tax credit to occupational therapists, physical therapists, social workers and speech-language pathologists; "clinical psychologist" is defined.
9	Sen. Feldman	Bill 180148.1	Tax alcohol	Increases the liquor excise tax, with the increase in revenues dedicated to Medicaid programs.
10	Sen. Griego	Bill 179377.1	Disabilities concerns task force	Creates a Disabilities Concerns Task Force and Advisory Committee composed of 17 members of various disability communities to develop an accommodation plan for New Mexico.
11	Rep. Picraux	Bill 180107.1	Rights of individuals with disabilities	Amends the Human Rights Act to align with recent changes to federal law to protect the human rights of individuals with disabilities.
12	Rep. Picraux	Bill 180097.1	Osteopaths as medical home providers	Amends the medical home statute to allow osteopaths and osteopathic physician assistants to serve as primary care providers.
13	Sen. Feldman	Bill 180151.1	Raising taxes on tobacco products	Raises cigarette tax to \$1.91 and other tobacco products to \$.40, with the increase in revenue dedicated to Medicaid programs.
14	Sen. Feldman	Bill 180152.1	Soft drinks tax	Removes food tax exemption from soft drinks.
15	Rep. Picraux	Memorial 180098.1	Medical homes	Supports the funding of medical homes through Medicaid contract provisions and asks for an expansion of medical homes to include other models.
16	Rep. Picraux	Memorial 180099.1	Credentialing task force	Requests the Public Regulation Commission (PRC) to work with various partners to centralize credentialing and align processes.

#	Proposer	Bill or Memorial	Short Title	Description
17	Rep. Picraux	Memorial 180100.1	Track nursing faculty funding	Requests the Higher Education Department to develop tracking and reporting mechanisms regarding nursing school funding and to participate in developing a statewide nursing education plan.
18	Rep. Picraux	Memorial 180102.1	Expand efforts re: hospital-acquired infections	Requests the Hospital-Acquired Infection Advisory Committee to expand its scope of work to include pre-admission screening, quality improvement and cost-saving projections and to expand the task force to include nurses.
19	Sen. Feldman	Memorial 180090.3	Health care reform working group	Requests the Insurance Division of the PRC to convene a health care reform working group to make policy recommendations to align New Mexico with federal reform legislation.
20	Rep. Picraux	Memorial 180105.1	Private managed care medical homes	Requests private managed care plans to adopt medical home models of care.
21	Rep. Campos	Bill 179448.1	EMS Funding	Funds emergency medical services through a premium surtax on homeowners insurance and vehicle insurance.
22	Sen. Rue	Bill 180325.1	Breastfeeding Rights	Extends to schools the requirement to provide private locations for breastfeeding mothers.
23	Rep. Picraux	Memorial 180448.1	Clinic-based, health commons, health care delivery system	Requests collaboration between a federally qualified health center in southwestern New Mexico and others to design and identify funding for a clinic-based model of health care delivery and reimbursement.
24	Sen. Harden	Memorial 180456.1	Autism Study	Requests the PED to study how schools provide for the needs of students with autism spectrum disorder.

## **WORK PLAN AND MEETING SCHEDULE**

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**2009 APPROVED  
WORK PLAN AND MEETING SCHEDULE  
for the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**Members**

Rep. Danice Picraux, Chair  
Sen. Dede Feldman, Vice Chair  
Sen. Rod Adair  
Rep. Nora Espinoza

Rep. Joni Marie Gutierrez  
Sen. Linda M. Lopez  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Advisory Members**

Sen. Sue Wilson Beffort  
Rep. Ray Begaye  
Rep. Jose A. Campos  
Rep. Eleanor Chavez  
Rep. Nathan P. Cote  
Rep. Miguel P. Garcia  
Rep. Keith J. Gardner  
Sen. Clinton D. Harden, Jr.  
Rep. John A. Heaton  
Sen. Gay G. Kernan  
Rep. Dennis J. Kintigh

Rep. James Roger Madalena  
Rep. Rodolpho "Rudy" S. Martinez  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen  
Sen. Nancy Rodriguez  
Sen. Sander Rue  
Rep. Jeff Steinborn  
Rep. Mimi Stewart  
Sen. David Ulibarri  
Rep. Gloria C. Vaughn

**Work Plan and Focus for 2009**

The Legislative Health and Human Services Committee (LHHS) this interim will continue to provide oversight of the Human Services Department (HSD); the Department of Health (DOH); the Aging and Long-Term Services Department (ALTSD); the Children, Youth and Families Department (CYFD); and the Workforce Solutions Department. The committee will review and analyze the state's role in complementing federal "stimulus" legislation, the American Recovery and Reinvestment Act of 2009 (ARRA), and federal health care reform efforts put forward by Congress and the Obama administration upon New Mexico's health and human services climate. Namely, the committee will look at whether this legislation and state action will afford a sustainable expansion of health care coverage and opportunities to achieve legislative goals for health care integration, quality, transparency and disease prevention. The committee will consider what state efforts will be needed to supplement federal action on human services in order to ensure that human services are adequate for meeting the increased need for assistance in employment, housing, nutrition, utility assistance and services directed to New Mexicans who are disabled, elderly or veterans.

Public health coverage programs such as Medicaid, the Children's Health Insurance Program (formerly the State Children's Health Insurance Program) and the State Coverage Insurance will be examined in light of ARRA funds, new legislation such as the Children's

Health Insurance Reauthorization Act (CHIPRA) and the new waiver that may be required to cover childless adults.

The committee will move forward in its discussion of health information technology, including a health information exchange, electronic medical records, telehealth and the issues of interconnectivity, broadband technology and privacy protection, in light of state-based efforts and ARRA's extensive funding and direction on these matters.

Integration of physical, dental and behavioral care models will also be an important focus for the committee. Models such as the medical home and health commons will be further explored, as will integrated approaches such as school-based health and telehealth centers. Oversight of agencies such as the ALTSD, CYFD, HSD and DOH will examine the extent to which services emphasize an integration of care that addresses physical care and social support needs.

#### Memorials

The committee has been requested, pursuant to House Appropriations and Finance Committee Substitute for House Memorial 94, to investigate the performance of the Human Services Department regarding Medicaid, state coverage insurance and children's health insurance programs, including:

- maximizing ARRA funds;
- eligibility and coverage policies;
- administrative practices; and
- reporting data on enrollment and retention.

Upon completing its investigations, the committee will make legislative recommendations for increasing enrollment, maximizing resources and determining enrollment and coverage policies and administrative practices supporting enrollment and retention.

The committee was requested in House Memorial 102 to examine existing law pertaining to cancer clinical trials and make recommendations for legislation to address the needs of New Mexico children with cancer.

#### Other Areas of Study

The committee proposes to examine:

- early childhood services;
- innovative juvenile justice, domestic violence and interventions for prevention in these matters;
- integrated nutrition programs that connect low-income individuals, children and seniors with locally produced, nutritious food, nutrition education and healthy lifestyle opportunities;
- self-sufficiency, including work force, transportation and housing supports;
- health care work force needs and opportunities;

- long-term care, including home- and community-based waivers and supports for individuals aging in their homes and communities with minimal disruption;
- behavioral health and substance abuse, including a review of the new statewide entity's operations;
- public and private health care delivery systems;
- health behaviors and disease prevention;
- issues relating to prescription drugs, including recycling, re-importation, prior authorization rules and coverage policy;
- public health, including hospital-acquired infections, emergency preparedness and immunizations; and
- site visits to health and human service facilities throughout the state, including the Pueblos of Laguna and Pojoaque and the Mescalero Apache reservation.

Subcommittees:

The committee has received approval for the creation of an ad hoc subcommittee dedicated to exploring comprehensive health care reform in a joint meeting with the Legislative Finance Committee on August 13 in Angel Fire, New Mexico. This subcommittee would be composed of four voting members and four advisory members appointed by the Legislative Council.

A disabilities subcommittee of the committee has been charged with reviewing legislation and health and human services policy in light of the concerns of the disabilities community. The members of the disabilities subcommittee will be appointed by the Legislative Council. Two two-day meetings have been approved for this subcommittee, and the meeting dates will be mutually agreed upon by the appointed members of the subcommittee.

## **2009 APPROVED MEETING SCHEDULE**

<u>Date</u>	<u>Location</u>
June 18	Santa Fe
July 6-8	Pueblo of Laguna, Gallup
August 5-7	Ruidoso
September 16-18	Rio Rancho, Albuquerque
October 12-14	Santa Fe, Pueblo of Pojoaque
November 4-6	Santa Fe

## **AGENDAS**

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Revised: June 16, 2009

**TENTATIVE AGENDA**  
for the  
**LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**  
**Organizational Meeting**  
**June 18, 2009**  
**Room 307, State Capitol**  
**Santa Fe**

**Thursday, June 18**

- 10:00 a.m.    **Call to Order**
- 10:05 a.m.    **Welcome and Introductions**
- 10:10 a.m.    **Interim Legislative Meeting Protocols**  
—Paula Tackett, Director, Legislative Council Service (LCS)
- 10:30 a.m.    **Legislative Health and Human Services Committee Process and Ground Rules**  
—Representative Danice Picraux, Chair
- 10:45 a.m.    **2009 Legislation Summary**  
—Michael Hely, Staff Attorney, LCS
- 11:15 a.m.    **American Recovery and Reinvestment Act (ARRA) Overview**  
—Michael Hely, Staff Attorney, LCS  
—Karen S. Wells, Researcher, LCS
- 11:45 a.m.    **Federal Health Reform Overview**  
—Karen S. Wells, Researcher, LCS
- 12:15 p.m.    **Review and Discussion of Work Plan, Meeting Dates and Locations for 2009 Interim**  
—Michael Hely, Staff Attorney, LCS
- 1:00 p.m.    **Public Comment**
- 1:30 p.m.    **Adjournment**

Revised: July 2, 2009

**TENTATIVE AGENDA  
for the  
SECOND MEETING  
of the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**July 6, 2009  
Administrative Center  
Pueblo of Laguna**

**July 7, 2009  
New Mexico Cancer Center  
2240 College Drive  
Gallup, NM**

**July 8, 2009  
Gallup-McKinley County Schools Administration Building  
640 South Boardman  
Gallup, NM**

**Monday, July 6, Pueblo of Laguna**

- 9:00 a.m.           **Call to Order; Welcome and Introductions**
- 9:05 a.m.           **Welcome by Pueblo of Laguna Governor John E. Antonio**
- 9:15 a.m.           **Federal Health Care Reform Update**  
—Senator Dede Feldman, Vice Chair
- 9:30 a.m.           **Federal American Recovery and Reinvestment Act of 2009 (ARRA):  
Medicaid**  
—Karen S. Wells, Researcher, LCS
- 9:45 a.m.           **Medicaid and State Coverage Insurance Budget; CoLTS Enrollment  
and Reimbursement Update; Transparency and Reporting**  
—Pamela S. Hyde, Secretary, Human Services Department (HSD)  
—Carolyn Ingram, Division Director, Medical Assistance Division  
(MAD), HSD

**Monday, July 6 (continued)**

- 11:00 a.m.           **Children's Health Insurance Program Reauthorization Act (CHIPRA) and Impact on State Coverage Insurance Program**  
—Charles Milligan, Executive Director, The Hilltop Institute, University of Maryland, Baltimore County (UMBC)  
—Carolyn Ingram, Director, MAD, HSD
- 12:00 noon           **Maximizing Health Care Opportunities Under CHIPRA**  
—Bill Jordan, Policy Director, New Mexico Voices for Children  
—Sireesha Manne, Staff Attorney New Mexico Office on Law and Poverty
- 12:30 p.m.           **Lunch**
- 2:00 p.m.           **Barriers to Obtaining Health Insurance Among Native Americans in New Mexico (2006): Progress and Potential ARRA Impact**  
—Colinda Garcia, Native American Liaison, Medical Assistance Division, HSD
- 3:00 p.m.           **Acoma-Laguna Joint Health Care Work Group**  
—Richard Luarkie, former member, Laguna Pueblo Tribal Council
- 4:00 p.m.           **Pueblo of Laguna Health and Wellness Priorities**  
—Paul Pino, Mental Health Counselor, Department of Community Wellness, Pueblo of Laguna
- 4:30 p.m.           **Public Comment and Discussion of Written Appropriation Requests**
- 5:00 p.m.           **Recess**

**Tuesday, July 7, New Mexico Cancer Center, Gallup**

- 9:00 a.m.           **Call to Order, Welcome and Introductions**
- 9:05 a.m.           **ARRA Update: Early Childhood, Hunger, Workforce**  
—Jennie Lusk, Staff Attorney, LCS
- 9:20 a.m.           **Nurse Home Visitation Program; Bernalillo County Proposal**  
—Leigh Mason, Coordinator, Bernalillo County Health Commission

**Tuesday, July 7 (continued)**

- 10:20 a.m.           **Early Childhood and Child Protective Services — Initiatives and Trends**  
—Dorian Dodson, Secretary, Children, Youth and Families Department (CYFD)  
—Bill Dunbar, Deputy Secretary, CYFD  
—Jared Rounsville, Acting Protective Services Director, CYFD
- 12:00 noon           **Lunch**
- 1:30 p.m.           **Hunger and Food Insecurity: Intergenerational Summer Food Program**  
—Nancy Pope, Director, New Mexico Collaboration to End Hunger
- 2:15 p.m.           **Women, Infants and Children (WIC) Program and Supplemental Nutrition Assistance Program (SNAP, fka "Food Stamps") Updates**  
—Katie Falls, Deputy Director, HSD  
—Deanna Torres, Family Food and Nutrition Section Chief, Department of Health, (DOH)  
—Jane Peacock, Deputy Director, Public Health Division, DOH
- 3:00 p.m.           **Pediatric Cancer Clinical Trials Interim Study Panel: HM 102 (2009)**  
—Stuart Winter, M.D., Pediatric Hematology and Oncology, University of New Mexico Cancer Center  
—Barbara L. McAneny, M.D., Managing Partner and CEO, New Mexico Cancer Center, Albuquerque, New Mexico  
—Terri Stewart, M.H.A., Executive Director, New Mexico Cancer Care Alliance
- 4:30 p.m.           **Public Comment and Discussion of Written Appropriation Requests**
- 5:00 p.m.           **Recess**

**Wednesday, July 8, Gallup-McKinley County Schools Administration Building**

*Joint meeting with Legislative Finance Committee*

- 8:30 a.m.           **Update on Workforce Development Training and Temporary Assistance for Needy Families (TANF):**
- Status of Key Recommendations from the 2006 LFC Review of the *New Mexico Works Program and Workforce Development System Integration***
- Brent Earnest, Senior Fiscal Analyst, LFC  
—Renada Peery-Galon, Senior Fiscal Analyst, LFC

**Wednesday, July 8 (continued)**

**Workforce Investment Act (WIA) Funding for Adults and Dislocated Workers — Status of ARRA WIA Funding**

**Status of ARRA WIA Funding**

—Betty Sparrow Doris, Secretary, Workforce Solutions  
Department

**How Local Boards Are Spending ARRA Funds and Tracking Performance**

—Lou Baker, Chair, Northern Area Local Workforce  
Development Board

**TANF — Providing Cash Assistance and Building Self-Sufficiency:**

**Caseload Growth and Maximizing ARRA**

—Patricia Anders, Staff Attorney, New Mexico Center on Law  
and Poverty  
—Kate Jesberg, Human Services Policy Analyst

**Are We Building Self-Sufficiency — New Mexico Works  
Workforce Program and Other Support Services**

—Katie Falls, Deputy Secretary, HSD

11:30 a.m.

**Update on Behavioral Health Collaborative**

—Linda Roebuck, CEO, Behavioral Health Collaborative  
—Sandra Forquer, CEO, OptumHealth NM

12:30 p.m.

**Working Lunch and Roundtable Discussion — New Mexico  
Behavioral Health Caucus: Clients Served and Denied  
Provider Reimbursement Rates and Time Lines  
Effectiveness of Managed Care Network  
Transition to OptumHealth**

—Representative Edward C. Sandoval, Co-Chair  
—Senator Sue Wilson Beffort, Co-Chair  
—Karen Wells, LCS

2:00 p.m.

**Adjourn**

Revised: August 3, 2009

**TENTATIVE AGENDA  
for the  
THIRD MEETING  
of the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**August 5-7, 2009  
Eastern New Mexico State University  
Ruidoso, New Mexico**

**Wednesday, August 5**

- 9:00 a.m.      **Call to Order; Welcome and Introductions**
- 9:05 a.m.      **Welcome by Dr. Michael Elrod, President, Eastern New Mexico University (ENMU), Ruidoso Campus**
- 9:15 a.m.      **Aging in Place: A National Agenda; Projecting Work Force Needs**  
—Deborah Armstrong, Delta Consulting Group  
—Michelle Lujan Grisham, Delta Consulting Group
- 10:30 a.m.     **New Mexico's Efforts to Support Aging in Place; Work Force Development Needs**  
—Cindy Padilla, Secretary, Aging and Long-Term Services Department (ALTSD)  
—Emily Kaltenbach, Director of Policy and Planning, ALTSD
- 11:45 a.m.     **Maintaining Elder Independence**  
—Wendy Basgall, Staff Attorney, Senior Citizens' Law Office
- 12:15 p.m.     **Working Lunch and Public Comment**
- 12:45 p.m.     **Medicare and Long-Term Care Medicaid: A Primer**  
—Karen Wells, Researcher, Legislative Council Service
- 1:00 p.m.      **Rebalancing for Home and Community-Based Services: Cost, Quality and Collaboration; What This Means for Work Force**  
—Cindy Padilla, Secretary, ALTSD  
—Pam Hyde, Secretary, Human Services Department (HSD)
- 2:30 p.m.      **CoLTS: Program Potential and Barriers; Adequacy of Provider Network**  
—Laura Esslinger, Executive Director, Evercare of New Mexico  
—Mark Padilla, Vice President, Government Relations, Amerigroup New Mexico

**Wednesday, August 5** (continued)

3:30 p.m.     **Stakeholders Perspective on Meeting CoLTS Program and Work Force Goals**  
—Linda Sechovec, Executive Director, New Mexico Health Care Association  
—Gil Yildiz, Independent Living Resource Centers  
—Doris Husted, Public Policy Director, ARC of New Mexico

4:30 p.m.     **Discussion: Policy Direction for Long-Term Services and Work Force**

5:00 p.m.     **Recess**

**Thursday, August 6**

9:00 a.m.     **Call to Order**

9:05 a.m.     **Clinical Work Force and Emergency Medical Services (EMS) Training Programs at ENMU**  
—Dr. Michael Elrod, President, ENMU-Ruidoso  
—Bonnie Rossiter, Coordinator, Certified Nursing Assistant Program, ENMU-Ruidoso  
—Jane Batson, Chair, Division of Health, ENMU-Roswell  
—Dr. Leslie Paternoster, BSN Completion Program, ENMU-Portales  
—Dr. Debra Teachman, Chief Academic Officer, ENMU-Alamogordo

10:05 a.m.    **Viability of Trauma and EMS Work Force and Infrastructure**  
—Don McNutt, Statewide EMS Advisory Committee  
—Kyle Thornton, Emergency Medical Services Bureau Chief, Department of Health (DOH)

11:30 a.m.    **Biologic Disaster Preparedness and Work Force Needs**  
—Mack Sewell, MD, Director, Epidemiology and Response Division, DOH

12:00 noon    **Working Lunch**

1:00 p.m.     **Public Comment**

1:30 p.m.     **Public and Community Health in New Mexico: Work Force Needs; Hospital-Acquired Infection Act (SB 408): Progress Report**  
—Dr. Alfredo Vigil, Secretary, DOH

**Thursday, August 6** (continued)

- 3:00 p.m.     **Implementation of Statewide Comprehensive Health Plan; Community and Provider Involvement**  
—Sam Howarth, Director, Division of Policy and Performance, DOH;  
                  Director, New Mexico Health Policy Commission  
—Penny Jimerson, Deputy Director, Division of Policy and Performance, DOH
- 4:00 p.m.     **Discussion: Policy Direction for Disaster Preparedness, Emergency Medical Services and Viability of Work Force**
- 5:00 p.m.     **Recess**

**Friday, August 7**

- 9:00 a.m.     **Call to Order**
- 9:05 a.m.     **Health Information Technology: HIPAA, ARRA/HITECH Updates**  
—Michael Hely, Staff Attorney, Legislative Council Service
- 9:30 a.m.     **Electronic Health Records: A Provider Perspective**  
—Arlene Brown, MD, Practicing Physician
- 10:30 a.m.    **Electronic Health Records and Broadband Access: Next Steps**  
—Bob Mayer, Chair, New Mexico Telehealth Commission
- 11:30 a.m.    **ISD2 Update, YES New Mexico Progress Report and Reporting and Accountability Objectives**  
—Katie Falls, Deputy Secretary, HSD
- 12:30 p.m.    **Public Comment**
- 1:00 p.m.     **Discussion: Policy Direction for Health Information Technology**
- 1:30 p.m.     **Adjourn**

**AGENDA**  
**Legislative Finance Committee**  
**Angel Fire Resort**  
**10 Miller Lane**  
**Angel Fire, NM**  
**August 12, 13, 14, 2009**

**Wednesday, August 12**

- 8:00 -- Welcoming Remarks -- Larry Leahy, Mayor, Village of Angel Fire ; Linda Calhoun, Mayor, Town of Red River (invited); Don Day, County Manager, Colfax County
- 8:30 -- Health Care Reform: Controlling Costs and Improving Quality of Care  
-- Update on Federal Health Care Reform: Implications for States -- Carolyn Ingram, Director, Medical Assistance Division, Human Services Department  
-- Cost Containment Strategies: Medicaid -- Pamela Hyde, Cabinet Secretary, Human Services Department  
-- Review of the Dartmouth Atlas of Health Care Project on Variations in Health Care Spending: Utilization and the NM Experience -- Dr. Bill Weiss, Director, Institute for Public Health, UNM HSC  
-- Improving Quality of Care -- Pat Montoya, NM Medical Review Association  
-- Payment Reform: Patient Centered Medical Homes -- Dr. Michael Kaufman, NM Medical Society
- 12:30 -- Lunch
- 1:30 -- University of New Mexico Health Sciences Center Strategic Initiatives -- Dr. Paul Roth, MD, FACEP, Executive Vice President, UNM Health Sciences Center and Dean, School of Medicine; Steve McKernan, CEO, UNM Hospitals; Ava Lovell, CPA, Vice President, Health Sciences Center/University of New Mexico Finance/University Controller, Associate Vice President for Finance  
-- Hospital Finances  
-- Academic Programs Admission and Pipelines, including BA/MD  
-- Nurse Training  
-- Strategic Planning Update
- 3:30 -- Overview of Federal Office of Management and Budget Program Assessment Rating Tool (PART) -- Arley Williams, Principal Analyst, LFC
- 4:00 -- Tour of Vietnam Veteran's State Park and Eagle Nest State Park -- David Simon, Parks Director
- 5:30 -- Adjourn

**Thursday, August 13**

- 8:00 -- Public School Funding, Accountability and Enforcement  
-- Affordable and Targeted Investments to Improving Student Outcomes -- Winston Brooks, Superintendent, Albuquerque Public Schools; Dr. Jim Abreu, Superintendent, West Las Vegas Public Schools

**Thursday, August 13 (continued)**

- Sanctions and Incentives to Improve Accountability -- Stan Rounds, Superintendent, Las Cruces Public Schools; Dr. Sheila Hyde, Assistant Secretary, Quality Assurance and Systems Integration Division, Public Education Department LFC AGENDA August 12, 13, 14 2009 Page 2 8/7/09
- Update on Statewide Schools of Education Activities to Coordinate Leadership and Teacher Preparation Programs -- Dr. Richard Howell, Dean, College of Education, University of New Mexico
- 11:00 -- Review of Findings of 2003 Blue Ribbon Tax Commission; Review of Tax Credits and Exemptions 2003 to Present and Relation to Tax Policy Principals -- Dr. Tom Clifford and LFC Economists
- 12:30 -- Lunch
- 1:30 -- Status of State Building Initiatives and Other Capital Outlay Acquisitions – David Millican, Finance Director, City of Santa Fe; Kathy McCormick, Economic Development Director, City of Santa Fe; Arturo Jaramillo, Secretary, General Services Department; Gary Giron, Secretary, Department of Transportation; Bill Cisneros, CEO, NM Finance Authority
  - College of Santa Fe
  - Health and Human Services Complex
  - Department of Transportation (Main Complex)
  - Department of Transportation (District V)
- 3:30 -- General Services Department / Information Technology Rates -- David Archuleta, Senior Fiscal Analyst, LFC; Arturo Jaramillo, Secretary, General Services Department; Marlin Mackey, Secretary, Department of Information Technology
- 5:30 -- Adjourn

**Friday, August 14**

- 8:00 -- Preliminary FY09 General Fund Report and Update for FY10-FY12 -- Katherine Miller, Secretary, Department of Finance and Administration; Marilyn Hill, Deputy Secretary, Taxation and Revenue Department; Dr. Tom Clifford, LFC
- 10:00 -- Adoption of LFC Budget Guidelines -- LFC Staff
- 10:30 -- New Mexico Highlands University Forest and Watershed Restoration Institute -- Dr. Kent Reid, Interim Director
- 11:00 -- Miscellaneous Committee Business

**Action Items**

1. LFC FY11 Budget Request
2. Approval of LFC Minutes -- July 2009

**Information Items**

3. July BAR Report
4. July LFC Budget Status Report
5. July Cash Balance Report
6. Monthly Report on Federal Stimulus Funding -- LFC Staff
7. LFC Program Evaluation Status Report

12:00 -- Adjourn

To attend and participate in any scheduled Legislative Finance Committee meeting, please contact Samantha A. Montoya, (505) 986-4549 [TDD (505) 986-4657], at least five (5) working days prior to a scheduled meeting. Agendas and minutes of scheduled meetings can be made available in alternative formats upon request.

Revised: September 15, 2009

**TENTATIVE AGENDA  
for the  
FOURTH MEETING  
of the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**September 16, 2009  
Santa Ana Star Center  
3001 Civic Center  
Rio Rancho**

**September 17-18, 2009  
University of New Mexico Health Sciences Center  
Family Practice Center, Room 340  
2400 Tucker NE  
Albuquerque**

**Wednesday, September 16**

- 8:30 a.m.     **Call to Order; Welcome and Introductions**
- 8:35 a.m.     **Welcome and Remarks**  
—Thomas E. Swisstack, Mayor, City of Rio Rancho
- 8:40 a.m.     **Medicaid Cost-Containment: What Other States Are Doing**  
—Laura Tobler, Program Director, Health Programs, National Conference of  
State Legislatures
- 9:40 a.m.     **New Mexico Medicaid Cost-Containment Issues**  
—Pamela S. Hyde, Secretary, Human Services Department
- 11:40 a.m.    **Report from Health Reform Subcommittee**  
—Representative Danice Picraux, Chair  
—Senator Dede Feldman, Vice Chair
- 12:00 noon    **Lunch**
- 1:30 p.m.     **The Economic Impact of Medicaid Cost-Containment**  
—Lee Reynis, Ph.D., Director, Bureau of Business and Economic Research,  
University of New Mexico (UNM)

**Wednesday, September 16 (continued)**

- 2:30 p.m.     **Medicaid Coalition Perspective**

- Ruth Hoffman, Lutheran Advocacy Ministry-New Mexico
- Sireesha Manne, Staff Attorney, New Mexico Center on Law and Poverty
- Kim Posich, Esq., Executive Director, New Mexico Center on Law and Poverty

3:30 p.m. **Public Comment**

5:00 p.m. **Recess**

**Thursday, September 17**

8:30 a.m. **Call to Order**

8:35 a.m. **Welcome and Remarks**

- Paul Roth, M.D., Executive Vice President, UNM Health Sciences Center (HSC); Dean, UNM School of Medicine

8:45 a.m. **Overview of Medical Homes, Accountable Care Organizations and Payment Reform Issues**

- Justina Trott, M.D., Fellow, Robert Wood Johnson Foundation

9:45 a.m. **Alternative Models of Medical Home**

- Jeff Thomas, MSW, Executive Director, Southwest Care Center
- Anita Ralston, C.N.P, American Academy of Nurse Practitioners
- Kristen Ostrem, C.N.M., New Mexico Primary Care and Midwifery

11:00 a.m. **UNM Medical Home Model**

- Carolyn Voss, M.D., Executive Director, Ambulatory Services, UNM Hospital, UNM HSC
- Jamie Silva-Steele, R.N., M.B.A., Administrator, Ambulatory Services, UNM Hospital, UNM HSC

12:00 noon **Working Lunch**

1:00 p.m. **Molina Healthcare: Coordination of Care: Quality Improvement and Cost Savings Through Integration and Disease Management**

- Eugene Sun, M.D., Medical Director, Molina Healthcare

2:30 p.m. **Medical Home Implementation (HB 710)**

- Michael Kaufman, M.D., Taos Medical Group
- Lowell Gordon, M.D., Medical Director, Medical Assistance Division, HSD

3:30 p.m. **Further Options for Implementation of the Medical Home**

- Nikki Katalanos, Ph.D., P.A.-C., Director, Physician Assistant Program, School of Medicine, UNM HSC

**Thursday, September 17 (continued)**

- Tom White, J.D., P.A.-C., Academic Coordinator, Physician Assistant

Program, School of Medicine, UNM HSC  
—William Barkman, D.O., San Juan Independent Practice Association  
—Ralph McClish, Executive Director, New Mexico Osteopathic Medical Association

4:30 p.m.     **Public Comment**

5:00 p.m.     **Recess**

**Friday, September 18**

8:30 a.m.     **Call to Order**

8:35 a.m.     **Advance Practice Oral Health Provider: A Kellogg Foundation Initiative**  
—Albert Yee, M.D., Program Director, W.K. Kellogg Foundation  
—Dolores Roybal, Executive Director, Con Alma HEALTH Foundation

10:00 a.m.    **UNM: Primary Care Work Force; Update and Future Projections on BA/MD Program; Nursing Program Update**  
—Paul Roth, M.D., Executive Vice President, UNM HSC; Dean, UNM School of Medicine  
—Nancy Ridenour, Ph.D., R.N., Professor and Dean, College of Nursing, UNM HSC

11:30 a.m.    **Use of Telehealth to Extend the Primary Care Work Force in New Mexico; Update on Community Health**  
—Arthur Kaufman, M.D., Vice President for Community Health, UNM HSC  
—Sanjeev Arora, M.D., Director, Project Echo; Professor of Internal Medicine, UNM HSC

12:30 p.m.    **Working Lunch: Guardianship Update; Oversight of Developmental Disabilities Planning Council**  
—Janice Ladnier, Master Guardian, Guardian Angels, LLC  
—Rose Marie Sanchez, Parent Advocate  
—Anna Otero Hatanaka, Executive Director, Association of Developmental Disabilities Community Providers  
—Patrick Putnam, Executive Director, Developmental Disabilities Planning Council

**Friday, September 18 (continued)**

- 1:30 p.m.     **High School Pipeline Programs to Health Careers; Dream Makers Program and Health Careers Academy**  
—Valerie Romero-Leggott, M.D., Director, Office of Diversity, UNM HSC  
—Bob Sorenson, Director, Santa Fe Capital High School Health Care Careers Pathway  
—Matt Probst, P.A.-C., Chief Programs Officer, El Centro Family Health, Semillas de Salud
- 3:00 p.m.     **Department of Workforce Solutions and Workforce Development Boards: Focus on Health Care Professions**  
—Ken F. Ortíz, Secretary, Workforce Solutions Department  
—Jerry Gaussoin, Executive Director, Northern Area Local Workforce Development Board  
—Beth Elias, Director, Monitoring and Integration, Eastern Area Workforce Development Board  
—Pat Newman, Executive Director, Central Area Workforce Development Board  
—Steve Durán, Executive Director, Southwestern Area Workforce Development Board
- 4:30 p.m.     **Public Comment**
- 5:00 p.m.     **Adjourn**

Revised: October 8, 2009

**TENTATIVE AGENDA  
for the  
FIFTH MEETING  
of the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**October 12, 2009  
Tribal Council Chambers  
Tribal Administration Building  
39 Camino del Rincon  
Pueblo of Pojoaque**

**October 13-14, 2009  
Room 322, State Capitol  
Santa Fe**

**Monday, October 12 — Health Care Services Integration**

- 8:30 a.m.      **Call to Order; Welcome and Introductions**
- 8:35 a.m.      **Welcome from Pueblo of Pojoaque**  
—The Honorable George Rivera, Governor, Pueblo of Pojoaque  
—The Honorable Linda Diaz, Lieutenant Governor, Pueblo of Pojoaque
- 9:30 a.m.      **Impact of Nursing Faculty Shortages (HJM 40)**  
—Pat Boyle, Executive Director, Center for Nursing Excellence  
—Teresa Keller, Ph.D., R.N., Associate Director for Undergraduate Studies, New Mexico State University School of Nursing
- 11:30 a.m.     **Women's Health Council Report**  
—Giovanna Rossi Pressley, Executive Director, Women's Health Office
- 12:00 noon    **Lunch**
- 1:00 p.m.      **Integrated Behavioral Health Services Delivery: Pathway of Innovation Model**  
—Lauren Reichelt, Health and Human Services Director, Rio Arriba County

**Monday, October 12 (cont.)**

- 2:00 p.m.     **Health Insurance Legislation; Proposed Executive Bills**  
—Steven Randazzo, Legislative Liaison, Human Services Department (HSD)  
—Ruby Ann Esquibel, Director of Policy, HSD  
—Harvey Licht, Director, Rural Health Practitioner Tax Credit Program,  
Department of Health (DOH)  
—Jennifer Thorne Lehman, Deputy Director, Developmental Disabilities Support  
Division, DOH  
—Steve Jenison, M.D., Medical Director, Infectious Disease Bureau, DOH  
—Sam Howarth, Ph.D., Director, Division of Policy and Performance, DOH;  
Executive Director, New Mexico Health Policy Commission (NMHPC)
- 4:30 p.m.     **Public Comment**
- 5:00 p.m.     **Recess**

**Tuesday, October 13 — Beginning- and End-of-Life Matters**

- 8:30 a.m.     **Call to Order**
- 8:35 a.m.     **Provider Credentialing — Opportunities to Improve the Process**  
—Debbie Gorenz, President, Hospital Services Corporation  
—Kathy Ganz, M.D., Clinical Compliance Director, First Choice Community  
Health
- 10:00 a.m.    **Opportunities for Improved Credentialing Coordination Pursuant to Section 27-  
2-12.12 NMSA 1978**  
—Julie Weinberg, J.D., Deputy Director, Medical Assistance Division, HSD
- 10:30 a.m.    **Medicaid Breast and Cervical Cancer Treatment Program**  
—Gena Love, Cancer Prevention and Control Section Head, DOH  
—Julie Weinberg, J.D., Deputy Director, Medical Assistance Division, HSD  
—Kathryn Karnowsky, Management Analyst, Medical Assistance Division, HSD
- 12:00 noon    **Lunch**
- 1:30 p.m.     **Cambiar, New Mexico**  
—Dorian Dodson, Secretary, Children, Youth and Families Department
- 2:30 p.m.     **Behavioral Health Survey Results**  
—Gerald Ortiz y Pino, New Mexico State Senator
- 4:00 p.m.     **Public Comment**
- 5:00 p.m.     **Recess**

**Wednesday, October 14 — Prevention and Healthy Behaviors**

8:30 a.m.      **Call to Order**

8:35 a.m.      **Health New Mexico Task Force: Goals and Progress; Program to Integrate Early Intervention and Case Management in Underserved Communities**  
—Alfredo Vigil, M.D., Secretary, DOH

**Disease Management and Healthy Lifestyle Promotion in Employee Health Plan**  
—Nancy Bearce, Bureau Chief, Employee Benefits Bureau, Risk Management  
Division, General Services Department

**Primary Care Case Management**  
—Larry Heyeck, J.D., Deputy Director, Medical Assistance Division,  
HSD

**Chronic Disease Management Initiatives in Private Insurance**  
—Sam Howarth, Director, NMHPC

11:15 a.m.      **Cost of Chronic Disease and Wellness (HJM 24)**  
—Heather Balas, President, New Mexico First

12:15 p.m.      **Lunch**

1:15 p.m.      **Eating Disorders Programs**  
—Sandra Lynn Whisler, M.D., Professor of Pediatrics, University of New Mexico  
Health Sciences Center

1:45 p.m.      **Research Report: Threats to the Behavioral Health Safety Net Providers  
Since the Implementation of the Behavioral Health Collaborative**  
—Marnie Watson, M.A., Research Associate and Senior Ethnographer,  
Behavioral Health Research Center of the Southwest  
—Miria Kano, M.A., Program Manager and Senior Ethnographer, Behavioral  
Health Research Center of the Southwest

2:30 p.m.      **Public Comment**

3:00 p.m.      **Adjourn**

Revised: October 29, 2009

**TENTATIVE AGENDA  
for the  
FIRST MEETING  
of the  
DISABILITIES SUBCOMMITTEE  
of the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**October 30, 2009  
Room 307, State Capitol  
Santa Fe**

**Friday, October 30**

- 9:00 a.m.     **Call to Order**
- 9:05 a.m.     **Housing**  
—Gil Yildiz, Independent Living Resource Center, Albuquerque
- 10:00 a.m.    **Job Discrimination**  
—Nancy Koenigsberg, Legal Director, Disability Rights New Mexico  
—Timothy L. White, Esq., Valdez & White Law Firm, LLC
- 11:00 a.m.    **Brain Injury Services: Incidence and Prevalence of Traumatic Brain Injury and  
Acquired Brain Injury in New Mexico**  
—Elizabeth Peterson, Director, New Mexico Brain Injury Advisory Council
- 12:00 noon    **Working Lunch: Waiver Waiting Lists**  
—Doris Husted, Policy Director, The Arc of New Mexico (Invited)  
—Jim Jackson, Executive Director, Disability Rights New Mexico  
—Carlos Moya, Director, Aging and Disability Resource Center, Aging and  
Long-Term Services Department  
—Wendy Basgall, Staff Attorney, Senior Citizens' Law Office
- 1:30 p.m.     **Autism Services for Adults**  
—Liz Thompson, President, New Mexico Autism Society  
—Pat Osbourn, Deputy Director, Center for Development and Disability,  
University of New Mexico
- 3:00 p.m.     **Adjourn**

Revised: November 5, 2009

**TENTATIVE AGENDA  
for the  
SIXTH MEETING  
of the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**November 4-6, 2009  
Room 322, State Capitol  
Santa Fe**

**Wednesday, November 4**

- 8:30 a.m.     **Call to Order; Welcome and Introductions**
- 8:35 a.m.     **Health Care Services Common Interest Report (SJM 1)**  
—Ruby Ann Esquibel, Director of Policy, Human Services Department (HSD)
- 9:30 a.m.     **Bulk Purchasing (SJM 5)**  
—Lisa Marie Gomez, Management Analyst, New Mexico Health Policy  
Commission (HPC)  
—Sam Howarth, Director, HPC
- 10:30 a.m.    **Prescription Drug Reimportation (HM 80)**  
—Wayne Propst, Director, Retiree Health Care Authority (RHCA)  
—Mark Tyndall, Deputy Director, RHCA
- 11:15 a.m.    **Social Worker Study (HJM 55)**  
—Romaine Serna, Communications Director, Children, Youth and Families  
Department  
—Mark Dyke, Ph.D., New Mexico Highlands University  
—Lynne Christiansen, L.I.S.W., Department of Health
- 12:00 noon    **Lunch**
- 1:00 p.m.     **Health Insurance Exchange (HJM 57)**  
—Morris "Mo" Chavez, Superintendent, Insurance Division, Public Regulation  
Commission
- 2:00 p.m.     **Substance Abuse: Behavioral Health Collaborative Report on Memorials**  
  
**Substance Abuse Strategic Plan (SM 71)**  
—Michael Coop, President, Coop Consulting, Inc.  
—Christine Wendel, Chair, Behavioral Health Planning Council
- Opioid Addiction Treatment Barriers (HM 9)**  
—Karen Meador, Senior Policy Director, Behavioral Health Collaborative

4:00 p.m. **Breastfeeding Student Mother Needs (HM 58); Pregnant Substance Abuse Services (SM 19)**  
—Giovanna Rossi Pressley, Executive Director, Office of the Governor's Council on Women's Health

4:30 p.m. **Public Comment**

5:00 p.m. **Recess**

**Thursday, November 5**

8:30 a.m. **Call to Order**

8:35 a.m. **Update on Statewide Entity Implementation**

**Behavioral Health Collaborative Overview and State Actions to Address Problems**

—Linda Roebuck Homer, Chief Executive Officer, Behavioral Health Purchasing Collaborative

—Katie Falls, Acting Secretary, HSD

—Dorian Dodson, Secretary of Children, Youth and Families

—Dr. Alfredo D. Vigil, Secretary, Department of Health

**Provider Perspective**

—Shannon Freedle, Chief Executive Officer, Teambuilders, Inc.

—Roque Garcia, Director, Rio Grande Behavioral Health Services

—Dr. David Ley, Director, New Mexico Solutions

—Jim Kerlin, Executive Director, The Counseling Center

12:00 noon **Lunch**

1:30 p.m. **Consumer, Family, Native American and Advocate Panel**

**Consumer Perspective**

—Christine Wendel, Chair, Behavioral Health Planning Council

—Mark Simpson, Project Coordinator, New Mexico Connections to Wellness

**Family Perspective**

—Carol Brusca

**Advocate Perspective**

—Angie Vachio, Early Childhood Advocate

**Local Collaborative Perspective**

—Susie Trujillo

3:30 p.m. **Public Comment**

4:00 p.m. **Recess**

**Friday, November 6**

8:30 a.m. **Call to Order**

8:35 a.m. **Proposed Executive Legislation: Assisted Outpatient Treatment**

—Paul Ritzma, Esq., Deputy Chief of Staff, Office of the Governor

—Brian Stettin, Esq., Treatment Advocacy Center

—Nancy Koenigsberg, Esq., Legal Director, Disability Rights New Mexico

10:30 a.m. **Public Comment**

11:30 a.m. **Lunch**

12:30 p.m. **Disability Subcommittee Report**

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

—Karen Wells, Researcher, LCS

1:00 p.m. **Review and Discuss Proposed Legislation**

—Michael Hely, Staff Attorney, LCS

—Karen Wells, Researcher, LCS

3:00 p.m. **Adopt Final Endorsements**

5:00 p.m. **Adjourn**

Revised: December 16, 2009

**TENTATIVE AGENDA  
for the  
LAST MEETING  
of the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**Friday, December 18, 2009  
Room 307, State Capitol  
Santa Fe**

**Friday, December 18**

- 9:00 a.m.     **Call to Order, Welcome and Introductions**  
—Representative Danice Picraux, Chair, Legislative Health and Human Services  
Committee
- 9:05 a.m.     **Approval of November 2009 Minutes**
- 9:10 a.m.     **Home- and Community-Based Waivers: How Administrative and Financial  
Duties Are Apportioned Among Departments**  
—Larry Heyeck, Deputy Director, Medical Assistance Division, Human Services  
Department  
—Dr. Alfredo Vigil, Secretary, Department of Health  
—Michael Spanier, Acting Secretary, Aging and Long-Term Services Department
- 11:00 a.m.    **Coordinated Long-Term Services (CoLTS) Survey Results**  
—Michael Hely, Staff Attorney, Legislative Council Service (LCS)
- 11:30 a.m.    **Lunch**
- 1:00 p.m.     **CoLTS Providers' Panel**  
—Joie Glenn, Executive Director, New Mexico Association for Home and  
Hospice Care  
—Linda Sechovec, Executive Director, New Mexico Health Care Association  
—Jeff Dye, President and Chief Executive Officer, New Mexico Hospital  
Association
- 2:30 p.m.     **Public Comment**
- 3:00 p.m.     **Endorsement of Legislation**  
—Michael Hely, Staff Attorney, LCS  
—Karen Wells, Researcher, LCS
- 4:30 p.m.     **Adjourn**

# MINUTES

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

**June 18, 2009**  
**Room 307, State Capitol**  
**Santa Fe**

The first meeting of the Legislative Health and Human Services Committee (LHHS) was called to order at 10:10 a.m. by Representative Danice Picraux, chair. The roll was called and a quorum was established for subcommittee purposes.

**Present**

Rep. Danice Picraux, Chair  
Sen. Rod Adair  
Rep. Nora Espinoza  
Rep. Joni Marie Guttierrez  
Sen. Linda M. Lopez  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

Sen. Dede Feldman, Vice Chair

**Advisory Members**

Sen. Sue Wilson Beffort  
Rep. Ray Begaye  
Rep. Jose A. Campos  
Rep. Eleanor Chavez  
Rep. Nathan P. Cote  
Rep. Miguel P. Garcia  
Rep. Keith J. Gardner  
Rep. John A. Heaton  
Sen. Gay G. Kernan  
Rep. James Roger Madalena  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen  
Sen. Nancy Rodriguez  
Sen. Sander Rue  
Rep. Gloria C. Vaughn

Sen. Clinton D. Harden, Jr.  
Rep. Dennis J. Kintigh  
Rep. Rodolpho "Rudy" S. Martinez  
Rep. Jeff Steinborn  
Rep. Mimi Stewart  
Sen. David Ulibarri

**Staff**

Michael Hely  
Karen Wells  
Tim Crawford

**Guests**

The guest list is in the meeting file.

**Handouts**

Handouts are in the meeting file.

**Thursday, June 18****Welcome and Introductions**

The chair invited members of the committee and staff to introduce themselves.

**Interim Legislative Meeting Protocols**

Raúl Burciaga identified the number of members necessary to constitute a quorum for voting purposes and to establish a subcommittee. Five voting members are required to vote on an issue; the vote must be representative of both parties to carry. A majority of the voting members from each house can block a vote from passage. A committee can function as a subcommittee without establishing a voting quorum so long as at least five of the voting or advisory members or ad hoc attendees are present. He discussed the proposed meeting schedule and the attempt to create it to minimize conflicts. Committee members were urged to resist changing meeting dates, if possible.

**Legislative Health and Human Services Committee Ground Rules**

The chair invited discussion of protocols to facilitate efficient meetings, including the suggestion that debate be limited in time and should remain focused on the topic. Requests were made that PowerPoint presentations be summarized and not read verbatim. Representatives from departments should be available at each meeting.

Protocols that were adopted include:

- time for questions and answers should be limited to five minutes per topic;
- members are discouraged from leaving the room during presentations;
- no bills will be approved in concept; only bills presented in draft form will be considered for endorsement;
- legislative requests should be reviewed at each meeting;
- simple appropriation requests will be offered in writing and read into the record;
- a "parking lot" should be created for topics that the committee needs to consider at a later time;
- cell phones and computers should be muted; and
- the chair may rule anyone out of order.

Committee members debated issues around using Twitter, and the chair requested that this be engaged in only with discretion. General agreement was expressed that committee members should avoid any activity that is disruptive of the process.

Concern was expressed at the disproportionate ratio of Republicans to Democrats among the voting members. Michael Hely explained that the proportion was set by statute. Senator

Beffort requested that the statute be reviewed to determine if there is any flexibility around this issue. The possibility of amending the statute to have more voting members was raised.

A quorum of voting members was established.

### **2009 Legislative Summary**

Mr. Hely presented a summary of action taken on the bills and memorials that this committee endorsed, emphasizing those measures that passed. Health care professional scope of practice issues and other health-related issues were identified and briefly described. Joint and simple memorials that are anticipated to come before this committee were described. A request was made for more information regarding HM 74 (2009), which concerns out-of-county indigent funding for the university of New Mexico hospital. Committee members requested a copy of the matrix of memorials. Mr. Hely highlighted two simple memorials that passed, each of which requested that an interim committee be established to address disability issues. The Legislative Council did not create such a committee, so the work plan for this committee includes a request to create a subcommittee to address disability concerns.

Committee members had questions regarding the implementation of HB 130 (2009), which requires transparent reporting of data by the Human Services Department. The Human Services Department will be requested to address this issue when it comes before the committee. Clarification was offered on the statement that the federal Screening, Brief Intervention and Referral to Treatment (SBIRT) Program was funded in HB2; that statement was said to be incorrect. Members expressed a strong desire that the administration find funds to continue this valuable program. A comment was made that the memorial calling for the continuation of the obstetrical task force consider research regarding the potential danger of sonograms on fetuses. A recommendation was made that bills that passed but were vetoed receive continued focus by the committee. A request was made to identify the number of businesses that are protected by the Employee Retirement Income Security Act (ERISA), and therefore are exempt from state insurance mandates, be presented at a future meeting.

### **American Recovery and Reinvestment Act of 2009 (ARRA) Overview**

Mr. Hely and Karen Wells gave a presentation on ARRA, often referred to as the federal stimulus package, identifying the broad parameters of the legislation and specific elements that are likely to affect the work of this committee. The total amount of funding available through ARRA is \$787 billion. Mr. Hely described the four funding mechanisms through which New Mexico can receive funds as formula grants, competitive grants, loans and tax credits. He highlighted the Health Insurance Portability and Accountability Act (HIPAA) changes and privacy provisions and the human services elements of the act, including housing, employment and unemployment assistance, nutrition and temporary assistance for needy families (TANF). Ms. Wells presented the health care provisions, including Medicaid, electronic health records, health information technology, prevention and wellness, research, community health infrastructure and consolidated the Omnibus Budget Reconciliation Act (COBRA). Medicaid is expected to receive in excess of \$700 million through an enhanced federal medical assistance percentage (FMAP). In order to receive the enhanced match, the Human Services Department must meet several requirements, including the requirement that no money attributable to ARRA be placed in a rainy day or reserve fund. Senator Beffort requested a definition of "rainy day"

fund, and Mr. Hely read the pertinent section from the federal act. A request was made to follow up with the Department of Health to see if they will be applying for any federal ARRA funds to address plague, West Nile virus and other infectious diseases seen in New Mexico. Committee members asked for clarification regarding the process for applying for competitive grants. The role and responsibility of the New Mexico Office of Recovery and Reinvestment was covered and resource information was provided. Mr. Hely explained that more in-depth reports on ARRA funding will be provided at each meeting, relative to the topics being covered at that meeting.

### **Federal Health Reform Overview**

Ms. Wells gave a brief overview of the efforts to reform the health care system at the federal level. She began with a historical perspective of reform efforts in the United States since 1912. Ms. Wells covered President Obama's principles of reform and the activity to date in the Congress. General areas of agreement and disagreement were identified. More details will be provided at subsequent meetings, keeping committee members apprised of the progress of legislation. It was noted that Senator Feldman was absent from the meeting because she was invited, along with 22 other legislators from other states, to meet in the White House and contribute ideas for health reform from a state perspective. Senator Feldman will be asked to report to the committee on that meeting at the next meeting of this committee.

### **Review and Discussion of Work Plan, Meeting Dates and Locations for 2009**

Mr. Hely briefly reviewed the proposed work plan, highlighting themes to be addressed by the committee, including oversight of departments, ARRA, federal health reform, medical homes, health commons, integration and transparency. Two memorials were identified that request the committee to address specific topics. One is a request that the performance of the Human Services Department be investigated relative to their activity on ARRA, transparency and reporting requirements. The second memorial requests a study of existing laws pertaining to cancer clinical trials. Two subcommittees are proposed: one that would permit interested members to attend a Legislative Finance Committee (LFC) hearing regarding health reform to be held in Angel Fire in August; and the other would address disability concerns. Other individual items were suggested, and proposed meeting dates and location were identified.

Committee members had questions and made comments regarding the following:

- support for a disability subcommittee, with one focus being cochlear implants;
- the need to address the shortage of dental providers;
- clarification as to whether the committee can establish subcommittees;
- support for a subcommittee to work with the LFC on issues of health reform;
- a request that the Department of Health brief the committee on its efforts regarding bubonic plague, West Nile virus and tuberculosis;
- a request that Coordination of Long-Term Services (CoLTS), particularly payment to providers be covered at the July meeting;
- a request that issues of transition to OptumHealth, particularly reimbursement to providers be covered at the July meeting; and
- a request to review the University of New Mexico School of Medicine and its effectiveness in retaining medical students to practice in New Mexico upon graduation.

Mr. Hely recited the requirements for creating a subcommittee. The opportunity for a joint meeting of this committee with the LFC in lieu of a subcommittee was discussed. Senator Ortiz y Pino made a motion, and Senator Lopez seconded the motion to create a subcommittee on disabilities. Committee members questioned whether a subcommittee is needed, or if a day devoted to the topic would suffice. The details of SM 41 (2009), the memorial calling for a disability concerns committee, were reviewed. Clarification was sought regarding whether this committee is obligated to create a subcommittee on this topic, given that the Legislative Council did not establish the committee, as requested in the memorials. Representative Antonio Lujan, Representative Joni Gutierrez and Representative Nora Espinosa objected; the motion failed. Senator Adair moved and Representative Espinosa seconded a motion to devote a full day to disability issues. The motion passed.

Representative Gutierrez made a motion, seconded by Representative Cote, that a subcommittee be formed to meet with the LFC on August 13 to participate in a discussion regarding health care reform, with the chair appointing the subcommittee. The motion passed.

Senator Lopez made a motion, seconded by Representative Lujan, that the work plan be adopted as amended. The motion passed.

### **Public Comment**

Pug Birge, University of New Mexico Health Sciences Center, and Mark Saavedra, lobbyist for the University of New Mexico, spoke on behalf of Dr. Paul Roth, president of the Health Sciences Center. Dr. Roth would like the committee to hear testimony regarding the B.A./M.D. program; the medical school; the nursing program, presented by the new dean of the college of nursing; health care provider pipeline issues; and other related programs. Dr. Roth would like an opportunity to present the University of New Mexico Health Sciences Center's legislative request to the Legislative Health and Human Services Committee.

Terry Reilly, Health Security New Mexico, expressed disappointment regarding the exclusion of a single payer model of health reform from the federal reform debate. New Mexico has a great opportunity to institute such a model at the state level.

Debbie Maestas Trainer, NM Health Underwriters, testified that they have specific ideas that they would like to present.

The meeting adjourned at 2:20 p.m.

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

**July 6-8, 2009  
Pueblo of Laguna and Gallup, NM**

The second meeting of the Legislative Health and Human Services Committee (LHHS) was called to order at 9:30 a.m. by Representative Danice Picraux, chair.

**Present**

Rep. Danice Picraux, Chair  
Sen. Dede Feldman, Vice-Chair  
Sen. Rod Adair (7/6 and 7/7)  
Rep. Nora Espinoza (7/6 and 7/7)  
Sen. Linda M. Lopez (7/8)  
Sen. Gerald Ortiz y Pino

**Absent**

Rep. Joni Marie Gutierrez  
Rep. Antonio Lujan

**Advisory Members**

Sen. Sue Wilson Beffort (7/8)  
Rep. Ray Begaye (7/8)  
Rep. Nathan P. Cote  
Rep. Miguel P. Garcia (7/8)  
Rep. Keith J. Gardner  
Rep. Dennis J. Kintigh  
Rep. James Roger Madalena (7/6)  
Sen. Cisco McSorley (7/8)  
Rep. Bill B. O'Neill (7/6, 7/7)  
Sen. Mary Kay Papen (7/8)  
Sen. David Ulibarri  
Rep. Gloria C. Vaughn

Rep. Jose A. Campos  
Rep. Eleanor Chavez  
Sen. Clinton D. Harden, Jr.  
Rep. John A. Heaton  
Sen. Gay G. Kernan  
Rep. Rodolpho "Rudy" S. Martinez  
Sen. Nancy Rodriguez  
Sen. Sander Rue  
Rep. Jeff Steinborn  
Rep. Mimi Stewart

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

**Staff**

Karen Wells  
Jennie Lusk  
Mark Harben

**Guests**

The guest list is in the meeting file.

## **Handouts**

Handouts are in the meeting file.

## **Monday, July 6**

### **Welcome and Introductions**

The chair invited members of the committee and staff to introduce themselves and acknowledged and thanked Pueblo of Laguna Governor John Antonio. The chairs also acknowledged the passing of Mr. Vaughn, and members expressed condolences to Representative Vaughn. Governor Antonio opened with a prayer.

### **Report from Pueblo of Laguna**

Governor Antonio mentioned challenges that result from a shrinking Indian health service (IHS) budget. However, the Pueblos of Acoma and Laguna have agreed to work jointly to improve health care and have created a joint commission on health care that includes the governors or their designees and that is focused on minimizing duplication of efforts so that all health care dollars are efficiently used.

### **Minutes**

The minutes of the previous meeting were unanimously approved.

### **Federal Health Reform Overview**

Senator Feldman talked about being called to the White House for intergovernmental cooperation on health care reform. Some 22 legislators met with Kathleen Sebelius, the secretary of the federal Health and Human Services Department. The meeting caused Senator Feldman to miss her first LHHS meeting in 13 years.

Senator Feldman was invited as one of 700 persons who signed a letter urging reform of health care at the federal level. Representatives from states that have tried various forms of health care reform and have considered a range of options discussed their experiences as the administration listened. There were certain themes repeated as priorities, including using primary care efficiently, creating medical homes, cutting costs and reimbursing Medicaid efficiently based on outcomes. The senator said President Obama's basic priorities are to preserve choice and include a public health care option nationally. The administration wants a strong bill out of Congress by mid-August. Senator Feldman encouraged other committee members to sign on to the letter supporting a national solution for health care coverage.

### **American Recovery and Reinvestment Act of 2009 (ARRA) Update**

Legislative Council Service (LCS) staff member Karen Wells gave an update of the federal stimulus package known as ARRA, as promised for each agenda in this interim.

She reported that federal medical assistance percentages (FMAPs) have increased beginning last October under the provisions of ARRA, an increase that will continue through September 2010. She reviewed "attestations" required by the federal government of state

agencies that receive the funding, including that the Human Services Department (HSD) will have to guarantee that the money is not being placed in any "rainy day" fund, noting that House Bill 920, passed last session, segregates the ARRA funds from the state's general fund.

Ms. Wells reviewed other pertinent provisions of ARRA, including cost-sharing arrangements with Native American tribes, nations and pueblos; increases in FMAP for increases in unemployment; construction costs for a new veterans' long-term care facility; rescinding of school-based administrative costs for students with disabilities; and changes in approved benefits for services provided at an outpatient hospital or clinical service benefit.

### **Medicaid and State Coverage Insurance Budget; Coordinated Long-Term Services Enrollment and Reimbursement Update; Transparency and Reporting**

Secretary Pamela S. Hyde, HSD, reviewed the Medicaid and State Coverage Insurance (SCI) budgets and noted that enrollment has continued to rise and, therefore, projections for costs have changed. Children's numbers in particular have risen every month, both because of the economy and the department's outreach efforts.

The department's challenge is to "draw down" the maximum number of federal dollars through getting and using enough state general fund money as a match for the federal dollars. The caseload per income support worker is now at 737, up from 600 when Secretary Hyde came to the HSD.

Although the HSD's entire computer system overhaul is still two or three years into the future, the department does have a web-based application screening tool called "Yes NM", which will be online by the fall. The department is redesigning the recertification process and is considering reinstating continuous eligibility. The problem caused when the federal government began requiring documents that many tribal people did not have has been solved for the moment, and tribal people can be on Medicaid for 90 days while they compile the required documents.

The stimulus funds are awarded, she said, on the basis of guarantees that a state will spend the funds right away. The state has used the federal stimulus funds to replace general fund money and has created through House Bill 920 a fund to hold the general fund money no longer required for Medicaid. Some \$120 million in general fund money saved will be used for fiscal year 2011, she said, when the federal stimulus money is no longer available. She declined to characterize the general fund arrangement as a "reserve" prohibited by ARRA and said she had consulted with attorneys at the Legislative Finance Committee (LFC), the LCS and the HSD. The department still has not heard from the Centers for Medicare and Medicaid Services (CMS) about its definition of a "reserve" fund.

To contain costs, she said, ARRA prohibits reductions ineligibility. The department can, however, slow its aggressive outreach. Thus far, the department has not taken steps to slow the outreach.

The secretary promised legislators that they would hear more regarding behavioral health on the third day of this meeting, when LHHS members will be meeting with members of the LFC. Nonetheless, Secretary Hyde noted that the department is beginning fiscal year 2010 with a new behavioral health "single entity" contractor, Optum Health. The contract will be \$378 million, \$10 million more than the previous years.

Carolyn Ingram, director, Medical Assistance Division, HSD, mentioned that the HSD is working with the Aging and Long-Term Services Department (ALTSD) to do coordinated long-term services (CoLTS). The services, now available statewide to 36,000 persons, are higher in costs than expected, she said.

Questions and comments from legislators focused on:

- why services were not available to a client in Roswell;
- chronic abuse of emergency room facilities;
- projected enrollment of children;
- why some persons have to transfer from "Mi Via" to CoLTS;
- problems getting enough general fund money to draw down all potential federal dollars for SCI;
- problems with the state getting enough credit for increasing its enrollment;
- the adequacy of the Native American liaison program of the HSD to meet the growth of enrollment of Native American clients;
- citizenship certification; and
- Pueblo of Zuni and Navajo Nation temporary assistance for needy families (TANF).

Ms. Ingram, reviewed her handout and noted that the SCI program has an enrollment of 32,000; that childless adults will be moved from the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) to Medicaid; and that the department is trying to keep benefits among programs comparable. The average group size of the 1,295 employer groups on SCI is 4.7 employees. The department is currently negotiating contracts for both Salud! and SCI providers and is focusing on ensuring that premiums are being spent on direct services rather than administration.

### **Children's Health Insurance Program Reauthorization Act and Its Impact on the State Coverage Insurance Program**

Chuck Milligan, executive director of The Hilltop Institute at the University of Maryland, Baltimore campus, refreshed the memories of legislators as to the history of the creation of CHIPRA. Leftover funds from SCHIP led to the creation of SCI, which uses unspent SCHIP money to cover uninsured adults in New Mexico. When SCHIP was reauthorized, its name was changed to CHIPRA. States must quit covering childless adults under CHIPRA, but may cover them under Medicaid. However, the Medicaid match to the state is less beneficial than the CHIPRA match. Currently, only three states cover childless adults with CHIPRA money — New Mexico, Michigan and Idaho.

The base dollar allocation for CHIPRA block grants will be based on the amount spent on childless adults in the federal fiscal year 2009. The dollar amount will change next year but will not be changed thereafter.

Mr. Milligan and Ms. Ingram discussed a study funded by the Robert Wood Johnson Foundation that is gathering more information regarding employers' participation in SCI. The study looked at employers that wanted more information on SCI, but did not join, and employers whose employees are in the program. The two also talked about the current national debate on providing insurance for people on Medicaid and other programs, noting that part of the health coverage debate centers on whether "connectors" that put clients in touch with appropriate programs for coverage will be organized on a local, regional or national basis. Further, because eligibility for federal programs changes with life events of clients — as their income changes, their children grow and they become elderly — it is important to keep coverage current.

Questions from the legislators included:

- the number of childless adults under 200% of the federal poverty level (FPL) that are enrolled;
- whether employers are reluctant to acknowledge that their employees earn less than the FPL and are therefore eligible for the state coverage; and
- whether "connectors" will be established on a state, regional or federal basis to help people choose their coverage plans under the new Obama health coverage plan.

### **Maximizing Health Care Opportunities Under CHIPRA**

Bill Jordan, policy director, New Mexico Voices for Children, and Sireesha Manne, staff attorney, New Mexico Center on Law and Poverty, urged legislators to press the HSD to make absolutely sure that every federal penny available for covering children in New Mexico be used, leaving "no federal dollars behind" through leveraging matching dollars. They said that maximizing the number of clients on SCI and Medicaid helps to stimulate the local economy, as such programs more than match state dollars, with the federal government putting in 80% of every local Medicaid recipient's benefits. Mr. Jordan cautioned that the state must use all of its remaining funds or return them in October 2010 to be redistributed; funds returned to the federal government will cause the overall level of federal support to be reduced in future years.

Ms. Manne said that it is likely that the state will leave \$100 million behind in fiscal 2011, according to her organization's calculation. To make up \$100 million, the state would need to invest only \$25 million in state funds. At a 20% matching rate, the state would pay only \$640 per child per year and \$1,560 per adult per year.

In a recent LFC report, she said, the HSD estimated a current enrollment of 13,000 children and 41,000 adults. If this is accurate and the numbers remain steady, New Mexico will have lost an estimated \$100 million. On the other hand, she noted, the HSD just today estimated that figure at \$27 million — a significant difference from earlier estimates. While she was glad to hear that the HSD expects to lose fewer federal dollars, she hoped that the department would explain the wide fluctuation in its estimates.

The center proposed that legislators continue to monitor the spending of dollars for children's programs by asking the HSD to return to testify before the LHHS. To get the higher dollar amount, the state would need to cover a total of an additional 18,000 children, according to the center.

Ms. Manne also said that the HSD should make children continuously eligible, regardless of fluctuations of family income. The department is already doing this for SCI enrollees, she said, and reduced interruptions for health coverage have helped to maintain New Mexico's federal funding. With automatic renewal, the department can presume that persons are eligible and automatically renew them until it finds otherwise as to eligibility. There is a higher federal match for language interpretation services, she continued, which can be as high as 75% for Medicaid and 85% for CHIPRA for Medicaid services.

Mr. Jordan reminded committee members that it was a year ago that the governor called a special session, in part to ensure that children were covered under state medical insurance. The governor called \$20 million for children allocated during that session as a "down payment" for covering all children. However, that \$20 million was the first item to be cut in the regular session. Now, the state government has broken its promise to the children. He asked that now, when coverage is less expensive than ever because of federal matching dollars, the state make good on its promise to children by reconsidering the cut. The state continues to run forty-ninth in the nation for the rate of uninsured children. The federal match is nine to one, but the state is still insisting that it does not have enough money for a match, even at that rate. The state is not taking advantage of enrollment opportunities, he said. Over the next year or two, as health care reform rolls out, there will be more federal incentives to cover all citizens. SCHIP was a test drive, he said, and New Mexico has crashed.

Mr. Jordan also stated that Native American enrollment is not increasing much, even though Medicaid enrollment has increased.

Secretary Hyde was asked about coverage by the state versus by the IHS, and she answered that the state covers Native American children that are enrolled in Medicaid, regardless of whether or not they are covered by IHS.

Other questions and topics included:

- problems in making sure that the state Medicaid match is adequate to leverage all the federal dollars available and that the HSD's outreach is aggressive enough to enroll adequate numbers of clients to warrant the federal match and the state dollars;
- the rate of new enrollment, which is estimated at 4,000 per month;
- examining tax breaks the state has given to decide whether the breaks are earning the state money, especially if the state is due to lose money if it does not increase Medicaid enrollment;
- how to get people that no longer need Medicaid off the Medicaid rolls;

- the importance of reaffirming that it makes good economic sense to invest in child coverage in the current budget, then provide a supplemental appropriation later so that the administration would be less likely to feel a need to cut back on outreach measures; and
- whether private funders have stepped up to help in enrollment efforts.

### **Public Comment**

Ana Otero-Hatanaka spoke to committee members to emphasize that health care reform is vital to agencies that provide services to persons with disabilities. Many small nonprofits have lost the ability to offer health care for their staff.

### **Barriers to Obtaining Health Insurance Among Native Americans in New Mexico**

Colinda Garcia, Native American liaison for the Medical Assistance Division of the HSD, presented information on a survey on resistance to enrollment in health insurance plans among persons in Native American communities. A focus group was formed after statistics in 2006 indicated that Native Americans are disproportionately uninsured in New Mexico. The study was the first of its kind in the nation and was funded by the Robert Wood Johnson Foundation.

Ms. Garcia reviewed the findings of the study, which included not only financial and bureaucratic obstacles to enrollment but also cultural resistance. Many persons answered that they had health insurance since they were covered by the IHS. However, if a Native American client is not near an IHS facility, that person is treated as "uninsured".

Ms. Garcia has been working with the IHS to talk about Medicaid and Medicare enrollment and has done eligibility training with the IHS, too. She has partnered with physical health and long-term services providers to educate the Navajo Nation bureaucracy on what managed care organizations in New Mexico can do. The HSD has stationed income support workers in eight Native American communities to accept enrollment, the HSD has opened its own office at the Pueblo of Zuni.

Outreach in Native American communities was made possible by a special appropriation, Ms. Garcia said. March 2009 figures indicate that 80,980 Native American clients are enrolled in the HSD's programs — representing 18% of total Medicaid enrollment. According to Ms. Garcia, 82% of eligible Native Americans are already enrolled.

### **Pueblos of Acoma and Laguna Joint Health Care Work Group**

Richard Luarkie, former member of the Pueblo of Laguna Tribal Council, asked Governor Antonio to join him for a presentation on the health work being undertaken by the Pueblo of Laguna in conjunction with the Pueblo of Acoma. The governor reported that the Pueblo of Laguna hospital got some cosmetic improvements through the IHS although, with over 550 federally recognized tribes, it had a good deal of competition. The state needs to help improve the hospital, he said, and the pueblo is asking for state help. He noted that health care expenditures for prisoners in the United States is higher than that for Native American people.

The pueblo is working with the University of New Mexico (UNM) Hospital and Presbyterian Hospital to examine "P.L. 90-638" — the federal contracting process for IHS health care. The pueblo is attempting to find ways it can partner with UNM, Lovelace and Presbyterian to decide whether it is advantageous for the pueblo to purchase insurance for its people.

Mr. Luarkie noted that the number of members of each pueblo is shrinking, creating a complex set of problems in providing coverage and affording coverage. Together the pueblos have created a joint health care commission to examine regional health care issues and avoid duplication of services and expenses.

Committee members asked several questions. Among them were whether the current behavioral health collaborative organization was working well for the Pueblos of Laguna and Acoma; and whether tribal members seem to have an interest in pursuing medical careers — to which the answer was that family members are in dental school and four students from New Mexico pueblos are in the BA-MD program at UNM. One tribal member just finished a residency at the UNM school of Medicine and the Pueblo of Laguna has its first dentist.

The governor was also asked about prospects for an improved IHS budget, especially as IHS had \$17 million in arrears to New Mexico hospitals and Grants-Cibola county hospitals are reluctant to accept new IHS patients because of the arrearages. The governor responded that he is hopeful that with reauthorization of IHS, there will be more funding. He and others have met with New Mexico's congressional delegation.

### **Pueblo of The Pueblo of Laguna Health and Wellness Priorities**

Paul Pino, mental health counselor, Department of Community Wellness, Pueblo of Laguna, reported to the committee. A mental health counselor for approximately 30 years, Mr. Pino met with the tribal council regarding the pueblo's top five priorities, of which health care is number two. The goal is to create a state-of-the-art health care system for the Pueblo of Laguna, perhaps with a regional health services model. Ideally, the system will generate revenue. The pueblo, he said, sees itself as part of a larger area along the I-40 corridor, with the ability to supply fire and rescue services, transportation, health insurance and long-term services, among other services. Currently, there is no nearby program to address cancer or give women mammograms, although the impact of uranium mining on health is great and likely to be profound because of the Jack mine near the Pueblo of Laguna. The pueblo lacks foster homes — currently there are only four foster care families — so the community is working to develop Title IV to support families interested in foster care. As to behavioral health services, there are no long-term programs, and for most people, 28 days of treatment is all that is possible. There are not enough inpatient mental illness services for depression and suicide, as most are for a maximum of two weeks. These programs will not pay for persons under the influence of alcohol or drugs. The pueblo does have a decent domestic violence shelter and has had it for 30 years.

Questions included:

- programs for newborns and expectant mothers and for smoking cessation;

- the mechanics of getting services from and getting paid by the new single entity for behavioral health services; and
- suicide statistics and ways to slow the growth in suicide rates.

### **Public Comment**

Joe Cordova, co-chair of the Behavioral Collaborative Local 17, said that transparency is still lacking in the new single entity. It is still difficult to get information on the amount of funding and its percentage compared with total behavioral health funding for Native American behavioral health. Mr. Cordova said he would get a copy of the behavioral health contract for committee members to examine.

### **Tuesday, July 7 — Gallup Cancer Center**

The committee reconvened at 9:30 a.m. in Gallup. Ms. Wells presented the committee with information on its subcommittees and social plans. The work plan was approved by the New Mexico Legislative Council, she said, and the council created a subcommittee on disabilities concerns, even though the committee had not asked for its creation. In addition, the council appointed a subcommittee to attend a joint meeting with the LFC on health care reform. Committee members volunteered for each of the two subcommittees.

Paul Sanchez, director of the New Mexico Cancer Center, welcomed committee members and talked about how important it is for the center to provide cancer treatment near homes. He thanked Senator Feldman for helping the center get a commitment for funding during the most recent session.

### **ARRA Update: Early Childhood, Hunger and Work Force**

Ms. Lusk presented a summary sheet on federal stimulus funds devoted to the areas of early childhood, hunger and work force. See the committee file for that information.

### **Nurse Home Visitation Program; Bernalillo County Proposal**

Leigh Mason, coordinator, Bernalillo County Health Commission, joined school health advocate Janet Mason, YWCA Director Donna Odette and College of Nursing Dean Nancy Ridenour, to talk about the importance of doing home visits by nurses as part of a complete early childhood education.

The presenters shared various stories of success and distributed handouts documenting stories in which success in early childhood programs can be predicted as a result of careful home visits by nurses. A little bit of intervention and critical information can make the difference in whether children are raised in a nurturing environment or are emotionally abandoned. Early experiences can make a difference in IQ scores as well as in emotional health.

Ms. Odette talked about the Pregnancy Task Force, which she chairs, working with the nurse-family partnership. Pregnant teens form the focus of the task force, which is backed with 37 years of research. Dr. Ridenour, the new dean at UNM College of Nursing, emphasized the importance of focusing on prevention, early intervention and collaboration. She noted that even

keeping two newborns out of the intensive care unit of a hospital would pay for the entirety of the program.

The program is the number one priority of the Bernalillo County health council.

While the nurse home visiting program is not universally followed in New Mexico, the proponents saw it documented as effective. The First Born program used elsewhere in the state is effective but does not offer such well-documented results. Dorian Dodson, secretary of children, youth and families, who was in the audience, said she would cover the varieties of early childhood programs in her later presentation.

### **Early Childhood and Child Protective Services — Initiatives and Trends**

Secretary Dodson, Bill Dunbar, deputy secretary, and Jared Rounsville, acting protective services director all of the Children, Youth and Families Department (CYFD), gave a presentation on initiatives and trends in early childhood education.

The department has received stimulus money to establish the Early Childhood Education and Care Advisory Council and is implementing the recommendations of the home visiting task force. The department has allotted some "formula" funds based on participation in early childhood programs and some competitive grants. One staff person is assigned to find and use every federal dollar available to the department through the stimulus package. The department, with the help of Mr. Dunbar, is also supporting agencies and community organizations that are eligible for federal stimulus money to apply for that money, lending letters of support to the initiatives for which federal funds are requested. The department received \$17.8 million in child care development block grant money under the federal stimulus package for child care assistance and quality. The CYFD is using \$13.9 million in fiscal year 2010 and the first quarter of fiscal year 2011. The funds must be spent by September 30, 2010. According to Secretary Dodson, the department will make available another 200 slots for child care services for children whose families make below 200% of the FPL.

The secretary also reported on infant deaths resulting from "unwilling caretaker" situations in which infants were left in the care of neglectful or violent family members or friends. She said, based on very accurate previous predictions, that the department can anticipate more of these sorts of tragedies if money for child care is not provided continuously and children are left with persons that do not want to be there. It is possible that persons that have received state-subsidized child care could be cut or put on waiting lists if funding is not consistent, but the department is attempting to avoid that scenario at all costs.

Mr. Dunbar noted that in the special session, the rate for covering child care was increased to 200% FPL and the department received \$7.2 million in TANF funds. The budget that sustains this enrollment includes not only the federal TANF funds but also the \$13.9 million in stimulus money and the CYFD's budget. However, there is no certainty of funding after 2010. The department, he said, is making the critical decisions on whether and when to ramp down by

keeping careful track of funding, but the challenge remains to manage the program to use every dollar without jeopardizing families.

Secretary Dodson said that every state that receives stimulus money is required to spend at least 4% of the money on quality child care. The department has taken that requirement as an opportunity to put in place initiatives that will have a lasting effect even if stimulus funds go away. There is the "stars" program for which providers receive increasing reimbursements as their teachers are better educated and the ratios of children to teachers decrease. The professional development program has allowed the department to start providing a family, infant and toddler studies degree program online. The TEACH scholarships are now given to at least 150 more child care providers statewide. There are "mind in the making" courses statewide on child brain development.

The CYFD has just released a request for proposals for an urban and a rural program to demonstrate quality. Up to 250 small contracts will also be issued to providers to help them get staff through the "stars" program. The department also continues its toy lending library and professional resource libraries for child care providers and is conducting a recruitment campaign for more infant and toddler child care providers.

As to home visit models, Secretary Dodson said that the department is using a "continuum" model — and not pitting various types of home visiting programs against each other. Instead, community-to-community home visiting programs will be constructed to suit local needs. Originally, the home visit program was contracted from the CYFD through the single entity behavioral health services program, but the secretary pulled it back as she felt home visiting was not behavioral health. The department is working closely with the Public Education Department, the HSD and the Department of Health to get federal government funding not provided in the stimulus package for home visiting programs.

Dr. Mary Dudley, a member of the Child Development Board, mentioned a recent LFC audit that was somewhat critical of early childhood programs. She said the board was surprised by the way that overhead costs were defined in the report — for instance, counting professional development as a cost for pre-kindergarten programs. Ruth Hoffman, Lutheran Advocacy Ministry, commented that it is important to keep funding in place to protect children. Having reliable, good child care makes it possible for families to be successful in the workplace, she said.

Mr. Rounsville reported on key initiatives in protective services, responding to October 2008 federal legislation. The CYFD has created a youth transition database that helps to identify successful independent living programs for foster children who age out of foster care. Finding stability for foster children is the biggest challenge for the department, Mr. Rounsville said. The national goal is for two or fewer placements in a 120-month period, but New Mexico is not at that point yet.

Questions from committee members included:

- whether it would be possible to perform drug tests on children in community placement;
- priorities for using state funds to open new home visit programs in other counties;
- how many children go into foster care in a given year;
- the federal shift in priorities away from permanent group home placements for foster children;
- the increased rates for foster parents, brought about through Representative Vaughn's bill sponsorship, the first increase since 1991;
- federal stimulus money for Head Start programs;
- the governor's veto of a bill requiring equal funding for public and private pre-K programs while equal amounts were, in fact, dedicated to each in this budget cycle;
- vacancy rates in staffing for protective services;
- how many children from foster care enter college versus entering the criminal justice system;
- foster care in pueblos, the Navajo Nation and Apache reservations; and
- the possibility of more support for grandparents who are raising family members.

### **Hunger and Food Insecurity: Intergenerational Summer Food Program**

Nancy Pope, director of the New Mexico Collaboration to End Hunger, reported on the successes of the summer food plan. Ms. Pope wrote a plan for ending hunger in New Mexico over a three-year period, and the plan was privately funded at \$100,000 per year for three years. The plan covers everything from free school lunches to improving food in retirement communities.

Currently, one in four children in New Mexico does not know when the next meal will be available. One in eight senior citizens has the same problem. New Mexico is the worst in the country for food insecurity.

A private-public partnership has raised \$1.9 million to end hunger, leveraging federal funds with state and private dollars. Last summer, the project fed 5,600 children at 37 sites. This year there are 46 sites and 37% more families and children have been fed. In addition, the program provided weekend food bags and some free breakfasts. Senior volunteers throughout the state are helping to plant gardens at the meal sites.

Legislators expressed support and thanks for the work of the collaboration. Questions and discussion topics included concerns over communities that still have no meal sites and the increase of homeless children in Albuquerque this year — some 4,000 new homeless children in addition to the estimated 3,000 already identified.

### **Women, Infants and Children (WIC) Program and Supplemental Nutrition Assistance Program (SNAP) Updates**

Katie Falls, deputy director, HSD; Deanna Torres, family food and nutrition section chief, Department of Health; and Jane Peacock, deputy director, Public Health Division, Department of Health, reported that some \$360 million per year is provided in federal food

stamp benefits to New Mexico. The participation rate is improving. In 2006, only 71% of eligible persons participated.

Stimulus funding in the amount of \$2 million has been made available for increases in caseloads resulting from the recent economic downturn. Currently, the average caseload for workers is 734 cases per worker; with the stimulus money, perhaps that number will decrease.

The state approved a supplement for elderly persons on Supplemental Security Income (SSI) at \$10.00 per person, but with the stimulus funding the amount went up to \$16.00. Now, no one in New Mexico gets less than \$30.00 per month for food stamps.

The HSD received a federal waiver in order to put into place a combined application project. Under the program, the department reviews applications of people who receive SSI payments and let them know if it is likely they are also eligible for other programs.

Ms. Falls reviewed the department's response to the food stamp enrollment, outreach and community partnering memorial passed last session.

The HSD is not only complying with the memorial's suggestions but has eliminated a financial asset limit, qualifies persons by telephone and provides information in English and Spanish to all low-income comprehensive tax rebate clients. The HSD is using old vans from the Department of Health to do Medicaid outreach and has been to Taos, San Juan, Luna, Bernalillo and Lea counties. Although it used to require 100% face-to-face interviews, the department has now eliminated half of those. Telephone interviews are also used for recertification. These changes are important because the department is finding that some persons with very little money are being rejected because of owning two cars, even if one is not reliable. The federal program does not require an asset test, on the theory that people with assets generally have too much income to qualify for food stamps. New Mexico is not forced to perform an asset test in order to qualify for federal funding.

Now, people applying for food stamps can do so by phone, so long as they meet an expanded definition of hardship.

Questions included:

- the potential to do drug testing for able-bodied adults without children;
- uses of electronic benefit transfer cards;
- oversight of the SNAP program;
- ways to discourage destructive uses of benefits; and
- differences in approved uses for food stamp cards and cash assistance cards.

Ms. Peacock and Ms. Torres talked about the WIC program, including the Department of Health's programs to encourage the purchase of healthy food at farmers' markets. The WIC program in New Mexico involves 67,000 participants per month, which represents 80% of persons eligible.

The program offers food benefits as well as nutrition education and referrals. Only certain foods — milk, eggs, juice, beans and other basic nutritional foods — can be purchased with a WIC benefit. Some 237 grocers participate in the program statewide. Beginning October 1, a new federal regulation will accommodate cultural preferences better aligned with New Mexico food habits — including whole wheat tortillas, corn tortillas and fresh fruits and vegetables.

As part of Governor Richardson's initiative to reduce obesity, the WIC program is coordinating with several New Mexico groups, including the New Mexico Healthier Weight Program Council. The groups are partnering to create a healthy foods 10-year plan. A pilot project in Las Cruces, "Healthy Kids", is in process. In the 10-year strategy, each community decides how it will create better health through local opportunities. The program wants to expand into Chaves County and has had a kickoff meeting there.

### **Pediatric Cancer Clinical Trials Interim Study Panel HM 102 and SB 42 (2009)**

Stuart Winter, a pediatric oncologist, Barbara McAneny, CEO of the New Mexico Cancer Center, and Terri Stewart, executive director of the New Mexico Cancer Care Alliance, reported on the progress of cancer clinical trials coverage in New Mexico. With the passage of SB 42, insurance companies in New Mexico are now required to cover participation in phase I clinical trials. However, Dr. Winter expressed concern that children still cannot participate in phase I trials. Dr. McAneny talked about the importance of bringing cancer treatments close to patients since patients often do not feel well enough to travel. She said that infrastructure still needs development so that people in the Gallup area can participate in trials and get transportation and other support networks in place for participants. Sometimes Medicaid coverage remains a barrier to participation, she said. Also, amendments are contradictory, and insurers are getting mixed messages from the law.

Questions from committee members included:

- whether health care coverage is the proper way to fund medical research;
- the need for close monitoring of application of the new law; and
- numbers of participants in cancer clinical trials.

### **Public Comment**

Ms. Otero-Hatanaka again addressed the committee, this time expressing concerns that stimulus funds may be used for new enrollment in entitlement programs. She would prefer that the money be used to retain professional staff.

### **Committee Discussion**

Committee members discussed several issues raised during the meetings on the second day and, on motion of Senator Ulibarri, seconded by Senator Feldman, the committee voted to write the HSD encouraging it to enroll all 18,000 eligible children not currently enrolled in Medicaid.

## **Wednesday, July 8: Joint Meeting with Legislative Finance Committee (LFC)**

The meeting was called to order by Representative Luciano "Lucky" Varela, chair, LFC, at 8:40 a.m.

### **Update on Workforce Development Training and Temporary Assistance for Needy Families**

Renada Peery-Galon, senior fiscal analyst, LFC, reported that a performance review on the New Mexico Works program and workforce development system integration was completed in 2006 and contained three significant findings: New Mexico Works families lack sufficient access to effective and comprehensive workforce development services, including child care, through one-stop centers; New Mexico Works policies need adjustment to help families transition off welfare into self-sustaining employment; and lack of an office of training and workforce development authority and decentralized administration may impede further progress to meet the needs of New Mexico's businesses and job seekers.

Brent Earnest, senior fiscal analyst, LFC, reported the review made seven recommendations concerning the Temporary Assistance for Needy Families (TANF) program, including requiring that employment and training service contractors provide their services through one-stop centers; amending state law to create a post-TANF job retention bonus program; and creating a separate state two-parent cash assistance program to avoid federal penalties for not meeting work participation rates. Ms. Peery-Galon said that there were two key recommendations for the CYFD: the department should co-locate child care eligibility workers at a minimum of three one-stop centers; and the legislature should consider maintaining the child care income eligibility threshold at 155 percent of federal poverty level and should target future expansion funding to raise the exit level eligibility threshold. There were also two key recommendations for the Workforce Solutions Department (WSD): a legislative study of options to consolidate workforce development programs into a single department; and a recommendation for how services should be delivered to job seekers and employers.

Questions were asked regarding the delay in passing through child support funds to TANF clients. Mr. Earnest said the change in law allowed the department to increase the pass-through and additional general fund revenue was appropriated to the child support enforcement division, because it was likely to lose other state funds to support its operations. Senator Beffort asked that the process be expedited.

A question was asked about whether CYFD is providing access to child care services through one-stop centers. Julianne Smrcka, African American liaison, CYFD, responded that information technology (IT) has been an issue in terms of being able to screen applicants at a site and placing someone at those sites. An integrated IT system with HSD and the WSD is being reviewed.

## **Workforce Investment Act Funding for Adults and Dislocated Workers — Status of ARRA Funding**

Betty Sparrow-Doris, secretary, WSD, reported on the ARRA funding. The ARRA provides funding to the state from the United States Department of Labor (DOL) and follows legislation initially provided for various programs. The WSD serves as the administering agency for all DOL-funded programs. These programs include the unemployment insurance program, Wagner-Peyser Act of 1933 program (labor exchange activities) and the Workforce Investment Act (WIA) program. The WIA in New Mexico received more than \$11 million provided through local workforce boards for the actual provision of services; four local boards represent all regions in the state. The Navajo Nation also received more than \$1 million. The state serves as the recipient of the funds but has no authority over the funds. The WIA is composed of three parts providing for adult services, youth services and dislocated-worker services. The department is operating in a comprehensive and integrated workforce system with all integration completed as of December 31, 2008. Support services are also provided and include needs-based payments to assist individuals in getting to job interviews. Funds under the ARRA must be expended by June 30, 2011.

The governor established an oversight office for the ARRA, called the New Mexico Office of Recovery and Reinvestment, which is overseeing all funds related to the ARRA and how they are leveraged with other funds. In addition to providing an initial report of the plan for use of the funds, there have been and continue to be weekly reports, which must be provided to the office. Subsidiary plans are also submitted in addition to the overall plan. A liaison is assigned from the office and meets with the department on a weekly basis to review expenditures and performance.

Secretary Sparrow-Doris said the state Workforce Development Board is responsible by law for the oversight and advice to the governor in terms of bringing together coordination to improve the economic viability of the state and providing a trained workforce. Nationally, an annual report is required by state boards and quarterly information is provided. Secretary Sparrow-Doris said the state board last met and expired in December 2008. Orientation for the new board is scheduled for July 24, 2009, and a full board meeting will be held on August 21, 2009. A concern was expressed regarding regulatory citations, and a report for the last two years was requested.

Committee members had questions and made comments about whether:

- provisions, policies or both could be put in place requesting the federal government to provide reports of the Navajo Nation to the state;
- pueblos and tribes were eligible for state funding under the workforce;
- it were possible to work with libraries and local schools so that displaced and unemployed individuals could access services provided by the department;
- job listings were accessible on line; and
- the legislature would consider funding the WIA program with state as well as federal funds.

## **How Local Workforce Boards are Spending ARRA Funding and Tracking Performance Measures**

Lou Baker, chair, Northern Area Local Workforce Development Board, reported that the mission of the board is to be the labor market's number one choice. The WIA requires that 51 percent of board composition represent the business community; 49 percent of those board members are federally mandated members. There are 25 members, five staff members and one service provider on this board, which covers 10 northern counties and serves a population of more than 300,000. Since 2002, the WIA formula funding has seen a 67 percent reduction.

ARRA funding has enhanced existing programs such as the Attain and Sustain Film Industry Project; the Commercial Driver's License (CDL) program, allowing city and county governments' access to training for their employees; and the Raytheon Program. Alex Martinez, executive director, SER-Jobs for Progress, reported that the Raytheon Program is in the Farmington area, and 167 candidates were identified for prescreening. Sixteen individuals have met the minimum requirements for employment with Raytheon. On-the-job contracts have been generated and the board is paying 50 percent of the wages for training of specific occupations, with Raytheon paying the other 50 percent. These individuals will transition into employment once training is complete.

Ms. Baker said staff met with business owners to discuss the summer youth employment program funded with ARRA funds. Funds received totaled \$838,000; 83 percent went to administration. The northern board implemented a Youth Employment for Success (YES) initiative that currently has 360 registrants. Staff members interact with business owners in the community and provide assessment profiles and work readiness skills.

Committee members had questions and comments about whether:

- there is a federal formula used to draw resources on a cost reimbursement basis or distribution of resources. Secretary Sparrow-Doris said dollars are allocated by formula and not specific activities to the local boards. The formula is based on the number of individuals living in poverty and the unemployment rate; and
- a meeting could be set up specifically with northwest legislators.

## **Temporary Assistance for Needy Families — Providing Cash Assistance and Building Self-Sufficiency: Caseload Growth and Maximizing ARRA**

Patricia Anders, staff attorney, New Mexico Center on Law and Poverty, reported that New Mexico should take steps to ensure that no federal TANF stimulus funds will be left on the table, seize the opportunity presented by the TANF ARRA funds to implement an emergency assistance program and discuss policies to prevent poor families and their children from being cut off of TANF cash assistance when facing hardships. A TANF emergency contingency fund was created in ARRA to help states weather the recession. In addition to the fund, a regular contingency fund has long been available to states. Drawing on both funds, New Mexico will be eligible for up to \$55.3 million over federal fiscal years 2009-2010. To date, New Mexico has accessed \$16.6 million from the regular contingency fund. New Mexico is eligible for emergency contingency funds through basic cash assistance, short-term nonrecurring assistance

and subsidized employment. New Mexico could set up a short-term TANF benefit program and be eligible to receive 80 percent federal reimbursement for these expenditures. The other 20 percent of expenditures does not have to be new state funding. The state could claim existing state spending as the matching funds. In addition, spending from nonprofit organizations and charities already providing assistance and services meeting the TANF purpose and other maintenance effort requirements can be used toward the additional 20 percent. Participants in subsidized employment receive wages rather than cash assistance. The ARRA funding also provides the opportunity to expand this program.

A policy option is currently available to New Mexico, ensuring that families with children facing hardships are not cut off of TANF benefits because of the time line. Generally, there is a 60-month time limit on how long families can receive TANF cash assistance; however, federal law in recognition of the special hardships faced by the very poor allows states to provide hardship extensions up to 20 percent of the TANF caseload. The legislature has statutorily codified its intent that families facing hardships be provided extensions. To date, HSD has not fully used the flexibility granted by the legislature. The department is in the process of making the extension more accessible to families.

### **Are We Building Self-Sufficiency — New Mexico Works Workforce Program and Other Support Services**

Katie Falls, deputy secretary, HSD, reported that the TANF program is a federally funded program for low-income families with dependent children. The record low enrollment for the program was in July 2007. Since May 2009, the program has seen an increase of 20 percent, attributed to the economy. Individuals on the program are required to participate in a work activity unless they are exempt from it. The TANF program focuses on ending dependency of needy parents by promoting job preparation, work and marriage. The New Mexico Works program focuses on improving the quality of life. National trends show the people on TANF are people who have multiple problems and barriers and are ill-equipped for work. As TANF imposes time limits, people are leaving the program without jobs. Their most common sources of income are food stamps and child support. One-third of them are moving in with family or friends. Reasons for not working include poor health, not finding a job and no child care. Forty percent of people on the TANF program in New Mexico are exempt from work because of these problems. Ms. Falls testified that beginning in FY11, the same TANF contract for support services will not be issued because the population has changed. TANF clients will be interviewed about services they are receiving and how those services are helping them, and what additional services they need. Individuals who have left the program will also be asked what helped them get off TANF and what could have been done better. Work will then be done with the public and advocates to design a request for proposals enabling the department to provide services in the future that meet the needs of current TANF clients.

The TANF program is funded with a federal block grant spent on cash assistance, support services and administrative costs. HB 590 appropriated funding to the Taxation and Revenue Department (TRD) for the working families tax credit. HSD has applied for and has drawn

down \$11 million for cash assistance. The amount of money appropriated for cash assistance has been declining, while the amount of funding for support services has been increasing.

Chairman Varela requested that the HSD provide a written response to the report submitted by the Center on Law and Poverty. Senator McSorley requested that extensions (triggers) be included in the response.

### **Update on Behavioral Health Collaborative**

Linda Roebuck-Homer, chief executive officer, the Behavioral Health Collaborative, reported that the collaborative re-bid its statewide entity contract and awarded it to OptumHealth New Mexico effective July 1. Eleven core service agencies have been identified across the state establishing clinical homes to allow people with multiple needs to receive thorough assessments and assistance. The first round will go live in October; it will take 12-18 months to have the entire state covered. Implementation of a housing plan focuses on housing and developing capacities with specific focus on people with behavioral disorders. Stimulus funding coming into the state will be invaluable to populations. The goal is to get people into permanent housing.

The number of local collaboratives has expanded by three to a total of 18. Expansion occurred to accommodate additional Native American local collaboratives; there are now five local collaboratives for Native Americans.

Other accomplishments include the expansion of projects for returning soldiers and veterans, pilot projects for a quality service review system and the New Mexico Consortium for Behavioral Health Research and Training (CBHTR). The total projected for the FY10 contract is approximately \$378 million (both general fund and federal funds), with an overall administrative cost of \$47 million. Approximately \$10 million to \$12 million will return to New Mexico in taxes.

Sandra Forquer, CEO, OptumHealth New Mexico, reported that a regional model has been developed to ensure that members of their staff are in communities assisting in facilitating care. Regional offices with between 12 to 18 staff members have been put in place in six areas of the state and include family and consumer peer specialists. The care coordination function has also been moved to the regional offices along with a provider care team. Fifty-three peer and family messengers were hired and have met with more than 3,000 consumer and family members. Ms. Roebuck-Homer said there is less funding available for behavioral health, with an increasing need and demand for services.

The Behavioral Health Planning Council works with local collaboratives around the state and has identified priorities across the state. Priorities include crisis services, supportive housing, transportation and support for the local provider base. OptumHealth has committed to assist in developing a crisis system. Local collaboratives have been funded at \$21,000 a year. Each collaborative receives \$3,000 from OptumHealth and the remaining \$18,000 is given out of a federal Systems Transformation Grant; grant funding ends in September 2010.

## **Working Lunch and Roundtable Discussion — New Mexico Legislative Behavioral Health Caucus**

Karen Wells, researcher, Legislative Council Service, provided an overview and historical perspective on the Behavioral Health Collaborative. ValueOptions was chosen as the first statewide entity. The Behavioral Health Collaborative oversight team has engaged in ongoing contract compliance to make sure the contractor is meeting their contract. A program assessment was conducted and covered the first year of the contract with ValueOptions. Local collaboratives and key stakeholders were involved in developing a strategic plan through an evaluation of the planning process. The New Mexico Medical Review Association (NMMRA), the external quality review organization for the state, conducted annual compliance audits and several specialized audits. External audit findings from the Lewin Group indicated access to care increased in the first year of the contract with ValueOptions. Forty-four percent of providers were dissatisfied because of untimely payments or reimbursements being too low. Consumers of the behavioral health services were satisfied, with the exception of Native Americans, who felt that the program effectiveness ranked low. The external audits from NMMRA compared ValueOptions' annual performance with regulations and standards set in the New Mexico Administrative Code (NMAC). In the final audit, it was found that ValueOptions was compliant with the regulations, and the overall audit compliance was 96.7 percent. Over the course of four years, there was a variation among the different standards; however, ValueOptions always had at least some standards that met only minimal compliance. If ValueOptions was found to be in minimal compliance in any area, a plan of correction was automatically put in place. LFC reviewed and evaluated the collaborative in 2006 and did a follow-up report in 2007. Those findings and recommendations led to the passage of HB 181, which established rulemaking authority for the collaborative regarding standards of delivery and contracts and amendments. It also required the appointment of a director, quarterly reports of performance measures and a separately identifiable consolidated behavioral health budget. The 2007 report asserted ongoing concerns with prepayments for non-Medicaid services. As of July, they have transitioned to a fee-for-service basis. There were also concerns with fragmented reports on performance measures and problems with residential treatment services for adolescents.

Ms. Wells testified that the LHHS has heard testimony from the collaborative annually since its inception. There were consistent issues, questions and comments made regarding administrative overhead, the value received for the money expended and how consumers and family members received timely information regarding services. Concerns were brought to the Courts, Corrections and Justice Committee asserting that there had been drastic cuts in services for youth, as well as elimination of residential treatment centers. The transition poses uncertainty, and the legislature has a consistent continuing interest in ensuring transparency, accountability, quick resolution of problems, responsiveness by both the collaborative and OptumHealth and providing assurance that the behavioral health needs of New Mexicans are met efficiently, safely and compassionately.

Senator Feldman requested information on the number of providers that failed and are no longer in New Mexico. Ms. Forquer said an expedited payment process has been put in place for providers who have been deemed vulnerable by the collaborative. A contract was developed

with the National Council of Behavioral Healthcare. Every provider in the state was asked to provide a financial viability assessment, including audited or unaudited financial statements from 2008. Technical assistance will be provided for improving business practices for those in trouble.

Bill Belzner, deputy Director, Behavioral Health Collaborative, said the increasing number of denials for out-of-home placements over the last six months has raised concerns. The oversight team is analyzing changes in denials that began in November 2008. The reasons for denials, reductions of care and termination of care have been tracked. The covering agencies were asked to look at the utilization management decisions by ValueOptions. ValueOptions was placed on a corrective action plan for denials regarding treatment foster care. In cases where alternative levels of care were not appropriate or denials exceeded a particular percentage, the medical director or other clinical staff was required to report back.

Chairman Varela requested a progress report for OptumHealth during the regular session as well as a status report of the ValueOptions contract as of December 31, 2009.

The joint session of the LHHS and the LFC was recessed, and the LHHS meeting was adjourned at 3:00 p.m.

**MINUTES**  
**of the**  
**THIRD MEETING**  
**of the**  
**LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**  
**August 5-7, 2009**  
**Eastern New Mexico University**  
**Ruidoso, New Mexico**

The third meeting of the Legislative Health and Human Services Committee was called to order by Representative Danice Picraux at 9:06 a.m. A quorum was present.

**Present**

Rep. Danice Picraux, Chair  
Sen. Dede Feldman, Vice Chair  
Sen. Rod Adair (8/5)  
Rep. Nora Espinoza  
Rep. Joni Marie Gutierrez (8/5, 8/6)  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

**Advisory Members**

Rep. Ray Begaye  
Rep. Keith J. Gardner (8/5)  
Sen. Clinton D. Harden, Jr. (8/5)  
Rep. John A. Heaton (8/5)  
Sen. Gay G. Kernan  
Rep. Dennis J. Kintigh (8/5, 8/6)  
Rep. Rodolfo "Rudy" S. Martinez (8/5)  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen  
Sen. Nancy Rodriguez (8/5, 8/6)  
Sen. Sander Rue  
Rep. Gloria C. Vaughn

Sen. Sue Wilson Beffort  
Rep. Jose A. Campos  
Rep. Eleanor Chavez  
Rep. Nathan P. Cote  
Rep. Miguel P. Garcia  
Rep. James Roger Madalena  
Rep. Jeff Steinborn  
Rep. Mimi Stewart  
Sen. David Ulibarri

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

**Staff**

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

**Guests**

The guest list is in the meeting file.

## **Handouts**

Handouts are in the meeting file.

## **Welcome and Introductions**

The chair welcomed everyone. Committee members and staff introduced themselves. Brad Treptow greeted the committee and announced that the Lincoln County Medical Center and Presbyterian Healthcare Services would be hosting a reception for the committee at the Lodge at Sierra Blanca that evening. Representative Kintigh noted that many behavioral health providers are not being paid on a timely basis and requested the committee to address this issue.

## **Welcome by Dr. Michael Elrod**

Dr. Michael Elrod, president, Eastern New Mexico University (ENMU), welcomed the committee to Ruidoso and made brief comments regarding the university. Committee members expressed appreciation for the work being done in Ruidoso by the university.

## **Aging in Place: A National Agenda; Projecting Work Force Needs**

Deborah Armstrong and Michelle Lujan Grisham, Delta Consulting Group, offered testimony regarding trends in long-term care on a national level. Ms. Armstrong provided a historical perspective and highlighted current initiatives in long-term care. She identified the vision and principles under which the federal Centers for Medicare and Medicaid Services (CMS) are operating, focusing on consumer choice and independence and an array of high-quality services and supports that are intended to reverse the institutional bias and increase flexibility for states. Initiatives include money follows the person, the program for all-inclusive care for the elderly (PACE) and managed long-term care. The goals and funding priorities of the strategic plan of the federal Administration on Aging were presented. Project 2020, an initiative of the National Association of Area Agencies on Aging, builds on the promise of enhanced home and community-based services and is supported by federal legislation.

Ms. Grisham described innovations and proposed models of services to promote aging in place. In New Mexico, Jewish Family Services is operating naturally occurring retirement communities (NORC) and is expanding service to Native Americans. Hidalgo Medical Services is partnering with the Area Agency on Aging to promote health and wellness through a medical home model and is exploring implementing a rural PACE model of care. New Mexico compares favorably to the nation as one of the top states in funding long-term care services. Opportunities for additional programs include "Green House" projects as alternatives to nursing home care and increased development of medical homes and university-affiliated retirement communities. The potential for a University of New Mexico (UNM) center on aging was described. The need for direct caregivers, family support services, all levels of licensed health care providers and older workers and volunteers was identified as critical to meeting the growing need for services. Demographics were provided emphasizing the dramatic anticipated growth of the aging and disability populations in New Mexico and the nation.

Committee members had questions and comments regarding the following:

- the work force needs of the future: telehealth was highlighted and suggestions were made for effective expansion of telehealth;
- the need for revisions to licensure for all levels of caregivers;
- the potential for providing college credit for training of direct care providers to high school students;
- ways in which retired health care professionals could be incentivized to volunteer;
- the experience of some states in paying for long-term care insurance for elders;
- the current problem of long waiting lists for services;
- clarification regarding the New Mexico data that was provided, especially rural disparities, and a request for additional data to be provided;
- clarification regarding the model of care provided by Hidalgo Medical Services;
- the need for viable, active senior centers;
- the value of ombudsmen in helping consumers to navigate the long-term care system; and
- the need of many elders for assistance with taking medications.

### **New Mexico's Efforts to Support Aging in Place; Work Force Development Needs**

Cindy Padilla, secretary, Aging and Long-Term Services Department (ALTSD), and Emily Kaltenbach, director of policy and planning, ALTSD, presented information regarding the ALTSD's role in providing long-term care services that support aging in place. Secretary Padilla began by introducing members of the ALTSD staff that were present. The ALTSD has organized its strategic plan around the following eight priorities: access to home and community-based services; support of caregivers; support for an individual's ability to self-direct care; zero tolerance for abuse, neglect and exploitation; empowerment of healthy and active lifestyles; support for behavioral health needs; advocacy for economic security; and promotion of civic engagement. The priorities are viewed by the department as essential elements of a continuum, all of which are necessary for a comprehensive and integrated approach to care. Ms. Kaltenbach highlighted the importance of the Aging and Disability Resource Center in connecting individuals to the services and supports they need and identified future steps to improve the center. Efforts to streamline and enhance eligibility determinations for Medicaid and other low-income subsidy programs are underway. Coordination of services and support for persons who are victims of abuse, neglect and exploitation are being expanded. A grant application has been submitted to allow face-to-face long-term care planning and short-term case management for community-based service options in the resource center. Work is underway to better manage the waiting lists for services; however, it was noted that additional dollars will ultimately be needed to fully eliminate the waiting list.

Secretary Padilla highlighted the challenges in meeting both formal and informal work force needs. The critical nature of adult protective services was stressed. Ms. Kaltenbach described the elder economic security initiative, an initiative in which the ALTSD has been chosen to participate that is designed to promote elder economic security. The ALTSD will be developing an elder economic security standard index to identify the actual cost of basic expenses for elders, such as transportation, housing and food in addition to long-term care and

health care services and supports. The ALTSD will be partnering with Wider Opportunities for Women and the Gerontology Institute at the University of Massachusetts to complete the work.

Committee members had questions and made comments about the following topics:

- the number of and type of people that the ALTSD has been able to hire under the current hiring freeze; most have been hired for adult protective services;
- the amount of funding that is available for senior volunteers;
- the role of the ALTSD in determining the budget needs for Medicaid in light of the anticipated growth of the aging population;
- clarification regarding the economic security initiative and how the department will manage this project in light of diminishing resources;
- whether eligibility for programs should be limited to people older than 50 or 55; eligibility standards are in large part set by the federal government;
- how to expand valuable programs such as the senior companion program;
- the ways in which ombudsmen volunteers are recruited and trained;
- how the area agencies on aging are designated and how they are able to service the different regions of the state;
- the strategic plan to address extreme poverty in rural New Mexico;
- a suggestion that frailty should be more important than age in determining allocation of scarce long-term care resources; and
- whether the economic security initiative will address declining retirement funds in today's economy.

### **Maintaining Elder Independence**

Wendy Basgall and Reina Owen DeMartino, staff attorneys, Senior Citizens' Law Office (SCLO), described the legal services that the SCLO provides to maintain elders' independence in the community. One important element of their work is to assist their clients to execute all necessary documents, such as powers of attorney and end-of-life decision-making documents, to preserve their rights to delegate decision-making according to their own wishes and desires and to protect their property. Ms. DeMartino provided details about counseling and legal help given to clients regarding housing, renting and ways to avoid foreclosure. Ms. Basgall described elements of financial counseling and health care counseling available to clients covering many benefit programs such as subsidized housing, home and community-based care and other public benefits that allow seniors to remain in their own homes. The SCLO also represents clients in special issues such as exploitation, denials of services and other barriers to needed services. Clients that are in need of legal guardians are assisted in the process of obtaining one.

Committee members asked questions and made comments regarding the following topics:

- clarification regarding the role of the SCLO in the execution of legal documents;
- clarification between guardianship and conservatorship; guardianship is over the person, and conservatorship is over the person's finances;
- clarification regarding the Uniform Health-Care Decisions Act that establishes parameters for health care decisions when other decision-making documents are lacking;

- the array of funding sources for the SCLO;
- the geographic area covered by the SCLO and the caseload of the attorneys;
- the extent of direct representation that the SCLO attorneys provide;
- expressions of appreciation for the work done by the SCLO;
- ways in which the ALTSD works with the SCLO and legal services for low-income elderly services and funding streams for each;
- the impact of reductions in state general funding on these programs; and
- how the ALTSD prioritizes funding for legal and other services.

### **Public Comment**

Jim Jackson, Disability Rights New Mexico, spoke to the effect of the reductions in funding for legal services. He reminded the committee that New Mexico has a progressive law on mental health decision-making.

Anna Otero Hatanaka, Association for Developmental Disabilities Providers, commended the SCLO for its work and expressed the importance of such services in addressing exploitation of elders.

Ellen Pinnes, Disability Coalition, reminded the committee that \$750,000 was appropriated for FY09 to serve more people on the disabled and elderly (D&E) waiver; she does not believe it is being spent for that purpose.

### **Medicare and Long-Term Care Medicaid: A Primer**

Karen Wells, researcher, LCS, described Medicare as health insurance for people who are elderly or disabled that helps pay for hospitalization, physician office visits, prescription drugs and other acute and post-acute services. Medicare does not cover long-term care; only short-term (up to 100 days) rehabilitation in a long-term care facility and skilled intermittent home health care and hospice are included.

Medicaid is a federal/state partnership offering a broad array of coverage for low-income individuals. Long-term care services are covered in two way, one of which is personal care option (PCO) services, such as a personal care attendant, are a basic benefit for low-income individuals who need help with two or more activities of daily living. The number of hours of service are limited based on an approved services plan. Waiver services special programs for which New Mexico has applied to the CMS to provide an array of home and community-based services were described. New Mexico has several waivers, including the D&E waiver, the developmental disabilities (DD) waiver and Mi Via, the self-directed waiver. Once a person is on a waiver, a broader array of services is available, including a personal care attendant, but also includes such services as assisted living, adult daycare and private duty nursing. The waivers have long waiting lists and are limited based on the number of slots funded by the legislature. Income eligibility for waivers is higher, but individuals must also need assistance with two or more activities of daily living, which is the nursing home level of care criteria. The coordination of long-term services (CoLTS) program has both PCO and the D&E waiver in it. Access to D&E is no greater since CoLTS was implemented.

## **Rebalancing for Home and Community-Based Services: Cost, Quality and Collaboration: What This Means for Work Force**

Secretary Padilla and Carolyn Ingram, director, Medical Assistance Division, Human Services Department (HSD), presented information on what it means to rebalance long-term care in favor of home and community-based services and how the CoLTS program helps with the rebalancing effort. Secretary Padilla discussed the rationale for engaging in rebalancing efforts and described New Mexico's experience in this area. She identified the number of people on waiting lists for services in all the waivers, including CoLTS. Currently, only people being reintegrated into the community from a nursing home are being put on the D&E waiver in CoLTS. Secretary Padilla provided an overview on the CoLTS program, which is a coordinated and integrated managed long-term care program. The goals of the program are to promote home and community-based services, reduce unnecessary institutional placements, coordinate Medicare and Medicaid funding streams and improve the health status of the population served. The eligibility criteria to enter the program were reviewed. Ms. Ingram provided specifics regarding the number of participants, which managed care company they are enrolled in and elements of service coordination and quality of care. She identified a broad array of quality and performance measures that are in place for CoLTS. Disease management programs are a requirement of the contract with the managed care organizations. She described the ways in which the managed care companies are able to help people remain in their homes and how legislative appropriations affect their ability to meet all the needs of this population.

The program is financed through risk-bearing contracts with managed care organizations. Value-added services that each managed care organization offers were identified. Oversight of the program is extremely intensive and includes numerous internal and external audits. When problems are identified, the managed care companies are put under corrective action plans and may be sanctioned.

Secretary Padilla highlighted successes and lessons learned from the first year of implementation. Specific challenges that were faced were described, along with the solutions to those challenges. In the future, the departments hope to achieve improvements in coordination of Medicare and Medicaid, with an ongoing focus on quality improvement activities. The benefits of the collaboration between the HSD and the ALTSD in implementing this program were described.

Committee members had questions and comments in the following areas:

- how people are approved for participation in the CoLTS program and how determinations are made regarding nursing home care versus home and community-based services;
- how much time elapses before a service coordinator visits an enrolled member;
- the confusion about what is actually available since the implementation of CoLTS;
- a comparison between nursing facility costs and the cost of home and community-based services;
- serious problems with CoLTS providers not getting paid;
- the necessity for some individuals to still be served in nursing homes;

- a request for a report on how the legislative appropriation for the D&E waiver was utilized;
- a request for a written description of how eligibility for CoLTS is determined and for verification that nursing home placement is not a prerequisite for being enrolled into the program;
- the number of people on Medicaid for whom the department has an inaccurate address;
- the way in which oversight of the personal care option occurs to identify potential billing abuse by family members;
- the national average cost of a nursing home per year, which is estimated at \$75,000 per year, or between \$3,600 and \$4,200 per month;
- how New Mexico compares to other states in the cost of long-term care; and
- clarification regarding the formula by which per member, per month payments to the vendors is calculated.

### **Stakeholder Perspective on Meeting CoLTS Program and Work Force Goals**

A panel was invited to give stakeholder perspective on the effectiveness of the program. The panel included Linda Sechovec, executive director, New Mexico Health Care Association; Gil Yildiz, executive director, Independent Living Resource Centers; and Doris Husted, policy director, the ARC of New Mexico.

Ms. Yildiz identified transitions to community living, even with the CoLTS program, as problematic due to inadequate housing and housing assistance programs. It is the position of the Independent Living Resource Centers that the statutory requirements of the Money Follows the Person in New Mexico Act have not been implemented through CoLTS.

Ms. Husted stated that although CoLTS may have introduced elements of coordination and flexibility, it did not alter any Medicaid eligibility requirements, so no new categories of people are served by the program. She noted that CoLTS does not only serve seniors; young people with disabilities are also served. She reminded the committee that concerns were raised in a memorial that passed the legislature in 2008 and highlighted those concerns. She asserted that individuals should have the choice to live in the community, even if that does not appear to be a safe choice, and that they should have the ability to hire and train their own caregivers. She noted that many people will choose to enter the CoLTS program through a nursing home because nursing home coverage is mandatory under Medicaid, and home and community-based services are not. Once a person is enrolled in CoLTS by virtue of admission to the nursing home, the likelihood that they can be transitioned back into the community is higher. She emphasized that New Mexico has made a fundamental change in how long-term care services are provided in the state and urged the committee to hold the departments accountable for running the program well.

Ms. Sechovec spoke representing nursing facilities, residential care facilities and independent living facilities. She made a comment provided by Joie Glenn on behalf of the home health care agencies, thanking the departments, acknowledging that progress is being made but that problems remain. She provided general demographic and payment information from the

CMS and highlighted nursing facility reimbursement issues. A national audit report compares New Mexico's costs and reimbursement rates, reflecting that nursing facilities are underfunded in the state by an estimated \$11.20 per person per day. Nursing facilities in New Mexico are losing money every day. Some have ceased admitting Medicaid patients. Ms. Sechovec explained that CoLTS exacerbates these issues due to late payments. Medicare pays enough, so far, to offset losses under Medicaid, but Congress is considering reducing those payments. Jodi Knox, director of a not-for-profit home health hospice, nursing facility and assisted living facility in Carlsbad, noted that many of her clients are too ill to be cared for at home, that they are losing \$1,300 per day in Medicaid and that payments are not timely. She has a shortage of nurses and cannot pay competitively with the hospital. Medications are not being approved or provided by the managed care organization, putting patients and the nursing facility at risk. She predicts that if Congress approves the Medicare cuts it is considering, nursing facilities around the state will close.

Committee members had questions and made comments as follows:

- clarification regarding what constitutes a "clean claim";
- the timeliness or lack of timeliness of payments and support for the time period being shortened to at least 14 days or less;
- reasons for providers having difficulty satisfying claims requirements under CoLTS that they did not experience prior to CoLTS;
- the number of nursing facilities at financial risk due to this program and the disproportionate effect on rural facilities;
- recognition that rural facilities have a higher number of Medicaid patients than urban facilities;
- the insupportable cost of bureaucracy in the delivery of health care and long-term care;
- situations in which physician-ordered medication could be denied payment by a managed care organization;
- recognition that the state budget is currently overspent by \$400 million and that there is no more money available to increase payments to providers; and
- clarification about which businesses being discussed pay taxes in New Mexico.

### **CoLTS: Program Potential and Barriers**

Laura Esslinger, executive director, Evercare of New Mexico; Quinn Glenzinski, director, Regulatory Affairs, Evercare of New Mexico; Janine Davis, chief operating officer, Amerigroup New Mexico; and Mark Padilla, vice president, Government Affairs, Amerigroup New Mexico, composed a panel representing the CoLTS managed care vendors. Mr. Padilla began by stating that he believes that CoLTS is part of the solution to long-term care in New Mexico, but recognizes that many people in the room disagree. He does not expect to change any minds, but assured the committee that the testimony the panel will provide is a true representation of how they are doing. Ms. Davis presented combined data reflecting early program successes, including the number of calls answered, average length of time to pay claims, days to transition someone from a nursing home into the community, outreach events and

more. She provided a case study of one 96-year-old client to demonstrate the benefits of the program.

Ms. Davis drew the attention of the committee to materials in the packet that contain other anecdotal stories such as this. Ms. Esslinger acknowledged that the day has been long and emotional. She identified a few program challenges and barriers that could be worked on to improve the program. Many of these barriers existed prior to CoLTS implementation, but CoLTS may hold the solution to them. Despite the program goals of CoLTS, services remained siloed within the program. Policies and regulations, including waiver allocations, often hamper the managed care organization's ability to be creative in care planning and delivery of services that could save money for the state. The third-party assessor process in New Mexico is cumbersome and results in delays to care. The costs of community services could be better managed under CMS criteria. The stability of the nursing facility industry, the inability of the state to locate members and Medicare cross-over claims are other areas in which the managed care venders would like to work with the state to identify and implement creative alternatives or solutions. Mr. Glenzinski presented information regarding the adequacy of the provider network. Overall, nearly 1,300 primary care physicians, 2,600 specialists, 64 hospitals and 746 ancillary and long-term service providers are now contracted with one or both of the managed care venders. Access to services is being provided in rural and frontier areas of the state. In conclusion, Mr. Padilla remarked that the CoLTS venders are proud of the program and feel they are poised to make the system much better and more responsive. The initial period of implementation is behind them, and the program is becoming a mature and effective one.

Committee members had questions and comments as follows:

- clarification regarding who can be a caregiver within the PCO program and how the caregiver is paid;
- how someone qualifies for Medicaid and CoLTS and receives home and community-based services;
- whether out-of-network reimbursement is available; in-network reimbursement is a negotiated rate and out-of-network reimbursement is 100% of the Medicaid rate;
- whether there is an active program to direct clients to receive their care from network providers;
- whether the administrative cost and the cost to the state of providing long-term care have increased since the implementation of CoLTS;
- a request for evidence that the program is streamlining service provisions and saving money for the state;
- an expression of appreciation to the venders and the state for their efforts to solve program problems;
- a request for a status report on Money Follows the Person in New Mexico Act; community integration has been occurring and some funding exists for transitional costs;
- a comment by Ms. Pinnes that money follows the person is not being implemented;
- a request that the money follows the person be placed on a future agenda;

- whether all nursing homes have contracts with CoLTS vendors; not all have signed up with both vendors;
- the method by which noncontracted providers are paid;
- the method by which clients are assigned to or choose a managed care organization;
- clarification regarding outreach efforts to educate potential clients about their choices;
- whether the goals of service coordination have been successful;
- whether a provider survey queried the timeliness of reimbursement;
- whether there is a dollar figure that could be generated that would make providers whole that could be used during a special session;
- a request for a memorandum from the managed care organizations regarding the barriers to implement the program more efficiently; and
- the potential for development of a common claim form and common credentialing process.

The meeting was recessed for the day at 7:00 p.m.

### **Thursday, August 6**

Representative Picraux called the meeting to order at 9:25 a.m. Sandi Aguilar, executive director, Ruidoso Valley Chamber of Commerce, welcomed committee members and thanked them for coming.

### **Clinical Work Force and Emergency Medical Services (EMS) Training Programs at ENMU**

Dr. Elrod introduced a panel of presenters, including Juanita Garcia, coordinator, student advising, ENMU-Ruidoso; Jane Batson, Division of Health, ENMU-Roswell; Beth Hardy, instructor, BSN Completion Program, ENMU-Portales; and Steven Atkinson, EMS coordinator, ENMU-Alamogordo, to discuss health care work force and EMS issues in eastern New Mexico.

Ms. Batson presented data that reflect critical health care professional shortages in the state, with rural areas most severely affected. New Mexico ranks forty-ninth in the nation in the number of dental hygienists and pharmacists, forty-eighth in the number of radiologic technologists, forty-first in the number of respiratory therapists and thirty-ninth in the number of emergency medical technicians and paramedics. Thirty-two of the 33 counties in the state qualify as health professional shortage areas or medically underserved areas for a lack of primary care physicians. Ms. Batson is actively interested in changing those statistics. Ms. Hardy spoke about efforts to recruit and assist associate degree nurses to complete their BSN degree and described a nursing assistant program in place at ENMU-Portales that serves as a career ladder for nurses. The federal Workforce Investment Act of 1998 (WIA) provides financial support for individuals in both of these programs. Ms. Batson reminded the committee that two years ago, all the nursing programs in New Mexico aligned their entrance requirements. Mr. Atkinson described training programs for paramedics; Alamogordo teaches the higher level of paramedic training; however, the city has a shortage of EMS workers and paramedics. Mr. Atkinson is

working to train and retain these workers. Education is the biggest challenge for small communities and rural areas. Once trained as a paramedic, there are educational requirements to retain licensure. Ms. Batson identified various measures that ENMU is taking to address the challenges identified. The school is working to develop and implement online courses and live streaming video for all certificate and degree programs. The university has applied for grants, including a United States Department of Labor grant, and has worked hard to develop strong partnerships with employers to help fund the cost of acquiring state-of-the-art equipment for use in training. Last year, the school piloted live video streaming for the nursing program, which resulted in a 100% pass rate with national boards. ENMU has also partnered with UNM for distance learning opportunities for local students. One local hospital provided the salary for an instructor. Collaborations are essential to the success of these programs.

Challenges in addressing rural health care work force issues include EMS workers who do not live in an area where refresher training is offered, recruitment and retention of qualified faculty, sources of funding to cover the cost of tuition, books and transportation and a lack of educational preparation at the high school level. A survey conducted by ENMU showed that 90% of the students entering that college needed at least one remedial course in order to be accepted.

Ms. Hardy discussed the problem of hiring qualified faculty; ENMU-Portales has had one vacancy for more than one year. Last year, ENMU went 100% online in its BSN completion program. Its goal is to "grow our own", taking associate degree nurses working in the area and assisting them to complete their bachelor's of science degree in nursing. Currently, the program has only three full-time staff. She supported the importance of partnerships with businesses and other educational institutions to be successful.

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

- whether students using online educational methods are isolated from other students;
- how clinical experience is incorporated into online training programs;
- steps ENMU is taking to prepare high school students to be ready for health professional courses of study;
- whether data are available on the areas of the state suffering the most severe health professional shortages; New Mexico Health Resources and the New Mexico Health Policy Commission have both conducted surveys on this issue; ENMU and possibly other universities have conducted surveys;
- clarification regarding the availability and use of federal American Recovery and Reinvestment Act of 2009 (ARRA) funding for health professional work force development; ARRA funds do not support allied health work force training;
- whether the local work force development boards are providing any support for health care work force development; money is available for allied health care work force training; however, not all the local boards are responsive;

- a request that the committee write a letter to the Eastern Area Work Force Development Board urging it to use funds in support of allied professional training; the request was unanimously supported by the members;
- sources of state general funding to support individuals entering allied health professional training;
- whether there are limitations to the number of scholarships for individuals desiring to enter nursing school; entrance to nursing school is more limited by a lack of faculty;
- clarification regarding a proposed telepharmacy program; a model program exists in North Dakota; Hidalgo County Medical Center is implementing this program and ENMU is collaborating with it;
- the potential for rural pharmacies to participate in the federal 340B pharmacy program;
- whether ENMU offers training for audiologists and by what means they are able to determine levels of deafness;
- clarification regarding the difference between emergency medical technicians and paramedics and what board licenses them; the EMS Bureau in the Department of Health licenses them;
- details regarding a proposed EMS management degree being developed at ENMU;
- what can be done that is currently not being done to recruit allied health professionals;
- the requirements to become nurse faculty;
- the importance of inspiring young people to think about careers in health care in elementary school;
- how the education funding formula does or does not support higher education;
- the long-term viability of the partnerships ENMU has with UNM and others; and
- problems with access to anesthesiologists and certified nurse anesthesiologists.

### **Viability of Trauma and EMS Work Force and Infrastructure**

Don McNutt, Statewide EMS Advisory Committee, introduced the panel and others in the audience involved in EMS and trauma in New Mexico. He identified the goal of today's presentation to be a request for legislation called the New Mexico EMS Legacy Act, which would generate an estimated \$17 million through a 1% service charge on all homes, rentals and auto insurance policies in New Mexico, with proceeds to be earmarked for EMS services. He provided background information regarding the system of EMS in New Mexico, including a history of legislative funding.

Dale Kester, M.D., chair, New Mexico Trauma Fund Authority, identified the tiers of trauma designation. Level one is the highest level, with 24/7 access to trauma and with educational development at the site. New Mexico has no level two centers; however, San Juan County Regional Hospital and Christus St. Vincent are applying to move from level three to level two. Four additional hospitals are now level four trauma centers, with several more in the pipeline to become certified trauma centers. The Trauma System Fund, which received \$5.9

million in FY 2009, suffered a cut in funding in FY 2010. In order to maintain the integrity of the trauma system, additional funding is needed.

Mike Miller, advocate and past chair, EMS Advisory Committee, provided a historical perspective on the development of the state's EMS system, including the "dollar for life" funding stream established in 1987, which generated \$1.8 million for EMS services in New Mexico. In 1992, EMS funding was returned to the general fund and funding increased up to approximately \$4 million, which is used to purchase equipment and conduct necessary training. In recent years, general funding has declined.

Kyle Thornton, EMS bureau chief, Department of Health (DOH), spoke about the current need for additional funding for EMS. The Trauma System Fund Authority Act exists to assist municipalities and counties to establish and enhance EMS systems. He identified that currently the fund has \$3,875,900, which allows the state to fund just over one-third of the requests for funding in the state. House Memorial 20, passed in 2007, identified a need for an additional \$8 million to fully fund EMS services. He clarified that fire departments and EMS services are funded separately, even though they are often co-located. Fire funding is much more generous than EMS funding.

Jennifer Witten, executive director, American Heart Association, provided data regarding the extent of strokes and heart attacks in New Mexico and the system components that are needed to address these diseases. The costs of heart disease and stroke in New Mexico combined totaled nearly \$85 million last year.

Jim Stover, director, Lincoln County EMS, and a board member of the Region III EMS Board, presented information about EMS activity in Ruidoso last year and the effect of inadequate funding in the area. Training, transportation and the ability to respond to emergencies are all affected. He described the circumstances and challenges of a bus accident in Corona and the mobilization of EMS personnel to the event.

Tim Gorsky, Region II EMS Board chair, noted that neither hospital in Las Cruces is a certified trauma center. Tom Reilly, chief of a fire department, provided information about cross-training of firefighters as paramedics. James Markham, mayor of Silver City, expressed frustration at the current lack of funding for EMS services. Jan Bell, EMS paramedic for 28 years, has trained many personnel and volunteers. As a homeowner, she spoke in support of the proposal. Jan Elliott, representing 135 EMS facilities, spoke in favor of the proposal and asked for support of the committee.

Committee members asked questions and made comments as follows:

- the percent of EMS personnel who are volunteers;
- clarification about when funds were last increased for EMS services; it was in 2006;
- whether fire funding should be extended to include EMS funding; the panel does not support this idea, believing it would harm fire response statewide;

- could fire funds currently be use to fund EMS? No, fire funds are specifically earmarked;
- recognition that EMS volunteers have been personally funding these services, but the need far exceeds their continued ability to do so;
- clarification regarding thrombolytic therapy to treat blood clots and strokes;
- whether any other revenue sources were considered in putting together the proposal;
- whether the Public Regulation Commission would need to amend any insurance regulations to enact this proposal;
- whether EMS services can be billed;
- clarification regarding EMS certification and recertification requirements;
- whether the governor has been approached for his support of this proposal; not yet, but that is planned;
- the value and potential for promoting the proposal via an email campaign;
- a suggestion that the proposal be funded by local option incremental tax increases;
- whether some regions are struggling more than others with this issue; generally speaking, rural areas are more affected; and
- an observation that the New Mexico Finance Authority is also discussing a similar idea to fund the State Road Fund.

A motion was made by Senator Ortiz y Pino, seconded by Senator Feldman, that a straw poll be taken to endorse the concept of the proposal on a 1% premium tax to fund EMS and trauma services; clarification was given that the vote would be nonbinding. No vote was taken on the motion itself, only a vote was made pursuant to the motion's content: a vote to endorse the concept of the proposal presented by the panelists speaking about EMS services. After discussion, Senators Feldman, Ortiz y Pino, McSorley and Rodriguez and Representatives Picraux, Lujan and O'Neill voted in favor; Senators Papen, Lopez and Kernan and Representative Espinoza opposed the concept of the proposal. Objections were raised and clarified about the vehicle of a straw poll.

### **Public and Community Health Work Force in New Mexico**

Dr. Alfredo Vigil, secretary of health, presented an update to the committee on the surveillance of hospital-acquired infections (HAI). He asserted that this initiative is an outgrowth of the desire of all of us to have transparent information that enables people to make good health care decisions. He began with historical information regarding the initiative, who was involved and what the goals of the initial pilot project were. Six hospitals participated in the pilot. Secretary Vigil noted that the experience and ability of hospitals to survey and collect data regarding HAI vary greatly based on the type of hospital. Two indicators were chosen to study: central line bloodstream infections and health care worker vaccination rates. The rationale for choosing those indicators was given. The database of the National Healthcare Safety Network is being utilized for the project. Results from the pilot were presented. So far, 0.8 infections per line days were detected, compared to much higher national results. Secretary Vigil cautioned that the sample size in New Mexico was too small to be very significant. Vaccination rates exceeded the requirements of the joint commission in all cases. Senate Bill 408, the Hospital-Acquired Infection Act, was passed in the 2009 legislative session. Secretary Vigil reviewed the

act and noted that although the requirements of the act seem simple, it will demand a great effort on the part of the department and the hospitals of New Mexico. The HAI Committee has established specific goals to satisfy the statutory requirements. More hospitals are currently being recruited to collect data on the two indicators. Training will be provided to any interested hospital, and a state HAI plan will be developed and submitted to the federal Department of Health and Human Services (DHHS) by January 1, 2010.

Committee members asked questions and made comments on the following topics:

- the value and potential problems of sharing the findings of such data with the public;
- whether the DOH has all that it needs to accomplish the task;
- a comment that a stricter measure in Pennsylvania reportedly saved the state \$638 million in one year;
- an observation that federal reform measures being discussed in Congress propose not reimbursing hospitals for some HAIs;
- whether hospitals in New Mexico screen patients on admission for methicillin-resistant staphylococcus aureus (MRSA); no, best practice data do not support this as a meaningful action; and
- recommendations regarding the flu vaccine and the pneumonia vaccines.

Secretary Vigil invited Jerry Harrison, executive director, New Mexico Health Resources, and Harvey Licht, division director, Primary Care Division, DOH, to join him to present information on the need for health care professionals in New Mexico. Secretary Vigil noted that 30 years ago, there were projections that the health professional work force would be adequate into the foreseeable future, but this has not proven to be true. He commented that the pipeline for training health care professionals begins with elementary and high schools and that much work must be done to improve education at that level. He noted that universities are having a very difficult time recruiting professionals as faculty, and that providers in private practice are far out-earning their colleagues in public health or in education.

Mr. Licht commented that his youngest daughter just graduated from nursing school and her starting salary is higher than his. There is a fine balance to be reached in predicting the number of health care professionals that will be needed. Since the early 1990, the need has been underprojected. He reviewed the programs in place in New Mexico to recruit and retain practitioners that are managed by the DOH, including the centralized clearinghouse for this activity run by New Mexico Health Resources, the New Mexico Health Service Corps stipend program, the J-1 visa program, the tax incentive program for rural health professionals and coordination of the National Health Service Corps program. Mr. Harrison reviewed the successes that have come from all the activities just identified by Mr. Licht. New Mexico ranks third in the nation for the number of health professionals recruited to work here; however, all counties and communities still do not have the full complement of health professionals that are needed. He highlighted the particular need for dental health care professionals in the state. Mr. Licht noted there are tremendous opportunities in the federal ARRA funding as well as in the Senate health care reform proposal sponsored by U.S. Senators Kennedy and Bingaman, including money for states to develop plans for meeting their health professional work force

needs. He delineated four additional opportunities for consideration for state support: expansion of the oral health care work force; expansion of professional education financing; expansion of the tax credit program; and cooperative licensing and credentialing.

Committee members had questions and comments in the following areas:

- an observation that primary care physicians are not seeing increases in their salaries, mainly due to low reimbursement under Medicare;
- an observation that fewer and fewer physicians are in private practice; many are employed in hospital-owned practices; a recent survey indicated 70% of physicians in New Mexico are employed versus in private practice;
- clarification regarding the average age of a physician in New Mexico, which is in the upper forties; the average age of dentists in Roswell is in the mid-sixties;
- clarification regarding shortages among specialties;
- the preference for addressing shortages with New Mexico residents;
- the potential and benefit for using more physician's assistants and other professionals with advanced scopes of practice;
- the additional value of community health workers (*promotoras*) in meeting health care needs;
- the extent to which New Mexico's recruitment and retention programs are used for physician extenders;
- acknowledgment that the programs, however successful, are not funded sufficiently to meet all of the demand for those programs;
- the extent to which the development of a dental school would address the need for dentists in the state; a preliminary study is underway to evaluate this;
- recognition that the requirement that physician assistants be directly supervised by a physician limits their ability to engage in independent practice; efforts are underway to change this requirement;
- clarification regarding the ARRA funding and whether it is being funneled through the DOH; the funds are being managed by the National Health Service Corps; the DOH is working to maximize participation;
- whether any of the ARRA funds will be used to fund the UNM Medical School scholarship program (probably not);
- a request for information about whether UNM is applying for funds to support the medical school, thereby freeing up general fund dollars to fund the scholarship program;
- recognition that the number of physicians practicing in New Mexico has increased, not decreased as is often alleged;
- whether WIA funding can be used to fund health professional work force development;
- whether funds to build a dental school would be better spent in the Western Interstate Commission for Higher Education program; Pug Burge suggested that Dr. Roth from the UNM HSC would be glad to testify on this topic; they are looking at partnering with a dental school in Arizona for this purpose;

- ways in which New Mexico will be able to address special needs such as autism or deafness in the future;
- whether the funds for the dental school feasibility study are available to be used for bricks and mortar, or just for the study; the dollars are strictly for the study;
- recognition that an earlier study found that a better use of New Mexico's resources would be to fund dental education elsewhere than to have a dental school here;
- what efforts are underway to encourage people to enter the profession of dentistry; pre-dental clubs at UNM have resulted in an increasing number of students pursuing dentistry;
- recognition that there are too few residency slots to accommodate all the physicians who graduate from the medical school;
- the potential for expansion of medical training at New Mexico State University in Las Cruces;
- acknowledgment that the anticipated shortage of health care professionals is a national crisis that is not being addressed at any level;
- a request from the chair to assemble the necessary people to come to New Mexico and before this committee to address this critical policy issue;
- the possibility of limiting medical school admission to students who attended high school in New Mexico as some other states have done;
- a request for data about the number of students at the UNM School of Medicine who never attended high school or college in New Mexico; and
- the difficulties and the costs contingent with the development of internship programs at hospitals in New Mexico; Dr. Romero-Leggett of UNM is working to identify ways to introduce these programs in charter schools in New Mexico.

### **Biologic Disaster Preparedness in New Mexico**

C. Mack Sewell, Dr.PH, director, Epidemiology and Response Division, DOH, provided a brief overview and update on H1N1 influenza (swine flu) in New Mexico. He provided background information on the genesis of the pandemic, beginning in April 2009, and statistics on the numbers of cases worldwide and in New Mexico. New Mexico has had 156 cases with 20 hospitalizations, although currently and from this point forward only cases resulting in hospitalizations and deaths are being counted. The characteristics of this flu were described. It predominantly affects young people and has been relatively mild except for those with high risk conditions. New Mexico has an effective process for tracking and identifying H1N1 and other flu infections. Surveillance is much greater in some other countries such as China. Early in the course of this epidemic, the federal government released 25% of the antiviral stockpile, recognizing the potential seriousness of the virus. Plans are being developed at the federal and state levels for an anticipated increase in H1N1 this fall. Two vaccines will be available: one for seasonal flu and one for H1N1. The DOH is collaborating with tribes and tribal health providers to identify the best way to distribute vaccines on tribal lands. The DOH has 18 different committees around the state addressing various aspects of this pandemic.

Committee members had questions and comments in the following areas:

- the potential for the virus to mutate and the vaccines to not be effective;

- the significance, if any, of recent outbreaks in other parts of the world;
- clarification regarding the recommendation for flu vaccines this fall; this fall, seasonal vaccines will be available followed at a later time by the H1N1 vaccine, which will likely be in two doses;
- how populations will be prioritized for the H1N1 vaccine;
- the incidence of deaths from influenza on an annual basis; 36,000 die per year in the nation and around 200 to 300 in New Mexico;
- whether there is an overreaction to H1N1 compared to seasonal flu; no, there is much unknown about H1N1, and it is therefore much more unpredictable than seasonal flu;
- recognition that one reason to vaccinate children is that they are carriers of the flu and can quickly spread the disease;
- what plans the DOH or the nation has to educate the public regarding the severity of the disease should it become deadly; and
- the significance, if any, of protests against anticipated mandatory vaccinations.

There being no public comment, the committee recessed for the day at 5:15 p.m.

### **Friday, August 7**

Representative Picraux called the meeting to order at 9:05 a.m.

#### **Health Information Technology: HIPAA, ARRA/HITECH Updates**

Michael Hely, staff attorney, LCS, testified that ARRA has funding for infrastructure and implementation of health information technology (HIT). It is anticipated that regional extension programs and centers will be established in every state, and a national research center, to be called the National Institute of Standards and Technology, will partner with nonprofits to provide technical support. The total amount of funding is not yet determined as no regulations have yet been developed; however, there is \$19.2 billion in incentive payments for health care providers to establish and implement electronic medical records (EMRs), provided that they are able to demonstrate "meaningful use" of these records. Additionally, \$2 billion is available for support of such projects as HIT logistics support for telemedicine. The term "meaningful use" has not yet been defined; however, a HIT committee has been established and has identified specific objectives. A national coordinator of HIT will promote the objectives of ARRA. Mr. Hely discussed a number of steps New Mexico could or should be taking to take advantage of all the ARRA funds such as whether the state has a strategic plan for the implementation of HIT statewide. Nine additional considerations were presented.

Mr. Hely described privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) that were changed in ARRA. The section of ARRA that describes HIT enhancements is called HITECH, which exists as a law within the law. Individual rights to information contained in EMRs have been expanded, making it clearer that individuals can have access to, or choose to withhold personal information. Comprehensive protocols regarding response by holders of personal health information to breaches to health records are now in law,

and increased penalties for violation of the law are in place. New marketing and sales restrictions will have the effect of limiting such practices as data mining. Business associates are now covered by the same rules as other health care providers. The DHHS is now required to issue annual guidance on the most effective and appropriate technical safeguards for compliance.

Committee members had questions and made comments as follows:

- the extent to which providers will have input into the development of technological standards;
- guidance regarding the specific type of technology that is most effective;
- the possibility that some physicians will choose to retire rather than implement EMRs;
- the rapidly changing nature of technology that may make EMRs systems installed now obsolete in the future; and
- to whom the \$65,000 payments will go and on what schedule.

### **Electronic Health Records and Broadband Access: Next Steps**

Bob Mayer, chair, New Mexico Telehealth Commission, provided additional information regarding ARRA funding for HIT and broadband. Improving the quality of health care, improving the health of populations and improving the efficiency of health care systems are the broad goals and intent of HITECH. The funding will be divided between incentives for providers to establish EMRs and funding for research, a health information exchange, a possible loan program, research and work force development. Incentive programs are established in both Medicare and Medicaid; funding is limited to one stream or another and is limited to a five-year period. The definition of "meaningful use" is under development, but will likely include requirements for reporting of certain clinical outcome measures. Two billion dollars is available in competitive grants to develop a health information exchange, to adopt EMR technology, to conduct research on HIT and for work force development.

Mr. Mayer estimated that \$7 billion is available to establish broadband access throughout New Mexico through a competitive grant process. The funding requires a nonfederal match. New Mexico is collaborating to provide a single grant, with partners in the private sector providing the match. Two federal telehealth bills are now working through Congress that will expand the capacity of New Mexico to utilize telehealth. Both bills focus on home health and expanding access to rural areas.

### **Electronic Health Records: A Provider's Perspective**

Arlene Brown, M.D., has been utilizing computer technology to manage her practice since she first arrived in Ruidoso in 1983. Since 2004, she has been fully engaged in use of EMRs. Learning to use an EMR system can be frustrating, but it is worth it. She is able to access her patient's records from anywhere in the world and believes the quality of care provided is improved. In her experience, the cost of transitioning to an EMR system was not cost-prohibitive, and the costs are coming down. In her view, the money was well spent. The only major problem in a rural area such as Ruidoso is the cost and unreliability of electricity. Dr. Brown currently prints copies of all the EMRs and entries. One of the largest costs of practicing

medicine today is in the redundancies of the system. Confidentiality concerns are overstated and hamper a physician's ability to exchange necessary information about patients with other physicians. A well-designed national EMR system should reduce redundancy and could greatly reduce costs. Dr. Brown recommends standardized encryption for all users in the state.

Questions from the committee for both of the previous presenters covered the following topics and areas:

- the critical need for EMR systems to be able to exchange information; right now they do not;
- progress that is being made to achieve interoperability and effective exchange of health information;
- ways to address problems related to an unreliable power grid;
- how patients react to and benefit from EMRs;
- the use of email to communicate with patients and for patients to communicate with their physicians;
- how redundancy and duplication of effort occur due to lack of access to EMRs, especially in emergency departments;
- the existence of a state "supercomputer" and how that will enhance HIT; it exists and is primarily designed as a research tool;
- New Mexico management and accountability of a health information exchange;
- how the development of EMR systems will interface with Native American tribes, pueblos and the Indian Health Service;
- the potential for copying medical records onto a personal jump drive to enhance portability and personal access to records; physicians are concerned about the possibility of the records being altered;
- the amount of time that is needed to train staff in the use of an EMR system;
- the amount of lost productivity during the transition versus the amount of time saved in physician paperwork time;
- the importance of clearly identifying what medical information can and cannot be shared electronically;
- privacy concerns with the use of email;
- recognition that different EMR systems have vastly different costs;
- whether confidential patient records can be electronically transferred in the event a physician retires or sells the practice; current revisions to HIPAA allow this, unless the patient chooses to block it;
- concerns regarding an insurer's ability to rescind a health insurance policy due to information that was not previously revealed that could be considered a pre-existing condition;
- clarification regarding marketing prohibitions in HITECH and whether this applies to pharmacists; there was a request to see the language that relates to this; and
- acknowledgment that New Mexico has a restrictive law that limits data mining.

## **Public Comment**

Ms. Otero Hatanaka addressed some issues regarding the CoLTS program. Developmental disability providers are experiencing problems with lack of timely reimbursements, similar to the nursing home industry. Additionally, assessment information that is performed by the managed care organizations is not being shared with providers, requiring them to conduct another assessment for which they cannot be reimbursed. Developmental disabilities providers reassert their longstanding position that they do not want the DD waiver incorporated into CoLTS. Ms. Otero Hatanaka reminded the committee that DD providers have not had reimbursement increases sufficient to keep up with costs. Appropriations to increase funding for the DD waiver do not translate into provider increases. Many agencies have lost the ability to provide health care benefits to their employees and are finding it increasingly difficult to recruit staff due to an inability to pay competitive wages. Finally, Ms. Otero Hatanaka commented that the ongoing costs of the *Jackson* lawsuit are detrimental to providing care to recipients.

### **ISD2 Update, YES New Mexico Progress Report and Reporting Accountability Objectives**

Katie Falls, deputy director, HSD, introduced Steven Randazzo and Jan Christine of the HSD. Ms. Falls began with an overview of the ISD2 system, which is 25 years old and is not a relational database. It is an onerous and inadequate system and does not produce information that is useful in managing the HSD programs. Upgrades to ISD2, now being called ISD2R, will provide far better information. The HSD is buying existing technology and modifying it to meet New Mexico needs. Fourteen million four hundred thousand dollars has already been appropriated, and the department will ask for more money, recognizing that the economic situation of the state is poor. The HSD is developing a business intelligence tool to integrate and coordinate the many programs it manages and administers in coordination with other departments. Tentative completion is slated for January 2010. Reporting and accountability will be greatly enhanced when these changes are in place. Document imaging will allow scanning of all client applications and will store the data for future use such as recertification applications. Client encounter tracking will allow greater efficiency for workers.

Ms. Falls addressed the requests in House Memorial 125, which called for greater reporting and accountability from the HSD. She described the way in which client and budget information is currently being tracked and projected. To alter that would be very costly. Information is more readily available regarding enrollment and has only a three-month lag time. The department is exploring posting these reports on the web site. Information regarding denials and terminations are not readily available on the current ISD2 system and are often inaccurate. The business intelligence tool will allow them to obtain this data.

YES New Mexico is a web-based program that includes a screening tool and a tool to apply for benefits. Seven state agencies are involved in the development of YES New Mexico and will be able to utilize it. It will eventually replace ISD2. It is currently being phased in three counties, with statewide implementation tentatively set for October or November. Ms. Falls provided a demonstration of the tool. The program was imported from three states and modified for New Mexico. When fully implemented, it will allow online screening and

application for numerous programs such as Medicaid, child care, the WIC program, the low income home energy assistance program, food stamps and others.

Questions and comments from committee members covered the following areas:

- whether, the YES New Mexico system will be able to interface with other systems; currently, permits interface between the DOH, HSD and Children, Youth and Families Department; in the future, the ALTSD, the Developmental Disabilities Planning Council and others will be included;
- whether YES New Mexico will assist in managing waiting lists and identifying who on the list needs immediate help;
- whether current offices for applications will be co-located to facilitate paper compliance with the online application process; when combined with the new document scanning capability, collaboration will be greatly enhanced;
- an observation that in New Mexico, birth certificates contain the statement "do not copy"; this statute could be changed with legislative action;
- the charge to get a certified copy of a birth certificate;
- the way in which a client utilizing this system is notified that the client's application has been received and approved;
- privacy protections that are in place to preserve privacy of information; protections are similar to online banking;
- a description of the plan for identifying and addressing false information;
- whether some information is more restricted than others, and who has access to it;
- the extent to which the HSD is eliciting email addresses and gaining permission to communicate by email;
- other mechanisms that are intended to simplify and streamline the application, including access to a caseworker; and
- when all these upgrades are implemented, where New Mexico will stand relative to other states; within three-and-a-half years, it will be in the top 10.

### **Public Comment**

Patricia Anders, staff attorney, New Mexico Center on Law and Poverty, complemented the department on its efforts and the legislature for its support.

Representative Picraux suggested that at the next meeting, a policy discussion will occur sooner in the meeting to try to focus the committee's policy debate and consideration.

There being no further business, the meeting was adjourned at 12:40 p.m.

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

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

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

**Present**

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

**Absent**

**Advisory Members**

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

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

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

## **Staff**

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

Karen Wells, Researcher, LCS

Jennie Lusk, Staff Attorney, LCS

Josh Sanchez, Intern, LCS

## **Guests**

The guest list is in the meeting file.

## **Handouts**

Handouts are in the meeting file.

## **Wednesday, September 16**

### **Welcome and Introductions**

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

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

Laura Tobler, program director, Health Programs, National Conference of State Legislatures identified actions taken by other states to save money in their Medicaid programs. She noted that Medicaid costs cannot be separated from general health care spending and provided statistics about national health expenditures. A graph demonstrated the growth in Medicaid acute care spending between 2002 and 2006 and the impact of federal Medicaid spending that is attributable to the federal American Recovery and Reinvestment Act of 2009 (ARRA). To date, state budgets have reported a funding gap of \$348.3 billion through federal fiscal year 2012. Ms. Tobler identified actions and strategies under way in other states to improve Medicaid quality and lower costs, such as quality improvement measures and care management for individuals with high, chronic care costs that may not save money in the short run, but are valuable strategies to manage the program in the long run. Examples of short-term strategies were provided, including provider rate cuts, which have been implemented in California, Louisiana, Florida and Ohio. Pharmacy utilization and cost control initiatives, such as prior authorization, preferred drug lists and bulk purchasing arrangements, are under way in 31 states. She will provide much more detailed information about pharmacy cost control initiatives and which of these measures are the most effective. Ms. Tobler discussed benefit reductions and restrictions or eliminations of optional services. The most common services under consideration for reduction, restriction or elimination are dental benefits for adults and chiropractic, podiatric and optometric services. Eligibility reductions are not permitted under the provisions of ARRA through 12/31/10; however, several states are taking measures to slow Medicaid enrollment growth. New or higher co-payments are being implemented in Illinois, Massachusetts, Mississippi and Nevada. New York, South Carolina and Indiana are strengthening fraud and abuse detection efforts. Ms. Tobler highlighted New Mexico for its efforts in long-term care cost containment with the implementation of the CoLTS program. Ohio is working to shift 2,000 people from nursing homes to home and community-based care. A request was made to identify the impact of cuts and potential cuts on Native Americans. Several

states are investing in programs and systems that ensure that Medicaid is always the payer of last resort. Washington State has a program that connects veterans with services to which they are entitled. Steps for reducing Medicaid expenditures were identified in the order of difficulty of implementation. The simplest cost-containment measure identified was across-the-board provider cuts, followed by elimination of optional services and capping enrollment. Chronic disease management and outcome-based pay for performance were highlighted as measures that should improve quality as well as reduce costs. Other more desperate measures are anticipated to emerge as states continue to face serious budget constraints. Ms. Tobler described some strategies that show great promise for Medicaid reform and cost containment, such as targeting high-risk, high-cost members for care management activities. The body of evidence is growing to support the effectiveness of enhanced care management and coordination of the needs of clients with chronic and complex conditions. Several states are implementing payment reform initiatives, such as pay for performance, payment for episodes of care and global budgeting. Minnesota has expanded the payment reform effort beyond Medicaid with bundled payments for what they call "baskets of care".

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

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

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

Pamela S. Hyde, secretary, Human Services Department (HSD), outlined future projections for the Medicaid program, which is growing beyond appropriated amounts due to enrollment growth, increases in utilization and loss of federal ARRA funds. The HSD expects a general fund shortfall of between \$53 million and \$58 million in the current fiscal year, close to \$300 million in fiscal year 2011 and another \$140 million in fiscal year 2012. Significant cost-containment efforts will be necessary, and some, such as administrative changes and steps to slow enrollment growth, are already under way. The HSD will consider benefit elimination and reductions and provider rate reductions. Specific examples of each of these areas were provided. The HSD is currently planning fundamental restructuring of the Medicaid program, and possible eligibility changes to deal with the loss of ARRA funds in fiscal year 2012. Secretary Hyde identified future cost-containment measures for which the department is seeking input from the legislature and the public. She emphasized that all these efforts are time-consuming and resource-intensive. She drew the committee's attention to a list of possible cuts and changes and the estimated amount that would be saved if implemented. Also provided to committee members was a list of the services and populations that are mandatory and which services are optional. Prescription drugs, for example, are optional, while nursing home coverage is mandatory.

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

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

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

- clarification regarding the income levels of various covered eligibility groups;
- areas of the biggest cost growth; it is long-term care and disability services;
- the highest-cost maintenance prescription drugs; asthma, behavioral health and hypertension account for the highest costs of drugs in New Mexico;
- whether federal funding may be lost in the future if the program is reduced now, especially in the children's health insurance program (CHIP);
- recognition that short-term cuts will result in long-term problems;
- the difference between state administrative costs, managed care organization (MCO) administrative costs and provider administrative costs;
- variations in managed care administrative costs in Salud, CoLTS and behavioral health managed care;
- the amount of MCO payments of premium taxes and assessments for the high-risk pools; the total profit of managed care companies, as reported to the Insurance Division of the Public Regulation Commission, is in the range of 2.4%;
- a request for the breakdown of administrative amounts in writing;
- ways in which auto-assignments take place;
- how the governor's request for an additional 3% reduction in state agency budgets affects the Medicaid deficit and whether there are alternative ways of achieving an overall 3% reduction without harming Medicaid;
- the negative impact of vacancies at the HSD on the administration of the Medicaid program;
- how New Mexico compares to other states regarding the provision of optional services;
- the optional services that could be eliminated and could achieve the biggest savings with the least disruption;
- whether a redefinition of the poverty level is under discussion at any level;
- how the MCOs cap on profits compares with other states;
- the total number of individuals on Medicaid today and in the past;

- a request for a breakdown regarding the most costly Medicaid recipients;
- the potential for revenue enhancements that could be dedicated to Medicaid;
- clarification regarding plans for the SCI program;
- clarification regarding restructuring possibilities, including "buy-in" to various parts of the Medicaid program, and whether such restructuring would require legislation;
- a request for the HSD to present a formal plan, when developed, to this committee; Secretary Hyde indicated willingness to work with staff and hold a special meeting with interested LHHS members;
- ways in which federal reform efforts may affect Medicaid restructuring;
- possibilities for renegotiating MCO contracts mid-year; and
- how rate negotiations with providers occur, and under what circumstances those rates might be changed by the MCOs.

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

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

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

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

on Medicaid in achieving access to needed health care services but also has a fragile infrastructure of providers to meet the needs.

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

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

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

### **Medicaid Coalition Perspective**

Kim Posich, executive director, New Mexico Center on Law and Poverty (CLP), stated that all the members of the panel have a bias that Medicaid should not be cut. Siresha Manne, staff attorney, CLP, presented information regarding the number of people served by Medicaid and the economic impact of the program to New Mexico. She reviewed eligibility criteria to qualify for Medicaid, discussed the critical nature of Medicaid services and contended that without these services costs of health care will increase for all New Mexicans. The services being suggested for cuts are essential to the health and welfare of clients. Mr. Posich briefly identified ways in which cuts to Medicaid will impact the New Mexico economy; a \$1.00 cut out of Medicaid takes between \$6.00 and \$7.00 from the New Mexico economy. Cutting Medicaid will mean a loss of jobs, particularly in the health care sector. He demonstrated ways in which cuts to Medicaid will negatively affect wages and salaries and result in lost business activity. He detailed the specific ways in which health care providers such as hospitals and rural primary care clinics would be harmed by cuts to Medicaid of this magnitude. Those who lose health care coverage due to these anticipated cuts will sometimes defer getting needed health care services and seek care when they are much sicker. He contended that cuts to the Medicaid program will damage the health care system and are basically unfair.

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

Committee members had questions and concerns in the following areas:

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

### **Public Comment**

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

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

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

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

Anna Otero Hatanaka, Association for Developmental Disabilities Community Providers (ADDCP), reminded the committee of several very important programs that the ADDCP

members provide. She testified that the providers are very over-regulated due to the *Jackson* lawsuit. She commented that although provider rate reductions may be easy to implement, they have devastating effects that result in fewer services and poorer quality services to the developmentally delayed. This would make it harder for the state to get out of the *Jackson* lawsuit. The ADDCP supports revenue enhancement approaches and adequate opportunities for stakeholders to decide what cuts to impose.

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

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

Alicia Corral introduced the committee to her daughter who is developmentally delayed, and though an adult, has the mental age of a five-year-old child. Cuts to the Medicaid program would severely limit her care options and quality of life. She urged the committee to maintain the developmental disabilities (DD) waiver program.

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

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

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

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

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

the goals of the case are close to being met, and are important, and should not be curtailed prematurely.

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

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

### **Thursday, September 17**

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

### **Welcome and Remarks**

Representative Picraux welcomed everyone and introduced the staff. Members of the committee introduced themselves. Dr. Roth welcomed the committee to UNM. He remarked on the importance of this committee and the importance of the HSC as health reform unfolds. He noted that challenges and opportunities face the university and the nation, and they are looking forward to facing them. Diane Snyder, Greater Albuquerque Medical Association, also welcomed committee members and reminded them that the Greater Albuquerque Medical Association is sponsoring a reception for them at Los Poblanos.

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

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

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

Committee members had questions and concerns in the following areas:

- whether true efficiency can be achieved in a medical home with the duplicative requirements from insurers and multiple regulations;
- reasons for the increase in health care costs; research shows rising costs are primarily due to new procedures, very expensive biologics and over-utilization;
- whether evidence-based medical research is reliable;
- an observation that the system of payment and the system of care are different issues with different solutions;
- the potential role of mid-level providers in a medical home model;
- whether dental care is included in a medical home model; it could be;
- ways in which a medical home compares to the Veterans Administration system of health care delivery;
- recognition that many community health centers have been using a medical home model for decades;
- how advertising contributes to over-treatment of patients;
- whether ACOs are more efficient; they are generally thought to provide better quality, but it is unknown if they will save money;
- whether ACOs and medical homes have features that promote or allow competition in the marketplace;
- clarification about how medical homes enhance treatment of chronic disease; research shows major improvements in outcomes with better coordination of care;
- the potential for cost savings by serving patients with high-use or complex needs in medical homes;
- an observation that care in the Mayo Clinic is very well-coordinated and efficient and could serve as a model for the system of health care delivery in the nation;
- recognition of barriers that prevent widespread implementation of this model: aligning incentives, reforming reimbursement and preparing practitioners to change their style of practice are needed;
- whether New Mexico's electronic medical record statute will permit implementation of the medical home model; a request was made to have a review of this as a future agenda item for the committee; and
- whether the medical society has any projections about the cost of implementing a medical records system in a physician's practice.

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

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

Anita Ralston, nurse practitioner, described the scope of practice of nurse practitioners, which, in New Mexico, includes their ability to be in independent practice. Examples were provided of nurse practitioners in the state who operate medical home practices. She contended that not all medical homes are primary-care based. In her case, she feels she is providing that

kind of coordinated care at the New Mexico Heart Institute for specialty patients. Support exists in Congress and in the Centers for Medicare and Medicaid Services for inclusion of nurse practitioners in a medical home model of care. Ms. Ralston asserted that nurse practitioners should be included in any legislation directing the development of medical homes. She thanked the committee for its support of education of nurse practitioners.

Kristen Ostrem, representing the New Mexico Primary Care and Midwifery Association, testified that the association provides holistic, cradle-to-grave care for women. The association feels it is meeting nearly all of the criteria for medical homes identified in congressional legislation establishing medical home pilot projects. Keys to the services are case management and coordination of care, even after hours.

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

Committee members had questions and comments in the following areas:

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

### **UNM Medical Home Model**

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

often occur in combination. Physicians and nurses work as a team, anticipating patient needs and fostering patient self-sufficiency. UNM Hospital has a structural framework, including advanced information technology, that allows optimal administration of a medical home. The hospital continues to take steps to improve and further develop the program and is seeking recognition by the National Committee on Quality Assurance (NCQA) as a medical home.

Committee members had questions and comments as follows:

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

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

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

Committee members had comments and questions in the following areas:

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

Charlie Alfero was invited at that time to give a brief presentation to the committee about the Hidalgo Medical Services (HMS). He described the services provided and how they are organized. Over the years, the HMS board of directors has supported efforts to train primary care practitioners and steps to increase access to care, improve outcomes and reduce costs. HMS has received numerous federal grants to pursue its goals. Mr. Alfero noted that the current reimbursement system rewards treatment of procedures and visits but does not reward prevention or disease management. This focus results in new innovations in medicine targeted to diagnosis and treatment rather than care management and leads to the most expensive health care system in the world; yet, it cannot demonstrate good outcomes. Outcomes are not a priority as they are not reimbursable. HMS wants to redesign its system to reward outcomes of care. HMS is pursuing demonstration grants from the MCOs to redesign the system with reimbursement based on patient health outcomes, reduction in costs, societal improvements and community priorities. HMS is prepared to be accountable to these goals by agreeing to bear risk in its reimbursement. HMS proposes a per person, per month payment tied to key improvements in outcomes based on best practices and research. HMS has a contract with Molina to conduct field-based case management. Mr. Alfero gave an example of a patient who was homeless and a frequent visitor to the emergency department. With its interventions, HMS assisted the gentleman to get a job, find a home and stabilize his medications. The patient is no longer frequenting the emergency department.

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

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

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

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

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

Comments and questions from committee members covered the following areas:

- dissimilarities between North Carolina and New Mexico that may make a comparison with them difficult;
- what constitutes a reasonable incentive for a physician to participate;
- a request to present updated information and a proposal regarding the project later on in the interim;
- clarification that revisions to the managed care contracts required funding pilot implementation of the medical home model;
- a request that someone from North Carolina be invited to testify at a future meeting;
- whether the medical home would cover all patients or just Medicaid patients;
- a request to have a copy of the primary care network study that was the precursor to Medicaid managed care;
- clarification regarding the SALUD contracts and the "set-aside" amounts that are being used to fund medical homes;
- the need to identify and focus on specific high-cost conditions for the medical home model in the Medicaid program; this can be done through contract negotiations and does not require legislation;
- the need for flexibility in implementing the model to accommodate the variety of practice models and providers around the state;

- the importance of the UNM School of Medicine working more intensively to encourage medical students to choose primary care versus a specialty; without enough primary care physicians, there will be no ability to broadly implement medical homes;
- the potential for this model to result in real cost savings if implemented proactively for high-risk patients, and whether legislation is needed to put this in place;
- the potential for great savings by reducing poly-pharmacy use; and
- the costs of prescription drugs and emergency department visits for treating depression and psychoses.

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

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

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

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

The chair recognized Brent Earnest, analyst, LFC, to explain some highlights regarding the Medicaid budget shortfall. He stated that in 2010 the program is projected to grow to \$4.4 billion; to get there, \$300 million in new money would be needed. The LFC will be working very closely with the HSD to ensure that projections of shortfalls are current and accurate. It was noted that there are no projected cuts to the current Medicaid program; rather, cuts are anticipated to the growth in the Medicaid program. Clarification was sought regarding the impact of the loss of ARRA funds and the amount of projected growth that is due to enrollment growth. It was

acknowledged that the recession in the nation is having a profound impact, and many more people are likely to need services such as Medicaid. Mr. Earnest agreed that cuts to services and provider rates are likely; he was merely trying to put into perspective from where the \$300 million projection came. Committee members requested that Mr. Earnest's remarks be sent to all by email.

### **Public Comment**

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

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

### **Friday, September 18**

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

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

Albert Yee, M.D., program director, W. K. Kellogg Foundation (Kellogg), and Dolores Roybal, executive director, Con Alma Foundation (Con Alma), described an initiative to increase access to oral health services in New Mexico with the training and use of dental health therapists. Dr. Yee identified the goals of Kellogg to focus on community involvement and children, especially uninsured children in minority families. It has identified three priority states, including New Mexico, being identified as states with poor access to dental health services. Dr. Yee described a program in Alaska with which Kellogg is involved that trains and utilizes dental health therapists. Dental health therapists are widely used in over 50 countries around the world but have only been introduced in this country since 2005 through the Alaska project. The program owes part of its success to the use of local individuals who return to the communities in which they grew up after their training. Kellogg became involved in this program at the request of Alaska tribal officials who wanted to implement the model as it has been implemented in New Zealand. In the program, high school graduates are trained as dental therapists over a two-year period to provide preventive oral health care and who perform under general supervision as part of a team. After the two-year initial training, dental therapists spend 400 hours in an internship with a dentist. The Alaska model could be replicated in New Mexico or modified to meet New Mexico's needs and circumstances. Kellogg supports the model as one viable option to increase access to oral health services for children and underserved populations. Interest in this initiative is growing in this country. Kellogg has partnered with Con Alma to gauge the interest and feasibility of implementing the model in New Mexico. A brief video was shown about the Alaska experience.

Ms. Roybal identified Con Alma as the largest foundation in New Mexico dedicated entirely to health. The foundation has a special focus on rural communities and people of color. Con Alma has discovered that Hispanics suffer the greatest health disparities of any population,

and that New Mexico has the highest health professional shortages of any state in the nation. New Mexico ranks forty-ninth in the nation for dentists per capita. Four counties in New Mexico have no dentists at all. Con Alma feels that New Mexico shares some similarities with Alaska that may make the state a good candidate for implementation of this program. Con Alma intends to begin by convening all stakeholders and encouraging them to determine the feasibility of implementing this program. It would like the support of this committee to introduce a memorial in support of this effort.

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

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

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

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

distribution of funding through its system, noting that state funding accounts for approximately 9.5% of its revenues. More than 50% of its revenues come from patient revenues.

Dr. Roth described in detail how the university selects medical school students, all of whom are residents of New Mexico and 85% of whom have graduated from high school in the state. Of most recent graduating class, over 50% remained in New Mexico for their residency, with 48% choosing primary care as a specialty. He noted that, unfortunately, this percentage is dropping as a national trend. The UNM School of Medicine (UNM/SOM) compares favorably in many national benchmarks, including its experience in graduating primary care physicians. Graduates from UNM/SOM account for 37% of all the physicians practicing in New Mexico. He briefly spoke about the nursing shortage and efforts to develop a plan to address this at UNM. He noted that the current efforts to reform the health care system have the potential to exacerbate health professional work force shortages, as people with insurance coverage will seek medical care sooner. The result will be a growing crisis in access to care. He noted that estimates of shortages reflect a need for 400 primary care physicians, 400 non-physician clinicians, 556 specialty physicians, 600 dentists and 600 dental hygienists. A plan must be developed to address these priority needs. Dr. Roth then gave updated information regarding the BA/MD program, which is the only legislative request it will make this year. Students are already enrolled in the program and are critical to addressing the growing physician shortage in New Mexico. The program is an eight-year long program; four years for an undergraduate degree and four years of medical school. As the current class members complete their undergraduate degrees, there is the potential to expand the SOM class from 75 to 103 students. The legislature provided \$200,000 in funding in fiscal year 2009, allowing the university to fund the first year of medical school for this program. The UNM HSC request for fiscal year 2011 is \$853,400 to fund the second year of medical school. Demographics were provided regarding the students enrolled in the BA/MD program.

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

Committee members had questions and comments on the following topics:

- recognition that work is being done in various ways to expand the health professional work force;
- a need to permit anesthesiologist assistants to practice statewide;
- whether there is a program whereby nurse practitioners or PAs at UNM can apply to the UNM/SOM;

- whether there is data regarding the number of primary care physicians who remain in that specialty;
- identification of obstacles for admission to nursing school, including waiting lists and a burdensome application process;
- clarification regarding ways in which the School of Nursing is involved in altering the nature of the work of nursing, especially in hospitals;
- clarification regarding the difference between a resident and an intern;
- what the School of Nursing is doing to address the problem of nurses leaving the profession;
- whether there is coordinated planning for standardized nursing education;
- reasons why physicians and nurses leave practice to enter academia;
- whether current residency programs adequately prepare physicians for the rigors of practice;
- the need for more outreach to high school students in rural areas regarding the BA/MD program;
- the competitive nature of the application process and acceptance into the nursing program;
- clarification regarding methods of billing for services by residents and how that benefits the UNM/SOM;
- whether patient encounters can be segmented by zip code in all UNM HSC practice areas;
- whether there is any coordinated planning regarding the need for new hospital facilities; currently, data show there is enough need for more hospital beds than are being planned;
- what the university plans to do to address a growing aging population;
- the importance of a continuing focus on cultural competence in all health profession training efforts;
- clarification regarding the screening process for applicants to the UNM/SOM and the School of Nursing;
- clarification regarding the nature of the relationship between the pharmaceutical industry and the UNM/SOM; the school has a rigorous policy restricting influence in clinical settings; and
- encouragement for UNM HSC to emulate the Mayo Clinic.

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

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

which prisoners were trained as CHWs and taught methods of preventing and treating hepatitis C. Future plans for expansion of Project ECHO were identified, as were current benefits of the project to clinicians around New Mexico. Project ECHO has received national and international recognition and acclaim.

Committee members had questions and comments in the following areas:

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

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

Questions and comments included:

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

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

Nonnie Sanchez provided personal testimony alleging poor treatment by the Developmental Disabilities Planning Council (DDPC). Rosemary Sanchez, Nonnie's mother, provided a written statement alleging incompetency of the staff of the DDPC. Janice Ladnier spoke about the issue of guardianship. She is a master guardian and has experience as a mental health provider and as an ombudsman with the Aging and Long-term Services Department. She has been an active member of the board of the Guardianship Task Force that developed recommendations for legislation that were passed by the legislature this year. She created an organization called Guardian Angels that has developed training modules for guardians. She contends that the Office of Guardianship has no oversight, has hired unqualified people and has compromised its integrity in the legislative process. She claimed the office has breached court orders. She has approached the office to ask for its support to promote her training modules, to no avail. She recommends that the Office of Guardianship be moved to a larger agency that has the resources to conduct training and properly monitor the guardians. Ms. Otero Hatanaka testified that many of her member agencies interface with guardians regularly. She stated that

guardians have exercised undue authority in removing clients from providers' care against their wishes. She provided documents that support her contention that she and others have been excluded from important work, despite the fact that they are members of the guardianship committee. She referred to an investigation by the HSD that was critical of the DDPC and its management of the Office of Guardianship. She reported that the DDPC has engaged in legislative efforts to permit itself to investigate complaints against itself and to remove the HSD from that activity. She noted that she and the Guardian Angels organization have been notified that they have been removed from the council, and that now the council membership is biased and not properly representative.

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

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

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

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

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

Dr. Romero-Leggott described projects in the Office of Diversity that are aimed at students in middle school, high school and college. The Dream Maker program is an after-school program that provides hands-on, health-related activities and instructional interaction with health professionals. It works to improve math, science and writing skills. The program has multiple sites in schools throughout the state. She described the curricula and activities and identified costs associated with the program. Dr. Romero-Leggott then described the Health Careers

Academy, which is a six-week long nonresidential summer program for high school students. It is designed to prepare students for entry into college and to expose them to health careers. The program is designed to increase the number of ethnically diverse health care providers and is funded in part by grants from the Robert Wood Johnson Foundation and Con Alma. Costs to operate the program were identified. Success of both programs is attributable to key partners with leadership from within the HSC and financial support from the legislature.

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

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

Committee members made comments and observations as follows:

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

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

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

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

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

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

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

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

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

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

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

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

### **Public Comment**

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

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

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

**MINUTES**  
**of the**  
**FIFTH MEETING**  
**of the**  
**LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**  
**October 12, 2009**  
**Pueblo of Pojoaque**

**October 13-14, 2009**  
**Room 322, State Capitol**

The fifth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Danice Picraux, chair, at 8:55 a.m. A subcommittee was present.

**Present**

Rep. Danice Picraux, Chair  
Sen. Dede Feldman, Vice Chair  
Sen. Rod Adair  
Rep. Nora Espinoza  
Sen. Linda M. Lopez (10/13)  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

Rep. Joni Marie Gutierrez

**Advisory Members**

Rep. Ray Begaye  
Sen. Sue Wilson Beffort  
Rep. Eleanor Chavez  
Rep. Nathan P. Cote (10/12, 10/13)  
Rep. Miguel P. Garcia  
Rep. Keith J. Gardner (10/13, 10/14)  
Sen. Clinton D. Harden, Jr. (10/12, 10/13)  
Rep. John A. Heaton  
Rep. Dennis J. Kintigh  
Rep. James Roger Madalena (10/12, 10/14)  
Sen. Cisco McSorley (10/13, 10/14)  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen (10/13, 10/14)  
Sen. Nancy Rodriguez  
Sen. Sander Rue  
Rep. Mimi Stewart (10/13, 10/14)  
Sen. David Ulibarri (10/13, 10/14)  
Rep. Gloria C. Vaughn

Rep. Jose A. Campos  
Sen. Gay G. Kernan  
Rep. Rodolfo "Rudy" S. Martinez  
Rep. Jeff Steinborn

**Guest Legislator**

Rep. Nick L. Salazar

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

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Karen Wells, Researcher, LCS  
Jennie Lusk, Staff Attorney, LCS  
Mark Harben, Records Officer, LCS

**Guests**

The guest list is in the meeting file.

**Handouts**

Handouts are in the meeting file.

**Monday, October 12****Welcome and Introductions**

Representative Picraux welcomed everyone. The Honorable Linda Diaz, deputy governor, Pueblo of Pojoaque, welcomed the committee to the pueblo.

**Impact of Nursing Faculty Shortages (HJM 40)**

Pat Boyle, R.N., executive director, Center for Nursing Excellence, introduced Theresa Keller, Ph.D., R.N., associate director for undergraduate studies, New Mexico State University (NMSU), and other members of the task force that participated in the completion of this report. She reviewed the objectives of the memorial and the methods used to gather the information for the report. She provided statistics regarding the current and projected number of nurses in the state. She estimated that in order to meet the projected need for 5,000 nurses, between 48 and 171 faculty members will be needed. Ms. Boyle identified challenges to the recruitment and retention of nursing faculty, including faculty compensation, a weak educational pipeline for developing new faculty, educational models that prohibit collaboration among institutions and a heavy workload environment. Currently, nursing faculty members are paid an average that is less than what a registered nurse in practice is making. Advanced degrees are required to be nursing faculty members. Nurses with advanced degrees are finding many alternative options for careers besides nursing education. The models for the education of nurses lack standardized curricula. Workloads of nursing faculty are demanding, and new faculty are not well-oriented or mentored.

Recommendations from the report address funding, enhanced efficiency, pipeline development and stronger partnerships. The report highly recommends that the Higher Education Department (HED) convene a task force to analyze all state funding for nursing education and develop a system for transparency for all funding directed toward nursing education. The report also highly recommends development of a statewide plan for nursing education. Other recommendations include steps to identify, support and mentor future nursing faculty members utilizing best practices and promotion of the role of nursing. Some of these measures are already underway through collaborations among the schools of nursing across the state. The importance of online educational opportunities was stressed. A loan forgiveness program exists for nurses seeking graduate level degrees who commit to service as nursing faculty members. Ms. Boyle emphasized that nurses serve at all levels and in all health care settings and that can go a long way toward addressing the goals of health care reform.

Dr. Keller identified particular challenges and barriers experienced by NMSU. As a result of the measures implemented at NMSU, some progress toward building a stronger and more committed faculty is occurring. She highlighted ways in which the legislature can support successful nursing programs. NMSU is highly constrained due to limited space and other resources. She noted that NMSU has partnered with the University of New Mexico (UNM) to develop a statewide comprehensive plan for nursing education and would benefit from letters of support in grant applications. She invited committee members to visit NMSU.

Committee members asked whether private employers are providing any financial assistance to support this need. It was acknowledged that the nursing profession needs to be better at making the case for the value of nursing to begin to increase salaries in the private sector.

The chair interrupted the agenda to allow committee members to introduce themselves.

Committee members expressed their support for the value of nurses and appreciation for the scope of the problem. Clarification was sought regarding long waiting lists to enter nursing school, the shortage of hospice nurses and the qualifications to enter nursing school. Details were sought about the nature of the waiting lists to enter nursing school. A model standardized curriculum using tele-education exists in Oregon that the Center for Nursing Excellence will be reviewed. Committee members expressed willingness to write a letter of support for any efforts that are underway. The potential for the use of simulation experiences versus relying on, and overloading, hospitals and other settings was discussed. Uniform clinical contracts also hold promise for reducing the workload of faculty and enhancing efficiency. A suggestion was made that strong staff support at the HED is essential to accomplish these goals. Len Malry, director of workforce education, HED, identified himself as the point person for nursing education within the department. He referenced a report that the HED has published that reflects how funding is distributed through the funding formula. Ms. Boyle stated that the funding formula is very confusing to nursing schools that do not feel it is working effectively. The HJM 40 task force discussed the possibility of removing schools of nursing from the school funding formula and is working with the HED to explore this. Tracking funding allocations within public educational institutions and from special appropriations is critical information that the committee would like to see developed. Mr. Malry stated his belief that the funding formula is working and that the previously referenced HED report will show that. Discussion ensued about the potential impact of the trend to require all nursing faculty to have Ph.D.s. Currently, school accreditation standards require that nursing faculty have a degree that is higher than the level they are teaching. Concern was expressed about a mandate reportedly being considered by the Board of Nursing to require that all associate degree nurses obtain a bachelor's-level nursing degree. A question was asked about the extent to which retiring military nurses are being encouraged to move to New Mexico and whether there are any barriers to their obtaining a license in the state. Questions were raised about the ability of licensed nurses in the military to practice across state lines. An objection was stated regarding the nursing position to oppose the ability of non-nurse anesthesiologist assistants to practice in other locations in the state besides at UNM hospital. The ability of nursing schools to obtain national graduate medical education funds was discussed; this is being discussed in health reform proposals, but is not currently available. Clarification was sought about the data provided in the report relative to enrollment and nursing faculty, why salary information was not included in the report for nurse practitioners and the disposition of nurses upon gaining their licenses to various practice settings. It was recognized that the health care sector is one of the only job sectors growing in today's economy. Senator Rue made a motion, and Representative Vaughn

seconded the motion, that the committee draft a letter of support to assist the HJM 40 task force to pursue grants. Ms. Boyle said that she would prefer a letter targeted to a particular grant application, but would be grateful for any support the committee wished to give. Clarification was sought regarding to whom such a letter should be addressed. A request was made for the task force to bring back specifics to this committee at its November meeting. The motion was withdrawn. Support was expressed for the recommended memorials to continue the critical work of this task force.

### **Women's Health Council Report**

Giovanna Rossi-Pressley, executive director, Office of the Governor's Council on Women's Health, introduced Michelle Peixinho, a member of the advisory council to the office. She thanked the committee for its support. She discussed reasons why a specific focus on women's health issues is important. She described the administrative structure and mission of the office. She highlighted a public health model around which its work is conducted. Although not a direct service provider, the office works with provider organizations to address important issues affecting women. One example is the work they are pursuing to implement a new statute placing strict limitations on the use of restraints on prisoners who are pregnant or in labor. The office collaborates with UNM on the curriculum for a women's health policy course and supports outreach and education for such initiatives as National Women's Health Week.

Ms. Peixinho, a member of Tewa Women United, spoke about leadership development efforts being promoted through the Women's Health Advisory Council, of which she is a member. Ms. Rossi-Pressley described efforts to promote economic security for women by providing statistics about economic security and women both nationally and in New Mexico. The office has identified a list of policy issues to address economic security issues, including promotion of a living wage, access to health care, medical debt, high-quality and affordable child care, secure retirement and parity for part-time workers. Ms. Rossi-Pressley outlined the fiscal year 2010 and fiscal year 2011 goals for all these areas and identified budget needs and sources of revenue for the office.

Committee members expressed interest in why the office is not located in the Department of Health (DOH). Ms. Rossi-Pressley explained that it was felt that its independent status would allow for a greater focus on women. A question was asked about possible legislation that could address some of the problems identified. The relationship of the office to the Commission on the Status of Women was explored. The office is administratively attached to the commission and is co-located with it. Clarification was sought about some of the statistics. Ms. Rossi-Pressley noted that the office is required by statute to report annually to the governor and would be happy to share that report with this committee as well.

### **Integrated Behavioral Health Services Delivery: Pathways Care Coordination Model**

Lauren Reichelt, health and human services director, Rio Arriba County, presented a successful model of care for substance abuse that has statewide and national implications. She began with a historical picture of the very high rates of substance abuse in Rio Arriba County and the fragmented delivery system that has always existed there. A survey conducted by the county found many gaps in services at an unacceptably high cost. A pilot program was established to serve very difficult clients and achieve improved outcomes with limited resources. Early experience provided valuable data about the population being served and identified reasons for failure of the assessment and referral system being used. This pilot led Rio Arriba County to

partner with an organization utilizing a model of care called Pathways, wherein providers are paid for outcomes of care rather than a fee for services provided. The model has national support, which allows it to compare its project against best practices elsewhere in the country. The initial targeted population was pregnant women at high risk for using illicit substances during pregnancy. The care needs of 20 women were evaluated against pre-determined outcomes. Program evaluation showed great success in cross-agency collaboration, improvement in outcomes and high provider satisfaction. No new funding was needed to implement these changes. Rio Arriba County plans to expand the program to new populations, including the homeless, and to school-based services for at-risk youth. Jack Ortega, Rio Arriba County juvenile justice, described the Rio Arriba Youth Services Providers Partnership, which is using the Pathways model to improve the lives of at-risk youth through coordinated family, education and community services. He reviewed the services the partnership is able to provide due to this collaborative model without expending any additional dollars. Ms. Reichelt closed by asserting that this model, if more broadly applied, could save the state money and improve outcomes.

Committee members asked questions about the number of clients served by the model who were already on Medicaid, the extent of family support and whether the youth program will be able to follow at-risk children through high school. The ability to implement the Pathways model across different funding streams and in different program areas was explored. An explanation was given regarding the difficulty in serving the homeless. Mr. Ortega described the process in which the collaboration between such disparate entities, each with its own funding, was achieved. He credited Judge Robert Vigil with being the initial champion of the effort.

### **Health Insurance Legislation: Proposed Executive Bills**

Katie Falls, deputy secretary, Human Services Department (HSD), and Steven Randazzo, legislative liaison, HSD, described the priority legislative issues for the HSD. These include guaranteed issue of health insurance plans for individuals; exclusion of gender as an insurance premium rating factor; the redefinition of "small group" to allow coverage of self-employed individuals; direct services expenditures at 85%; and small group insurance rating. For each proposal, Mr. Randazzo offered the facts or problems that caused this bill to be proposed and implications if the legislation passes. Copies of draft bills were provided for the committee's consideration. Legislation may be proposed to consolidate administration or selection of different publicly funded coverage options. Additionally, the HSD will propose amendments to the licensed alcohol and drug addiction counselor statute to permit grandfathering of certain qualified, certified counselors. Other bills that will be proposed, but that were not in committee members' packets, were briefly mentioned.

Committee members wondered why some of these measures, particularly guaranteed issue, are being put forward at this time when federal reform may take care of these issues. Concern was expressed that proposed changes would negatively impact the New Mexico Medical Insurance Pool (NMMIP), also called the high-risk pool. The point was made that the high-risk pool offers six or seven insurance options to qualified people, with discounts available for people qualified up to 400% of the federal poverty level. Clarification was requested regarding the number of providers that are licensed to sell health insurance in the state; there are approximately 700 providers. Debbie Armstrong, director, and Michelle Lujan Grisham, deputy director, of the NMMIP offered to provide a list of those providers to the committee. Questions were asked about the interface between the State Coverage Insurance (SCI) program and the NMMIP and how these two programs are different. Clarification was sought about the percentage of insurance plans and

individuals in the state that are covered by federally protected insurance plans that would not be affected by this proposed legislation. The current premium tax obligation would not be included in the 85% direct services requirement. Clarification was sought regarding the current percentage attributable to direct services and to whom a requirement of 85% would apply. It would apply to all companies, not only those under contract with the HSD. Comments were offered in support of these measures, none of which is new to the legislature. Questions were asked about the waiting list for SCI and the reasons why a waiting list is being imposed. Questions were asked regarding the waiting list for the developmental disabilities waiver that was appropriated by the legislature. Concern was expressed that these proposed measures have unknown costs and should not be enacted in a time of economic insecurity when the state has waiting lists. Other committee members disagreed, stating that insurance reform measures are unrelated to the ability of the state to fund existing programs. A question was asked about the support or lack of support from insurance companies for these measures, especially in light of the absence of a bill to mandate the purchase of insurance, and whether the HSD intends to consult with insurance companies. Concern was expressed about NMMIP waiting lists for pre-existing conditions.

Sam Howarth, director, Division of Policy and Performance, DOH, described four priorities of the DOH, indicating that individuals with expertise in each area would describe them in more depth. Harvey Licht, director, Primary Care and Rural Health Office, DOH, spoke about a proposed expansion to the rural health care practitioner tax credit program to include new categories of health care providers. Details were provided projecting the cost to implement this measure. The program has been very successful with physicians and others currently covered. The goal is to incentivize health care providers to remain in practice in rural areas. Dr. Steve Jenison, medical director of the HIV program, DOH, described the department's desire to amend the Human Immunodeficiency Virus Test Act to allow the DOH to notify partners of those individuals newly diagnosed with HIV. The intent is to extend health protection to potentially infected partners. Mr. Howarth spoke about a proposed bill to raise the crime lab fee assessed on individuals convicted of driving while intoxicated. The fees have not been raised since 1997. The final proposal described would create a mid-level dental auxiliary with an expanded scope of practice that would provide dental licensure to dental residents and recognize as licensed any dentist who has been certified regionally.

Committee members asked whether there is any potential for expanding the dental bill to include additional activities for dental hygienists. Clarification was sought about whether this bill includes dental therapists, as previously presented by the Robert Wood Johnson Foundation (RWJF). The DOH is in conversation with the RWJF. The proposal is intended to serve as a career ladder to increase access to dental services with the creation of a mid-level dental practitioner. Charlotte Roybal, consultant with the Con Alma Foundation, provided clarification about the differences between the dental therapist proposal presented to the committee by the RWJF and this proposal. Debbie Maestas-Traynor, a lobbyist for dental hygienists offered further clarification about the current and proposed roles for hygienists if they are added into the DOH proposal. Concern was expressed about the extent of the expanded scope of practice. Committee members asked whether there is support or opposition to the HIV partner notification proposal and what the full impact of the rural health care practitioner tax credit would be.

### **Public Comment**

Ms. Armstrong offered a few comments to follow up the previous testimony. The high-risk pool offers guaranteed issue for individuals who cannot get insurance or who are losing group

insurance. She stated that the guaranteed issued proposal as discussed would have the potential to negatively impact the market. One important function of a high-risk pool is that it stabilizes the premiums in the small group and individual markets. She believes the proposal would be confusing and would drive up individual premiums. Finally, she commented that people are not diverted to the NMMIP from SCI due to pre-existing conditions.

The meeting was recessed for the day at 4:50 p.m.

## **Tuesday, October 13**

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

### **Provider Credentialing**

Debbie Gorenz, president, Hospital Services Corporation (HSC), briefly described the process of credentialing, whereby health care providers are determined to be qualified and capable of providing services to patients that enable these health care providers and institutional entities to get reimbursed for those services. A handout (in the meeting file) identified the requirements of the National Committee for Quality Assurance (NCQA) and the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) for credentialing of providers. She also provided a flow chart reflecting the process. The HSC is a private entity that is a subsidiary of the New Mexico Hospital Association. Ms. Gorenz described efforts that HSC, in collaboration with the New Mexico Medical Society (NMMS) and others, have pursued to streamline the process of credentialing, including the development of a statewide application, an online application process and cooperation with the New Mexico Medical Board to license new physicians. HSC performs primary source verification of the information submitted in a credentialing application. In addition to the medical board, the HSC provides these services for 49 other health care entities in the state. Recently, it partnered with the health plans.

Dr. Kathy Ganz, clinical compliance director, First Choice Community Health, provided a provider perspective of the credentialing process. First Choice has over 50 sites statewide and is a client of the HSC. She reiterated that credentialing is necessary in order to be reimbursed by any health plan or insurance entity. It is the process of verifying and assessing the qualifications of a practitioner to provide care in or for a health care organization. The HSC conducts the primary source verification part of the process. Dr. Ganz provided a historical overview of how credentialing has developed in New Mexico. She highlighted the burdensome, administrative nature of credentialing. In the past, credentialing was only required for reimbursement by Medicare; today, Health South has to repeat this process for 27 different payer sources. She noted that the providers as well as the plans all have credentialing committees and staff dedicated to ensuring the completeness of the applications and that they are progressing through the process on a timely basis. Until recently, the process took up to 120 days to be complete, during which time providers could not get paid for their services. She noted that every month, new requirements are added to the credentialing process by the managed care organizations (MCOs), adding administrative burden and delay. She offered several suggestions to further address these problems. Close monitoring of the new Public Regulation Commission's Insurance Division credentialing regulations will be essential. Establishment of a single credentialing entity for the state to retain a single file for each provider and reasonable fees for the primary source verification part of the process would help. She suggested that Congress should be requested to require

alignment of the requirements of the NCQA and the JCAHO and establish shorter time frames for credentialing and re-credentialing.

The chair invited representatives of health plans and others in the audience to comment on this topic. Linda Hubbard, Lovelace Health Plan, noted that the Committee for Accreditation of Quality Healthcare (CAQH) has created a single standardized national application; coupled with a national database of information, it allows a once-in-a-lifetime application process that Lovelace providers utilize. Lovelace conducts primary source verification internally and has its own credentialing committee to approve or deny applications. She provided statistics supporting the effectiveness of this universal application process. She spoke about the practice of the other health plans, some of which use the HSC. Laura Hopkins, Amerigroup, described her company's process. Dawn Brooks, executive director of the San Juan IPA, stated that it uses the New Mexico standard application and conducts primary source verification and approval or denial in-house. It is certified by the NCQA as a physician credentialing organization. At the request of the chair, Ms. Brooks described her organization.

Victor Lundsford, director of quality at Molina Healthcare, described the process that Molina uses. Primary source verification is performed at a national corporate office. The CAQH national application is used. The time to complete the process has been reduced to approximately 30 to 35 days. Dr. John Sandoval, medical director, Lovelace, affirmed that credentialing is a difficult and frustrating process for providers. He asserted that a more streamlined, centralized process is already in place and working for 800,000 physicians across the nation through the CAQH. Ms. Gorenz clarified that the CAQH application is utilized primarily by national health plans. The HSC will accept that application when it conducts primary source verification. New Mexico has its own standardized application that 95% of the physicians that the HSC credentials use, and it is working well for them. Dr. Ganz agreed that there are opportunities to work together to create more efficiencies to the process. Ms. Gorenz noted that with the new Insurance Division regulations, there will be an opportunity to track the effectiveness and time it takes to credential a provider. Improvement should be seen.

Committee members requested clarification of whether the HSC is state-run and its relationship with the New Mexico Medical Board. A question was asked about who is required to be credentialed in hospitals and other settings. Options were discussed to achieve administrative simplification of the process and the potential for a group of stakeholders to come together to do this. Committee members wondered whether corporate national policies are a barrier to individual state solutions to these problems and whether the Indian Health Service (IHS) mirrors the process for everyone else. The IHS has its own internal process for credentialing; neither the HSC nor the San Juan IPA credentials those providers. It was noted that credentialing seems to duplicate licensure and is very expensive. Some discussion occurred regarding whether an "any willing provider" law would eliminate any of these problems. Support was expressed for a more streamlined credentialing process to retain doctors as providers in New Mexico. Questions were asked about the total cost of credentialing: individual physicians are not usually charged and the hospital or the health plan absorbs the cost. It was noted, however, that it can take between 20 to 40 hours for a practitioner to fill out one application. Considering all the associated documentation that must be accumulated, the cost in lost productivity can be enormous.

Clarification was sought regarding whether the Insurance Division regulations apply to all providers who need to be credentialed; these new regulations apply to the health plans and require

more timely processing of applications. The committee recognized that during the 120 days that a physician is awaiting credentialing, the physician is seeing patients but not getting paid. Questions were raised regarding which insurance companies are taking the longest and shortest times to process applications. A request was made that the committee see the data accumulated by HealthSouth on this topic.

It was acknowledged that delays occur during post-credentialing, when a health plan enters the information into its systems. These delays contribute to providers not getting paid; this additional time can take from 30 to 45 additional days. A committee member commented that credentialing through the health plans has a stranglehold on health care providers and that this is a major contributor to the cost of health care in New Mexico. A question was asked regarding whether providers who are not members of the San Juan IPA can get credentialed through it. Ms. Brooks is working with the insurance companies and plans to accomplish this. Clarification was sought regarding how and why practitioners are referred to the national practitioner database and whether or not this step can be abused. The committee acknowledged that this issue is very complex and difficult to address.

### **Opportunities for Improved Credentialing Coordination Pursuant to Section 27-2-1.2 NMSA 1978**

Larry Heyeck, deputy director, Medical Assistance Division (MAD), HSD, stated that he has personal experience with the credentialing process that predates his current role in the HSD. He asserted that the process does need to be simplified and that the HSD is obligated to work on this. HSD contract provisions and regulations require that the process must be completed within 45 days. The MAD reviews applications of all questionable providers; this is a federal requirement and one for which it is audited. Great care must be taken to ensure that providers caring for Medicaid clients meet high standards. The contracted health plans have all met these high standards. Mr. Heyeck spoke in support of the accreditation processes required by the NCQA and the JCAHO, including the credentialing requirements. This does not mean the process should not be simplified, and the HSD is working with the Insurance Division to do this. He suggested that a memorial calling for all stakeholders to come together to address this would be very valuable.

Committee members asked whether the Insurance Division new 45-day time line applies to Medicaid. Mr. Heyeck stated that the time line does apply, but that the requirement for use of a standardized form does not. More consultation with the Insurance Division is needed, but the goal of a uniform process and form is reasonable. He offered to respond to this committee with a letter before the end of the calendar year responding to these requests. The chair noted that the committee's last meeting is the first week in November and requested that something be presented at that time. Mr. Heyeck agreed.

Morris J. (Mo) Chavez, superintendent of insurance, was invited to make comments. He stated that the Insurance Division is ready and willing to work together with interested parties to achieve simplicity and uniformity and will be diligent in implementing the new regulations.

### **Medicaid Breast and Cervical Cancer Treatment Program**

Gena Love, cancer prevention and control section head, DOH, Julie Weinberg, deputy director, MAD, and Kathryn Karnowsky, management analyst, MAD, provided information about the breast and cervical cancer treatment program in New Mexico. Ms. Love described the DOH

program, which is funded by the federal Centers for Disease Control and Prevention (CDC) and which screens low-income women for breast cancer. Currently, the funding allows the department to screen an estimated 18% of eligible women, according to the eligibility standards set by the CDC. The goal is to screen early enough to allow for the most effective treatment. In 2002, treatment for these women became a benefit of Medicaid. The DOH and the HSD have worked together to ensure that all screened women have access to treatment. Funding comes from various sources, including a CDC grant, the tobacco settlement funds (TSF) and revenues from license plates. Approximately 90 women per year are referred to Medicaid as a result of this early screening. Ms. Weinberg provided background information about this program in Medicaid. The program is an optional eligibility category, which includes a requirement that the woman has been screened through the DOH's screening program. She provided data regarding the number of women served since its inception, how much the program has cost in actual paid claims and statistics regarding screenings and diagnoses of women in New Mexico. In 2008, 11,822 women were screened by the DOH; 95 were diagnosed with breast cancer and eight with cervical cancer. She noted that the federal medical assistance percentages (FMAP) for this program is 80%, which is higher than the traditional Medicaid program.

Committee members asked questions regarding the growth in the number of women served and the overall cost of the program; why the costs have increased substantially more than the number of women served; whether any woman is ever rejected for care once referred; and how quickly women are served once they are referred. Presumptive eligibility allows women to be served on the same day that cancer is diagnosed. The DOH case manager works with the diagnosed women to ensure that treatment is provided immediately in the most appropriate setting. Clarification was sought regarding the numbers of women who are covered for these services and how many new women are served each year. Approximately 90 women come into the program each year. A question was asked about the source of the TSF that is allocated to Medicaid; the Tobacco Settlement Permanent Fund is not tapped for Medicaid. A question was asked about the outcome and survival rate for women served by this program. Overall, women who are screened early have vastly better survival rates, which is why the DOH works diligently to screen women early. Women who are Medicaid-eligible tend to be screened at a much more advanced stage of the disease. Women remain on the program as long as the physician certifies that they are receiving treatment. Traci Cadigan, American Cancer Society, affirmed that one-half of the TSF goes into the permanent fund as part of the settlement and the other one-half remains available to be used for purposes such as this program. Clarification was sought regarding the eligibility process, presumptive eligibility and whether illegal immigrants are eligible to receive these services. Medicaid cannot cover women who are not legal.

### **Cambiar New Mexico**

Bob Tafoya, chief of staff, and Debra Pritchard, director, Juvenile Justice Division, Children, Youth and Families Department (CYFD), presented updated information regarding the Cambiar New Mexico program. The program, based on the Missouri model, holds youth accountable for their actions through the use of youth care specialists who serve as counselors, mentors and coaches to the youth. Services are provided in settings that resemble a home or college campus setting. This program was implemented in New Mexico over a 12-month period beginning in July 2007. Demographic information about the clients served was presented; 96% of the clients are being served in 10 southern counties. The CYFD has a training institute to assist supervisors and managers to understand the goals and expectations of this model. The CYFD has collaborated with the Missouri Youth Services Institute (MYSI) to accomplish this training as well

as to manage the units through appropriate evaluation and policies. Emphasis on team units allows for improved relationships with clients, as well as positive staff-to-staff and client-to-client relationships. The CYFD has established a supervised release panel to evaluate the progress and treatment plans of the clients. The CYFD continually monitors facility population trends to ensure appropriate use of secure and non-secure facilities. The CYFD has redesigned the focus of community corrections programs to also emphasize a team approach and to ensure that juvenile probation officers are supporting youth in the community through case planning and case management. Ms. Pritchard identified numerous ongoing challenges. Transitioning from a correctional to a rehabilitative model and addressing behavioral health issues of clients on an ongoing basis are ambitious tasks. Issues of employee recruitment, retention and overtime are demanding and some staff continue to resist the model. Secretary of Children, Youth and Families Dorian Dodson has established a juvenile justice commission, consisting of experts in the field, to provide external recommendations to the department regarding the juvenile justice system. Recommendations have been made regarding Cambiar New Mexico, as well as other areas. Performance measures that the CYFD reports quarterly to the legislature were provided.

Committee members had questions about whether youth are followed for a period of time after discharge into the community; community parole officers are much more engaged in helping youth be successful in the community and reducing recidivism rates. Questions were asked about the characteristics of the client population, where they are housed and whether members of the legislature are welcome to visit these facilities unannounced. A question was asked about how many youth are in a facility due to violence and the comprehensiveness of risk assessments that are performed on admission. Ms. Pritchard asserted that all clients in the CYFD facilities receive the same attention to safety. Questions were asked about the disposition of youth who are older than age 18 who re-offend; the CYFD is tracking the long-term disposition of these youth. Concern was expressed that the legislature does not have a clear picture of the problems with youth offenders based on the information presented. Thanks and appreciation were offered regarding the service provided by this program. Questions were asked about how youth are helped to continue their education while in a CYFD facility; the nature and extent of psychiatric services provided to the youth; and how youth with continuing behavioral health needs are served after discharge. Assurances were sought that facilities and behavioral health providers are receiving their funding on a timely basis.

Committee members had questions and made comments about Cambiar New Mexico. Recognition was offered that the Missouri model is a valuable model that has a very low recidivism rate and serves to rehabilitate youth and keep them out of the adult system. A committee member urged other committee members to visit Missouri and witness the model first-hand. Ms. Pritchard suggested that visiting a New Mexico facility would be equally valuable. A suggestion was made that during the next interim, the committee consider visiting the J. Paul Taylor Institute in Las Cruces. A question was asked about how the model serves youth with severely unstable mental health conditions; Ms. Pritchard assured the committee that the excellent staff is very well qualified to meet these needs and does so on a daily basis.

### **Behavioral Health Survey Results**

Senator Gerald Ortiz y Pino presented the findings of a survey he requested the LCS to conduct on his behalf regarding community providers' perception of the transition to OptumHealth New Mexico (OHNM) as the statewide entity (SE) to manage behavioral health services. He noted that the survey consisted of 10 questions that were sent to 62 behavioral health providers, 49

of which responded. He stated that this survey does not purport to be a statistically valid survey; nonetheless, it reflects some serious concerns among the provider community. He reviewed the questions and responses as reflected in the handout (see the meeting file).

Linda Roebuck, director, Interagency Behavioral Health Purchasing Collaborative, (IBHPC) and Dr. Sandra Forquer, president, OHNM, were invited to comment if they wished. Ms. Roebuck stated that she is well aware of the problems and has become increasingly dissatisfied. She has called in national consultants to conduct a diagnostic assessment; they found that the problems are not attributable to providers, but that serious system issues exist. Dr. Forquer acknowledged that there are serious issues and that she is working very hard to fix them. They have prepared a letter to the provider community to get their input on the proposed changes. She described "service registration", which is an area of serious problems. Ms. Roebuck noted that service registration is closely tied to payment of claims, so a problem with one affects the other. Although the system established to provide expedited payments will ultimately require a reconciliation to an actual claim, Ms. Roebuck stated that no recoupment of inaccurate payments will occur until the registration and claims system is working well. OHNM is in the process of customizing payment processes for the future until the system is working smoothly. Four administrative relief pieces are being put in place to ameliorate the problems: first, providers will only need to register consumers at the beginning and end of care; second, providers will not need to enter service requirements prospectively; third, enrollment of clients will only have to occur once, regardless of how many sites the client utilizes within a single organization; and fourth, enrollment and registration will be brought in-house for institutional providers.

Committee members had many questions and concerns as follows:

- the amount of administrative cost incurred by OHNM; approximately 12.6% of a total of approximately \$46 million;
- a concern that New Mexico is outsourcing money to an out-of-state, for-profit organization;
- a contention that the concept of the IBHPC should be revisited;
- an assertion that one provider is owed close to \$1 million and has hired an attorney; attorney costs will only add to the cost to the state;
- frustration about not understanding the entire behavioral health system, including the roles of the IBHPC and the SE;
- frustration about whether IBHPC money is being well-spent, whether there is enough being spent and a feeling that there is inadequate accountability over the system;
- frustration that inadequate system testing was conducted in advance of taking over the contract;
- concern that the lack of ability to play claims will drive providers out of the state;
- a request that a similar survey be conducted for the coordination of long-term services (CoLTS) program;
- an observation that the collaborative concept has not solved the problem of fragmentation;
- an acknowledgment by Ms. Roebuck that a deeper look needs to be taken at all levels of behavioral health (BH) administration;
- concern that providers are feeling a sense of retaliation when they raise questions or concerns; Dr. Forquer strongly asserted that any individual instance of retaliation that she becomes aware of would result in that staff person being terminated;
- thanks to Senator Ortiz y Pino for conducting this survey;

- appreciation to the provider community for shielding clients from the effects of these problems;
- a fear that clients are not receiving needed services;
- a question of why this occurred because OHNM has experience in other states; New Mexico has some unique issues, including more funding streams than other states and more complexity;
- a hope that the IBHPC will conduct surveys on an ongoing basis;
- frustration regarding assurances (August) from the IBHPC that providers would be paid and problems would be fixed;
- consideration of what would work better;
- whether any corrective action is called for or required at this time; Ms. Roebuck has asked for a legal opinion on exactly what corrective actions and sanctions are available to the IBHPC;
- a request that by the next day, the IBHPC lawyers identify what the sanctions will be, what interest will be paid to providers for late or improperly denied claims and how the state will be made whole;
- a comment that the vendor should pay the bill for the independent assessment that is being performed;
- a fear that some clients will end up in the correctional system;
- a desire that the issue be handled like a business, with OHNM held accountable, not the clients;
- clarification regarding when interest is paid on unpaid claims; interest can only be assessed on claims that have been entered into the system;
- a request was made that information about claims paid be made available to the committee in some form other than in the aggregate to allow the committee to fully comprehend the financial landscape of the problem; and
- a request was made of Deputy Secretary Falls to provide the same information regarding the CoLTS program.

A committee member read a statement calling for the HSD to immediately discontinue the CoLTS program and return to the previous long-term care system. It was noted that the statement is unrelated to the debate about the IBHPC. A committee member expressed concern that the motion would lead to contractual problems. Following a brief discussion, the chair suggested revisiting the topic at a later time.

### **Public Comment**

Dr. David Ley, director, New Mexico Solutions, one of the organizations that responded to the survey, and Shannon Freedle, C.E.O., Team Builders, Inc., thanked the committee and Senator Ortiz y Pino for conducting the survey. They stated that providers are frustrated that the IBHPC has not made more progress in three years. The system is complex with many conflicting rules. Having a single contractor limits the effectiveness of the state system. Providers have been asking the same questions for a long time, and they feel they have not been invited to be part of solving the problem. In other parts of the country, providers or provider cooperatives are part of the decision-making during the planning process and not only as problem solvers. Dr. Ley commended OHNM and Ms. Roebuck for working very hard to fix things, but the system is still not fixed. Providers are requesting an invoice billing system until the OHNM billing system is fixed. Providers have absorbed the impact of the problem, using all reserves and leaving no reserves to deal with projected Medicaid shortfalls. Mr. Freedle testified that his agency has a

presence in 14 counties around the state. It submits well over \$4 million in claims, about 40% of which have not shown up in the OHNM claims system. This appears to be a systemic problem for which no one receives notification. In August, his agency was paid for only about \$.60 on the dollar; in July, around \$.30 on the dollar; and no reimbursement has yet been received for September. He contends that no amount of training would have helped because the system does not work. He implored the committee not to do away with the whole SE contract, as providers could not survive another major change. Dr. Ley stated the desire of the provider community to work with OHNM and the IBHPC to address and fix the problems.

Committee members expressed a belief that small providers should be paid interest on late payments. Clarification was sought about whether providers are or are not currently involved in the problem-solving process. Dr. Ley and Mr. Freedle stated that they have ability to make public comment but are not partners to the IBHPC process. A question was asked regarding whether the state could automatically pay a percentage of unpaid claims. The expedited payment system was set up to address just that. The IBHPC and the SE are working on solutions, and Mr. Freedle hopes that the problem will not be ongoing. Committee members expressed concern that OHNM gets the state's money with no repercussions for its failures. One committee member believes this problem is very widespread in other departments, other contracts and other programs where payments are not being made for contracted services. A clarification was sought regarding whether providers fear retaliation or being labeled as troublemakers; the fear is for lost referrals or having concerns discounted. A question was asked regarding the rejection rate of claims; this was recognized as a new problem, the extent of which is unknown. When claims are rejected, the provider is not receiving notification of the rejection and neither is OHNM. Previously, providers have seen one-third of claims paid, one-third denied and one-third pending. So far, providers are continuing to provide services, but soon they may no longer be able to. Expedited payment has helped, but it promotes a false sense of viability.

Deputy Secretary Falls corrected information given yesterday regarding the SCI. There are no pre-existing conditions for SCI; however, some applicants are encouraged to apply to the NMMIP instead, as it is a better program.

The committee recessed for the day at 5:20 p.m.

### **Wednesday, October 14**

The meeting was reconvened by the chair at 8:50 a.m.

### **Healthy New Mexico Task Force: Goals and Progress: Program to Integrate Early Intervention and Case Management in Underserved Communities**

Alfredo Vigil, M.D., secretary of health, offered preliminary comments regarding prevention and wellness efforts in the DOH and the nation. He described the goals and mandates in SB 129, legislation that required the development of a Healthy New Mexico Task Force in the DOH. He updated the committee on statistics regarding chronic disease and what the DOH is doing to address chronic disease and its impact in New Mexico. He described the process the DOH followed to address the requirements of the legislation, which included working with New Mexico First to convene two town hall meetings to gather input from a broad audience. Over 170 people participated in one of two town hall sessions and generated nearly 100 recommendations. Secretary Vigil briefly summarized recommendations that were made in the areas of healthy

eating, physical activity, tobacco control and clinical preventive services. Legislative recommendations were highlighted. Ongoing efforts to address these focus areas were described. The department will continue to monitor these efforts, as well as continue to lead the Interagency Council for the Prevention of Obesity and to partner with the Healthy Weight Council statewide. The DOH supports the integration of medical, dental, behavioral and public health services to meet the needs of the community such as those provided at the South Valley Health Commons and the Hidalgo Medical Services. Health commons delivery systems are emerging in other locations and are supported by the department as well.

Committee members asked whether early results are available comparing these initiatives to determine whether any model is more successful than any other. The DOH tracks and monitors all the DOH programs; a racial and ethnic health disparities report card was provided to committee members that reflects this information. Members wondered which approaches motivate people to change; the best results are seen when an entire community becomes involved. A request was made for the DOH to provide data on the characteristics of the obese, especially very young children. The critical importance of collecting and monitoring data in all areas was stressed, and committee members expressed a need for guidance from the DOH regarding establishing priorities for data collection. Dr. Vigil noted that data collection is an expensive and underfunded venture. Questions were asked regarding why the town hall recommendations contain no recommendations on alcohol use and abuse and whether the DOH is still actively involved in this area. Clarification was sought about a Las Cruces health and wellness initiative and the changes in school schedules that promote healthier behaviors without adding to the cost of education. These measures are now being replicated in schools in other locations. A suggestion was made to add diet drinks to the recommendation to impose a tax on sweetened beverages and junk food. Patty Morris, director of obesity programs, DOH, provided details about the numerous initiatives being promoted around the state, including collaborations with the Women, Infants and Children (WIC) program, outreach to schools, cooking classes and others. Clarification was sought regarding the source of the recommendations. The recommendations came from the 170 participants of the town hall meetings. Concerns were expressed regarding the unique health issues affecting Native Americans and how they are being addressed within the DOH. Committee members asked how parents are educated about the health needs and behaviors of their children. Appreciation and support was expressed for family gardens and other initiatives that can be implemented in schools and that work to change behaviors at little or no cost. Committee members were interested in how outreach to rural areas is accomplished. The importance of personal and parental responsibility was raised. A committee member volunteered to work with the department to obtain funding from the Millbank Foundation to develop a research project on obesity. Obesity was compared to a public health problem, as the impact of obesity is so great and affects so many areas of health care delivery, coverage and reform.

Dr. Vigil provided an update on the H1N1 vaccine. This vaccine has been developed on an expedited basis, and new shipments will be distributed to states and providers on a rolling, weekly basis as they become available. The DOH has an effective distribution system that is working. It is being administered to all high-risk populations under the direction of the DOH. He acknowledged that the virus is in full swing and is ahead of the availability of the vaccine. Just yesterday, instructions were sent to all state employees urging them to stay home if they are sick and included instructions about how to use their sick leave.

## **Disease Management and Healthy Lifestyle Promotion in Employee Health Plans**

Nancy Bearce, bureau chief, Employee Benefits Bureau, Risk Management Division, General Services Department, presented information on efforts undertaken by the state to promote healthy behaviors among state employees. State employee health insurance statistics were provided. She described the advantages of medical, pharmacy, dental, vision and wellness benefits. Disease management programs are available for an additional per member, per month fee, with employees most interested in disease management for asthma, diabetes, low back pain and heart/pulmonary disease. A wellness initiative, called *Get Well New Mexico*, began in 2005. It includes activities such as health fairs, risk assessments and education in healthy eating, exercise and tobacco and alcohol cessation activities. In 2008 and 2009, the state began mobile mammography and expanded the activities of health fairs to include blood pressure, naprapathy and raffles for memberships to gyms, bicycles and other prizes that promote health and wellness. Physicians are encouraged to prescribe walking for diabetics in a program known as the prescription trails program. Currently, the bureau is working to re-energize wellness efforts; performance measures have been added to track effectiveness in this area. All the health plans offering state employee health insurance have wellness, disease management and case management staff, including 24-hour nurse hotlines. The Risk Management Division was able to retain many prevention and wellness benefits in the state health insurance plan despite budget cuts. The return on investment reported by carriers is \$2.00 saved for every \$1.00 spent on wellness activities. The Risk Management Division is eager to continue to participate in and partner with the Health New Mexico Task Force.

Given the positive ratio of savings for prevention and wellness, questions were asked about barriers to keeping these benefits in the face of rising health insurance premiums. It was acknowledged that individual savings do not necessarily translate into aggregate savings for the state. Clarification was requested regarding the disease management vendors; these are within the health plans at an average cost of \$2.60 per member, per month. The results of the use of disease management are measured and reported quarterly to the state. A question was asked as to whether employees receive a discount on premiums for participation in disease management; no, employees are eligible for discounts for such things as gym memberships directly from the plan in which they are enrolled. Ms. Hubbard stated that there is new interest in offering discounts that are directly connected to outcomes; an important element of such a program is to have educational support to help enrollees quit smoking, lose weight or other activities. These incentives, however, are not available to state employees at this time. Joanie Pompeo, Presbyterian Health Plan, stated that employee wellness initiatives have been successful and resulted in no increases in premiums, but they do not offer discounts. Ms. Pompeo emphasized that these are not available to state employees. Jennifer Sedillo of United Healthcare stated that United Healthcare offers no discounts to state employees compliant with wellness behaviors, but it does offer some discounts to other customers. Clarification was requested regarding whether state laws relative to premium allocation would need to be changed to allow state employees to have access to the discounts that are available to other insurance beneficiaries. The responses stated that the law is silent with regard to healthy behaviors; permissive language in the law would be beneficial to giving access to discounts to state employees. An observation was made that collection of data about prevention, wellness and disease management activities among state employees could lead to an ability to project and measure productivity, absenteeism and lifestyle changes as well as reduced health care costs. Ms. Bearce agreed that collection of this data would be beneficial; currently, this would require close collaboration with other state agencies and divisions, such as the State Personnel Office. A consolidated database would be helpful. A question was asked about why state

employees choose an indemnity plan rather than a managed care plan. A question was asked about the coverage, if any, of behavioral health services; yes, all four plans provide this coverage, including coverage for diagnosis and assessment of autism.

### **Primary Care Case Management**

Mr. Heyeck testified that Medicaid fee-for-service clients, who are the only ones who could benefit from a primary care case management program, represent a very small portion of the total population enrolled in Medicaid. The department has tried to develop primary care case management for Native Americans, but has been unable to find a vendor to implement it. He stated, however, that the development of patient-centered medical homes is being started and closely mirrors the concept of primary care case management.

Mr. Heyeck was asked if the HSD is, in fact, not implementing this pilot program as required by law. He stated that the HSD has been unable to find a provider to implement it and was not funded to do it. Approximately 80,000 people remain in fee-for-service programs, but that number is shrinking. The promise of patient-centered medical homes within managed care will serve more people going forward. With the implementation of the CoLTS program, many expensive Medicaid recipients previously in the fee-for-service population, such as the developmentally disabled, are now in a managed care environment. A question was asked about which HSD Native American liaison efforts are underway. A committee member referenced the primary care network model that predated managed care in Medicaid. A study performed by UNM indicated a savings to the program of \$53 million in that project. Mr. Heyeck responded that the implementation of managed care was a result of the success of that project and has resulted in major savings to the state every year. Additionally, as more Medicaid recipients are covered by managed care, the savings will increase. A request was made for the studies that show savings under managed care. A committee member contended that reimbursement for primary care physicians is so low that they are simply referring patients to specialists. If primary care physicians were adequately reimbursed for care management, the overall cost of health care would decrease. This is the concept of the patient-centered medical home.

### **Chronic Disease Management Initiatives in Private Insurance**

Mr. Howarth, director, New Mexico Health Policy Commission (HPC), described a survey conducted by the HPC of seven managed care plans, four of which responded to the survey. Results of the survey indicate that three of the four respondents do offer incentive programs that reward health care providers for controlling chronic diseases. The chronic diseases for which these incentives are awarded are asthma, behavioral health issues, cardiovascular conditions, diabetes and hypertension. Other incentive program components include breast and cervical cancer screenings, early prenatal care, immunizations and postpartum depression and well child visits. Participating managed care plans use health care effectiveness data and information set (HEDIS) measures to track the effectiveness of these initiatives. No studies have been conducted to determine the actual benefit of these incentives; however, managed care companies perceive benefits in the areas of improved health of beneficiaries, clinical effectiveness of care provided and decreased hospitalizations. Disadvantages noted were increased administrative costs, a presumption that providers should be providing this kind of care anyway without incentives and that the current system of reimbursement is based on fees for services rendered, not outcomes, and therefore does not easily accommodate incentive pay. The HPC offered three recommendations: continue to monitor national health reform, focusing especially on wellness initiatives; perform a literature review analysis to determine what existing wellness and prevention programs have

demonstrated success; and perform a literature review on outcome-based models of reimbursement.

Committee members asked whether the UNM Cares model has improved health outcomes and reduced emergency room use. An observation was made that managed care companies have very little incentive to provide wellness programs when many members have the opportunity to change plans on a yearly basis, thereby robbing the plans of the benefits of a healthier membership. Alternately, these benefits can be considered to be enticements to members choosing a particular managed care organization. Ms. Hubbard offered the comment that health plans believe that over time, they will realize cost benefits of wellness programs. The survey did not address this issue. It was noted that there is a big difference between chronic care management and screening. The cost-to-benefit ratio is more easily demonstrated in chronic care management. Committee members were interested in the variation of premiums for the health plans to state employees. Mr. Howarth will see that the information is provided. Ms. Hubbard was asked whether Lovelace has conducted any definitive studies regarding the effectiveness of disease management. She replied that HEDIS measures, which are nationally measured, do demonstrate effectiveness of disease management; however, wellness and prevention studies have not yet demonstrated their effectiveness.

#### **Cost of Chronic Illness and Wellness (HJM 24)**

Heather Balas, president, New Mexico First, described the process by which this report on HJM 24 was prepared. The working group included a cross-section of participants representing business, state government and wellness providers. She described the known impact of chronic illness on employers and the return on investment that can be realized through implementation of workplace wellness programs. Many large employers are already implementing wellness programs, but most small employers cannot afford to do so. Recommendations include things that employers can do, that insurance companies can do and that the legislature, as an employer of state employees, could do. Recommended legislative solutions include a requirement for nutritious food to be available in vending machines in the workplace, tax credits for employers who implement worksite wellness programs, investment in comprehensive wellness programs for state employees and requiring state employee health insurance to conduct risk assessments on at least 5% of enrollees. Finally, the report recommends that this committee host an expert presentation by a national worksite wellness economist during the 2010 interim. The HJM 24 working group is looking into sponsorship for this expert's travel and expenses.

Committee members asked how the projected savings were estimated. The information was derived from a study that was conducted by the Wisconsin Public Health and Health Policy Institute, which is included in the report. Questions were also asked about the voluntary steps being recommended for health plans to take and whether the contract with health plans for state employees insurance coverage requires availability of health risk assessment. Health risk assessments are available, but are not a requirement. Setting a benchmark would incentivize the plans to educate members about this benefit. Jim Campbell, Wellness Improvement Experts, noted that the cost of chronic disease to an employer is three times the cost of the absenteeism rate for that employer. Susan Jacobi, Johnson & Johnson, who is a member of the HJM 24 task force, stressed that a cooperative effort is necessary among employers, employees and insurers to ensure the effectiveness of wellness programs.

## **Eating Disorder Programs**

Sandra Lynn Whisler, M.D., professor of pediatrics, UNM, shared a personal story of her daughter's struggle with anorexia, the lack of providers to treat this condition and the exorbitant cost of obtaining treatment. She provided background information about eating disorders and the lack of availability of providers in New Mexico. Eating disorders have increased since the 1950s and now cross all ethnic groups, affecting younger and younger children. It can progress to a chronic, lifelong disease. Eating disorders have the highest mortality rate of all the psychiatric disorders. To effectively treat this condition, UNM contemplates an integrated approach managing physical, psychiatric and nutritional needs of patients. Outpatient programs should have both intensive and supportive levels of treatment, and an inpatient program is needed as well to treat children in New Mexico. Preventive programs are also critical. Dr. David Graeber, M.D., noted that treating this disease is very challenging. Early and intense evaluation would help determine the level of care and support needed for each child.

Committee members asked whether the current physician capacity at UNM could accommodate such a program. Dr. Whisler and Dr. Graeber are trying to generate interest in this concept, which is in the conceptual stage of development. The disease is unrecognized and underdiagnosed. By the time an anorectic child is seen, the disease is generally very advanced. A question was asked about how a concerned parent or health care provider could find a provider with expertise in eating disorders. It was emphasized that treatment requires a well-coordinated team approach to be successful. Questions were asked about the scope of this problem statewide. Those providers who do treat eating disorders report incidents all over the state; however, the belief is that many cases are going undiagnosed.

## **Research Report: Threats to the Behavioral Health Safety Net Providers Since the Implementation of the IBHPC**

Marnie Watson, research associate and senior ethnographer, along with Miria Kano, program manager and senior ethnographer, Behavioral Health Research Center of the Southwest, began by defining ethnography, which is a qualitative approach to conducting research. Ms. Watson apologized for the absence of the principal investigator on this project, Cathleen E. Willging. The purpose of the study is to provide an overview of major themes in behavioral health safety net institutions (SNIs) within the context of New Mexico behavioral health reform. She identified the sample and characteristics of the SNIs that participated in the study and the methods of gathering the information, which included both qualitative and quantitative approaches. Themes that emerged were that the new behavioral health structure in New Mexico has resulted in administrative demands, financial issues, issues surrounding the comprehensive community support services (CCSS) program transition, fee-for-service transition issues and statewide entity transition issues. Administrative burdens resulted in increased costs to 60% of providers and decreased accessibility of services to clients. In general, financial problems increased throughout the four years of the study and were particularly profound in rural and economically depressed regions of the state. Specific issues included such problems as insufficient funding, fewer resources and transition stress. The lack of reimbursement for transportation was especially difficult in the CCSS program because it requires that services be provided *in vivo* as opposed to clients visiting a centralized location or office. Providers who formerly relied on reimbursement made in one-twelfth draw-downs find the transition to fee-for-services billing very difficult due to the variability of this reimbursement.

Some good findings were also found, such as an ability to bring up new services, increased access to continuing education and training and a reorientation to the possibility of recovery for the most seriously ill clients. Clients and families are generally happy with the services they are receiving. Recommendations include the following: augment support for rural SNIs, or those that lack reserves; ensure providers that the new SE will not experience the same problems experienced by the previous SE; continue improved communication channels; reduce paperwork requirements; further evaluate of the effectiveness of CCSS; and continue to work with SNIs to improve their availability to track authorization and utilization of services.

Appreciation was expressed for the work of the researchers. Questions were asked regarding the people interviewed, the ultimate length of the study and a request for a copy of the final report when it is completed. A statement was made in support of hearing testimony such as this from someone other than state officials.

### **Public Comment**

Roque Garcia commented that the BH system under the IBHPC has consistently discounted provider input and is a dismal failure. It is an inefficient system and is getting worse. Many providers used to have six months of reserves but are now down to 30 days or less. Administrative costs increased from 12% to more than 30%.

### **Behavioral Health Issues Revisited**

Testimony the committee heard the previous day about the failures of the behavioral health system, particularly the failure of the new SE, were brought before the committee for additional debate and consideration.

Dr. Forquer, Ms. Roebuck, Deputy Secretary Falls, Bill Belzner, deputy director, IBHPC, and Mark Reynolds, general counsel, HSD, each made comments addressing the problems previously raised and indicated their willingness to respond to questions and concerns of the committee. Dr. Forquer noted that OHNM had experienced unanticipated logic problems with its computer system, but fixes are already in place. In response to a question regarding whether timeliness of payments is defined in the contract, Mr. Reynolds replied that time frames are set within which claims must be paid and this is supported by regulations. He is analyzing the current situation and preliminarily disputes whether OHNM is timely. Clarification was sought about the allegation that some submitted claims had been lost in the system.

Dr. Forquer admitted that there is clear evidence that providers have submitted more claims than OHNM can identify. Through diagnostic assessment, OHNM knows that there are approximately 30 large providers that use a particular software product called "connectivity directors". OHNM cannot identify claims the providers know they have submitted. Some of these claims are rejected without OHNM's knowledge; therefore, OHNM did not know the claims were submitted. OHNM has now committed to work through these rejected claims. Dr. Forquer reiterated proposed changes to the billing process (described on Tuesday), indicating that these changes are outlined in a memo to providers. Provider input is necessary as the proposed changes are very significant. A copy of the memo was given to committee members.

Committee members asked if the IBHPC has determined if the SE is in compliance with the contract relating to payment of claims. Mr. Belzner reported that it is in substantial compliance with that one element of the contract. OHNM is currently under a plan of correction

for one (unidentified) area of the contract, and diagnostic assessment may reveal other areas that are out of compliance. Ms. Roebuck clarified that the timely payment requirement concerns "clean claims"; OHNM is in compliance with that. OHNM is *not* paying the number and amount of claims submitted by providers. In fact, many claims are lost, and OHNM is unable to provide an explanation for what has happened to the lost claims. The IBHPC is assessing overall compliance with the contract.

Committee members had questions regarding penalties for lost claims and late payment of claims. Dr. Forquer advised the committee that she has received approval to use a provider's original date of claims submission to determine interest payments. A committee member asked to receive that in writing. Ms. Roebuck indicated that when the IBHPC and OHNM agree in writing on terms of compliance, they will share that written document with the committee. She noted that a formal agreement will have to be developed; she is reluctant to specify the details of that agreement until all findings are examined. Deputy Secretary Falls said that when it comes back before the committee in November, the IBHPC will be in a much better position to answer all of the committee's questions. She asserted that it has the same questions that the committee has.

Committee members wanted to know if the contract with the SE is tight enough or whether changes in the contract are anticipated. Additionally, the committee wanted to know whether sanctions are specified in the contract. Mr. Reynolds responded that sanctions are included in the contract. Analysis of compliance with the contract is ongoing; the early belief is that there is non-compliance with the contract. Article VIII addresses enforcement and the process for an array of sanctions and options. Once a determination is made that there is non-performance, Ms. Roebuck will take the finding to the IBHPC to determine the level of sanction. In response to a question, Mr. Belzner noted that the previous SE, ValueOptions New Mexico, was sanctioned 12 times; civil monetary penalties totaling \$12 million were assessed, some of which are still outstanding.

Committee members expressed dissatisfaction with the claims processing process, asserting that the process to validate OHNM's claims processing process was inadequate. A question was raised of whether a requirement for validation of the claims processing process was in the contract. Mr. Reynolds stated that it is not in the contract, but that it would be nice if it were. Committee members expressed general discontent with the lack of connection among the committee, the IBHPC and contract development and oversight. With a contract of this magnitude, the committee members expressed the opinion that they should be involved in the process of creating it at the beginning. Committee members also were surprised to hear that the previous SE had been sanctioned and felt that they should have heard about that at the time. Ms. Roebuck stated that this information was reported to the Legislative Finance Committee (LFC) and that committee members sought assurance that providers know before signing a contract with the SE what services are covered in the contract. Mr. Belzner responded that OHNM was required to contract with all providers who wished to participate with no changes in covered services. There were changes to fee schedules and classifications.

Grave concern was expressed that providers will be put out of business due to the lack of reimbursement during the first three months of the transition to OHNM. In an emergency such as this, claims should be paid and providers protected. Regardless of the reasons, providers are not currently being paid, and they should be paid with no questions asked. In response to a question, providers in the audience indicated that the previous SE is paying claims. Concern was expressed that these and other issues should have been worked out during the transition.

Clarification was sought about the relationship between providers and the IBHPC if the system is not performing and what obligation the IBHPC has to make providers whole. Mr. Reynolds stated that the contract is between OHNM and the state; there is no contractual relationship between the state and providers. Ms. Roebuck added that the primary obligation of the IBHPC is to keep the services provided and paid. A committee member expressed a strong feeling that OHNM should be put on a 180-day notice and its contract terminated. It was noted that page 70 of the contract states that "the SE shall make every effort to reduce administrative burden on providers", and OHNM is not doing that.

Discussion followed regarding whether the IBHPC considered all the options, including a state monitor. Mr. Reynolds noted that the review of contract compliance is not yet complete. Appointment of a state monitor is one option. Should a state monitor be called for, it would be necessary first to determine what a state monitor should do. Committee members desired to know the cost of the diagnostic assessment and expressed the opinion that the assessment should be paid for by OHNM, not the IBHPC. Strong sentiment was expressed that payment for the diagnostic assessment should not come out of funds dedicated to development of new and innovative services and projects.

### **Public Comment**

Mr. Garcia, director, Rio Grande Behavioral Health Services, testified that up to July 1, 2009, his company was being paid for 99% of claims on a timely basis. After July 1, payments went to zero.

Mr. Freedle stated that claims issues for providers are more than a technical issue and that finding OHNM to be in substantial compliance with payment requirements does not help providers get through the day. Of 78 claims his business submitted in July, OHNM only received 46. He implored the IBHPC to stop saying OHNM is in substantial compliance; the statement does not recognize rejections or denials of claims for reasons that are not understood. Providers feel things are not substantially OK.

Patsy Romero, consultant for northern providers and a former employee of ValueOptions New Mexico, said she was testifying as a taxpayer. She feels that the state was sold a bill of goods in this contract. The state was assured that things would go smoothly; however, providers cannot get answers and things are not working. A provider in Espanola had to postpone hiring a Spanish-speaking clinician because it has submitted \$1 million in claims but has only been paid a little over \$100,000. She feels that a state monitor is needed to monitor both the IBHPC and OHNM.

Jim Jackson, Disability Rights NM (DRNM) (on behalf of Nancy Koenigsberg), stated that the DRNM has heard many of the same issues, but has not been flooded with consumer complaints, which he feels is a testimony to the providers. If these issues are not dealt with quickly, there will be consumer complaints.

Carol Reinhardt, a provider, stated that her company's reserves are exhausted and a line of credit has been denied. She has already laid off some employees and cannot last much longer.

Violanda Nunez, executive director, Ayudantes, echoed previous comments and stated the situation is very urgent. She requested restoration of the one-twelfth draw-down method of reimbursement. Ayudantes is closing on October 30.

Following all the public comment, committee members sought assurance that payment would be sent to providers within one week. Ms. Roebuck stated that she could not guarantee that and that the issue of denials needs to be resolved first. A committee member asked Dr. Forquer if she has been paid by the state for September. Dr. Forquer replied that from July 1, 2009 through September 30, 2009, OHNM has received \$69,548,000. Of that, \$54 million is remaining. She declined to commit to paying providers within one week, but said OHNM is carefully looking at an invoice method of payment requested by providers. The committee member reiterated the request that payments to providers would be out within seven days. At least two providers have already made a decision to close. Deputy Secretary Falls and Secretary Vigil were urged to exert strong management and get this done. Deputy Secretary Falls replied that she will be working on that and that she does understand the emergency nature of the situation. Dr. Forquer asserted that nothing new is needed; an expedited payment process already allows for presumptive payments, but she cannot promise to pay all claims within seven days.

Committee members felt strongly that no providers should have to close their doors this month. A committee member stated that recoupment is a necessary part of this process; however, another committee member stated that the providers should not have to be held accountable for this round of payments because the SE has not been held accountable. This committee member will pursue further action if she hears that these claims are not being paid.

Senator Feldman made a motion urging the IBHPC to ensure that the SE make payments in full within seven days and with no recoupment. The motion was seconded by Representative Lujan. Brief discussion acknowledged the separation of powers and that the legislature does not have the authority to direct action in such a motion, but the motion expressed the strong feeling of the committee calling for action by the executive. The chair called the question, and the motion was passed unanimously.

A committee member asked whether the interest rate of 1.5% on unpaid claims goes to the provider. The contract language seems unclear on this point. Mr. Reynolds thinks it is not clear, but that in the past, the interest has gone to the state. Committee members stated their belief that the provider should get the interest and that the contract should be changed to make that clear. A committee member, in a strongly worded statement, claimed that this whole set of problems should be seen as a failure of the executive and that if checks do not go out within seven days, resignations should be submitted. He stressed that the executive branch of government is ultimately accountable.

There being no further business, the committee adjourned at 5:20 p.m.

**MINUTES  
of the  
FIRST MEETING  
of the  
DISABILITIES SUBCOMMITTEE  
of the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**October 29-30, 2009  
Room 307, State Capitol**

The first meeting of the Disabilities Subcommittee (DS) of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator David Ulibarri, chair, at 10:15 a.m. A subcommittee quorum was present. The chair stated that a report of this subcommittee will be made to the LHHS, along with legislative recommendations, at its meeting next week.

**Present**

Sen. David Ulibarri, Chair  
Rep. Danice Picraux, Vice Chair  
Rep. Nora Espinoza  
Sen. Gerald Ortiz y Pino  
Sen. Nancy Rodriguez

**Staff**

Michael Hely, Staff Attorney, Legislative Council Services (LCS)  
Karen Wells, Researcher, LCS

**Guests**

The guest list is in the meeting file.

**Handouts**

Handouts are in the meeting file.

**Thursday, October 29**

**Welcome and Introductions**

Senator Ulibarri welcomed everyone. Members of the subcommittee introduced themselves.

**Disability History 1841-1990: The 150-Year Struggle for Civil Rights and Community Living**

Jim Parker, director, Governor's Commission on Disability, provided detailed information describing the long struggle to achieve civil rights and community living for disabled individuals. As early as 1892, Samuel Gridley Howe warned of the dangers of segregation based on disability. Other early champions of disability rights included Dorthea Dix, Henry H. Goddard and the Catholic Church. In 1927, the U.S. Supreme Court, in *Buck v. Bell*, ruled that forced sterilization of people with disabilities violates their constitutional rights. President Franklin Delano Roosevelt put a personal face on disability as the first seriously, physically disabled person ever to be elected as a head of government. The federal Civil Rights Act of 1964 outlawed discrimination on the basis of race and became a model for subsequent disability rights legislation. In 1973, Congress

passed the Rehabilitation Act, which served as a framework for the Americans with Disabilities Act (ADA), and in 1975, the Developmentally Disabled Assistance and Bill of Rights Act was passed. Also in 1975, Congress passed the Education for All Handicapped Children Act requiring education for children with disabilities to be integrated with fully abled children. In 1984, the U.S. Supreme Court ruled that localities cannot use zoning laws to prohibit group homes from opening in residential areas solely because their residents are disabled. In New Mexico, 1987 was a critical year in which 21 people with disabilities filed a class action lawsuit on behalf of residents of Fort Stanton and the Los Lunas Hospital and Training School. The lawsuit, *Jackson v. Ft. Stanton*, came to be known as the *Jackson* lawsuit and resulted in the de-institutionalization of those residents. The lawsuit is ongoing as the state strives to meet the terms of the agreement. On July 26, 1990, President Bush signed the ADA, which awarded people with disabilities the same civil rights as fully abled citizens.

Subcommittee members had questions and made comments as follows:

- recognition that there is still work to be done to overcome prejudice against people with disabilities;
- a description of relatively recent injustices and poor treatment at the New Mexico School for the Deaf;
- recognition of several individuals referenced in the presentation who were important figures in advancing the rights of the disabled in New Mexico; and
- expressions of thanks for the very informative presentation.

#### **Legislation: Disabilities Task Force (Senator Eric G. Griego)**

Mr. Hely, joined by disability advocates Marina Cordova, Esq., and Nannie Sanchez, presented a draft of a bill requested by Senator Eric G. Griego to create a disability concerns task force. Mr. Hely described the task force that would be created through this bill, which would be composed entirely of people with disabilities, legislators and members of the executive branch serving in an advisory capacity. The primary goal of the task force would be to study the needs of the disabled and to develop a plan to accommodate those needs in New Mexico. A report of the findings and recommendations of the task force would be required by October 1 of each year beginning in 2011.

Ms. Sanchez expressed appreciation for the development of this draft, noting that there are many areas of need that a task force such as this could address. Ms. Cordova noted the importance of a variety of different types of disabilities on the task force and stated that the task force could not only identify problems, but also highlight their strengths. She distributed some suggested changes, including a list of specific priorities for the task force to study. Jim. Jackson, director, Disability Rights New Mexico (DRNM), reported that he previously provided some comments on the draft to Mr. Hely. He pointed out that input from the full range of people with various disabilities should be sought. The DRNM supports a combined committee of legislators and advocates and suggests that the ultimate focus of the bill might need to be narrowed, as the issues are very broad. The task force should be given the direction to identify the specific issues to address in a given year.

Subcommittee members asked questions and made comments as follows:

- the need for a central telephone number to streamline and facilitate access to services for the disabled and the need for more accountability in the service delivery system;
- a suggestion that a mother of a disabled child be a member of the task force;

- the importance of including the administration on the task force, but only as advisory members to the full committee;
- acknowledgment that Senator Eric G. Griego has not yet provided input on the bill draft;
- ways in which the proposed task force would coordinate with the Governor's Commission on Disability;
- recognition that there is a difference between a deaf person and a person who is hard-of-hearing; the needs of the two are dramatically different and should be so specified in the bill;
- recognition that the bill might not be determined germane in a short session of the legislature and a suggestion that the bill could be converted into a senate joint memorial; and
- the importance of working together to create solutions.

### **Report from the 2009 Southwest Conference on Disability**

Ms. Wells gave a brief overview of the 2009 Southwest Conference on Disabilities. She introduced Anthony Cahill, director of the Center for Development and Disability, University of New Mexico (UNM) Health Sciences Center School of Medicine, and Mr. Parker as co-sponsors of the conference. She identified the conference as an extraordinary opportunity to learn about disability issues and solutions.

### **Public Comment**

Ms. Cordova identified herself as a blind person with a blind daughter and spoke to the specific nature of blindness as a disability. She urged the subcommittee to ensure continued funding for the Commission for the Blind, highlighting services the commission provides. She recommended that licensure requirements for teachers of the blind require completion of the National Literary Braille Competency Test. She requested that regulations be changed to remove the provision allowing special education teachers to provide services to students who are blind or visually impaired. She would like to see an evaluation of the current system for recruiting and maintaining licensed teachers of the blind and visually impaired. Currently, some blind students are not offered the opportunity to learn braille due to the lack of available teachers. Finally, she advocated for the development of a comprehensive, statewide system to recruit and contract with qualified teachers. She provided a handout that discussed each of these issues in greater detail.

Raya Soleil identified herself as the single mother of a son with visual and physical disabilities. She spoke of the importance of the Medicaid medically fragile and developmental disabilities (DD) waivers, both of which have benefited her son. He is now enrolled in the Mi Via waiver, which allows him to independently manage his life with the help of his mother. She requested subcommittee members to protect the funding for these vital waiver programs. Subcommittee members stated that during the recent special session of the legislature, the DD waiver and the Medicaid programs were not cut; the legislature does not agree with the governor's interpretation of this issue.

Joanne Tapia Eastham identified specific problems inherent in the public school system for children with disabilities and the lasting effect of inadequate supports while they are of school age. The challenging and important role of mothers was recognized. Ms. Eastham advocated for a system of licensed Medicaid providers who could serve children in schools and assist families to link up with local resources. Ellen Pinnes noted that the federal Medicaid program has a

"medically needy" option that would allow a family to "spend down" their income to qualify for Medicaid, but New Mexico has not adopted this provision. She clarified some of the numerous income eligibility categories for Medicaid.

Deb Dennison told her story as a mother of a recently deceased son who was enrolled in the Mi Via waiver. She spoke about the difficulties of navigating a very confusing and inaccessible system. Her son was denied the DD waiver five times. Ultimately, he could not be served at home and was admitted to a nursing home at the age of 26. She noted that nursing home care is an entitlement, while home and community-based services are not. She feels there is a state bias that results in people remaining in nursing homes. It was very difficult to get him discharged back to the community.

Subcommittee members requested clarification about the difference between entitlement services and waiver services, the reasons for and the numbers of people on waiting lists for waiver services and how long a person might remain on a waiting list. The community reintegration program, which allows people to receive home and community-based services following a nursing home admission, allows people who are in nursing homes to receive priority placement on waivers. Ms. Pinnes stated that this is not a state or federal law, but is state policy. The legislature was acknowledged for its generous funding of the DD waiver, even in difficult times; however, it was noted that the disabled and elderly (D&E) waiver does not benefit from additional funding as often. It was noted that funding in excess of \$9 million has been appropriated for the DD waiver, but no people have been taken off the waiting list as a result of this funding. The subcommittee expressed interest in having Secretary of Health Alfredo Vigil clarify this issue.

Jeanne Hamrick spoke in favor of the proposal for a disability task force. She described problems with finding adequate parking and asked for support for legislation regarding handicapped parking. She described an episode of discrimination that she experienced in the housing complex in which she lives.

Yvonne Horn stated that she has had chronic illness and disabilities her whole life. Despite having private insurance, out-of-pocket expenses have been overwhelming. Additionally, regulations and processes make it very difficult to access needed services. She does not qualify for public assistance, despite having medical expenses that exceed \$3,500 per month.

Susan Gray provided testimony from the Aging and Long-Term Services Department (ALTSD) regarding the lack of coordination around disability services. The ALTSD, through a federal grant, established the Aging and Disability Resource Center, which is a central location and single point of entry for information about services for the disabled. The number for the center is 1-800-432-2080 or 505-476-4846 out of state.

Anthony Alarid, Governor's Commission on Disability, gave a brief report on HM 111, which called for a study of abuses of handicapped parking. Approximately 68,000 parking placards are being issued each year, yet very few citations are issued for violations of that parking privilege. He highlighted legislative recommendations of the task force, which were also provided in a handout to subcommittee members.

Carl McKibben voiced concerns regarding the DD waiver and the inadequacy of payment for providers of group home services.

Carl Dellinger, Alegria Family Services (AFS), testified that cuts to the DD waiver program would be devastating. The needs of this population are profound. AFS teaches family members many techniques that allow their disabled loved ones to remain independent at home. A gentleman spoke as a recipient of services, stating the importance of the program.

Ernestine Morales is the parent of a 41-year-old microcephalic daughter. After years of waiting, her daughter was finally put on the DD waiver, and it has opened up her world for her. She is concerned about what will happen to her daughter in the future, as she and her husband are her primary caregivers and they are in their 70s.

Gregg Trapp, director, Commission for the Blind, provided statistics about the extent of blind and visually impaired people in New Mexico, especially those children being served at the New Mexico School for the Blind and Visually Impaired. There has been a drastic increase in the rate of children in need that will require additional resources in the future.

Marilyn Bennett spoke as an advocate for adult services representing New Vistas, an independent living center. She posed questions to the subcommittee regarding proposed cuts to the DD waiver and Medicaid. Additionally, she asked whether the number of people who have been de-institutionalized under the coordination of long-term services (CoLTS) program is known.

Eva Tafoya, a parent of a child being served through the DD waiver, spoke about her son's potential and talents and stated that the waiver has opened up employment opportunities for him and provided the necessary physical therapy services. The waiver is critical in his life and allows him to be a contributing member of the community. She implored the subcommittee not to cut the waiver.

Rose Gonzales is a brain-injured person. She, too, implored subcommittee members not to cut the budget. Without the waiver, she could die. Even though she may not look like she is disabled, she is, and she needs the waiver services.

LaVeda Halliman spoke about the disability of mental illness. She is bipolar and has children and grandchildren with mental illness. She spoke about the prevalence of untreated mental illness in prisons and in the general society. She identified numerous types of mental illness, including depression, bipolar disease, schizophrenia, attention deficit disorder and other disorders. These disorders are difficult to treat and often go undiagnosed. A team approach of mental health providers has the greatest chance of success. Solving this problem will require many people to come together to work on it.

The chair made concluding remarks acknowledging that much work needs to be done and that legislators need much more education about disabilities. He stated that this day had been an eye-opening for him and the other subcommittee members. He thanked subcommittee members and members of the audience.

The meeting was recessed for the day at 2:20 p.m.

### **Friday, October 30**

The meeting was reconvened by the chair at 9:15 a.m.

## **Housing**

Gil Yildiz, executive director, Independent Living Resource Center (ILRC), highlighted the primary issues in housing for the disabled, including universal design and availability of community-based living for the elderly and disabled. Homes that do not include elements of universal design create serious access problems for people living with disabilities. The New Mexico Home Builders Association has incorporated an award in the Parade of Homes for homes that best reflect universal design. Elena Gonzales, Housing Division, ILRC, described her efforts to promote universal design statewide as a standard for the design of any home. The New Mexico Mortgage Finance Authority (MFA) supports this concept. The ILRC hopes to work with the attorney general to limit predatory lending practices by businesses outside of New Mexico offering loans to residents of the state. People with disabilities are among those with the lowest incomes in New Mexico. The ILRC is actively looking for ways to help these people become homeowners. The federal Department of Housing and Urban Development (HUD) Section 8 program is a very successful program that provides vouchers to assist those with physical and mental disabilities to purchase a home. Ms. Yildiz urged subcommittee members to encourage local housing authorities to offer this program. She added that the ILRC is a nonprofit service organization and is not a developer.

The chair noted that the attorney general has an action addressing mortgage fraud. Subcommittee members asked for clarification about which local housing authorities are and are not offering the HUD Section 8 programs and who that program can potentially benefit. The length of time for which the housing vouchers can be used was explored. Clarification was sought about the process that the ILRC uses to interact with the MFA to assist disabled people to obtain housing. The ILRC partners with the MFA to ensure the identification of appropriate financing mechanisms to assist disabled people in obtaining financing; there are multiple approaches depending on the circumstances. Subcommittee members asked what percentage of home loans obtained through the MFA go to disabled people and whether there is a waiting list. Ms. Gonzales estimates that less than 5% of MFA loans go to disabled people, but she does not have the exact percentage. She believes there is a waiting list for Section 8 vouchers available through the local housing authorities. Mr. Parker raised the issue that a number of people get "taxed out" of their homes. Previous legislation proposed a freeze on tax increases and future limits based on the consumer price index.

## **Job Discrimination**

Nancy Koenigsberg, Esq., legal director, DRNM, gave case examples of persons with disabilities who were terminated from their positions or prevented from obtaining a position due to a disability. Despite the ADA, discrimination is still occurring. Ms. Koenigsberg estimates that the problem is widespread because pursuing legal action is very complex and time-consuming and may prevent people from seeking remedies.

Timothy White, Esq., Valdez and White Law Firm, LLC, stated that 90% of his practice is in employment law. Of those cases, approximately 30% deal with people with disabilities. He represents both employees and employers. He repeatedly sees many instances wherein a person's disability is not recognized and the required accommodations are not made. Disability carries a significant stigma. He suggested that the legislature consider an amendment to the Human Rights Act to extend to New Mexicans the same civil rights that federal law offers. Congress recently amended the federal law to clarify critical terms such as "major life impairments" and "daily life

activities"; he suggested that the courts be directed to interpret New Mexico law to provide at least as much protection as that afforded by the federal law. Ms. Koenigsberg added that a change such as this would eliminate the need to litigate many cases and is simply a recommendation to align New Mexico law with federal law. The chair and Senator Rodriguez offered to sponsor such an amendment. Additionally, there are resources available to employers in New Mexico to help them understand what an accommodation is. The New Mexico Business Leadership Network has a valuable web site for both employers and workers. A more proactive stance on educating employers about this would open up employment opportunities to many disabled people in the state.

Subcommittee members asked for clarification about when federal laws apply and why the New Mexico law needs to be amended. The ADA only applies to employers of more than 15 employees. Further, the New Mexico law contains a restrictive interpretation of accommodation that the federal law has now removed. Subcommittee members are very interested in pursuing an amendment and would consider asking the governor to include it in his message to ensure it is germane. Clarification was sought about the meaning of "at will" employment. Ms. Koenigsberg stated that if a person has been performing the essential functions of a job, the "at will" provisions should not be a factor. Mr. White stated that, when lacking a contract specifying that a person will be employed for a certain period of time, an employer can terminate a person for any reason at all, except that the employer may not terminate a person for an illegal reason. A question was asked about a written, distributed statement alleging the misuse of job coaching in the intensive supported employment program. The chair noted that the statement had been provided by Senator Clinton D. Harden, Jr.; the chair recommended that the statement be forwarded to the full LHHS for its consideration. Instances of noncompliance with the ADA were noted, such as the lack of TTY machines in many state agencies.

### **Brain Injury Services**

Elizabeth Peterson, director, New Mexico Brain Injury Association, described her handouts, which include a CD of a brain-injury resource manual. She identified two types of brain injury: acquired brain injury and traumatic brain injury. She described the programs that are funded by the Brain Injury Services Fund and offered through the ALTSD. She provided statistics regarding the impact of brain injury in New Mexico arising from a study conducted by the Department of Health (DOH). She noted that there is no cure for brain injuries, making prevention critically important. The Mi Via program is a Medicaid waiver program that serves people with brain injuries. She would like to see an expansion of the Brain Injury Services Fund to allow use for acquired, as well as traumatic, brain injuries.

Subcommittee members requested clarification of limitations of funding. The Brain Injury Services Fund is composed entirely of state general funds and revenues from traffic tickets. Ms. Peterson noted that the Brain Injury Services Fund addresses short-term needs and provides assistance to people who may be on a waiting list for Mi Via or another Medicaid waiver. These services have less stringent eligibility requirements. The incidence and needs of veterans returning from Iraq and Afghanistan with brain injuries were noted; although the recent DOH study does not include veterans, they are known to represent a growing number of people with brain injuries. Clarification was sought about the amount of money in the Brain Injury Services Fund. Additional funding sources are needed in addition to greater flexibility in the use of those funds. Questions explored the ability of the Veterans Administration (VA) hospital to serve brain injury patients. Ms. Peterson asserted that the VA hospital might be able to provide long-term support, but that

access to the short-term brain injury services funds ensures more immediate assistance to veterans. A subcommittee member identified motorcycle or bicycle license registration as a possible source for additional revenues for that fund.

### **Waiver Waiting Lists**

Doris Husted, policy director, ARC of New Mexico, disclosed that she is the mother of a child served by the Mi Via waiver program. She began by describing basic information about the Medicaid program and Medicaid waiver basics. She noted that eligible individuals are entitled to nursing home care, but that waiver services are not an entitlement, which is why waiting lists exist. To be eligible for waiver services, an adult must meet both financial and medical eligibility requirements. Ms. Husted and Mr. Jackson identified the differences between eligibility requirements and services of the DD waiver, the medically fragile waiver, the D&E waiver and the AIDS waiver. The Mi Via waiver is not separately funded; participants enter the Mi Via program by virtue of being served by one of the other waivers. Mr. Jackson described the CoLTS waiver, which provides managed long-term care services, and how the previously described waivers interface with that program. Ms. Husted stated that there is a process for individuals to be exempted from managed care and receive services on a fee-for-service basis, but this process is only rarely approved. Mr. Jackson reiterated that Medicaid waiver services are not entitlements. Two issues emerge from this: the number of slots the state requests to be authorized under the waiver and the amount of money the legislature appropriates to fund those approved slots. Clarification was sought regarding whether the state is obligated to fund all the approved slots and whether the federal government ever refuses to authorize a requested number of slots. Mr. Jackson noted that the number of slots the state has requested closely approximates the number of funded slots. Ms. Husted stated that people on the DD waiver have been pre-screened for eligibility; for the D&E waiver, there is no pre-screening, and anyone who wants to can be put on the waiting list. Between 3,800 and 3,900 individuals are now served by the DD waiver, with approximately 4,800 individuals on the waiting list. Approximately 3,400 individuals are being served by the D&E waiver, while an estimated 16,000 are on that waiting list. The medically fragile and AIDS waivers are very small waivers and do not currently have waiting lists. It can take 10 to 12 years for a person on the waiting list to be put on a waiver. Many people will die before they receive services under the DD waiver.

A subcommittee member commented about the administrative costs that have been paid to managed care companies. Mr. Jackson noted that the decision to put Medicaid services under a managed care arrangement was made many years ago. The DD waiver is the only waiver not under a managed care arrangement at present. The original SALUD program was developed based on state law, but no law enabled the CoLTS program, which was instituted administratively. A subcommittee member asked a question about an appropriation made in the 2008 special session for DD waiver services. Carlos Moya, director, Aging and Disability Resource Center, ALTSD, noted that the resource center and the ALTSD handle the CoLTS program, but not the DD waiver. The resource center conducts an assessment when people call in to determine whether an application should be classified as "expedited". He noted that other services are offered when a person is put on a waiting list. A question was asked about why an appropriation was not made to the DOH to reduce the DD waiver waiting list, as required by the legislature. Ms. Dennison testified that her son, who recently died, waited five months to get waiver services through the community reintegration program.

Senator Ulibarri turned the chairmanship of the subcommittee over to Senator Rodriguez, as he needed to leave. He thanked all the presenters for their testimony and the subcommittee members for their presence.

Concerns were raised about the disposition of the appropriated funds, the number of the people still on the waiting lists and why a transfer of those funds appropriated to reduce the waiting list was not transferred to the DOH for that purpose. A request was made to have all the responsible entities present at the next LHHS meeting to resolve these issues. The chair noted that a copy of a letter previously sent to LHHS members and redistributed now answers many of these questions, but not all. The outstanding unresolved question regards the appropriation made to reduce the DD waiver waiting list. Cindy Padilla, cabinet secretary, ALTSD, noted that the executive has previously presented information regarding the ways in which the three departments work together to administer the waivers. She reported that staff in all three departments feel very strongly that the people served by and in need of waiver services should be treated with the greatest attention; it is difficult for staff members to maintain waiting lists when they realize the great needs of people. The \$750,000 allocated to the ALTSD to reduce the D&E waiver waiting list is addressed in the letter; 478 additional people were served as a result of that allocation. Clarification was sought regarding which department handles which waiver. Secretary Padilla stated that the Human Services Department (HSD) is the state fiscal agent for Medicaid and holds the managed care contracts. The ALTSD manages much of the administration of the CoLTS program. The two departments are trying to develop a matrix to explain the responsibilities of all entities in managing these programs. Upon request, Mr. Jackson clarified the differences between the DD and the D&E waivers, noting that there is some overlap between the waivers. Subcommittee members expressed a desire for one streamlined program to serve people with special needs. Mr. Moya stated that the Aging and Disability Resource Center is working toward becoming a single point of entry for access to services.

Subcommittee members asked for clarification of information provided in the letter from the HSD and the ALTSD, noting apparent discrepancies in some of the figures offered. More concise and clear data would be helpful for legislators to identify how much of an appropriation is needed. Kimberly Austin-Oser, division director, Elderly and Disabled Services Division, ALTSD, clarified that the discrepancy relates to per member, per month figures that managed care companies use to describe utilization. She stated that current estimates are that it requires approximately \$33,000 (state and federal funds combined) to take one person off the DD waiver waiting list. She noted that this amount will change as the federal medical assistance percentage (FMAP) changes. Secretary Padilla noted that approximately \$7,500 is needed to serve one additional person on the D&E waiver waiting list. A subcommittee member noted that the waiver costs are approximately one-half of the cost of a nursing home. Secretary Padilla reiterated that nursing home care is an entitlement and that waiver services are not. With a waiver, a state can limit, or cap, the number of people who can receive services. A suggestion was made that the LHHS request an additional day from the New Mexico Legislative Council for the LHHS to meet and resolve these issues. An additional request was made for a chart or a matrix to be provided to describe all the different waivers, funding streams and waiting lists, and which state agency has responsibility for what. A question was asked about the number of people who have been placed directly in a home setting without being admitted to a nursing home first. Secretary Padilla promised to deliver this information.

Wendy Basgall, staff attorney, Senior Citizens' Law Offices (SCLO), testified that people who call the office regarding waiver placement do so at the time that they need services, and not before. Ms. Austin-Oser clarified that the assessment done by the resource center helps to triage needs and identify those who have immediate needs. Many of these people can qualify for and receive personal care option services while they are on the waiting list for waiver services. A subcommittee member noted that in her personal experience, this did not happen and that steps must be taken to ensure that this does not happen again.

Mr. Jackson emphasized that from the perspective of the advocate community, state agencies have over the years not responded to legislative appropriation requests with reductions to the waiting lists. A chart was provided to demonstrate this. Finally, he drew the subcommittee's attention to provisions in state law that require state agencies to track and report to the legislature on waiting list information and information about who is served by the waivers. A request was made for information regarding projected as well as current needs for waiver services.

### **Autism Services for Adults**

Liz Thompson, president, New Mexico Autism Society, and Pat Osbourn, deputy director, Center for Development and Disability (CDD), UNM, presented information regarding autism services for adults. Ms. Thompson identified herself as the mother of an 18-year-old son who is still in high school, but who will soon graduate to adulthood. When children with autism graduate from high school, they face a cliff; virtually no services exist for adults with autism. There are few jobs and few appropriate living situations for adults with autism. She provided as a handout the personal statement of her son, Eric Hollins, that describes the paucity of opportunities. She noted that people with autism frequently cannot get or keep jobs, not because they lack the ability to do the work, but because they lack social skills. People in general society do not understand autism. The services that do exist, for example, through the DD waiver, are not designed to meet the needs of adults with autism. Parents are developing their own solutions to problems, such as creating group homes for their adult children with autism. Ms. Thompson noted that there are no requirements in the schools for education or skill development regarding autism. Ms. Osbourn acknowledged that most of the focus has been on the diagnosis and treatment of young children with autism spectrum disorder (ASD). She provided some data and statistics regarding ASD, but noted there is very little information about adults. The largest costs of serving people with autism will come as children with ASD become adults. In addition to the fact that there are no specific services for adults with autism, there is no autism-specific training required for providers working with adults with ASD. She identified that Pennsylvania is the first state to create an autism-specific waiver. At this time, no one knows the number of people in the state with ASD or what their needs are. New Mexico would benefit from a voluntary census to provide an accurate assessment of the number of children and adults with autism in the state and their needs and development of targeted services and supports specifically designed for adults living with ASD. Ms. Thompson identified the estimated incidence of ASD, which is approximately one in 100 in the general population and one in 56 in the military. Adults with autism are more difficult to manage, and autism is not a disease that results in early death. She spoke about the difficulty in making an application for the DD waiver, stating that it took a full year to make the application and then six years on the waiting list. Her son was able to receive some limited services, the most important of which was respite services. The depression rates of parents of children with autism are higher than that of parents of children with cancer.

Clarification was sought about the nature of services available through the gap program managed by the ALTSD; these services are primarily for environmental modifications and other one-time services and are not ongoing services. Ms. Husted noted that a small amount of funding, \$2,600 per year, is appropriated to the CDD for family support services to serve people on the waiting list for the DD waiver. Ms. Osbourn commented that provider training should require a level of competency.

Subcommittee members asked whether legislation to require provider training would be a good place to start and what elements of provider training are needed. A request regarding provider training will be presented to the full LHHS for its consideration. Ms. Thompson noted that the Development Disabilities Planning Council (DDPC) has set aside \$50,000 to develop a plan for ASD needs.

### **Public Comment**

Ms. Dennison clarified some information provided by the ALTSD. She stated that people can apply for both the DD waiver and the D&E waiver simultaneously, and many do so to double their opportunities of receiving services under at least one waiver. She also noted that due to long waits, many people end up in nursing homes as their conditions deteriorate. Additionally, she reported that there are many nondisabled people on the D&E waiver.

Ms. Sanchez and her mother, Rosemary Sanchez, thanked the subcommittee for holding the meetings. Ms. Sanchez read a written statement that is in the meeting file. Her statement addressed the history of disability and stated that there is still a lack of such services as education, employment, transportation and recreational activities. She requested that the subcommittee be made a permanent committee. Mrs. Sanchez also read a statement for the record, which is in the meeting file. She recommended that legislation be introduced to offer a tax break to businesses that hire people with disabilities and that people with disabilities be paid at least minimum wage.

John Block with the Governor's Commission on Disability thanked the subcommittee and offered support and help.

Charles Grote with La Familia addressed the committee in sign language. He is a job developer with La Familia. He identified that there is ongoing discrimination against the deaf in employment issues. Applications for jobs are difficult because approximately 88% of deaf people do not read or write well. Online applications are a big barrier to employment for the deaf. To begin to address this issue, the Workforce Solutions Department should rewrite applications, recognizing that deaf people have their own culture and language and do not communicate well, if at all, in the language of the hearing world. Laurel Sacks, responsible for outreach programs to the deaf at La Familia, concurred that there are many barriers for people who are deaf. She provided an example of an immigrant seeking citizenship who was not provided an interpreter for the citizenship interview. Mr. Grote asked if there are any resources dedicated in the state to ensure that deaf people on waiver programs are offered avenues to communicate that are appropriate to their disability. Mr. Block and Lisa McNiven of the Governor's Commission on Disability noted that the Governor's Commission on Disability is requesting the Workforce Solutions Department to require Walmart and other employers to have an application process that serves the deaf. The chair recommended that the subcommittee write a letter to the secretary of workforce solutions to address these concerns. Mr. Grote identified departments of state government that should be

required to have services available to serve deaf people properly. He would like to see a change in the law to require "benchmarkable" services to deaf people.

Representative Picraux read a letter from Morgan White, a constituent, requesting sustained funding for the DDPC as an organization that helps people with developmental disabilities to be successful.

Ms. Cordova commented that as a parent of a blind child and as an attorney, she has had a lot of contact with parents of children with special needs. She described a lack of specialized teachers in the classroom to help children with special needs learn adaptive skills. She read three letters from three teachers of blind and visually impaired children reporting difficulties at the New Mexico School for the Blind and Visually Impaired that caused 75% of the teachers to leave in one year. The school is underfunded and cannot pay competitive salaries. A school in Oregon has a model of education that could be duplicated in New Mexico. Dismay was expressed in the letters regarding the lack of outreach services to children and in the early childhood program. The letters contend that the exodus of so many teachers in such a short period of time leaves the school unable to meet the needs of children. The cost of inaction is an uneducated, illiterate population of blind people in the future. Ms. Cordova suggested that regional cooperatives should have consultants who could work with local schools to develop strategies to serve blind children better.

There being no further business, the meeting adjourned at 3:30 p.m.

Attachment to the Minutes of the First Meeting of the Disabilities Subcommittee of the Legislative Health and Human Services Committee

Medicaid waivers

10/30/09

1) **\$9.4 million appropriation for DD waiver waitlist** — Not a single person has been added to the DD waiver from the waitlist using these appropriations.

- \$4 million from 2008 special session
  - Money from nonrecurring funds, but clearly intended by Legislature to be used for recurring expenditures to serve people on DD waiver waitlist. (Jim Jackson will be part of the panel on waiver issues. You can ask him to clarify this as needed)
  - Appropriated to HSD, which should have transferred the money to DOH to be used for the DD waiver. According to DOH Secretary Vigil, HSD has not transferred the money to his department.
  - ◆ *If Secretary Vigil is in attendance, you might ask him if he's asked HSD to give DOH this money. If not, why not?*
  - ◆ *If someone from HSD is present, ask what HSD has done (or intends to do) with this money.*
- \$5.4 million in HB 2 in 2009 regular session
  - Appropriated directly to DOH.
  - Recurring funds, but Secretary Vigil has taken the position that he does not want to expand the program when the state is facing a budget shortfall.
  - ◆ *Possible questions for Secretary Vigil: Isn't it up to the Legislature to decide whether to expand the program? Didn't the Legislature make that decision when it appropriated the money for the DD waiver, at a time when it recognized that money was tight?*

2) Disabled & Elderly waiver

- The D&E waiver is now part of the Coordinated Long-Term Services (CLTS) program. Although the stated goal of CLTS is to serve people in the community rather than in nursing homes, the number of people receiving waiver services has fallen.
- Allocations to the D&E waiver are controlled by HSD, not by the CLTS managed care organizations.
- At the present time, the only people getting slots on the D&E waiver are individuals in nursing homes who want to return to the community. That means the only way to get on the waiver is to go into a nursing home (which is an entitlement in Medicaid) and then be transitioned to the waiver.
- This is not required by federal or state law. It is **policy** set by HSD.
- \$750,000 was appropriated by the Legislature in the 2008 regular session for the D&E waiver waitlist but the number of people on the waiver has decreased.

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

**November 4-6, 2009  
Room 322, State Capitol**

The sixth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Danice Picraux, chair, at 9:05 a.m. on Wednesday, November 4, 2009. A quorum was present.

**Present**

Rep. Danice Picraux, Chair  
Sen. Dede Feldman, Vice Chair  
Sen. Rod Adair (11/5)  
Rep. Nora Espinoza  
Rep. Joni Marie Gutierrez (11/5, 11/6)  
Sen. Linda M. Lopez (11/5)  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

Rep. Jose A. Campos  
Sen. Gay G. Kernan  
Rep. Rodolfo "Rudy" S. Martinez  
Rep. Jeff Steinborn

**Advisory Members**

Sen. Sue Wilson Beffort  
Rep. Ray Begaye  
Rep. Eleanor Chavez (11/5)  
Rep. Nathan P. Cote  
Rep. Miguel P. Garcia  
Rep. Keith J. Gardner (11/6)  
Sen. Clinton D. Harden, Jr. (11/5, 11/6)  
Rep. John A. Heaton  
Rep. Dennis J. Kintigh  
Rep. James Roger Madalena  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill (11/5, 11/6)  
Sen. Mary Kay Papen (11/5, 11/6)  
Sen. Nancy Rodriguez  
Sen. Sander Rue  
Rep. Mimi Stewart  
Sen. David Ulibarri  
Rep. Gloria C. Vaughn

**Guest Legislators**

Rep. Edward C. Sandoval  
Rep. Nick L. Salazar (11/5)

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

### **Staff**

Michael Hely, Staff Attorney, Legislative Council Services (LCS)  
Karen Wells, Researcher, LCS  
Jennie Lusk, Staff Attorney, LCS  
Mark Harben, Records Officer, LCS

### **Guests**

The guest list is in the meeting file.

### **Handouts**

Handouts are in the meeting file.

## **Wednesday, November 4**

### **Welcome and Introductions**

Representative Picraux welcomed everyone. She described the process by which she and Senator Feldman submitted bill requests on behalf of the committee.

### **Health Care Services Common Interest Report (SJM 1)**

Ruby Ann Esquibel, director of policy, Human Services Department (HSD), introduced the members of the task force who collaborated on the memorial report. SJM 1 asked all public entities engaged in health care coverage in New Mexico to meet and identify common interests and opportunities to work together. She described the New Mexico Health Insurance Alliance (HIA) and the New Mexico Medical Insurance Pool (NMMIP) as quasi-public entities that were created by the legislature but do not receive legislative appropriations. She described the process by which the task force addressed the goals of SJM 1, identifying all the ancillary partners that were also brought into the project. The task force identified options for consideration, but did not make official recommendations due to the lack of actuarial analyses of the options.

All the entities together cover approximately 250,000 lives that represent almost \$1 billion in claims costs, \$46 billion in third-party administrator (TPA) costs and about \$12 million in administrative expenses. Information was provided to reflect measures in which all the entities are already engaged to contain costs. Options for consideration covered cost savings, enhanced coverage, modified pooling arrangements, plan and benefit design, pharmaceuticals and data and administration. Specific options were described and are included in the report and the detailed handout. Next steps that require funding include continued study of the options and actuarial analyses in order to develop specific recommendations. Implementation of some of the options would require the creation of an authority or other overarching structure. The task force members were in agreement that additional actuarial analyses should be done.

Committee members asked for clarification or had comments in the following areas:

- how individuals are ensured continued coverage after losing group coverage under the federal Health Insurance Portability and Accessibility Act of 1996 (HIPAA); the NMMIP and the HIA are the current avenues in New Mexico to do this, though coverage may be costly;
- which individuals are not protected by HIPAA; those who do not have 18 months of creditable coverage before becoming uninsured;
- how the cost of the NMMIP compares with the cost of COBRA coverage that can be obtained through the HIA; the NMMIP rates are set by statute and include discounts for low-income individuals;
- whether the uninsured would be helped by implementation of these measures;
- whether estimates of cost savings for any of the options were done. The task force does not have aggregate estimates; however, individual agencies have done projections;
- what the Health Care Purchasing Act covers; it requires joint procurement for Interagency Benefit Advisory Committee (IBAC) agencies;
- clarification regarding self-insured entities and whether they participate in the IBAC;
- information regarding the potential for cost-savings and level of participation with wellness initiatives for IBAC agencies;
- the pros and cons of requiring a consolidated bid to serve all IBAC agencies and where resistance to that issue exists;
- why people have been transferred from the NMMIP into the state coverage insurance (SCI) program. The NMMIP has a six-month waiting period under some circumstances that would limit access to needed services while SCI does not have any waiting periods; additionally, less than one percent of SCI members qualify for the NMMIP;
- the potential for eliminating the six-month waiting period in the NMMIP;
- the effect that federal reform measures such as guaranteed issue and high-risk pool provisions would have in New Mexico;
- why NMMIP has (by statute) higher-than-average insurance premiums; losses in the high-risk pool are ultimately passed along to private insurance premiums;
- an observation that routinely reported administrative costs of health plans do not reflect the administrative costs of subcontracted providers;

- the potential cost-savings attributable to pooling;
- whether pharmaceutical cost-saving measures already in place in the NMMIP can be implemented by other state-funded insurance programs;
- opportunities to replicate throughout the system any cost-savings measures in any agency that are successful;
- whether decisions have already been made to contain costs in the Retiree Health Care Authority (RHCA); yes, changes were approved by the RHCA board and will be implemented in January and retirees have been notified;
- reasons why RHCA premiums are going up by 30 percent to 45 percent. Premiums are going up to address insolvency projections; however, options are available to keep premiums lower. The RHCA will work with retirees to help them identify the best options for them;
- a request for information regarding the RHCA reserves and solvency projections; currently, the RHCA projects it will remain solvent until 2026;
- whether market forces would take care of many of the issues and options raised in the report;
- a desire to identify and recognize unintended consequences of some of the options;
- the impact of reducing the annual claims cap in the SCI from \$100,000 to \$50,000; the re-submission of the SCI waiver contains a request for flexibility to do this;
- clarification regarding to whom the reported individual agency savings accrue; it appears that the recipients of coverage are not the beneficiaries of these savings; and
- a request for additional information regarding who TPAs are, what their corporate structure is, what their duties are and what the contracts with TPAs cost; the information will be provided.

### **Bulk Purchasing (SJM 5)**

Sam Howarth, director, New Mexico Health Policy Commission (HPC), and Lisa Marie Gomez, management analyst, HPC, presented a report of SJM 5, which studied the potential of bulk purchasing of health care supplies. The goals of the memorial were to identify how departments are currently using bulk purchasing and to develop a plan for ways to use bulk purchasing in the future. The HPC was unable to convene a task force for this purpose; however, it conducted a literature review and requested input and review from state agencies. Ms. Gomez reviewed the experience of multi-state bulk purchasing pools in Medicaid and in the private market. New Mexico does not participate in any multi-state bulk purchasing for Medicaid, as virtually all of Medicaid is under a managed care contract, and the managed care organizations (MCOs) have an individual ability to obtain bulk purchasing discounts. A study conducted by the

University of Maryland, Baltimore Campus, concluded that no additional savings are likely with participation in intra-state bulk purchasing in New Mexico under the existing structure. The report indicated that some additional savings could be realized with pursuit of additional rebates under the fee-for-services Medicaid program, measures to encourage greater use of generics, more intensive oversight of high-cost pharmacy products, redesigning the payment methodology for pharmaceuticals and implementing more cost-effective preferred drug lists. The report made recommendations for potential increased savings that are delineated in the report and the handout. Other suggestions for consideration were offered that derived from the experiences of other states and are contingent upon a return to a fee-for-service environment for Medicaid. New Mexico IBAC agencies also have opportunities for increased savings by participating in multi-state bulk purchasing arrangements.

Committee members had questions and comments in the following areas:

- clarification of who is involved in negotiations for pharmaceuticals and medical supplies, and how much leverage the state actually has;
- clarification of the difference between the average wholesale price (AWP) and the average manufacturers price (AMP); AWP has always been the standard for negotiating discounts; this changed with the federal Deficit Reduction Act of 2005;
- recognition that a statute requires the HSD to collect information regarding the AMP; however, the law does not permit the information to be released;
- clarification of how Iowa saved \$100 million per year on prescription drug costs;
- clarification of how federal reform proposals address this issue;
- the ability of IBAC agencies to engage in bulk purchasing now; and
- opportunities for private market solutions.

### **Prescription Drug Importation (HM 80)**

Wayne Propst, director, RHCA, and Mark Tyndall, deputy director, RHCA, reported on the study of the potential for importation of prescription drugs from Canada required by HM 80. Mr. Tyndall provided a description of the I-Save Rx program, initiated in Illinois and extended to seven other states. The federal Food and Drug Administration (FDA) continues to assert that this program is illegal, and all reviews by state attorneys general have concurred; however, no prosecutions have been pursued. Potential savings through instituting such a program are substantial to the individuals who use the program. Opponents of this program feel imported drugs may not be safe.

Committee members had questions and comments as follows:

- whether importation from Mexico has been explored; and
- whether any cost comparisons have been made of generic drugs.

### **Social Worker Study (HJM 55)**

Senator Ortiz y Pino provided background information regarding the purpose of HJM 55. Romaine Serna, communications director, Children, Youth and Families Department (CYFD), Mark Dyke, Ph.D., New Mexico Highlands University, and Lynne Christiansen, L.I.S.W., Department of Health (DOH), presented the findings of the study. Ms. Serna noted that the original intention of the memorial was to study the need for social workers in the state and whether there was a need for a loan repayment program for social worker education. She noted that the information provided to the committee in addition to the memorial report includes a handout reflecting information not endorsed by the CYFD. The CYFD supports the position that persons with related degrees can be hired into social work positions.

Dr. Dyke conducted the research that is the basis of the findings of the report. A survey was conducted that asked about the current and projected need for social workers in the state. The survey found that 13 percent of current social workers intend to retire within the next five years. Given the current rate of population growth, social worker caseloads will increase by more than 50 percent by 2030. The cost of an undergraduate social work degree was found to be approximately \$70,000 when all costs are included, and the cost of a graduate degree is close to \$35,000. The average salary of a social worker who is repaying student loans is \$35,000 to \$40,000 per year. Survey respondents reflected that a loan forgiveness program for social workers would encourage more people to pursue social work as a career and would especially benefit minority students. The task force presented recommended criteria for a social worker loan repayment program; details are included in the full report and in an executive summary of the report. Ms. Christiansen noted that responses to the survey were dramatic; social workers expressed gratitude that their input was being sought. She also noted that respondents included many social workers not employed by state government. She described the difficulty in recruiting and retaining social workers, especially in rural areas. Ms. Serna concluded by saying that the report shows that New Mexico does need social workers and that a loan repayment program is also needed.

Committee members had questions and comments as follows:

- recognition of the disparity between the national and state average wages for social workers;
- the unlikelihood that a loan repayment program would alter the low wages that social workers are paid in New Mexico;
- reasons why there are more unlicensed than licensed social workers in the state;

- whether obtaining a social worker license results in a pay raise in state government; no, it makes no difference;
- the percentage of minorities who are social workers; and
- the need to narrowly focus a loan repayment program to social workers in rural areas and in very challenging field positions for social workers such as child or adult protective services.

### **Health Insurance Exchange (HJM 57)**

Morris "Mo" Chavez, superintendent, Insurance Division, Public Regulation Commission (PRC), and Melinda Silver, health care attorney, PRC, presented the findings of HJM 57, a memorial tasked with exploring the potential for establishing a voluntary health insurance exchange. Mr. Chavez noted that virtually all major health plans and health insurers participated in the task force and stated that the federal reform initiatives will likely require the state to form an exchange. Ms. Silver provided an overview of the federal landscape, describing common elements of the reform measures being considered in Congress and what to expect with regard to exchanges. She reminded the committee of the definition of an exchange as stated in the memorial, noting that there are variations in how an exchange can function. Mr. Chavez described an exchange as it currently exists in Massachusetts and the Utah model, which is a web-based exchange and a more limited model. Regarding an exchange, the Senate Finance Committee version of health reform requires states to establish an exchange; other senate bills allow states to establish an exchange, and the house measure requires the establishment of a national exchange. Mr. Chavez noted that the high-risk pool in New Mexico will likely serve as an element for transition as an exchange is developed. States may be responsible for accomplishing the necessary risk adjustments and reinsurance mechanisms. The establishment of an exchange could enhance access, choice, affordability and portability of insurance products in New Mexico. The task force envisions an exchange as a quasi-governmental body with diverse membership on the board, including consumers as well as industry representatives. Individuals could access the exchange through brokers certified as navigators, employers or through a web site. The federal laws will mandate much of what the state is able to institute.

Committee members had questions and comments as follows:

- the potential for an exchange to get more people insured and for individuals to make informed choices;
- the opportunity to increase awareness about the NMMIP;
- whether an exchange could be started on a voluntary basis. It is possible; however, it is likely that very soon there will be federal mandates that direct the approach that will be taken;
- limitations and benefits of the Utah model;

- whether an exchange would help the uninsured. Currently, uninsured New Mexicans already have access to all these insurance products and are still uninsured; an exchange alone would not change that dynamic;
- whether an exchange would offer pre-tax benefits currently only afforded to employers;
- clarification of how Section 125 plans work; the federal tax code permits what are known as cafeteria plans allowing employees to purchase individual health insurance coverage with pre-tax dollars;
- the opportunity for the state to set up federal Section 125 plans through an exchange. It will depend on federal law parameters; New Mexico would need to get federal Internal Revenue Service approval to extend Section 125 plans to individuals;
- the anticipated ability of an exchange to facilitate an individual making health insurance purchases;
- an observation that an exchange, by itself, does not constitute health care reform, but does simplify the purchase of health insurance and promotes affordability;
- whether an exchange should include *all* insurance options, including a public option or the high-risk pool;
- whether an exchange makes insurance more portable; the exchange itself does not change portability laws;
- whether an exchange addresses affordability of health insurance; the cost of health insurance is driven by the cost of providing health care, and an exchange will not address that;
- an observation that exchanges are clearly beneficial to employers, but provide no obvious benefit to individuals with high medical costs;
- an observation that an exchange is part of a larger reform discussion; and
- the importance of including a discussion of the high-risk pool in any discussion of an exchange.

Dr. J.R. Damron was invited to make comments as a long-standing proponent of exchanges. He noted that the federal employee health benefit plan is a model of an exchange; 26 other states are looking at the exchange concept; and federal reform efforts place an exchange as a framework to provide one-stop shopping for consumers to help them identify available products. Additionally, an exchange acts as an administrator for an employer that participates in the exchange and removes the responsibility for an employer to make health insurance choices for its employees.

## **Substance Abuse: Interagency Behavioral Health Purchasing Collaborative Report on Memorials**

### **Substance Abuse Strategic Plan (SM 71)**

Michael Coop, president, Coop Consulting, Christine Wendel, chair, Behavioral Health Planning Council, and Yolanda Cordova, chair of the Substance Abuse Subcommittee of the Behavioral Health Planning Council, presented information about efforts to develop a statewide plan to address substance abuse in New Mexico. The work they have done establishes a permanent process for examining the needs of New Mexico in addressing substance abuse in the future. Mr. Coop described the statutory requirement for the Substance Abuse Subcommittee and the work of the subcommittee to address prevention, treatment, harm reduction and law enforcement elements of substance abuse. He reviewed statistics about the extent of substance abuse as a problem in New Mexico, which shows the seriousness of the work of the subcommittee and the recommendations it is making. Two specific legislative recommendations were highlighted: first, a recommendation that prevention be included in health education as a graduation component; second, that judges be allowed discretion, in cases of possession of small amounts of illegal substances, to send a person to treatment rather than incarceration upon the recommendation and assessment of a licensed behavioral health provider. Mr. Coop noted all of the recommendations will be presented to the Interagency Behavioral Health Purchasing Collaborative (IBHPC). He briefly highlighted some of the most important recommendations of the report in each of the key areas.

Committee members had questions and comments in the following areas:

- the extent to which youth are screened for substance abuse issues;
- the degree to which existing programs could be consolidated or enhanced to improve efficiency or effectiveness;
- whether OptumHealth was involved in the subcommittee, and the critical need to include it in the future;
- what the ultimate goal of all these recommendations is;
- whether the recommendations include rehabilitation of young alcohol or drug addicts;
- the recognition of the need for a better continuum of care for adolescents; school-based health centers are part of the solution;
- an observation that the report does not emphasize enough the lack of services; and
- the number of treatment facilities in the state.

### **Opioid Addiction Treatment Barriers (HM 9)**

Dr. Karen Armitage, medical director, DOH, Olin Dodsen, opioid treatment program, DOH, and Jeanne Block, advocate, presented the findings of HM 9. The memorial called for the DOH to put together an expert panel to identify the most important treatment methodologies and barriers to treatment of opioid addictions. Dr. Armitage described the scope of the problem in New Mexico. Methadone is a treatment for addiction that is administered under medical supervision. A new treatment modality, suboxone, is a combination of buprenorphine and naloxone that is available in pill form. Opioid overdose is a serious problem; at least half of the deaths are a result of prescription drug overdose. Barriers to treatment include a limited number of treatment programs and limited insurance coverage for that treatment. There are only a few providers who are trained in treatment of this addiction and, except for the University of New Mexico (UNM), all are for-profit entities. Finally, most people with opioid addiction have multiple other medical problems. The memorial called for a plan to reduce the barriers to treatment. Numerous recommendations were presented targeting actions to be taken by the IBHPC and member agencies; actions for communities, health councils and local collaboratives; actions for local detention facilities and law enforcement; and miscellaneous other recommendations. Overall, the recommendations seek to focus system changes and allocations of dollars to ensure that the best and most effective treatments are identified and used. Dr. Armitage noted that many of the recommendations can be accomplished with very little money.

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

- the number of people in the state with opioid addictions;
- reasons why OptumHealth and other payers do not cover suboxone treatment;
- acknowledgment that very few providers or collaborative members have experience with heroin users;
- a comment that most methadone patients are self-paying and receive no assistance to cover the cost of their treatment; and
- a need to introduce suboxone opioid treatment in prisons.

### **Breastfeeding Student Mother Needs (HM 58) and Pregnant Substance Abuse Services (SM 19)**

Giovanna Rossi Pressley, executive director, Office of the Governor's Council on Women's Health, provided a report of the findings of HM 58, which addressed the needs of breastfeeding student mothers. Data regarding the incidence of breastfeeding student mothers show that breastfeeding rates drop dramatically nine weeks postpartum. The report identified needed support for breastfeeding student mothers and recommendations to extend the duration and improve the initiation of breastfeeding among student mothers. New Mexico law mandates that a mother be permitted to breastfeed her child in any public or private location and requires employers to provide a clean and safe environment in which a mother may breastfeed her child. Neither law is

enforced. Recommendations were divided into direct services, outreach and education, leadership development and research.

Committee members sought clarification regarding whether students are not being allowed to breastfeed or are not being provided a location in which to breastfeed. Students are not provided an appropriate space; only a handful of schools have programs in place to accommodate pregnant or breastfeeding students.

Ms. Rossi Pressley next addressed SM 19, which looked at substance abuse treatment and prenatal care for pregnant women with substance abuse problems. She noted that a task force identified goals and a proposed work plan, but that the full work of this task force is not completed. The final report will be completed in 2010. Ms. Rossi Pressley identified the goals of the task force, which reflect federal Substance Abuse and Mental Health Services Administration (SAMSHA) guidelines. The chair asked whether the office has adequate funding to conduct these studies. Ms. Rossi Pressley stated she is not requesting any funding for this work, but would appreciate the committee's support in keeping the office open.

There being no public comment, the meeting was recessed for the day at 6:00 p.m.

#### **Thursday, November 5**

The meeting was reconvened by the chair at 8:55 a.m.

#### **Update on Statewide Entity Implementation: IBHPC Overview and State Actions to Address Problems**

Linda Roebuck Homer, CEO, IBHPC, was joined by Alfredo Vigil, secretary of health, Dorian Dodson, secretary of children, youth and families, and Katie Falls, acting secretary of human services. Secretary Vigil indicated the presentations of the day would include a brief description of the structure of the IBHPC and actions taken by it since the last meeting of the LHHS. Secretary Dodson provided a time line for the actions taken, noting that much more work has been done than can be reflected here. She also noted that the contract with OptumHealth, the statewide entity (SE) for behavioral health services, requires that the IBHPC provide certain opportunities for the SE to respond. Although payments are going out, she acknowledged that the system is still not working well and is in need of improvement. As a first step, OptumHealth agreed to relax edits in order to bypass billing system problems; an off-cycle payment was issued to get payments to providers quickly. Despite these changes, only a small number of outstanding claims had been paid by October 26; after meeting with the governor, it was determined that sanctions would be imposed and a letter to that regard was sent to OptumHealth on October 29. Critical contract requirements were reviewed, including maintenance of a working claims management system, prompt payment of claims, reductions of administrative burdens on providers and development and use of "user-friendly" forms and procedures. Secretary Falls provided details about the components of the sanctions that have been imposed: a directed corrective plan is required; civil monetary penalties in the amount of \$1.2 million were imposed as well as one percent of the total contract amount until such time as the plan is implemented to the state's satisfaction (fines will be allocated to providers); actual damages were assessed in the amount of

1.5 percent interest on unpaid claims; OptumHealth will be held responsible for all costs incurred by the IBHPC to identify and remedy contract noncompliance; and a state monitor has been appointed and will be paid for by OptumHealth. Ms. Roebuck Homer reported on claims that have been paid since October 14 following the LHHS meeting. She identified the number of providers who have received expedited payments, but noted that steps taken to pay claims quickly will result in more complicated reconciliation of claims at a future date. The IBHPC is conducting a weekly sampling of providers to validate that payments are being received. She provided a clarification regarding denials. OptumHealth was requested to reprocess all denied claims; OptumHealth is resisting due to legal concerns; however, the IBHPC attorneys feel there are no legal impediments to reprocessing previously denied claims. A graph depicted the nature of claims payments since July 2009. An explanation was provided regarding lost claims; some occurred due to OptumHealth connectivity problems. The IBHPC is analyzing reasons why additional claims appear to have been lost. Secretary Vigil concluded by reiterating that the IBHPC is taking the situation very seriously. From this point forward, the IBHPC will be considering whether the contract with OptumHealth should be terminated. An emergency meeting of the IBHPC is scheduled to discuss the SE on November 10, from 8:30 a.m. to 11:30 a.m. at the State Capitol. Progress has been made, but additional work remains to be done.

Committee members had questions and made comments as follows:

- whether recoupments of denied claims will occur; no, the state monitor is calling providers to discuss what arrangements can be made versus dunning calls; the IBHPC has directed OptumHealth to not dun providers;
- clarification regarding the time line for corrective action, including early actions taken prior to October 14;
- a request for a record of the calls to providers and information regarding the consultants and what they accomplished;
- a strong statement that the problems with OptumHealth are the responsibility of the executive and not the legislature;
- clarification regarding what the IBHPC is doing differently with OptumHealth to avoid problems experienced with the previous SE, ValueOptions;
- whether there were services that were interrupted or providers that went out of business as a result of the payment problems; some providers decided to no longer accept Medicaid clients;
- the seriousness of ensuring that all behavioral health clients in need of services are able to access services;
- clarification regarding the monetary penalties and a recognition that OptumHealth may not use the money contractually required to go to patient care;

- the consequences should OptumHealth decide to no longer continue its contract;
- issues with specific contracts for drug courts that were previously being provided, but have not yet been executed, under OptumHealth;
- when a state monitor will be in place and functioning. Monitoring is occurring daily by staff and consultants; an emergency procurement is underway to hire a specific state monitor, and the IBHPC hopes to have one in place within two weeks;
- whether there are any outstanding claims from ValueOptions;
- appreciation and acknowledgment that the measures taken are a giant step forward, but that much remains to be done;
- clarification regarding claims denied and which ones were legitimate denials;
- the priority placed on reconciling the number of denied claims and paying providers quickly;
- clarification regarding premium taxes paid by OptumHealth and the amount that is returned to OptumHealth through a premium tax credit;
- recognition of the enormity of the dollar amounts in the contract and that the amount is growing annually; legitimate tax and other revenues should not be lost to the state;
- clarification regarding whether claims are still being denied and whether there has been instituted a "hold harmless" provision for the time being;
- the implication of re-institution of a one-twelfth draw method of reimbursement to providers;
- whether OptumHealth or its parent company, United Health Care, is ultimately in charge of decisions. OptumHealth is in charge of day-to-day operations; however, when disputes arise such as with the information technology (IT) system or regarding recoupments, United Health Care is in charge;
- a request for clarification regarding the total budget for behavioral health services in New Mexico;
- what preparations are needed and/or underway to manage the system of behavioral health should the contract with OptumHealth be terminated;
- how much of the current problem is attributable to a faulty IT system;

- the importance of being vigilant in protecting providers from retaliation;
- a recognition that the IBHPC is required by law to contract with an entity or entities to provide behavioral health services;
- accountability of OptumHealth in managing the money that the state pays it for the SE contract; if OptumHealth does not comply with the sanctions, payments to it would be withheld as well as payments to providers made directly by the state; mechanisms are being developed to do that if needed;
- a suggestion that a contractual relationship with an entity under sanctions is adversarial and should be terminated;
- an acknowledgment that in the midst of system failures, safeguards were not sufficient to protect human interests, but that lessons have been learned and measures taken to correct that;
- assurances that the situation will be kept "under a microscope" and providers communicated with constantly as the IBHPC goes forward with this issue;
- whether the contract allows for a reduction of the amount of OptumHealth profits for noncompliance; the sanctions prohibit service dollars being used to pay penalties;
- recognition that OptumHealth has incentives to keep as much of the state's money as it can, while still finding a way to be in compliance with its contract;
- whether the state has the option of contracting with a New Mexico nonprofit or bringing the operations in-house;
- a request that the leadership of the LHHS be kept apprised of the situation as it unfolds and not only during the interim;
- recognition of the huge ongoing costs of lawsuits in which the state is engaged. A request was made for an accounting of the hours charged to the *Jackson* lawsuit and how that affects the ability of the DOH to provide services; staff is working on that;
- clarification of the amounts and reasons for sanctions that were imposed on ValueOptions. There were 12 corrective actions; more detailed information will be provided;
- an update regarding the protest and a lawsuit filed by ValueOptions; these are not yet resolved; and
- a suggestion that the IBHPC develop a proposal to transition out of the current contract with OptumHealth.

Patsy Romero, representing providers in Espanola, testified that although some progress has been made, providers are putting clients on a waiting list and have not received the technical support and training from OptumHealth that was promised.

Brent Earnest, Legislative Finance Committee (LFC), clarified that premium taxes are paid in lieu of all other taxes; insurers receive premium tax credits based on the amount they are assessed to support the NMMIP.

### **Update on Statewide Entity Implementation: Provider Perspective**

A panel of providers addressed the adequacy of measures taken to address OptumHealth problems. Dr. David Ley, director, New Mexico Solutions, stated that things are still pretty bad, but improvements are being made and providers feel they are being heard. He stated that the IT system is so integrated with human systems in OptumHealth that the solution will lead to greater problems later. The flawed system is still being used to fix the flawed system. A large number of providers across the state are still not being paid. Children and youth providers have many examples of Medicaid clients that are not being reimbursed. Significant data problems are anticipated down the road. The Children and Youth Alliance has no confidence in OptumHealth's ability to fix the problems. It is working with the state to identify better solutions to get providers paid.

Donald Naranjo, chair of the Adult Behavioral Health Provider Association, testified that quality is being damaged as providers are not able to provide the same amount of services. Adult providers continually have to deal with decisions that are made and then passed along to them; they need to be involved up front. Communication with OptumHealth is unreliable. Shannon Freedle, C.E.O., Teambuilders, feels that actions taken by the state prior to October 14 were inadequate. Although OptumHealth is now moving cash through the system, providers will still be subject to recoupment in the future, which will put providers at risk once again. The prior authorization system is not working; inaccurate authorizations are being approved, while some appropriate authorizations are not being approved. Roque Garcia, director, Rio Grande Behavioral Health Services, thanked the committee for putting the pressure on the IBHPC to address the problems. He also thanked Secretary Falls for the dialogue that is now occurring with providers. He contends that although the IT system is the largest part of the problem, there are many other problems that are not being addressed in the interest of getting providers paid. His organization supports the concept of the IBHPC, but feels the implementation of it has been poor. He feels that the current system is inefficient and input from providers is critical.

Questions and comments from committee members addressed the following:

- clarification regarding the long-term approach to recoupment and conditions under which denied claims will be reprocessed; the IBHPC has already told OptumHealth that its announced approach to recoupment is unacceptable;
- whether best practices exist for recoupment;

- a suggestion that discussions such as this are less valuable without the presence of OptumHealth;
- clarification regarding the impact on clients. For the most part, providers have continued to provide services; however, their ability to continue to do that is now dramatically diminished;
- a sense that OptumHealth is not supportive of the solutions and is not a cooperative partner in fixing the problems;
- the extent of the interaction with OptumHealth prior to July 1, 2009; providers offered to work with OptumHealth in advance to test the system, but this did not occur;
- acknowledgment that OptumHealth has become more reticent about working with providers; a provider request to be part of the transition team and to participate in the readiness review was not granted;
- the avenues pursued by providers to address problems with ValueOptions; there is current litigation on this issue;
- a feeling by providers that things are worse under OptumHealth than they were under ValueOptions;
- a sense that there is dialogue among providers, the state and OptumHealth, but that there is not meaningful dialogue;
- whether providers are being paid or denied for contracted services;
- the number of services and clients represented by the two provider associations: approximately 24,000 consumers and about 70 percent of all the providers; and
- clarification of the process by which clients get enrolled in the OptumHealth system.

### **Consumer, Family, Native American and Advocate Panel**

Ms. Wendel, Carol Brusca, family member, Mark Simpson, project coordinator, New Mexico Connection to Wellness, Susie Trujillo, local collaborative perspective, Regina Roanhorse, chair, Local Collaborative 15, and Nancy Koenigsberg, Disability Rights New Mexico (DRNM) advocate, convened as a panel to present various perspectives of the behavioral health system in New Mexico.

Ms. Wendel, representing consumers with substance abuse problems, spoke to the committee as a recovering alcoholic. She told her personal story about growing up in an alcoholic family. At a significant point in her life, when depressed and suicidal, she admitted herself to a small rehabilitation center. She learned the incredible importance of peer support, regained hope for a productive life and realized that she needed to live a life of service. She has now been sober for 20 years, but her disease is still with her. She believes her personal understanding of these

issues demonstrates the importance of the consumer voice in the system. Ms. Brusca, vice president of the National Alliance for the Mentally Ill (NAMI), Albuquerque, addressed a family perspective, noting that the NAMI's objective is to ensure that mentally ill family members have the same quality of life as everyone else. Prevention, medication management, availability of housing in the least restrictive environment and employment opportunities are critical. The NAMI wants to see money spent wisely and well to provide the above mentioned opportunities. Family members would like to be involved in choices and decisions for their family members. The NAMI every year conducts a grading of the states; New Mexico regularly gets graded "F". Mr. Simpson addressed the consumer perspective, stating that he has several health problems in addition to bipolar disorder. He expressed great appreciation to the committee for taking the time to listen to these various perspectives. He noted that there are many aspects in treating mental illness, from self-medication to inpatient care. He participates in an organization called Life Link and sees a therapist once a month. His mental illness is well under control, and he is productive in a career and in his life. He made the point that in small communities around the state, consumers are working with consumers to encourage self-sufficiency and prevention. He would like to see additional funding for medical management of mental illness.

Ms. Trujillo identified herself as a community health worker and the chair of Local Behavioral Health Purchasing Collaborative 6 in Silver City. She provided a brief history of local collaboratives, which were established to elicit community input. They are made up of consumers, family members, advocates and providers and reflect the unique and particular needs of sections of the state. There are 13 local collaboratives that are aligned with the 13 judicial districts; additionally, there are five Native American collaboratives. Previously, the delivery system was fragmented and duplicative; the input of the local collaboratives helps to ensure a continuum of care. She identified some successes of her local collaborative. The collaborative serves as a vehicle for counties to work together. She emphasized that something in the system redesign does work, and it is the local collaboratives.

Ms. Roanhorse identified herself as one of the original directors of a local collaborative. She represents four counties in the northwest part of the state. She noted that Native Americans do not have language to describe mental illness. She thinks of herself as an unofficial monitor. On the reservation, teen suicide, alcohol, drug abuse and poverty are huge issues. The 22 tribes, nations and pueblos are now represented by five collaboratives. It took a great effort to increase the number of Native American collaboratives. She feels the system is not serving Native Americans well, and she feels that her suggestions are discounted. She would like to see the IBHPC and the Behavioral Health Planning Council listen to consumers and families more, especially Native Americans.

Ms. Koenigsberg spoke representing the advocacy community. She stated that the original intention of the IBHPC was to have braided, bundled services and payment streams; however, it has been structured and funded as a Medicaid program and is pathology-based. Head Start; Family, Infant, Toddler Program (FIT); and other early education programs can prevent mental illness problems later on. Her hope is that the IBHPC will begin to emphasize that factors such as substance abuse, poverty, child abuse and others are needed for children. Additionally, she reported on a letter she wrote to the LFC on October 9 on behalf of providers who were afraid to

speak out due to a fear of retaliation. Since 1988, she has noticed a devolution of the system; with every system change, some part of the system is lost. She feels that now the system is in a very precarious situation and is in danger of falling apart. This lack of stability in treatment leads to far greater problems. She recommends that the original statute be revisited to require the IBHPC to report statistics on the number of people served, the status of contractors and providers, waiting lists and how long contractors and providers stay in service. She endorses the concept of the IBHPC and the community-based focus; however, it is not materializing in the manner envisioned.

Committee members had questions and comments as follows:

- appreciation for the perspectives of consumers and family members, and a recognition of a need for more data on how system changes affect them;
- a request was made for data as described by Ms. Koenigsberg to be provided quickly to committee members;
- an observation of how the transformation to OptumHealth has resulted in reduced services as reported by the NAMI;
- a suggestion that some LHHS members participate in the evaluation of the data; and
- the importance of preventing retaliation.

### **Public Comment**

Ms. Trujillo stated that with no new money, local collaboratives are learning how to utilize the natural and community support systems better. Funding cuts have led to new creative approaches at the community level.

Deb Dennison testified as the mother of a 19-year-old son who died a few months ago. He spent six years on the waiting list for the developmental disabilities waiver. Ms. Dennison said that she was deeply grateful that he was on the Mi Via waiver when he died. She noted the difficulty of navigating the system. Unless the agencies that are responsible for people with disabilities become more accountable, more and more people will die. She requested the creation of a disability task force as an agency liaison to assist people navigating the system, a complaint line and more money appropriated to remove people from the waiver waiting lists. She commented on some of the recommendations in the memorial report for SJM 1. Waiver waiting lists should be acuity-based, so that the people with the greatest need are served first.

Delphy Roach, director, Brain Injury Association, urged committee members to think about easy access to family support services. She would like to propose some changes to the Children's Code to protect the rights of children. She desires to give input on the CYFD child protective services system.

Della Garlitz provided the perspective of recovery support service providers. Her program serving methadone users was completely eliminated retroactive to June 1 with the transition to OptumHealth. Other services and the level of care were substantially changed and reduced. Funding was reduced by one-half and staff have been let go. Services that were not medically oriented were eliminated. Her agency's program had worked successfully for 18 months, and it had been assured that no services would change, but that has not occurred. Thanks to the

intervention of Senator Harden, barriers it was unable to overcome were eliminated. The previous SE understood the value of the program, but OptumHealth is not supportive.

Albert Dugan, NAMI New Mexico, noted that many NAMI concerns have already been addressed. He has served on several OptumHealth committees. He has major concerns about inpatient beds and inpatient care, premature discharge and recidivism to the state behavioral health institute. He is hopeful that data will begin to be produced that will lead to positive change to this system.

Ginny Wilson expressed appreciation for the generous sharing of time by the committee to try to improve the behavioral health system of care in New Mexico. She addressed concerns regarding the local hospital's study to see whether it will close the psychiatric unit. She also urged the committee to keep in mind the individual needs and gifts of people with mental illness. She was critical of the state's decision to change from ValueOptions to OptumHealth and is sad to see that the situation is worse than it was a year ago. Gainful employment, supportive housing and careful moderation of medication are all essential to the successful lives of people with mental illness.

Senator Harden thanked the chair and the committee for the very good work done over the interim.

The chair reminded the committee members that legislative endorsements will be considered tomorrow. There being no further business, the meeting was recessed for the day at 5:25 p.m.

### **Friday, November 6**

The meeting was reconvened by the chair at 9:10 a.m.

#### **Proposed Executive Legislation: Assisted Outpatient Treatment**

Paul Ritzma, Esq., deputy chief of staff, Office of the Governor, presented the concept of Kendra's Law, now called assisted outpatient treatment (AOT), stating that the governor is interested in introducing a consensus bill. The bill is intended to provide for mandatory treatment for mentally ill individuals who are considered a danger to society. There are many controversial aspects of the bill.

Brian Stettin, Esq., policy director, Treatment Advocacy Center, Virginia, presented information about the original Kendra's Law enacted in New York and sought to clarify some of the policy issues inherent in the bill. New Mexico is one of only seven states without some provision for court-ordered treatment. He highlighted some of the reasons for opposition to mandated treatment, including those who generally oppose any medical treatment and are in opposition to coercive, rather than voluntary, treatment choices. The chair requested that the opponents be permitted to identify their own reasons for opposition. Mr. Stettin noted that the population of people who would be affected under this law is small and only includes those who have been hospitalized or incarcerated for their conditions. Some people who suffer from severe mental illness lack the ability to make treatment choices or accept treatment choices that are offered to them. Proponents of the bill include family members who are genuinely fearful for the lives of their loved ones. The proposed law requires an individualized treatment plan before a

court order would take effect. He referenced a report that was distributed to committee members that summarizes the results of Kendra's Law in New York. An independent program evaluation, which came out in 2005, demonstrated very positive outcomes and reductions in hospitalizations, incarcerations and homelessness, and a greater sense of engagement and higher rates of compliance after initial treatment. It appears that the experience of going to court makes a deep impression on patients and causes them to take their treatment more seriously. Patients do not report feelings of coercion.

Committee members requested to be reminded about the specifics of the proposal and whether a bill has been drafted; no specific bill has yet been drafted. Mr. Ritzma noted that House Judiciary Committee Substitute for HB 609, introduced in 2007, is the rough template for the bill, but that the comments offered today and in other settings will influence any draft to be introduced in 2010. Mr. Stettin provided a brief overview of the concept, wherein a petition is made to the court for court ordered-assisted treatment. The patient would be represented in court by a psychiatrist as would the petitioner. Mr. Ritzma identified the criteria that would be required for a petition to be made to the court, which include episodes of violent behavior, repeated hospitalizations or incarceration and a history of noncompliance with treatment. A very limited list is typically included of who can make a petition for a court order. A treatment plan would be developed by a treating psychiatrist or psychologist. The sequence of events in which a person is referred to the court was described.

Committee members asked for clarification regarding whether funding will be sufficient for an adequate array of services to be available. It was clarified that this bill is intended for people who refuse to get treatment and does not address access to services for all mentally ill people. A question was asked about military people returning from combat who do not seek services at the Veterans' Administration Hospital and how this law would interface with the military. Military personnel would be eligible to receive court-ordered services. Issues that would need clarification were identified, including the consequences of noncompliance with court-ordered treatment; whether an individual could be committed to inpatient hospitalization on a long-term basis; recognition of the difficulty of identifying an effective treatment plan for a mentally ill individual; and the current lack of sufficient community-based services, acknowledging that New York's success is in part attributable to a significant infusion of new service dollars. It was noted that AOT is not a panacea for an underfunded system, but that there is a cost to doing nothing as well. On request, Mr. Ritzma summarized the case of John Hyde, a mentally ill person whose situation led to the death of two police officers. Ms. Koenigsberg observed that the tragic case of Mr. Hyde would not have been altered by a law such as this. He had been in a successful treatment program for 10 years. He sought treatment at a local hospital and was turned away because he did not have an appointment. He and the five people he killed were the victims of a failed system. A committee member described her personal experience with the serious mental illness of a family member. She contended that Mr. Hyde should not be the poster boy for this law; the law targets people who refuse treatment, not those who are turned away from treatment. This committee member advocated for crisis intervention team (CIT) training for all police officers. An AOT bill should be carefully crafted to protect not only the public, but the individual with mental illness. She asked whether the bill would be accompanied by the necessary funding so that the program will work well, observing that, currently, New Mexico lacks the hospital beds to perform the evaluations required in AOT. Mr. Ritzma was asked if the governor plans to have an appropriation in the bill. He acknowledged that a lack of funding could result in failure of the concept, and that he will bring this concern to the governor.

He reiterated that AOT is not a panacea, but is one tool for treating serious mental illness. Questions were asked about the legislative history of this measure; amendments that were previously added gained the support of the opposing advocates and should be included in any new iteration of this measure. A question was asked whether other states have passed similar legislation without appropriations. The answer was yes; however, only anecdotal information is available about the success of measures in those states.

Ms. Koenigsberg made numerous comments in response to previous comments and questions by legislators. She agrees that CIT training should be offered to police officers. She feels strongly that this bill is an unfunded mandate, that the behavioral health system is currently in tremendous disarray and that these provisions actually already exist in New Mexico law. The New Mexico Mental Health and Developmental Disabilities Code provides that most people admitted to a psychiatric hospital are discharged with a treatment guardian; this discharge planning tool is therefore already in place. If the person does not comply, the treatment guardian can bring the person in for readmission to the hospital. The Mental Health and Developmental Disabilities Code identifies who may petition the court to have a treatment guardian appointed. Finally, the services currently available are poorly managed and there are an inadequate amount of them. There is no continuum of care for behavioral health in New Mexico, which remains at the bottom of rankings in states' funding of behavioral health services. In order for a program like this to be successful, statewide availability of intensive case management services should be available. This service has been eliminated in lieu of comprehensive community support services that are limited to six hours and must be routinely reauthorized. New Mexico does not have the services in place to minimally support AOT. Current New Mexico law has all the elements to allow the state to do what AOT provides; however, New Mexico does not have the funds or the infrastructure to make it work. Ms. Koenigsberg recommends that New Mexico deal with the current crisis, ensure that the service delivery system does not erode any further and consider a modification of the IBHPC law to permit, rather than require, a contract with an SE.

Questions from committee members addressed the paucity of services in the New Mexico behavioral health system. Mr. Stettin contends that in an environment of inadequate services, AOT puts the sickest of the sick at the front of the list and has the potential to save dollars that would otherwise be spent in the most expensive settings. An observation was made that most of the people in need of AOT are already in the system and are imminently dangerous to themselves or others. A court order results in needed treatment being provided and episodes of violence being averted. A personal story was offered about a suicide that could have been prevented with a law such as is being presented today.

Representative Gutierrez, the intended sponsor of the bill, provided some history of this measure and why there is not a bill draft ready for the committee to look at today. She urged the committee to consider this bill and not be distracted by the important, but not essential, funding issue.

It was noted by a committee member that a very small percentage of people account for a large percentage of the behavioral health costs to Medicaid in particular, and the health care system in general. Consumers are already paying for the high cost of these seriously mentally ill individuals; this measure could reduce the overall cost to the system and the Medicaid program in New Mexico. Additionally, this law could provide for a better quality of life for mentally ill individuals and a safer society. A comment was offered that the committee cannot support a bill

when a bill draft is not available. The chair noted that if the New Mexico Legislative Council approves an extra day for the committee to meet, a bill could be reviewed at that time.

Steven Randazzo, HSD, offered clarification regarding New Mexico's ranking for behavioral health services. Most recently, the NAMI ranked New Mexico at a "C", and SAMSHA ranked New Mexico's behavioral health funding at twenty-fourth in the nation, in part because of the IBHPC and partly due to legislative support for behavioral health services. A request was made for this information to be provided in writing and incorporated into the minutes. One committee member recalled previous testimony from former Secretary of Human Services Pam Hyde that the calculation that ranked New Mexico last in the nation did not include money spent in Medicaid for behavioral health.

A quorum being present, the chair noted a motion to accept the minutes of the October meeting of the LHHS, with a correction offered by Senator McSorley that he attended all three days. The minutes were approved as amended. The minutes of the Disability Subcommittee of the LHHS were presented for approval. Representative Espinoza requested that the minutes include specifically what was presented to the subcommittee about funding and waiting lists that has now been submitted to the LHHS by her in writing. The motion to accept the minutes was so amended to reflect the additional handout. A motion to accept the minutes as amended was passed unanimously. Attention was drawn to a written statement regarding a controversy about job coaching that the Disability Subcommittee wished to have distributed to the LHHS. Senator Harden noted that the comments in the distributed statement might provide an opportunity to free up additional money for other purposes in the developmental disabilities waiver.

Ms. Koenigsberg stated that the DRNM is opposed to the AOT bill in concept for the reasons she previously stated.

### **Public Comment**

Veronica Garcia raised provider concerns about OptumHealth. Her agency, Esperanza New Mexico, has received payments, but does not know for what the payments have been made, whether they are subject to future recoupment and whether they might in the future be denied. Mr. Randazzo noted the information and will report it to Ms. Roebuck Homer.

Dick Mason, chair of the Legislative Committee of Health Action New Mexico, provided a handout and comments regarding federal health reform initiatives now being considered. He requested that the committee consider legislation to form a working group to ensure alignment of state laws and regulations with federal reform as it occurs.

Jim Ogle, president, Albuquerque NAMI, told committee members a story of a young man who developed mental illness after a bright beginning. Despite numerous psychotic breaks and episodes of hospitalization, this young man believes he is cured and routinely goes off his medication and treatment. Mr. Mason spoke in favor of a carefully constructed AOT bill. He asserted that the cost of multiple hospitalizations in this young man's life far exceeds any community-based treatment he could have received. The existing system of treatment guardians is cumbersome and not working.

Diane Wood, American Civil Liberties Union (ACLU), spoke in opposition to the AOT bill; the ACLU's position aligns with the DRNM position. The civil rights of the individual should be respected and protected.

Sherry Patridge spoke as the mother of a mentally ill daughter. After describing her situation, she spoke in favor of AOT as an approach that would preserve the long-term stability of treatment. AOT serves as a hospital without walls.

Dan Matthews, psychologist and legislative chair of the New Mexico Psychological Association, noted that previously the association took a position to not support the AOT bill without sufficient funding. Without seeing a draft, the association has not taken a position yet on this year's bill. He fears that implementation of AOT without funding would have the effect of prioritizing AOT candidates to the exclusion of other people who also need treatment, but who are not refusing services. Mental health advanced directives, which have not been mentioned today, could serve as a vehicle for mentally ill persons to identify future treatment options during a period when their mental illness is under control.

Jim Jackson presented the position of DRNM and noted that the controversy around this issue highlights the inadequacy of the mental health system in New Mexico. He contends that the bill as previously introduced has the potential to cover a very large group of individuals with mental illness in the state. The qualifying criteria is too broad, going well beyond what he believes most people want. He reiterated the variety of solutions that are already in place to address this problem; in any case, more funding is greatly needed.

Nancy Bailey, NAMI, related her personal experience with the mental illness of her granddaughter who has had hospitalizations too numerous to count. Ms. Bailey has been largely unable to get her the services she needs due to the fact that as an adult, she has civil rights that permit her to make decisions for herself. She urged the committee to enact a version of AOT to help people like herself and her granddaughter and to keep families like hers from being destroyed.

Carol Woleta spoke as a police officer who was shot by a mentally ill individual. She believes that an AOT law would make things safer for police officers.

Mr. Dugan, a retired doctor of internal medicine, believes that early intervention, diagnosis and treatment of mental illness will result in lower costs to the state, families and community. He spoke in support of AOT; however, he noted that virtually all perspectives presented today are accurate. He believes all mentally ill individuals should have treatment, whether or not they seek it. He disagreed with the position of the ACLU and stated that a person who is incarcerated due to mental illness does not have civil rights. Multiple problems exist with New Mexico's current treatment guardian program due in part to the inconsistent application and availability of treatment guardians around the state.

Glen Ford, advocate for people living with brain injuries, stated his appreciation for the committee's support for brain injury programs. He highlighted the incidence of brain injury in the military and in the general population. More funding and infrastructure are needed to address this invisible and often silent condition. Without the support system, mandated treatment will do nothing.

Ms. Roach spoke in opposition to AOT. She lost a husband to suicide and has a son who is bipolar. She recognizes this is a difficult decision, but she thinks attention should first be given to improving the system currently in place.

Representative Cote noted that next week, the interim Military and Veterans' Affairs Committee (MVAC) will hear testimony regarding pre- and post-deployment screening and what the military is doing to identify brain injury and mental illness. Representative Cote would like committee support for a bill he carried for two years to fund safe houses.

### **Approval of Proposed Legislation**

A voting quorum was recognized. Representative Picraux described a way of counting Representative Lujan's votes. He had to leave early; however, he marked the matrix to indicate the measures he supports. If amendments to the bill drafts are made, his vote will not be counted. If the bill is endorsed by the committee without amendments, his vote will be counted.

Mr. Hely and Ms. Wells presented the bills and memorials in the numbered order in which they were listed on the matrix (attached). Expert testimony was provided by Ms. Esquibel concerning HSD bills; Jack Callaghan provided expert testimony for the DOH bill requests.

A motion to endorse bill number 1, to exclude gender as a premium rating factor, generated debate. Questions were asked about how this would affect other factors upon which rates are generally based. Ms. Rossi Pressley stated that national information reflects that women are routinely charged up to 20 percent more than men for the same insurance; this bill is intended to provide gender equity. State law permits insurance companies to charge up to 20 percent more than a male is charged and most do. Clarification was sought regarding whether women cost more to cover. Susan Loubet, the Women's Agenda, contended it is only a perception that women cost more to cover; over their lifetime, they do not cost more, but they do use more health services. An observation was made that this bill would not prevent insurers from raising all premiums to achieve equity and that the overall effect would not be to lower the cost of insurance. Deborah Armstrong, executive director, NMMIP, stated that women are charged higher premiums in the individual market only. A committee member stated a preference for simply eliminating the word "gender" as a rating factor. The motion for committee endorsement was supported by Senators Feldman and Ortiz y Pino and Representatives Picraux and Gutierrez. Senator Adair opposed the measure.

A motion to endorse bill number 2, to redefine "small employer" to permit a group to be one person, passed with no opposing votes.

A motion to endorse bill number 3, to require insurers to utilize at least 85 percent of premium revenues for direct services, generated debate. A committee member felt the bill as written would have no real impact as there are no consequences or sanctions for noncompliance. It was mentioned that sanctions would or could be in contract language. The motion to endorse the bill was unanimously adopted.

A motion to endorse bill number 4, which mandates guaranteed issue of insurance to individuals, generated debate about whether the bill allows insurance companies to charge higher premiums to people who engage in unhealthy lifestyles. Ms. Esquibel clarified that the bill allows all individuals to be offered a policy; however, it allows rating based on rating factors. It does not

address the cost of the policy. A committee member observed that guaranteed issue already exists in New Mexico through the NMMIP. Another committee member noted this bill eliminates the possibility of an insurance company rescinding a policy for a lack of disclosure of a pre-existing condition. The motion to endorse the bill passed, with Senator Adair opposing it.

A motion was made to endorse bill number 5, which establishes premium rate limits in the small group market. Questions were asked about whether this would prevent insurers from responding to inflation, and why only small group rates were addressed. The motion to endorse the bill passed, with Senator Adair opposed.

Bill number 6, which gives Native Americans and others more time to meet the requirements and become licensed as alcohol and drug abuse counselors, was endorsed with no opposition.

Bill number 7 would create a mid-level scope of practice called dental auxiliaries. The bill reflects amendments offered in the last session by dental hygienists. A motion to endorse the bill was opposed by Senators Ortiz y Pino and Lopez and by Representatives Picraux and Lujan, and therefore did not receive the committee's endorsement.

A motion to endorse bill number 8, to allow for notification of partners considered at risk of HIV, generated debate. Mr. Callaghan described the bill as a public health intervention; the DOH does not disclose the name of the infected person. The bill was endorsed with no opposing votes.

Bill number 9 to expand the rural health care practitioner tax credit to other providers was endorsed with no opposition.

Senator Feldman asked for an amendment to bill number 10, to tax alcohol, to earmark the increase in revenues to all parts of the Medicaid program. Clarification was sought regarding the amount of the increase for beer and how this compares to taxes on neighboring states. The bill was endorsed, with Senator Adair opposing it.

Mr. Hely described bill number 11, to create a disabilities task force, that was previously presented to the Disabilities Subcommittee. Mr. Jackson commented that the DRNM made recommendations for language changes, as did others. Senator Feldman noted that it would require a message and suggested that the LHHS request a message for all bills endorsed that need a message. A suggestion was made to add an appropriation for per diem and mileage of committee members. A motion to endorse the measure was unanimously adopted.

Bill number 12 also was discussed by the Disabilities Subcommittee and calls for improved executive agency communication with deaf individuals. It was noted that it would be expensive and difficult for very small agencies such as the Commission on the Status of Women to comply. Clarification was sought about whether this was already required by the federal Americans with Disabilities Act. The bill was not endorsed.

A motion was made to endorse bill number 13 that seeks to align New Mexico law regarding the rights of individuals with disabilities with federal law. The bill was unanimously endorsed.

Bill number 14, to amend the current statute regarding medical homes adding osteopaths, was amended to provide a more technically correct definition of osteopath and to add osteopathic physician assistants. The bill was unanimously endorsed with the amendment.

Bill number 15, to raise taxes on cigarettes and tobacco products, generated debate. The bill was drafted according to American Cancer Society recommendations and previously presented to the Tobacco Settlement Revenue Oversight Committee. Senator Feldman requested the increase in revenues to go to Medicaid programs. The bill received the committee's endorsement, with Representative Gutierrez and Senator Adair opposing it.

A motion to endorse bill number 16 to remove the food tax exemption for soft drinks was passed, with Senator Adair opposing it.

Memorial number 17, calling for an expansion of medical homes, passed with no opposition.

Memorial number 18, calling for a central credentialing process and a task force, passed with no opposition.

Senator Adair moved that all remaining memorials be voted upon as one. The motion passed, and the remaining memorials, providing for tracking of nurse education funding, tracking of hospital-acquired infections, forming of a health reform work group and encouraging private managed care programs to support medical homes, were all endorsed. Senator Adair asked to be shown in opposition to all four memorials.

Senator Feldman notified the LHHS that she and Representative Picraux have written a letter to the governor asking that Medicaid not be cut as was the legislative intent.

### **Disabilities Subcommittee Meeting Report**

Mr. Hely and Ms. Wells provided a report of the meeting of the Disabilities Subcommittee. The subcommittee met for two days, October 29 and 30, in Room 307 of the State Capitol. LHHS members who attended were identified. The meeting was well attended by the public. The agenda was reviewed briefly. Mr. Hely observed that much public comment was offered throughout the meeting regarding the need for improvements to the education system and employment sector to accommodate disability and foster independence. Medicaid waiver programs generated extensive discussion, particularly policies relating to waiting lists. Because of this interest, an extra LHHS meeting day was requested. The importance of having all the departments present to answer questions was recognized.

There being no further business, the committee was adjourned at 5:15 p.m.

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

**December 18, 2009  
Room 307, State Capitol  
Santa Fe**

The seventh meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Danice Picraux, chair, at 9:05 a.m on Friday, December 18, 2009. A quorum was present.

**Present**

Rep. Danice Picraux, Chair  
Sen. Dede Feldman, Vice Chair  
Sen. Rod Adair  
Rep. Nora Espinoza  
Rep. Joni Marie Gutierrez  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

Sen. Linda M. Lopez

**Advisory Members**

Sen. Sue Wilson Beffort  
Rep. Ray Begaye  
Rep. Eleanor Chavez  
Rep. Miguel P. Garcia  
Rep. John A. Heaton  
Rep. James Roger Madalena  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill  
Sen. Nancy Rodriguez  
Sen. Sander Rue  
Rep. Mimi Stewart

Rep. Jose A. Campos  
Rep. Nathan P. Cote  
Rep. Keith J. Gardner  
Sen. Clinton D. Harden, Jr.  
Sen. Gay G. Kernan  
Rep. Dennis J. Kintigh  
Rep. Rodolfo "Rudy" S. Martinez  
Sen. Mary Kay Papen  
Rep. Jeff Steinborn  
Sen. David Ulibarri  
Rep. Gloria C. Vaughn

**Guest Legislators**

Rep. Gail Chasey  
Sen. Mary Jane M. Garcia  
Rep. Edward C. Sandoval

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Karen Wells, Researcher, LCS  
Mark Harben, Records Officer, LCS

**Guests**

The guest list is in the meeting file.

## **Handouts**

Handouts are in the meeting file.

## **Friday, December 18**

### **Welcome and Introductions**

Representative Picraux welcomed everyone. The minutes of the November meeting were unanimously approved.

### **Home and Community-Based Waivers: How Administrative and Financial Duties Are Apportioned Among Departments**

Michael Spanier introduced himself as the newly appointed secretary of the Aging and Long-Term Services Department (ALTSD) and made introductory comments. Dr. Alfredo Vigil, secretary of health, and Larry Heyeck, deputy director, Medical Assistance Division (MAD), Human Services Department (HSD), also introduced themselves and members of their staff that were present to answer questions during the presentation. Kimberly Austin-Oster, division director, Elderly and Disability Services Division, ALTSD, described the general elements of waivers, including who is eligible to receive services. An overview was provided about the current home and community-based waivers in existence in New Mexico, and how the ALTSD, Department of Health (DOH) and HSD interact with each other to administer these waivers. More detailed information was provided about each of the waivers. Secretary Vigil discussed the challenges of managing the developmental disability (DD) waiver, focusing especially on the waiting list. He highlighted other services that people on the waiting list receive while they wait for a DD slot to open up. He discussed the financial challenges of expanding the DD waiver, he noted that the Legislative Finance Committee (LFC) is currently auditing the DD waiver and he anticipates recommendations regarding how to streamline the program, operate it more efficiently and serve more people.

Secretary Spanier described the Coordination of Long-Term Services (CoLTS) program, providing updates on enrollment and costs of the program. The ALTSD maintains a central registry that constitutes the waiting lists for all of the waivers. He reiterated that many of the people on various waivers are receiving other services and are assisted in enrollment of those services by the Aging and Disability Resource Center (ADRC). Secretary Spanier identified the process by which people get on a waiting list, including the role of the ADRC. He identified the number of people who were placed on the disabled and elderly (D&E) waiver following an appropriation of \$750,000 by the legislature. He described community reintegration as the process by which people are now able to get on the waiver.

Mr. Heyeck described the goals and objectives for the CoLTS program, including the number of people served, and the potential to serve people with more services in the communities in which they live. He identified that up to 46 percent of the Medicaid budget goes toward paying for people who concurrently qualify for Medicare as well as Medicaid. He identified how CoLTS recipients are able to access the different services in the two programmatic components of CoLTS. He noted that there are serious challenges to aligning services with recipients due to differing categories of eligibility for the program. He acknowledged that there have been many problems in implementing the program in the areas of payments and claims, customer service, phase-in of a new third-party assessor and provider contracting issues. He described efforts that have been undertaken to address the problem areas and improve the program, including an audit of the claims

payment process in each managed care organization (MCO). He noted that the Personal Care Option (PCO) program, which is a service available in CoLTS, is extremely important to many recipients, but is laden with problems that have surfaced as a result of the implementation of CoLTS. The MAD is considering converting the PCO from a benefit in the state plan to a waiver program in order to have more control over the program. He noted that New Mexico is a leader in the nation in its efforts to streamline long-term services.

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

- clarification regarding a plan to move the PCO program from a state plan benefit into a waiver;
- the kind of waiver that would be pursued; the PCO might become a home and community-based services waiver, or the entire CoLTS program might be consolidated into a global waiver;
- whether conversion of the PCO into a waiver would result in some people losing services; it is too early in the process to know; the MAD hopes it will not have to cap the program;
- ways in which the department intends to reduce existing waiting lists; use of a universal assessment tool is part of the answer;
- whether there will be a waiting list for the PCO if it becomes a waiver; hopefully not at first, but possibly within three years as the program is growing at an unsustainable rate;
- whether MCOs are still needed to manage long-term services;
- what it would take to eliminate the waiting lists;
- clarification regarding the Mi Via waiver, and how it is different from the other waivers; Kathy Stevenson, ALTSD, provided the clarification regarding this self-directed waiver program; and
- whether the state has responsibility when recipients of care lose a provider.

The chair invited Jim Jackson, director of Disability Rights New Mexico, to join the panel and to offer a consumer perspective on the questions and comments. He noted that the question just asked is especially complex and challenging in the Mi Via waiver, where consumers are considered employers, but may not have the skills to know how to manage such a loss.

Questions and comments continued, as follows:

- acknowledgment of the importance of having clear parameters for determining when a family member gets paid for caregiving responsibilities;
- how and when decisions are made regarding end-of-life care, such as hospice, particularly on the DD waiver;
- why a unique universal assessment tool needs to be developed;
- why the problems occurred with payments to providers and why they cannot be fixed;
- whether it now costs more to provide services to recipients than it did when they were in an institution;
- whether the costs for long-term services have gone up under CoLTS and in what amount; costs have gone up, but it is due to the fact that many recipients have more needs than were anticipated; and
- reasons why the CoLTS MCOs have not been able to complete assessments for all CoLTS enrollees.

The chair recognized Diamond Tizhanet and his caregiver, Michael McGrath, for public comment. Mr. Tizhanet is unable to speak for himself due to advanced multiple sclerosis. Mr. McGrath requested Mr. Tizhanet to nod in agreement to indicate that he is very satisfied with the services he receives through CoLTS and the MCO, Amerigroup.

The chair asked the presenters to step down while the committee considered bills and memorials for endorsement as several voting members needed to leave early.

### **Endorsement of Legislation**

Mr. Hely and Ms. Wells described bills and memorials for consideration for committee endorsement. Copies of the bills and memorials are contained in the meeting file. After discussion, the following bills received the endorsement of the committee:

- a bill to fund emergency medical services through a premium surtax on homeowners' insurance and vehicle insurance; five voting members supported endorsement and two opposed;
- a previously endorsed memorial requesting a task force to create a single, credentialing process for health care providers was amended to include nurse practitioners on the task force; endorsement was supported unanimously;
- a previously endorsed memorial to track funding for nursing education and nursing faculty was amended to include the higher education funding formula and other sources of funding; endorsement was supported unanimously;
- a bill to extend to schools a requirement to provide private locations for breastfeeding mothers was amended to remove penalties; endorsement for the bill as amended was unanimous;
- a memorial to design a clinic-based model of health care delivery and reimbursement; four members voted to endorse and three were opposed; and
- a memorial calling for a study of how schools provide for the needs of students with autism spectrum disorder was unanimously endorsed.

A bill to require the HSD to study outcomes of patients enrolled in medical homes was withdrawn from endorsement consideration. A bill to provide disclosure and resident protections in continuing care communities and a bill to allow contract employees of Miners' Colfax Medical Center access to Tort Claims Act coverage were not endorsed.

### **Home and Community-Based Waivers: How Administrative and Financial Duties Are Apportioned Among Departments (resumed)**

Questions and comments from the committee covered the following areas:

- whether service dogs are permitted in the waivers; training of a service dog is covered, but not the ongoing care of the dog;
- clarification regarding the costs and effectiveness of the assisted employment program; the program is very valuable, but does not meet the needs of every DD person; the DOH offered to provide the exact costs of the program;
- whether there is really a need for a third-party assessor; the state consolidated two contracts into one through a formal procurement process;
- the number of people remaining in the *Jackson* lawsuit class; around 334;

- the number of staff and contractors at the DOH who monitor the members of this class; all 4,000 recipients of the DD waiver (which includes the members of the *Jackson* class) are monitored by around 156 staff in five regional offices;
- whether the state is close to disengaging from the lawsuit;
- clarification regarding why the DOH did not spend the money the legislature appropriated to reduce the DD waiting list;
- whether the DOH is close to having recommendations for cost-containment in the DD waiver; yes, the DOH will be resubmitting the waiver next year that will require that specificity;
- a recommendation that advocates be included in the development of the renewed waiver;
- whether there is any consideration of moving the DD waiver from the DOH to the ALTSD; not at this time;
- the number and types of nursing facilities there are in the state, and clarification regarding how these facilities are reimbursed;
- whether other states also have waiting lists for waiver services, and whether there is a higher incidence of disability in New Mexico;
- whether other states have experienced lawsuits similar to the *Jackson* lawsuit; and
- clarification regarding the Mi Via waiver, how it differs from the other waivers and how it fits within the CoLTS program.

### **CoLTS Survey Results**

Mr. Hely presented the results of a survey that was conducted at the request of Representative Heaton to identify concerns of providers in the CoLTS program. The survey is not a scientific survey. It was sent to home care providers, nursing homes, hospitals and pharmacies. Most respondents reported difficulties with payments, increased administrative costs and general inefficiencies in the program since the inception of CoLTS. More than 87 percent of providers felt the CoLTS program has not resulted in a more efficient and effective system than what was in place prior to the implementation of CoLTS.

Committee members had concerns and questions in the following areas:

- an observation that the CoLTS program does not seem to be working and that providers are not satisfied;
- whether most providers are contracted with both MCOs; and
- a desire to hear directly from providers.

### **CoLTS Providers Panel**

Joie Glenn, executive director, New Mexico Association for Home Care and Hospice (NMAHHC), commented that a fragmented, siloed and poorly reimbursed system of long-term services was turned over to two MCOs that have not improved the system, that costs more and that is more administratively burdensome. She emphasized that members of her association are actively involved in a waiver committee to revise regulations and to work with the MCOs to improve the program. Improvements have been made, and CoLTS is close to being a program that provides the right services at the right time to the right people. Continued work is needed to remove the silos, improve communication and ensure adequate reimbursement. Opportunities exist to improve the program, and these steps must be pursued. She urged a removal of the silos of care through a restructuring of the CoLTS program.

Linda Sechovec, executive director of the New Mexico Health Care Association (NMHCA), provided the perspective of nursing facility providers. She acknowledged that her association shares many of the concerns already mentioned by Ms. Glenn. She identified current concerns with managed care and with utilization review. Payment struggles remain the highest concern. Immediate issues concerning nursing facilities and the Medicaid benefit were highlighted. She has had to hire an additional person to deal with problems and complaints related to CoLTS. There is no effective negotiation of rates with the MCOs; the NMHCA advocates rates set by the state.

Jeff Dye, president and C.E.O., New Mexico Hospital Association, noted that while hospitals are probably better able to absorb delays in payments from CoLTS MCOs, they are facing dire consequences from recently announced payment cuts by the MAD in proposed regulations.

Committee members had questions and comments as follows:

- clarification regarding the "silos" that Ms. Glenn referenced;
- how Arizona has handled long-term services, especially regarding rate setting for nursing homes;
- clarification regarding the effects of federal reform efforts on nursing home, hospital and home health care reimbursement;
- ways in which the CoLTS program could be better structured;
- clarification regarding the methodology by which the state could set rates for nursing homes; and
- whether the system for reimbursement should be set by legislation or by regulation.

### **Public Comment**

Karen Wagner, office manager for her husband, a dentist in Albuquerque, provided insights regarding her billing experience in that office. The nature of her husband's practice is quite unique; he creates prosthetic appliances such as noses for people with cancer, palate inserts and replacements for other body parts in rare situations. Her job is to speak personally with insurers to advocate for reimbursement on behalf of her patients. She has had a very good experience with Amerigroup and would like to speak with Evercare but has not yet had the opportunity.

Michael Carter, C.E.O., Miners' Colfax Medical Center, discussed the difficulty the hospital has contracting with professional employees due to problems obtaining medical malpractice insurance and requested a bill to grant access to the Tort Claims Act.

Len Trainer, Heritage Home Healthcare and Hospice, noted that his agencies are experiencing problems with timely payment, responsiveness of MCOs, increased administrative costs, borrowing and other issues. He stated, however, that the survey misrepresents the actual feeling of providers in the state. He feels there is much about CoLTS that is good and that the MCOs are now much closer to the health needs of the patients around the state. He believes this model has the best chance of ultimately eliminating silos of care and achieving cost containment. He urged the committee to give the CoLTS program a longer chance.

David Foster, president, Maroland at Home, believes there is some validity to all the comments already made; however, as the chair of the NMAHHC waiver committee, he appreciates

the dialogue that is going on with the state and the MCOs. A program that is only one year old is too young to fully judge. Efforts need to be made to work together to achieve improvements, and these efforts are underway.

Lynn White, administrator, Santa Fe Care Center, agreed with the remarks of Ms. Sechovec and Representative Heaton and expressed appreciation for the survey. He noted there is duplication in the system. The fact that the survey showed that most CoLTS providers had to seek short-term funding is a reflection of the level of the problems. He fears that there will be long-term-care facilities that go out of business.

Debbie Vargas, Lorraine McGreatland and Marie Garcia, family living providers, testified on behalf of that program that cares for DD patients. It is a good program that allows people to live at home instead of in an institution or group home. They cannot sustain more cuts.

Charles Marquez, lobbyist, NMHCA, made clarifying comments about the problems of nursing homes negotiating rates with CoLTS MCOs. He supported the need to support adequate reimbursement for nursing facilities as vital providers.

Mr. Dye offered a comment on behalf of Michelle Lujan Grisham and Delta Consulting, which wished the committee to know that the Laguna Pueblo Nursing Home and Laguna Rainbow Elder Center have had excellent interactions with Amerigroup, but that Evercare has not been supportive of their programs.

Thanks were expressed for the committee's participation during the interim, for the leadership and for the support of staff. There being no further business, the committee was adjourned at 5:40 p.m.