

MINUTES OF THE
STATE OF NEW MEXICO
HEALTH POLICY COMMISSION
MEETING

September 21, 2006

CALL TO ORDER

Chair Lopez called a regular meeting of the State of New Mexico Health Policy Commission (HPC) to order on Thursday, September 21, 2006, at approximately 9:06 a.m. at the Health Policy Commission Office, 2055 South Pacheco, Santa Fe, New Mexico.

Members Present

Dr. Frank Hesse
Andy R. Lopez
Seferino Montano
Dr. Miles Nelson
Alicia Roman
Dr. Michael Trujillo

Members Absent

Waldo Anton (*excused*)
Moises Morales (*excused*)
Dr. Rick Crabtree (*excused*)

Welcome and Introductions

Dr. Larragoite welcomed everyone to the meeting and asked the Commissioners to introduce themselves.

Also present were: Jennie Lusk, Legislative Council Services; Erin Johnson, Student Nurse UNM; Janelle Kinner, Student Nurse UNM; Lisa Feely, Student Nurse UNM; John Booker, New Mexico Department of Health (DOH); David Roddy, New Mexico Prime Care Association (NMPCA); Bill Walsh, New Mexico Primary Care Association; Maggie Gunter, New Mexico Health Information Collaborative (NMHIC), Pamela Hyde, Human Services Department Secretary, Michelle Welby, Governor's Senior Health Policy Advisor, and Clifford Rees.

Staff members Dr. Larragoite, Kooch Jacobus, Kevin McMullen, Samuel Dominguez and Catherine Burton were present at the meeting.

Approval of Agenda

Commissioner Montano moved for approval of the agenda. Commissioner Roman seconded the motion, which passed by unanimous voice vote.

Approval of Minutes from July 21, 2006 Meeting

Commissioner Roman moved for approval of the July meeting minutes as written. Commissioner Montano seconded the motion, which passed by unanimous voice vote.

DIRECTORS REPORT AND BUDGET REVIEW

Budget

Dr. Larragoite reported he did not have the final budget report because bugs are still being worked out of the new state financial Share Project, which began July 1, 2006. The Share program handles all human resources and financial management in one IT system. He added the agency is in good shape with some funds being reverted to the State and plans to provide a final report to the Commission at the next meeting.

The agency currently has two vacancies, both Management Analyst positions. When he met with Secretary Miller to discuss the budget, he requested the budget be changed to accurately reflect what the agency spends on operating costs for salaries, benefits etc. He will also request the two vacant positions be reclassified.

Pursuant to the agency's new strategic plan, the HPC is collaborating with New Mexico Medical Review Association, New Mexico Medical Society, Greater Albuquerque Medical Society, DOH, New Mexico Health Resources, Inc., New Mexico Board of Medical Examiners, and the University of New Mexico to conduct the Physicians Survey. The survey has been developed and is ready for mailing but the results will not be available until after the legislative session begins.

The HPC is also a member of the New Mexico Prescription Improvement Coalition. HPC brought the issue to the table that all prescribing health providers should be included in the coalition. Currently, only physicians are part of this project.

The agency is also involved with the New Mexico Telehealth Commission and is moving forward with a newly appointed chair. HPC is also part of the Telehealth Alliance, a nonprofit group made up mostly by the private sector, and the Screening, Brief Intervention, Brief Treatment and Referral to Treatment (SBIRT).

The Governor's Oral Health Council (GOHC) is moving forward with a very aggressive legislative package including a number of health issues to be discussed during the legislative work session.

Old Business

At the last Commission meeting, a motion was passed to send a letter to all legislators and legislative leaders supporting the creation of a standing health committee in both the house and senate. Senator Michael Sanchez, Majority Floor Leader, responded requesting a meeting to discuss the issue. Dr. Larragoite suggested when a meeting date is set the Commission might want to be included. Senator Sanchez pointed out there are currently nine Senate and sixteen House standing committees.

A letter of support to elevate the level of oral health within the operation structure of the DOH was sent by the GOHC and the HPC. Since then an oral health manager, public health provisional director and dentist have been hired.

The Behavioral Health Purchasing Collaborative (BHCC), created pursuant to Section 9-7-11.2(E)(11) NMSA 1978, to ensure that any behavioral health projects, including those relating to mental health and substance abuse, are conducted in compliance with the requirements of Section 9-7-6.4., is still undergoing an audit by the LFC and the commission will receive a report when it becomes available.

New Business

Legislative Memorials Update

House Memorial 43, passed in the 2005 legislature, asked the New Mexico Hospital & Health Systems Association to work with the DOH and HPC to develop a process by which hospital charges, relative to hospital quality, and increased in charges of hospitals be made easily available to consumers. The HM43 report, completed by the HPC staff, included a background review of how hospitals are paid, how that payment ties to how they charge, what is done in other states regarding the process issues noted in the memorial, the positives and negatives of making public charge and quality information and the HPC's recommendation. Dr. Larragoite indicated that the HPC recommended a voluntary approach modeled after the Wisconsin law that requires a hospital to publish a notice of price increases of hospital services in the area's local newspaper. The law also dictates the size, content and format of the newspaper publication notice.

In 2001 two sections of law were enacted which require health insurers and HMOs that offer prescription drug benefits to also offer coverage for prescription contraceptive drugs or devices. Subsequent to the effective date of the law, complaints were received regarding the failure of health insurers and HMOs to provide coverage. As a result, HJM 32 was enacted in 2002 dictating that the DOI conduct a survey of health insurers to determine compliance with the law. The study found that fewer than 10% of health insurers offered prescription contraceptive coverage.

House Joint Memorial 38 enacted in the 2006 legislative session is a follow-up to HM32 and requires the HPC and DOI to evaluate the benefits of contraceptive use and to update

the 2002 survey. The HPC is named as the lead agency and is tasked with collecting and evaluating relevant health studies, and determining the benefits of having prescription contraceptive coverage. DOI is required to update the 2002 survey and report to the appropriate legislative committee no later than November 2006. In addition, DOI must prepare a list for public dissemination of health insurers that do not provide the prescription contraceptive coverage. Further, DOI is to use the data collected from the survey to begin a dialogue with insurance companies to encourage greater coverage of prescription contraceptives. Each agency is also required to prepare educational materials on the availability and access to prescription contraceptives.

The HPC has completed a draft report on the benefits of prescription contraceptive coverage and is awaiting DOI's survey results to be incorporated into the report. The task force is planning to meet soon to discuss the next steps.

MAGGIE GUNTER, PRESIDENT & EXECUTIVE DIRECTOR, LOVELACE CLNIC FOUNDATION

Maggie Gunter, PhD, NMHC Project Director, presented a report on health information exchange (HIE) including information on how HIE can improve health and reduce costs. She explained NMHC's overall goal is to build a cross-system HIE initially in Bernalillo and Taos Counties with future plans to expand statewide.

Community-based initiatives including a broad representation of health systems and plans, employers, labs, and the DOH would be part of the project. This would allow health care providers, with patient consent, to locate patient's records across multiple health care facilities, enabling the provider to have enhanced web-based access to information at the time of care. Eventually, patients would have access to their own health information thus becoming better managers of their own health and of chronic diseases.

The goals to benefit multiple stakeholders would provide cross-system access to comprehensive information at point of service for providers. It would also provide patients with web-enabled access to enhance self-management; provide employer engagement by promoting data sharing among health systems/plans. The long-term vision is to create a statewide health information exchange that improves quality coordination and efficiency, while restraining costs. It would also create a culture of personal accountability for health.

The collaborative would include all Albuquerque hospitals, health systems and health plans, major Albuquerque employers, United Way, McCune Foundation, all major New Mexico medical associations, Albuquerque and Rio Rancho public schools, UNM, the Taos Community Hospital and physicians, the DOH, and the Human Services Department.

The funding includes a \$1.5 million implementation grant from the Agency for Healthcare Research & Quality, \$1.5 million additional matching funds in cash and in-

kind services raised locally, \$450,000 state legislative appropriation through UNM Health Sciences Center in 2005, a Health Information Privacy and Security Project Contract, and \$337,000 to DOH administered by Lovelace Clinic Foundation.

NMHIC is important because one to two New Mexicans die and twenty-five to thirty suffer adverse medical events due to lack of complete medical information every week. There are gaps in health care information contributing to our health care crisis with escalating costs, inefficiency and duplication. Even electronic health record systems typically provide information for only one site of care, enormous frustration for both providers and patients by repeatedly providing the same information. Health information technology (HIT) offers the best hope to reduce costs and improve care.

The benefits to New Mexico include the reduction of duplication and costs, improved care, improved efficiency, improved detection and management of pandemics, mass disasters, and bioterrorism, streamlining of mandated public health reporting, and allows for community-wide management for chronic diseases. Progressive health care systems attract economic growth, companies want to locate to areas with high quality cost effective systems.

The progress to date includes broadly representative governance structure both private and public, data agreements and data from 10-12 sources. Two signed agreements have been obtained to share clinical data, basic technical architecture completed built internally to include decentralized network architecture (data source maintains control), master patient index to link patient records across health organizations, data engine to locate records across systems, secure electronic referral module/clinical messaging, and three exchange projects beginning in Taos. These projects are designed to test architecture in real-world information exchange, referrals and public health reporting.

Additional progress to date also includes multiple collaborations with the DOH, prospective Medicaid collaboration and a higher profile with governor and cabinet secretaries. Key HIT commissions (Telehealth), have helped with incorporation of wide range HIT initiatives in the state to be under one umbrella (RHIO Grande). Active community involvement in RHIO work groups – shift from advisory to decision-making.

Future plans and sustainability include the full implementation and evaluation of the Taos exchange projects; refining software for implementation in large health systems; obtaining signed clinical data agreements with large systems (UNM, Pres., Lovelace); initiating extensive health information exchange in large systems; and evaluating the impact on efficiency, care quality, satisfaction, etc.

Sustainability beyond the federal grant is a critical issue. Lovelace Foundation will need 3 years of additional seed funding to demonstrate full value of HIE and support business case (current grant ends 9/30/06). Possible funding sources – community partners, federal and foundation grants, state legislative appropriations; future business model – likely based on subscriptions paid by users of the HIE network – once proof of concept and return on investment are demonstrated.

GOVERNOR RICHARDSON'S 5-POINT PLAN

HUMAN SERVICES DEPARTMENT SECRETARY PAMELA HYDE

Human Services Department Secretary Pamela Hyde gave an overview of New Mexico's current insurance programs including New Mexico health insurance coverage demographics; public sector coverage – state and non-state; and commercial coverage.

The US Census Current Population Survey (CPS) released on August 29, 2006, shows the percentage of New Mexicans without health care coverage in 2005 statistically remained the same (21.1%) while nationally the uninsured rate increased. "Today's report shows that nationally people are losing coverage, while New Mexico as a whole is not losing ground, and with new initiatives, more New Mexicans will get health care coverage." New Mexico's 2003-2005 three-year average for insurance coverage decreased by .2% to 21.1% or about 402,000 people w/o health insurance, but statistically there was no change from the previous data year.

Ms. Hyde stated the New Mexico Public Sector Coverage State and Non-state include current contracts with Presbyterian, Cigna, Blue Cross Blue Shield New Mexico, Molina, Lovelace and others (Medicaid, etc.).

- There are 400,000 uninsured New Mexicans;
- 600,000 New Mexicans are covered by private/commercial coverage;
- 400,000 are covered by Medicaid;
- 300,000 through Medicare;
- 75,000 through General Services Department (GSD); and
- 125,000 through RHCA/PSIA/APS/Tri-Care.

New Mexico's public systems include:

- GSD 55,000 employees of the state and 55 other public entities covering 20,000;
- Retiree Health Care Authority (RHCA) 32,000 retirees of the state, public schools and other public entities;
- Public School Insurance Authority (PSIA) 60,000 public school employees;
- Albuquerque Public Schools (APS) 18,000 school employees.

Medicaid eligibility categories include:

- pregnant women up to 185% FPL disregarding income between 185% FPL and 235% FPL;
- working disabled individuals (WDI);
- SCHIP children of parents/families up to 235% FPL with generous income disregards;
- TANF children and parents over 30% FPL;

- Medicaid waivers (D&E, Med Frag, DD, Persons on SSI or SSDI due to disability up to 200% FPL); and
- Medicare premiums.

- Medicaid provides services to one in five New Mexicans
 - 154,265 adults and 256,494 children.
- 410,759 New Mexicans were on Medicaid in July 2005
 - 21% of the State's population
 - Approximately 62% of the Medicaid population are children
 - Medicaid primarily serves pregnant women and children
 - 75% female and 25% male adults; 51% female and 49% male children

Mandatory Medicaid services include:

- inpatient hospitalization;
- outpatient hospital services;
- physicians' services;
- lab & x-ray services;
- home health;
- nursing facility services for certain individuals; and
- early and periodic screening diagnostic and treatment services for children.

Optional Medicaid services include:

- prescription drugs;
- eyeglasses and hearing aids;
- organ transplants, psychologists' services;
- podiatrists' services;
- dental services;
- physical, occupational and speech therapies;
- rehabilitative services;
- ICF/MR;
- case management;
- emergency hospital services;
- hospice;
- transportation services;
- prosthetic devices; and
- personal care.

State coverage insurance benefit packages include:

- comprehensive benefits;
- hospital-inpatient/outpatient;
- emergency and urgent care;
- primary care/specialty care;

- preventive and women's health services;
- pharmacy;
- behavioral health (mental health and substance abuse);
- durable medical equipment and supplies;
- OT/PT/ST;
- lab/diagnostic/x-ray; and
- a \$100,000 annual limit.

Mandatory populations receiving services in New Mexico include:

- SSI (aged, blind, disabled);
- foster care;
- adoption subsidy;
- state custody;
- JUL Medicaid;
- transitional Medicaid;
- Medicaid assistance for pregnant women and newborns;
- qualified Medicare beneficiaries and disabled;
- specified low-income Medicare;
- medical assistance for refugees; and
- emergency medical for undocumented aliens.

Optional populations receiving services include:

- children at 133-185% FPL;
- pregnant related 133-185% FPL;
- family planning;
- WDI;
- breast/cervical cancer;
- institutional care;
- aged, blind, disabled;
- AIDS;
- disabled and elderly (aged, blind and disabled);
- medically fragile; and
- developmentally disabled.

The per person costs by population or program are:

- children's medical care – 256,494 participants at a cost of \$2,978/child;
- nursing home care – 6,616 participants at a cost of \$29,444/person;
- personal care option program for adults and seniors with disabilities – 8,738 participants at a cost of \$13,361/person; and
- home and community based waiver services – 5,485 participants at a cost of \$50,620/person.

Medicaid program health care costs for home and community based services waivers are:

- D&E waiver services for individuals with disabilities – 1,887 participants at a cost of \$23,717/person;
- Waiver Services for the developmentally disabled with medically fragile conditions – 147 participants at a cost of \$33,492/person; and
- home and community based waiver services for individuals living with AIDS – 16 participants at a cost of \$19,419/person.

New Mexico's commercial:

- health insurance coverage v. population
- employer-sponsored insurance, 59% in New Mexico versus 68% in U.S.
- estimates are that almost half of employer-sponsored coverage is self-insured
- individual coverage, 4% in New Mexico v. 5% in U.S.

Self-insured employer coverage:

- usually provided by larger employers
- not feasible for employees with less than 100 employees
- dominated by PPO designs (comprehensive coverage, drug formularies, deductibles and out-of-pocket expenses)
- best coverage in-network (highest benefits, lowest out-of-pocket)
- administered by third-party administrators (insurers, HMOs and others)

Insured employer coverage:

- 80% concentrated among three carriers in New Mexico
- dominated by HMO type coverage
- some PPO types designs

Individual coverage:

- one carrier has 50% of coverage in New Mexico (BCBS New Mexico)
- PPO type products dominate
- heavily underwritten
- high-risk pool.

The purpose of insurance mandates include:

- public policy;
- level playing field; and
- response to marketplace.

Types of mandates include:

- anti-discrimination (freedom of choice provisions);
- children coverage (adopted, immunizations, etc.);
- women's coverage issues (mammograms, prescription contraceptives, maternity transport, etc.);
- special needs (diabetes, cancer clinical trials, etc.); and
- other (smoking cessation, alcohol dependence, etc.).

Employer sponsored federal mandates:

- maternity coverage;
- mental health parity; and
- guaranteed issue-small employer.

The cost of insurance mandates in New Mexico:

- Industry trade associations indicate 15% to 25%.
- New Mexico HMOs have estimated 10% to 15%.
- DOI has estimated 3% to 15%.

GOVERNOR'S HEALTH POLICY ADVISOR – MICHELLE WELBY

Michelle R. Welby, Governor's Office Senior Policy Advisor for Health Care, reported on Governor Richardson's Five-Point Plan. The policies set the course and bridge the values to actions (or restraint of action) regarding legislation, budget, rules and regulations, call to private sector, and federal and state level. Policies results are measured, targets are set for future years, and activities with timelines are established.

Key policy areas include:

- a healthy New Mexico;
- a safer New Mexico;
- managing state resources;
- protecting and promoting the environment;
- making schools work;
- promoting and growing New Mexico; and
- service to New Mexicans.

The first goal is to insure New Mexico by providing small employers with more options for affordable health insurance and New Mexicans with more opportunities for health insurance.

The second goal is to improve health outcomes and family support for New Mexicans by:

- increasing immunizations for children and adolescents;
- reducing teen pregnancy;
- decreasing the transmission of infectious disease and expand treatment services;
- ensuring preparedness for pandemic influenza;
- improving health, developmental and educational outcomes for newborns;
- improving access and quality of child care; and
- linking low-income children, seniors, veterans and disabled individuals to needed health care services.

The third goal is to combat hunger and improve nutrition by:

- reducing hunger among New Mexico's children;
- reducing child and adolescent obesity and diabetes in all populations; and
- providing meals for seniors and persons with disabilities.

The fourth goal is to improve behavioral health by:

- reducing suicide among youth and high-risk individuals;
- improving access, quality and value of mental health and substance abuse services;
- providing enhanced services for high-risk and high-need individuals; and
- increasing rural, frontier and border access to behavioral health services.

The fifth goal is to eliminate abuse and exploitation of at-risk populations by:

- enforcing "zero tolerance" of abuse, neglect, or exploitation of children, senior and vulnerable adults;
- assisting seniors and others with limited or no prescription drug coverage;
- improving outcomes for vulnerable families and children; and
- increasing utility assistance to low-income households.

The sixth goal is to improve HHS services by investing in workforce development and infrastructure by:

- increasing the number of physical health care, allied professionals and oral health workers;
- enhancing New Mexico's behavioral health workforce;
- expanding health care access in rural and underserved areas through Telehealth services;
- expand health care for school-age children and youth through school-based health services; and
- providing a no "wrong door" to state services through enterprise eligibility information; and improve the trauma care system across the state.

Ms. Welby further reported that on July 20, 2006 Governor Richardson called for a comprehensive health care coverage solution to extend coverage to New Mexicans through his five-point plan.

The first point of the plan is to phase in the requirement that companies doing business with the state must offer health insurance benefits (or provide health coverage for employees and families in their compensation) to their New Mexico employees. The Governor has appointed certain members of his cabinet to set guidelines by spring 2007 to be effective July 1, 2008. Small employers now have more options but guidelines will be sensitive to their situation.

The second point is ensuring that all New Mexico state employees have access to insurance by:

- pinpointing the number of employees who cannot provide proof of health coverage from another entity or family member in lieu of asking if they decline;
- performing outreach to explain benefit options;
- decreasing or eliminating estimated 2% who decline insurance; and
- developing recommendations to address lowest income employees.

The third point is to provide Medicaid for more low-income adults via a two-year, phased-in approach by:

- raising Medicaid eligibility for parents and adding low-income non-parent adults to 100% FPL;
 - assuming half of the adults in this income category take up Medicaid:
 - 42,000 adults at a cost of \$62 million in state funds;
- \$190 million in new federal dollars that in addition to covering more New Mexicans will also help address uncompensated care issues.

The fourth point is to expand state coverage insurance to more working adults, raising FPL from 200% to 300% FPL with appropriate cost sharing based on income.

- SCI currently serves nearly 5,000 adults;
 - estimate 17,000 adults in this category:
 - \$15 million per year;
 - assumes take up rate of 30% of adults in this category due to cost-sharing;
 - \$15 million will bring in \$57 million in federal.

The fifth point is to analyze the cost of various models for providing coverage for New Mexicans through the collaborative task force set up by Governor and Legislative Leadership called “Coverage for New Mexicans Committee”.

- 23 member committee will select three to five models to achieve comprehensive coverage for national experts to analyze;

- RFP for independent consultants scheduled to be release in November 2006 – work will take approximately one year to be read in time for 2008 legislative session;
- universal coverage – realistic opportunity for all people living in New Mexico to purchase or be provided health care coverage, whether public or private.

Dr. Nelson moved for HPC to become involved with the Governor's Five-Point Plan. Commissioner Montano seconded the motion, which passed by unanimous voice vote.

CLIFF REES – PUBLIC HEALTH LAW REFORM; PUBLIC HEALTH CODE

Mr. Cliff Rees, a retired New Mexico State Government employee presented proposed legislation on public health law reform to the Commission. Mr. Rees provided a packet to the Commission including an issue brief he prepared last fall. The brief discusses public health law as an essential tool of public health practice by creating legal authority and defining the legal duties of government and responsibilities of individuals to protect the health and safety of society.

Public health law reform should be considered in order to allow New Mexico to address antiquated, fragmented and inconsistent non-emergency provisions of state law. There is a need to reform much of the current non-emergency public health law that is outdated, illogically arranged and scattered throughout the New Mexico statutes. Modernizing the public health laws in the state would allow public health agencies and their partners in the public health system to respond to contemporary health threats. New laws could arrange public health powers based on modern science, management of information systems and comport with current legal standards of privacy and due process.

New Mexico is among numerous states that have suffered from outdated, confusing public health laws. To help address this situation, a national initiative, the Public Health Statute Modernization Collaborative, released a Model State Public Health Act in 2003 for states to consider as part of a process of assessing existing public health laws and identifying those that need to be changed.

New Mexico public health law reform could include:

- amending or repealing outdated public health statutes and rules;
- identifying gaps in existing law;
- drafting new laws if needed; and
- recompiling all public health related statutes into a Public Health Code similar to the existing Motor Vehicle Code, Insurance Code, Children's Code, Probate Code and the newly enacted Emergency Powers Code.

In 2001, the US Department of Health & Human Services recommended public health law reform as part of its Health People 2010 initiatives, considering it one of the priorities for improving public health measures.

As of June 2005, according to the Center for the Law and the Public's Health at Georgetown and Johns Hopkins Universities, 32 states have introduced legislation related to the Model State Public Health Act. The State of Alaska's process to reform its public health laws during its 2005 Legislative Session was similar to the process used in New Mexico during 2002-2003 when it updated the emergency preparedness statutes and included the enactment of the Public Health Emergency Response Act in 2003.

Mr. Rees reviewed some of the examples of changes needed in New Mexico's statutes and explained the state engaged in a process to update its emergency preparedness laws in the 2002 Regular Legislative Session with the enactment of SJM 62 and HJM 34. These nearly identical memorials created a working group of attorneys from DOH, the Department of Public Safety, and the Attorney General's Office to evaluate the state's existing laws for the handling of emergencies and report back to the Legislature with recommendations. The findings along with drafted recommended legislation were presented to the Legislative Interim Health & Human Services Committee in August 2002. Most of the legislative recommendations were subsequently enacted into law in 2003.

It was immediately recognized that non-emergency public health law reform is needed to insure consistency with the newly enacted emergency preparedness laws. During the 2004 Regular Legislative Session, Representative Jim Trujillo sponsored HJM 30 directing the DOH and other interested state agencies and parties study the Model State Public Health Act, the New Mexico Public Health Act, and related New Mexico public health statutes and rules. Once the study was completed, recommendations would be made to the Interim Legislative Health & Human Services Committee for the eventual enactment of a modern New Mexico Public Health Code with technical assistance provided by the UNM Institute of Public Law and nationally recognized consultants. Since HJM 30 died upon adjournment of the 2004 Regular Legislative Session, little action in the area of non-emergency public health law reform has taken place.

Representative Trujillo introduced HJM 23 during the 2006 Legislative Session. This memorial, a slightly modified version of the memorial introduced in 2004, directs HPC to lead the study. With that in mind, Mr. Rees asked for HPC's support the movement to updated public health law.

WORKING LUNCH

In response to a question by Dr. Hesse, Dr. Larragoite agreed to have Commissioners return notebooks provided to them at previous HPC meetings so that the notebooks could be recycled.

LEGISLATIVE DISCUSSION & WORK SESSION

Catherine Burton created a legislative work session packet with information relevant to health and health policy concerns in New Mexico. The packet was provided to the Commission beginning with the United Health Foundation's report on New Mexico.

Uninsured

A press release regarding the Governor's Five-Point Plan explains the plan and lists the active participants for the Health Coverage for New Mexico Committee.

The Five-Point Plan includes:

- (1) a small group of cabinet secretaries, led by GSD and sensitive to the needs of small vendors, will develop a plan by FY 2008 to institute a requirement that companies that do business with the state must offer health insurance benefits to their New Mexico employees;
- (2) GSD will pinpoint the number of state employees who decline health coverage and this full accounting will help get an accurate picture of the coverage gaps and target outreach to get as many state employees covered as possible;
- (3) by FY 2008, the governor will seek funding to maximize the Medicaid program, specifically designed to help low-income adults up to 100% of the federal poverty level, increasing coverage with a phased-in 2-year program approach;
- (4) funding for the expansion of the state coverage insurance program covering more working adults and asking the federal government to raise the federal poverty requirement to 300% with cost-sharing based on income; and
- (5) the appointment of a 23-member task force (made up of a broad membership from the health care industry and insurance and advocacy communities) to analyze health coverage models and make recommendations on across-the-board coverage solutions for New Mexicans.

An analysis by Kevin McMullen outlined the plusses and minuses of the Governor's Five-Point Plan. Mr. McMullen added that he tried to provide as much information as he could in the analysis, pointing out that in addition to health care coverage, health care access needs to be addressed.

Mr. McMullen asked the Commission to review the analysis and give Dr. Larragoite or himself any comments or suggestions. Dr. Larragoite added he would provide the Commission with contacts and dates of any scheduled meetings regarding this issue. He added that oral health should be added to this insurance plan. As the process moves forward, the HPC can chime in on the process

UNM/NMSU Pharmacy Program Funding

The Regents of New Mexico State University (NMSU) and the University of New Mexico (UNM) have met to discuss how to bring a pharmacy program to southern New Mexico. UNM (which has the only pharmacy program in the state) and NMSU have

developed a program with a \$516,000 budget to change the current average of 40 pharmacists per 100,000 people in southern New Mexico.

The universities would offer the first two years of UNM's pre-pharmacy program at NMSU, which would allow southern New Mexico students to remain close to home, the next three years of pharmacy school at UNM, followed by a final year of residency that would be spent in the southern part of the state. The joint program calls for selecting 10 top high school seniors interested in a pharmacy career and under the program, they would receive scholarships and extra guidance. The universities also agreed to work out a plan to assure the schools were working together for the 2007 legislative session rather than competing for the same funds. This will set the stage for other partnerships and the possibility of a feasibility study for a dental school should be funded.

After a short discussion, Dr. Hesse moved for HPC to support a feasibility study for a dental school including the severe need for dental care. Commissioner Montano seconded the motion, which passed by unanimous voice vote.

Economic Credentialing

Economic credentialing is the use of economic criteria unrelated to quality of care or professional competence to determine a physician's qualifications for initial or continuing hospital medical staff memberships or privileges. Because current economic trends in healthcare have caused hospitals to base credentialing decisions on the level of a physician's referrals to that hospital, some hospitals have established "conflict of interest" policies or "loyalty oaths" to ensure that physicians will refer their patients to that hospital or risk losing their hospital privileges. Through these policies, some hospitals have refused to grant staff privileges to physicians who own, have financial interests in or have leadership positions with health care entities, or refer patients to competing health care entities.

Dr. Hesse suggested tabling any decision on this matter at this time.

Cultural Competency Memorial/Behavioral Health Cultural Component

Kooch Jacobus reported HJM 30, introduced by Dede Feldman, requested the HPC to create a task force to study language barriers that contribute to health care disparities and make recommendations on improving medical interpretation. She stated SJM 32, introduced by Bernadette Sanchez, requested HPC to study the importance of barriers to meeting the need for recruiting and retaining an adequate supply of bilingual behavioral health professionals in New Mexico.

After a brief discussion, Commissioner Montano moved the continuance to pursue improving medical interpretation. Commissioner Roman seconded the motion, which passed by unanimous voice vote.

Commissioner Lopez brought up the lack of interpreters for the hearing impaired and suggested that the commission recommend additional funding for this service as well.

Commissioner Montano then moved to reintroduce the two memorials and create funding for interpretation services. Commissioner Roman seconded the motion, which passed by unanimous voice vote.

Oral Health

Dr. Larragoite provided the Commission with a list of legislative priorities, activities and tasks identified by the Governor's Oral Health Council. Additional requests will be identified and added at a meeting on September 22, 2006. He briefly discussed the 17 proposed funding requests for the 2007 Legislation. Also provided in the packet was a copy of SB 588, introduced by Senator Linda M. Lopez, requesting an appropriation to determine the feasibility of opening a dental school in New Mexico.

After a brief discussion, Commissioner Montano moved to endorse the entire proposal by the Governor's Oral Health Council, including the 17 proposed items. Dr. Hesse seconded the motion, which passed by unanimous voice vote.

Alcohol Outlet Density

A summary of the relationship between alcohol availability and injury and crime was provided to the Commission. There is a growing body of research that shows areas with more alcohol outlets tend to experience more alcohol-related injury and crime. Incidents of sexual assault and other violent crimes, domestic violence, child abuse, youth violence, homicides, alcohol-related motor vehicle crashes, and drunk driving have all been shown to increase where the availability of alcohol increases.

Communities can influence both alcohol availability and consumption, thereby mitigating related problems by controlling the number of alcohol outlets, regulating the behavior of current outlets, and closing problem outlets. These measures, along with others such as stricter enforcement on underage sales of alcohol and responsible alcohol service training, are part of a broader strategy that communities can implement to prevent and reduce threats to the health and safety of their residents from alcohol abuse.

Dr. Hesse moved for the development of improved statewide educational programs and the development of treatment programs regarding alcoholism. Commissioner Montano seconded the motion, which passed by unanimous voice vote.

Violent Crime/Domestic Violence and Health Care

Domestic violence is a health care problem of epidemic proportions. In addition to the immediate trauma caused by abuse, domestic violence contributes to a number of chronic health problems including: depression, alcohol and substance abuse, sexually transmitted diseases and often limits the ability of women to manage other chronic illnesses such a

diabetes and hypertension. A critical gap remains in the delivery of health care to battered women, with many providers discharging women with only the presenting injuries being treated, leaving the underlying cause of those injuries unaddressed.

According to the United Health Foundation, New Mexico ranks 46th in the nation for violent crime. In 2004, 26,940 incidents of domestic violence were reported, up from 25,644 reported incidents in 2003.

After further discussion, Commissioner Roman moved to support any legislation presented by other agencies regarding domestic violence. Dr. Hesse seconded the motion, which passed by unanimous voice vote.

Dr. Hesse requested a presentation by Indian Health Service and other entities on Native American health, where it is today, where it is going, and what effects federal funding cuts will have. With this knowledge, the HPC can either suggest or support legislation in this area. Dr. Larragoite stated a panel had been created in the past and he would try to get it to reconvene and give an updated presentation to HPC.

Environmental Health

An article from the New Mexican regarding water policy changes reported that Governor Richardson has said the 2007 legislative session would be the “year of the water” and now environmentalists have come up with some policy solutions they say would help ease New Mexico’s water scarcity problems. Also included were policy recommendations from Environment New Mexico Research and Policy Center regarding water quality and a report on environmental health concerns from the NM Environment Department Border Program.

Loan Repayments/DC Legislation

Mr. Harrison, Executive Director of the New Mexico Health Resources, stated a presentation was made to a legislative committee requesting increasing loan repayment, loan for service, WICHE, nurse faculty funding, New Mexico Health Service Corps funding, the J-1 Visa Waiver process and other related issues.

The goal of proposed legislation that the chiropractic association will submit is to allow a select group of DC’s to be added to the advanced practice certification so they supplement PCP’s in underserved areas. The additional certification will also blend with the Public Health Service Corp commissioning.

Dr. Hesse moved to oppose this legislation but after a brief discussion, but then withdrew the motion.

A discussion was held regarding nurse practitioners being given the authority to write prescriptions.

Dr. Hesse moved to adopt a blanket policy opposing nurse practitioners being given the authority to write prescriptions. Commissioner Montano seconded the motion, which passed by unanimous voice vote.

Dr. Larragoite announced the dates of the next three HPC meetings:

- October 27, 2006
- November 17, 2006
- December 15, 2006

ADJOURN/NEXT MEETING

Commissioner Montano moved to adjourn. Commissioner Roman seconded the motion; which passed by unanimous voice vote. The meeting adjourned at 2:25 p.m.

Approved by:

Andy R. Lopez, NMHPC Chair

Date

Submitted by:
Michelle Gorman