NEW MEXICO'S

OFFICE OF HEALTH CARE REFORM

TRANSITION PLAN

DECEMBER 2010

FreeDigitalPhotos.net

RECOMMENDATIONS FOR NEW MEXICO

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

In March 2010, Congress enacted the Patient Protection and Affordable Care Act (PPACA), commonly known as federal health care reform. The legislation is constructed to expand health care coverage in the United States by extending health insurance to more citizens; stabilizing health insurance markets by requiring broader participation, enhanced regulation and consumer protections; and improving the affordability and quality of health care. The legislation has staggered rollout dates from now until 2014 for its various provisions. Although health reform was enacted through federal legislation, much of the responsibility for implementing its provisions has been delegated to states.

On April 20, 2010, Governor Bill Richardson, by Executive Order 2010-012 (Appendix A) established the Health Care Reform Leadership Team in response to passage of the PPACA. The Leadership Team was charged with creating a strategic plan, and coordinating across state agencies that would oversee planning, development and implementation of federal health care reform in New Mexico. On July 1, 2010, the Leadership Team sent to the Governor its report "Implementing Federal Health Care Reform – A Roadmap for New Mexico" (Appendix C.) Based on the report, on July 19, 2010, the Governor, by Executive Order 2010-032 (Appendix B):

- Charged the Leadership Team to continue in its mission to oversee the planning, development and implementation of health care reform in New Mexico;
- Expanded the membership of the Health Care Reform Leadership Team to include representation from the New Mexico Higher Education Department; Public Education Department; Department of Finance and Administration; General Services Department, Risk Management Division; Office of the Governor's Council on Women's Health; and the Workers' Compensation Administration;
- Created a New Mexico Office of Health Care Reform – administratively attached to the Human Services Department- authorized with decision-making authority and dedicated existing staff, including personnel from state agencies represented on the Leadership Team, to plan, coordinate, and administer implementation of federal health care reform while reporting to the Health Care Reform Leadership Team;

- Conducted tribal consultation regarding health care reform initiatives and policies that will impact American Indians in order to ensure the adherence to New Mexico's Tribal Collaboration Act SB196 and federal requirements mandated and regulated by the U.S. Health and Human Services Department (HHS);
- Maintained involvement of, and coordination with, New Mexico's Congressional delegation; providers; insurers; health plans; consumers; advocacy groups; tribes, tribal organizations, and urban Indians; and other members of the public.

The Leadership Team, consisting of 12 Cabinet Agencies, Office of the Governor's Council on Women's Health, the Workers' Compensation Administration, the Superintendent of Insurance, CEO of the Behavioral Health Collaborative, and a representative from the Governor's Office, have met monthly since April 2010. Public input was received in all meetings and contributed to the recommendations in this report.

The PPACA is voluminous and complex legislation, with many of the details and specific requirements still emerging through federal regulations. The purpose of this transition plan contained herein is to provide the incoming Executive Administration with key recommendations and information to assist in the successful implementation of national health care reform in New Mexico.

Recommendations are provided in the following categories:

- Leadership, Resources and Support
- Public Input, Education and Transparency
- Insurance Reform
- Medicaid Reform
- Long-Term Care Reform
- Health Insurance Exchange
- Native American Health
- Workforce Development

Key Elements of Federal Health Care Reform

Although the federal legislation and forthcoming regulations consist of thousands of pages with scores of new initiatives and programs, there are key elements that bear directly on the goals of expanding coverage and lowering the cost of health insurance. These provisions will take effect in 2014, when health care reform is fully implemented and include:

- An individual insurance mandate that requires individuals and families to purchase insurance if it is affordable to them;
- Expansion of Medicaid program to all citizens and qualifying immigrants earning up to 138 percent of the poverty level (with a 5% income disregard) and the federal credits to provide insurance subsidies for low- and middle-income earners up to 400% federal poverty level;
- Requirements that larger employers provide coverage or pay an assessment;
- Incentive for small businesses to provide coverage to their employees;
- New incentives to promote health care quality, care-coordination, and preventative care;
- Changes in insurance market rules that allow more people to buy and retain private coverage;
- Payment reform incentives and pilots favoring primary care, medical home and global payments;
- Opportunities to improve access to primary care by expanding the number of primary care settings and primary health care workforce;
- Indian Health provisions implemented in consultation with the Tribes;
- New taxes on certain health sector businesses, high-income families, and high-cost health plans; and,
- Support for states to improve public health, prevention and health care quality.

States that adopt a coordinated, strategic approach to implementing federal health reform will find that the new law contains many provisions that support significant improvements in their health care systems. At the same time, states will face significant challenges implementing the new law—as a result of the many tasks they must complete, and the extremely constrained financial and staff resources available. There is a natural tendency to focus on the most immediate issues. Indeed, our state must tackle these

issues, but it is equally important that we begin thinking about and planning for the many aspects of implementation that occur in later years, particularly in 2014, when many of the law's provisions take effect.

The National Academy for State Health Policy has identified ten aspects of federal health reform that states must get right if they are to be successful in their implementation of federal health care reform.[1] These ten areas are:

1. Be strategic with the health insurance Exchange.
2. Regulate the commercial health insurance market effectively.
3. Simplify and integrate eligibility systems.
4. Expand provider and health system capacity.
5. Attend to benefit design.
6. Focus on the dually eligible.
7. Use your state's data.
8. Pursue population health goals.
9. Engage the public in policy development and implementation.
10. Demand quality and efficiency from the health care system.

Governor Richardson launched the coordinated planning and implementation of the PPACA across New Mexico's state agencies through the establishment of the Health Care Reform Leadership Team and the Office of Health Care Reform. Continued planning, implementation and oversight by the new Administration will be necessary to assure ongoing comprehensive implementation of health care reform over the next several years. While many of the major reforms do not occur immediately, New Mexico must continue our active planning and get ready as "2014 will soon be tomorrow."

[1] Briefing, NASHP, May 2010, *State Policymakers' Priorities for Successful Implementation of Health Reform*, by Alan Weil

II. History of Health Reform in New Mexico, 2003-2010

On September 16, 2010, the 2009 U.S. Census Current Population Survey (CPS) was released and showed an increase in the overall number of people in New Mexico with health care coverage during the three year average 2007-2009. The percentage of insured children in New Mexico increased by 1.1 percentage points, while the percentage of insured adults in New Mexico increased by .2 percentage points. For the third year in a row, even in these economic times, New Mexico saw an increase in the number of insured children in New Mexico.

The CPS report found a decrease in the percentage of uninsured adults in New Mexico at 24.4 percent in 2009 down from 26.4 percent in 2008. Nationally, the number of adults who lacked coverage increased from 17.2 percent to 18.8 percent. The rate for all uninsured individuals in New Mexico decreased to 21.7 percent in 2009 down from 23.6 in 2008. The percentage of uninsured children in New Mexico was 14.8 percent in 2009 which was a decrease from 16.2 percent in 2008. [2]

New Mexico is currently at an all time high enrollment in public health coverage programs through the *Insure New Mexico!* programs, which include Medicaid and other premium assistance programs, with approximately 550,000 people enrolled, 330,000 of them children.

How did New Mexico arrive at this success in the face of numerous challenges?

1) Exploring Health Care Access and Coverage Options for New Mexicans

As reported by the Henry J. Kaiser Family Foundation, "having health care coverage makes a difference in whether, when, and where people get needed care and how well that coverage promotes access to preventive and primary care services and protects them from medical expenses when illness strikes. The uninsured are more likely to postpone or forego needed care and preventive services than the insured." During 2003-2010, a variety of *Insure New Mexico!* programs were initiated to make affordable health

[2] The CPS survey was conducted during the Spring of 2010 for the calendar year 2009. During that time respondents were asked whether or not they have had health insurance at any period during the previous year. If the answer was yes, that person was considered "insured." Medicaid and Medicare are considered insurance, however, individuals who rely on the Indian Health Services, free clinics, and/or a hospital emergency room as providers of health care are considered "uninsured."

care coverage available for New Mexico's employers, individuals and for New Mexico children under the age of 12.

In August 2006, the Governor and the state Legislature appointed the Health Coverage for New Mexicans Committee (HCNMC) to identify and develop several different health reform models that could realistically lead to universal coverage in the state. Each model had to provide health coverage for all New Mexicans regardless of their ability to pay, remove lapses in coverage because of unemployment, underemployment, or changes in health providers, identify ways to keep prices in check, include coverage for individuals with high health care needs and pre-existing conditions, and optimize the use of federal matching funds. Three models were chosen by the HCNMC for further analysis. Mathematica Policy Research, Inc. analyzed the three models and reported the results to the HCNMC. In 2007, the HCNMC drafted recommendations to the state Legislature, which did not include adopting any of the three proposals.

However, later in 2007-2008, Governor Richardson proposed a universal health coverage package, HealthSOLUTIONS New Mexico, for consideration by the New Mexico Legislature. HealthSOLUTIONS New Mexico included the following principles:

A. New Mexico's goal is access to universal health coverage through the identification of shared policies and comprehensive reform activities. All people living in New Mexico should have the opportunity to purchase or be provided with public or commercial health care coverage that is affordable for individuals, taxpayers, employers and other payers.
B. These policies and activities should:
    1. Recognize the unique cultural and linguistic diversity in New Mexico;
    2. Be transparent and accountable, with sufficient information and data available for individuals, employers, payers and policy-makers to make reasonable choices among competing opportunities;
    3. Be financially viable and possible in New Mexico, taking into account costs, impact on New Mexico's economy, the health of its people, and the rising cost of health care;
    4. Consider the quality (including health outcomes and individual wellness) of health care provided for individuals living in New Mexico;

5. Recognize that healthy people and a robust economy are intrinsically linked; health coverage for all people living in New Mexico will have a positive impact on economic development, and strong economic development will play a role in improving the health status of people living in New Mexico; and
6. Improve access to health care and improve health status and outcomes in New Mexico.

C. To achieve universal coverage, multiple public and private policies and approaches will be required to develop and finance options for different ages, populations, employers, and circumstances within New Mexico.
D. Persons and families with low incomes or high health care needs will require assistance in purchasing, accessing and enrolling in available health care coverage.
E. Safety net services must be maintained for those individuals who experience significant barriers to accessing health care due to geography, language, culture, disability or personal situation.
F. Access to high quality health care that offers choices of providers, plans and treatment options for consumers is critical to improving individual and systemic health outcomes and to containing rising health care costs.
G. The state and federal government should provide strong leadership and oversight, with government, employers, individuals, families, providers and the clinical community sharing responsibility for health outcomes and the cost of health coverage.
H. The New Mexico Public Regulation Commission's (NMPRC's) role is critical to regulatory oversight of the commercial insurance industry and to assure that consumer complaints about insurance are addressed. The NMPRC's Division of Insurance (NMPRC-DOI) should be a strong partner in health coverage reform efforts.

2) New Mexico's Health Insurance Exchange Legislation

In 2007 and again in 2008, bills were proposed to create a health insurance exchange that would have created a non-profit public corporation, separate from the state, to provide increased access, choice and portability of health insurance for New Mexicans. All eligible individuals would have been permitted to obtain health insurance benefits through the Exchange in accordance with provisions of the proposed act, the New Mexico Insurance Code and other applicable state and federal laws. The exchange would have been governed by a board of directors, who would be considered a governmental entity for purposes of

the Tort Claims Act, but neither the board nor the exchange would be considered a governmental entity for any other purpose. This bill would have eliminated the existing Health Insurance Alliance (HIA), replaced some of its functions by ensuring guaranteed coverage based on certain requirements, and expanded HIA functions to include consolidation of the individual and small group health insurance market through creation of an entity called the exchange which certifies and allows the purchase of health insurance benefit plans. The bill included a provision requiring individuals to carry health insurance or prove other means of financial responsibility and established a mechanism for the state to retain money due to the individual from the state for compliance.

In 2009, the Legislature passed House Joint Memorial 1 (HJM 1), which requested the Superintendent of Insurance to study a State Health Insurance Exchange, and to report to the Legislative Health and Human Services Committee on the findings. Following a series of task force meetings with interested stakeholders, the Superintendent of Insurance presented the results of the study to the Legislature on October 22, 2009.

3) Passage of Federal Health Reform and its Implementation in New Mexico

The following year, the 2010 Legislature passed Senate Joint Memorial 1 which created the Health Care Reform Working Group (SJM1 Working Group), consisting of legislators and key state agency personnel to study the needs of the state with the anticipation of passage of federal health care reform legislation. Just days after the close of the 2010 New Mexico Legislative Session, the President signed into law the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, known collectively as the Affordable Care Act (ACA). On April 20, 2010, Governor Bill Richardson issued Executive Order No. 2010-012, which established the Health Care Reform Leadership Team (HCR Team) to guide New Mexico's implementation of national health care reform with Human Services Department Secretary Katie Falls as the Chair of the HCR Team. The HCR Team, composed of administration officials was tasked with preparing a report on the New Mexico's readiness to implement PPACA provisions. On July 1, 2010, the Leadership Team sent to the Governor its report "Implementing Federal Health Care Reform – A Roadmap for New Mexico." Based on the report, on July 19, 2010, the Governor recommended that the state proceed with creating "New Mexico's own strong health insurance exchange." (Appendix B)

On July 22, 2010, Secretary Falls presented to the interim Legislative Finance Committee (LFC) a report on the steps that the state has made towards implementation of PPACA, which included decisions that need to be made to prepare for implementation of an Exchange(s). The presentation emphasized the goals of the Exchange: to promote competition, simplify shopping for insurance, enforce consumer protections, standardize consumer information, centralize enrollment, and contribute to market reform by shifting the market from competition based on avoiding risk into competition based on price and quality. Included in the presentation is an analysis of legislative needs regardless of which type of an Exchange the state will choose to participate in or to sponsor. (Appendix D)

Summary: What We Have Learned and Accomplished

1. In early 2010, states across the country were considering ways to prevent premium increases that were well above the consumer price index for medical services. The New Mexico Legislature passed two bills that sought to mitigate the problem of high and rising premiums. House Bill 12 set a minimum medical loss ratio (MLR) for the state and Senate Bill 148 phased out gender rating.

    a. House Bill 12 requires that at least 85 percent of premiums for health maintenance organizations and nonprofit policies in the small group market be used for direct services reimbursement. The Superintendent of Insurance will establish an MLR for the individual market that cannot be under 75 percent. The legislation narrowly defines "direct services," and it applies across all product lines of a given company. According to a February 2009 report from Families USA, in early 2010 only 13 states had MLR requirements in the individual market and 13 in the small group market. New Mexico's requirements were and remain some of the strongest in the country.

    b. Senate Bill 148 led the way to the prohibition of gender rating in New Mexico, phasing out the allowed differential between policies for men and women. Prior to passage of the legislation, individual rates in the state could be up to 20 percent more for women. New Mexico joined eleven other states that then prohibited or restricted gender rating in the individual market. These states then included Maine, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, New York, North Dakota, Oregon, Vermont, and Washington.

2. Currently, New Mexico is at an all time high of enrollment in publicly funded health care programs with approximately 550,000 people enrolled in 2010, with 330,000 of those enrollees being children. In 2003, the enrollment figures were 397,704 in total, with 261,614 children enrolled in January 2003.

3. All New Mexico children up to age 12 now have the opportunity for health care coverage through either the Medicaid/SCHIP Program or the Premium Assistance Program.

4. Income disregards were expanded for the New MexiKids program for children ages 0 to 5 with family incomes of up to 235 percent of the federal poverty level (FPL).

5. New Mexico was allocated federal funding from the American Recovery and Reinvestment Act to support the state's costs for the Medicaid and the Children's Health Insurance Program (CHIP), which has allowed Human Services Department to keep covering eligible children without changes in 2009 and 2010.

6. A federal grant for $957,221 from the U.S. Health and Human Services Department will allow the New Mexico Human Services Department to increase Medicaid enrollment and retention of eligible children in American Indian, rural and frontier areas of the state through 12 on-line application kiosks located in schools, community centers, chapter houses and other accessible public locations.

7. In 2005, the State Coverage Insurance (SCI) Program was implemented to provide health coverage for small employers and self-employed uninsured individuals. SCI provides a comprehensive benefit health insurance plan which is available to small employers with 50 or fewer employees and individuals below 200 percent FPL without employer coverage. SCI now serves more than 55,000 New Mexico adults between the ages of 19 and 64.

    a. In 2009, about 1,400 New Mexico small employer groups obtained coverage for their employees through the SCI program, with the average employer group size of just over nine employees. The majority of industrial categories are food service, hospitality, retail, health care and education services.

8. In the 2008-2009 school year, 22,130 students received services through school-based health centers, with 16,795 students receiving Medicaid-reimbursable service. In 2010, 84 school-based health centers operated in the state, with 47 approved to bill Medicaid.

9. In 2006, the Premium Assistance for Kids (PAK) and Premium Assistance for Maternity (PAM) programs were created to serve uninsured children, up to age 12 (and 18 with a sibling under 12) and pregnant women who were not Medicaid eligible. Approximately 173 children are enrolled in PAK, and 247 women are enrolled in PAM.

10. Legislation was passed to lower the premium rate band for the allowable premiums charged for coverage by the New Mexico Health Insurance Alliance (HIA). HIA now enrolls approximately 4,000 lives.

11. Legislation was passed to expand health coverage for unmarried dependents by allowing them to stay on their parents' individual and group health insurance plans until the age of 25.

12. Legislation was passed requiring health insurers to offer health insurance plans for part-time employees when employers choose to offer this coverage.

13. Medicaid eligibility was expanded for pregnant women by disregarding some income up from 185 percent FPL up to 235 percent FPL.

14. Funded was provided for enhanced Medicaid outreach to children, with a special enrollment outreach initiative for Native American and Hispanic children.

15. Enhanced Medicaid outreach was provided to the Navajo Nation, urban Indians and Apache tribes.

16. Medicaid recertification and income disregards were changed to encourage easier enrollment into the program for children who can document eligibility.

17. Medicaid eligibility was expanded to include foster children up to age 21.

18. A new customer web-portal known as Your Eligibility System. New Mexico (YES-NM) was established in 2009 by HSD. YES-NM interfaces with the array of HSD social and health services programs and will eventually interface with additional programs administered by other state

agencies. YES-NM is a quick and easy way for people in New Mexico to get answers to questions on health and nutrition programs, and can be viewed at www.yes.state.nm.us/selfservice.

19. Albuquerque was designated by the Robert Wood Johnson Foundation as one of 14 *Aligning Forces for Quality* (AF4Q) communities in April 2009. The New Mexico Medical Review Association, the Albuquerque Coalition for Healthcare Quality, a coalition of hospitals, health plans, medical providers, consumers and employers will work together to reduce racial and ethnic disparities and develop models for national reform in health care. To learn more go to www.abqhealthcarequality.org.

20. HSD recently concluded several public meetings that were held in September 2009 and again in December 2009 to hear feedback from New Mexicans about specific cost containment and Medicaid coverage ideas. In addition, a formal tribal consultation was held in December 2009 to solicit feedback and input from tribal leaders, providers and members of the public concerning the impact of Medicaid cost-containment and potential changes on the state's American Indian populations.

21. In September, 2010, New Mexico was awarded $1,000,000 in funding from the Department of Health and Human Services to plan for the implementation of the Exchange model.

22. New Mexico submitted and was approved by the Department of Health and Human Services to operate a temporary high risk pool program. This program is operational and is being administered alongside the existing State High Risk Pool by the New Mexico Medical Insurance Pool.

Resources for Further Information

http://www.insurenewmexico.state.nm.us/INMHealthcareReform.htm

http://www.insurenewmexico.state.nm.us/Inm/documents/HouseholdSurveyFinalReport.pdf

http://www.insurenewmexico.state.nm.us/Inm/documents/InsureNMInternet.ppt

http://www.insurenewmexico.state.nm.us/Inm/documents/MandatedNMBenefits.ppt

http://www.insurenewmexico.state.nm.us/Inm/documents/InsureNMreport020405.pdf

http://www.insurenewmexico.state.nm.us/Inm/documents/2005_Insure_NM_Report_to_Governor.pdf

http://www.insurenewmexico.state.nm.us/Inm/In%20Brief.pdf

http://www.insurenewmexico.state.nm.us/Inm/Native%20American%20Health%20FINAL%20REPORT%20(2-3-06).pdf

http://www.insurenewmexico.state.nm.us/Inm/documents/INM_MPR_FinalReport_2008Mar.pdf

http://www.insurenewmexico.state.nm.us/Inm/documents/INM_HCNM_Comm_Final_Report_20070809.pdf

http://www.insurenewmexico.state.nm.us/Inm/documents/INM_HCNM_Comm_Final_Report_20070809.pdf

http://www.insurenewmexico.state.nm.us/Docs/SJM1FinalReport11-1-09.pdf

http://www.health.state.nm.us/plans/2010ComprehensiveStrategicHealthPlanUpdate.pdf

III. Key Recommendations and Decision Points

The Office of Health Care Reform and the Health Care Leadership Team recommends to the Governor-elect, to continue the planning, development and implementation of health care reform. New Mexico will have the responsibility to determine Medicaid's new role in the health care system; design a benefit package for the Medicaid expansion group; set Medicaid payment rates and secure access to providers; implement insurance reforms; choose whether and how to design, govern and implement health insurance Exchange(s); coordinate Medicaid and the new Exchange(s) while ensuring access to coverage and seamless transitions between different sources of coverage; control growth in current and future costs; and improve the State's health outcomes.

The PPACA is broad and complex and many provisions will need further clarification and guidance by the federal government before New Mexico can fully plan and implement the provisions. The timetable in the PPACA indicates that direction from HHS and other federal agencies will roll-out over the next several years. (See Appendix E for a Health Reform Implementation Timeline)

The following recommendations, forwarded by the Office of Health Care Reform and the Health Care Leadership Team, were created with input from state agency representatives and public and legislative stakeholders and were considered in the context of the history of health reform in New Mexico, other state experiences, and evidence-based practice.

Leadership, Resources, and Support:

Implementing the health reform law will require significant attention and continued support of the Executive over the next several years. New Mexico has an initial structure in place within the Executive Branch through its Health Care Reform Leadership Team and Office of Health Care Reform.

Recommendations:

- Continue the Health Care Leadership Team with its mission to oversee the planning, development and implementation of health care reform in New Mexico and with representation from the 12 Cabinet Agencies, Office of the Governor's Council on Women's Health, the Workers' Compensation Administration, the Superintendent of Insurance, CEO of the Behavioral Health Collaborative, and a representative from the Governor's Office.
- Move the New Mexico Office of Health Care Reform to the Governor's Office. Authorize the Office to have decision-making authority and dedicated staff, including a Native American Ombudsman, to plan, coordinate, and administer implementation of federal health care reform.
- Hire a Director of Health Care Reform, who reports directly to the Governor's Office, and is the Chair of the Health Care Leadership Team. Recommend that the Director is a system thinker and has knowledge/experience with state and federal health care reform, including Medicaid and long-term care reform, New Mexico's individual and small group insurance market, workforce issues, and Native American health care.
- Utilize the Office of Health Care Reform as a central entity for housing and reporting data on all PPACA grants to ensure accuracy of grant tracking and federal reporting for all state agencies. It is imperative to keep accurate records of the grants New Mexico agencies, and non-state agencies, are applying for and receiving.

Public Input, Education and Transparency

New Mexico must be dedicated to effectively communicate with its customers, advocates, legislators, federal partners, health care providers, small and large employers and other stakeholders as health reform progresses in an effort to educate and conduct outreach. It is critical to ensure meaningful involvement of stakeholders in the implementation of the PPACA provisions.

Recommendations:

- Maintain involvement of, and coordination with: New Mexico's Congressional delegation; providers; insurers; health plans; consumers; advocacy groups; tribes, tribal organizations, and urban Indians; and other members of the public.
- Keep stakeholders informed and involved- continue the following Health Care Leadership Team Stakeholder/Working Groups: providers, Medicaid, insurance, consumer, health information technology, employers, and Native American. The purpose of these groups is to provide ongoing recommendations to both the Office of Health Care Reform and the Health Care Leadership Team.
- Establish a New Mexico Office of Health Care Reform website that will serve as the "go to" place for accurate information about the PPACA and contains, at a minimum, consumer information; grant opportunities; funding applications and reports; Leadership Team and public meeting schedules and minutes; legislation; agency progress with implementation; key decisions that have been made; policy considerations and recommendations; and a timeline.
- Develop a comprehensive and cost-effective consumer protection and education plan that (1) promotes widespread consumer education as components of the PPACA are rolled out, (2) creates an independent consumer protection system with procedures and resources available for every county and tribal community, and (3) obtains funding through the PPACA to coordinate and advance consumer protection and education throughout New Mexico.

Insurance Reform

Although federal reforms include many types of insurance market reforms New Mexico has already implemented, it will be important to review New Mexico's laws to ensure that they meet the minimum federal standards. PPACA (similar to earlier federal HIPAA reforms) largely relies on state insurance regulators to monitor compliance. If a state is unable or unwilling, then federal regulators can assume the responsibility to ensure New Mexico is compliant with national standards.

Recommendations:

To bring state law in line with the federal mandates, legislation and/regulation that does the following is needed:

- Prohibit annual and lifetime limits.
- Require coverage of certain preventive services
- Extend adult dependent coverage through age 26 (current law is 25)
- Prohibit exclusions for preexisting conditions for children under 19
- Require the provisions of certain information for insurers
- Enact non-discrimination provisions regarding income and providers
- Change the medical loss ratio standards
- Add minimum plan requirements to Patient Protection Act
- Create health insurance consumer office and ombudsman
- Mandate premium rate disclosure and transparency

Further recommendations include:

- Analyze how to create as much continuity as possible between the plans and rules for those sold inside and outside the Exchange.
- Analyze the pros and cons of establishing rules that affect plan pricing so that they are the same for insurers inside and outside the exchange –to avoid individuals and employers paying more to enroll through an exchange.

- Evaluate whether New Mexico should establish a competitive process, based on factors such as price, performance and customer satisfaction, to determine which plans can be offered in an exchange.
- Develop a comprehensive consumer education plan to help individuals and employers be smart buyers.
- Work with insurers and brokers to help create the right insurance reform for New Mexico.
- Develop incentives to encourage those under age 30 and other healthy individuals to purchase coverage through the Exchange.
- Develop a marketing plan that includes attracting individuals over 400% FPL to purchase coverage through the Exchange in order to create a larger pool

Medicaid Reform

Beginning in 2014, states will be required to make Medicaid available to all people earning up to 133 percent FPL[3]. The federal government will pay 100 percent of the cost of the newly eligible Medicaid enrollees through 2016, and then gradually reduce the federal share to 90 percent by 2020. In New Mexico, there are an estimated 142,000 adults who would be newly eligible for this benefit. Meanwhile, a "maintenance of effort" provision requires states to continue paying at the regular match rate (roughly 70% federal/30% state) for coverage of those who would otherwise qualify under existing income guidelines. The Human Services Department (HSD) estimates that over 200,000 New Mexicans, including American Indians, will be eligible for Medicaid once the expansion goes into effect in 2014. This figure includes 62,000 children who are already eligible for Medicaid or the Children's Health Insurance Program (CHIP), but who are not currently enrolled.

Recommendations

- Medicaid cost containment decisions should be consistent with PPACA provisions.
- Use the Health Exchange Planning Grant to conduct population and fiscal mapping to identify needs of New Mexicans that may qualify for Medicaid and cost to the state, including the Medicaid program.
- Identify, as soon as possible, who will run the Exchange so that entity and the Human Services Department can begin working together to create an integrated and seamless eligibility and enrollment system that is supported by new information technology.
- Move quickly to replace the Human Services Department's Medicaid eligibility system to assure seamless efficient application and enrollment procedures for New Mexicans applying for Medicaid or subsidies through the Exchange.
- Adopt policies and procedures that will facilitate coordinated care as people move between the Exchange and Medicaid.

[3] 133% FPL - $14,404 for an individual and $29,327 for a family of four (2009). With a 5% income disregard included in the provision, the income eligibility level will in essence be expanded to 138% FPL.

- Analyze pros and cons to a “Basic Health Plan” for New Mexicans with incomes between 133% and 200% of poverty in lieu of those individuals receiving premium subsidies to purchase coverage in the Exchange(s).
- Work with health care providers to reduce administrative burden through eliminating redundant paperwork and streamlining administrative requirements.
- Analyze and pursue demonstration grants and other opportunities to support New Mexico’s exploration of other ways to purchase and provide health care services.
- Support the passage of a “Protected Native American Medicaid Plan” that prevents New Mexico from eliminating services, as a result of cost-containment, for Native Americans receiving care in an Indian Health Service or tribal health facility.

Long-Term Care Reform

Reform of the long-term care system is a focus of the PPACA and is intended to meet the needs and preferences of a growing senior and disabled population. As indicated by the U.S. Census Bureau, New Mexico will dramatically increase its percentage of citizens over the age of 65 years from 39th in 2000 to 4th by the year 2030, going from 11.7 percent to 26.4 percent. Currently, 15 percent (300,000) of New Mexicans of all ages are living with a disability, of which 100,000 are 65 and older.

Over the past 10 years, New Mexico has been active in transforming its long-term care system to address the rapidly changing demographics, demand in services, limited resources and the growing preference for home- and community-based services (HCBS). The long-term care opportunities presented in the PPACA position the state to further enhance its long-term care system by creating funding opportunities that enable seniors and people with disabilities to determine how and where they wish to live.

Recommendations:

- Analyze and pursue the option of amending the state Medicaid State Plan to provide home- and community-based attendant services and supports through the Community First Choice Option.
- Analyze the option of applying for a Section 1915(i) waiver to provide more types of HCBS through a State Plan amendment, including the Medicaid behavioral health population.
- Apply for the Money Follows the Person demonstration program to offer choice for individuals residing in a qualified institution to transition to a home or community-based setting.
- Implement provisions of the Elder Justice Act, Nursing Home Transparency Act, and Patient Safety and Abuse Prevention Act (included in the PPACA) and apply for funding to increase protections, quality of services and accessibility of information for the elderly and those with a disability.
- Encourage participation in the CLASS (Community Living Assistance Services & Supports) Program.
- Continue to support the Aging and Long-Term Services Department and its Aging and Disability Resource Center (a nationally recognized model) as the point of entry into New Mexico's long-term care system and its role to provide outreach, assistance, counseling, and an integrated medical and social service system to help older individuals and those with disabilities remain in their own home and community.

Health Insurance Exchange

Beginning in 2014, states (if they choose) or the federal government (if states elect not to participate) are responsible for establishing and operating web-based health insurance "Exchanges" that offer group-rate private health insurance to individuals and small employers (100 or fewer employees). Subsidies will be available to individuals on a sliding scale, depending on income, and tax credits will be available for employers who purchase through the Exchanges. Policies that are offered through the Exchanges must meet federal standards for premiums, benefits and cost-sharing. States may operate a single Exchange for both individuals and employers, form multiple Exchanges for different regions within a state, or have the option of forming partnerships to operate regional Exchanges.

All employers with more than 50 employees will be required to offer group coverage to their workers. Employees in firms that do not offer coverage, and employees with job-based coverage that is deemed unaffordable, will have the option of purchasing insurance through the Exchanges. Employers will be assessed a tax penalty for each worker who qualifies for federal subsidies to buy through an Exchange.

Also, beginning in 2014, all U.S. citizens will be required to carry health insurance or pay a tax penalty for failing to carry health insurance. However, due to the trust responsibilities of the federal government to the tribes, American Indians are exempt from the federal mandate requiring health insurance coverage and will not be subject to paying a tax penalty for failure to comply with the requirement of obtaining minimum coverage.

Recommendations:

- Make decisions regarding the type, functionality and governance of the Exchange and pass legislation to create an Exchange(s) in the 2011 Legislative Session.
- Fully utilize the health insurance exchange planning grant to further research on the needs and health insurance issues facing New Mexicans; the planning grant can be used to provide valuable resources and data to inform future decisions.

- New Mexico should establish its own Health Insurance Exchange(s) rather than using a federally operated Exchange.
- The entity that should operate the exchange should NOT be a governmental agency or a non-profit; the entity should be a non-profit quasi-governmental entity or a adjunct state agency that is required to follow the State's Tribal Consultation Act.
- The Exchange governing board should be appointed by both the Executive and Legislative branch and should not include members with a conflict of interest.
- The Exchange(s) should assume an active role in driving market reforms and protecting consumers. This could include restricting plans from the Exchange that would exceed specified premium growth levels or by requiring cost containment initiatives of plans participating in the Exchange.
- Develop a strong Exchange that promotes competition between plans based on quality and price in a way that is transparent to consumers.
- Explore the option of combining the individual and small group markets.
- Explore the option of creating/participating in a regional exchange.
- Consult with the tribes to share information and learn about their decisions to develop Native American Exchange(s).
- Consider regional resource sharing, i.e. human resources, IT, and administrative systems.
- Analyze the option of creating a state run plan that can be purchased in the Exchange by any consumer or small business. Analyze the option of including in the state run plan the following populations whose health care is already being supported, or partially supported, by public funding: Medicaid; public employers; public retirees; and those who are incarcerated. The pooling of these populations can create a large enough risk pool and reduce adverse selection. Such a plan can increase competition in the private market, drive down costs, and potentially serve as a revenue generator for the State.
- Allow for the creation of Consumer-Owned and –Oriented Plans (CO-OPs) to be offered in the Exchange(s). CO-Ops are not-for profits cooperatives that can provide affordable health insurance and supports choice, increased quality and decreased costs.

Workforce Development

The PPACA includes competitive state health care workforce development grants; workforce diversity grants and demonstrations to address health professions' workforce needs. The PPACA also includes additional loan repayment options for certain types of medical professionals working in medically underserved areas and for certain medical professionals who are faculty at medical institutions.

Recommendations:

- Assess New Mexico's current capacity and distribution of health professionals in the state.
- Assess the impact of PPACA provisions on New Mexico's health care workforce, with an analysis on the impact on non-traditional and native healing practices.
- Apply for appropriate PPACA workforce development, recruitment and retention, and training grants.
- Work to attract and retain health professionals by encouraging investment in training programs, supplying more scholarships for health care workers, and improving the diversity of the workforce to create jobs in our local economy.
- Explore all options to increase funding to support loan forgiveness and debt repayment programs for medical and behavioral health providers.

Native American Health

American Indians and Alaska Natives are celebrating passage of the Patient Protection and Affordable Care Act. This law will improve the quality of health care and make it more accessible and affordable for all Americans, including American Indians/Alaska Natives. The Affordable Care Act also includes the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), which extends current law and authorizes new programs and services within the Indian Health Service and will impact New Mexico's 22 Tribes, Nations, and Pueblos of New Mexico.

Recommendations:

- Create a Native American Ombudsman position, located in the Office of Health Care Reform, in 2011 to address all Native American issues and Indian provisions of the PPACA, as well as provide education and outreach to tribal governments regarding the State's Office of Health Care Reform efforts.
- Create a mechanism to ensure that a state, non-profit or quasi state entity is required to adhere to the consultation provisions of the State-Tribal Collaboration Act.
- Conduct tribal consultation regarding health care reform initiatives and policies that will impact American Indians in order to ensure the adherence to federal requirements mandated and regulated by the U.S. Health and Human Services Department (HHS) and to honor our compliance with and commitment to the State – Tribal Collaboration Act SB 196.
- Ensure that the NM Indian Affairs Department continues to work closely with the Governor's Office, HSD, Office of Health Care Reform or other department tasked with implementing PPACA.
- Continue the Native American HCR Steering Workgroup that is responsible for advising and providing information to the Health Care Reform Leadership Team and the Office of Health Care Reform regarding the implementation of the Patient Protection and Affordable Care Act (PPACA).
- Communicate and coordinate with Indian Health Service/Tribes/Urban (I/T/U) on Native Americans' issues analysis, education, and data collection.
- Work closely with Medicaid and the Medical Assistance Division Native American Liaison to ensure information, coordination and support is provided to the I/T/U Express Lane agencies.
- Assure PPACA/IHCIA grant opportunities are communicated to I/T/U's and provide technical assistance when appropriate.

- Recommend that Health Information Technology systems adhere to the Indian provisions of the PPACA.

Additional Recommendations

- The Executive, Superintendent of Insurance, and the Legislature must continue to work together in planning and implementation of health reform.
- Continue to work with partners such as the New Mexico Medical Insurance Pool and Health Insurance Alliance.
- Use data and evidence-based practice to inform decisions.
- Continue to expand Health Information Technology, telehealth and the establishment of Electronic Medical Records to meet the requirements of PPACA, reduce administrative costs, and improve health outcomes.

Decision Points -from July 2010 Health Care Leadership Team Strategic Plan- and Progress Notes

Decision Points—Administrative Activities		
DATE	**PROPOSED ACTION**	**Progress**
By 7/31/10	- Continue convening the Health Care Reform Leadership Team - Expand membership of the HCR Leadership Team - Create an Office of Health Care Reform	- Complete - Monthly meetings of the Health Care Reform Leadership Team from June – December 2010 - Office of Health Care Reform and Steering Group created
By 11/10 & Ongoing	- Determine state statutes requiring amendment/enactment	- Complete (see legislative section)
By 12/10 & Ongoing	- Conduct fiscal analysis of PPACA in New Mexico	- Ongoing by Leadership Team Member Agencies (depending on provision) - Using Exchange Planning Grant Funds Awarded to HSD from DHHS to contract with an entity to develop of an economic and financial modeling tool. RFP under development. See Appendix F for a copy of the grant application.
By 12/10 & Ongoing	- Hold tribal consultation as needed to determine if legislation is required to reduce cost-sharing for individuals enrolling in qualified	- Tribal consultation held in November 9 , 2010 - Tribal-State workgroup meeting on December 16, 2010

	health plans; determine the special rules for Indian health care, items or services furnished through Indian health providers; and adopt no-cost sharing for Indians with incomes at or below 300% FPL through the state Exchange	
Decision Points –Financing of Health Care Reform		
DATE	**PROPOSED ACTION**	**Progress**
By 12/31/10	Undertake a mapping of where New Mexicans will enter the health care market and determine the impact on the Medicaid program, potential Basic Health Plan and private and group markets	Using Exchange Planning Grant Funds Awarded to HSD from DHHS to contract with an entity to develop of an economic and financial modeling tool. RFP under development.
By 12/31/10	- Conduct a detailed fiscal analysis of the federal tax and subsidy options and their impact in New Mexico - Develop a list of options for Medicaid, SCI and other programs - Analyze cost and feasibility of options	Using Exchange Planning Grant Funds Awarded to HSD from DHHS to contract with an entity to develop of an economic and financial modeling tool. RFP under development.
1/11 & Ongoing	- Enact legislation as needed to update Medicaid, SCI and other Insure NM! programs	Draft legislation needed.
2011 & Ongoing; Enact 1/2014	- Decision on whether to develop a Basic Health Plan and enactment of the Plan	Using Exchange Planning Grant Funds Awarded to HSD from DHHS to contract with an entity to develop of an economic and financial modeling tool.

		RFP under development.
Decision Points – Expansion of Publicly Funded Benefits		
DATE	**PROPOSED ACTION**	**Progress**
By 12/31/10	- Conduct financial analysis of impact of expanding to childless adults prior to 2014 - Determine additional state dollars for such expansion - Make decision on whether to expand prior to 2014	Using Exchange Planning Grant Funds Awarded to HSD from DHHS to contract with an entity to develop of an economic and financial modeling tool. RFP under development.
By 7/1/13	- Determine how New Mexico will identify former foster children to enroll in the Medicaid program and the associated costs of expansion	Pending further review and funding decisions
Between 7/1/10 & 7/1/13	- Determine whether SCI enrollees and those on the waiting list under 133% FPL are considered "newly eligible," entitling NM to a 100% FMAP (federal funds) for these individuals in 2014.	Under review for future action
Between 7/1/10 & 7/1/13	- Determine the benefit package for the "newly eligible" population of adults up to 133% FPL.	Under review for future action
Decision Points – Insurance Reform		

DATE	PROPOSED ACTION	Progress
Ongoing	- Work with NAIC and HHS on development of federal insurance standards	NAIC America Health Benefit Exchange Model Act – Released NAIC Medical Loss Ratio (MLR) Recommendations and Forms/HHS MLR Regulation – Released Uniform Health Carrier External Review Model Act/ Regulation – Released
By 11/10 & Ongoing	- Review Insurance Code provisions and PRC/Division of Insurance rules for consistency with federal requirements	Analysis Complete Enforcement legislation anticipated to be introduced in the 2011 Session
By 12/31/11 & Ongoing	- Decision on whether to increase small group to firms with 100 employees; decision on whether to merge small and non-group markets	Possible legislation to redefine "small employer" in Sec. 59A-23C-3(N) of the Small Rate Renewability Act so that it applies to "no fewer than one employee instead of two employees now required and increase 50 employee to 100 as defined by PPACA. Utilize research from the Exchange Grant Economic and Financial Modeling Tool to guide decision making.
7/7/10	- Apply for grant funding to enhance health insurance premium rate review	Premium Rate Review Grant Awarded to PRC/DOI on September 13, 2010. Appendix G Ombudsman/Consumer Assistance

		Grant Awarded to PRC/DOI on November 1, 2010. Appendix G
12/31/11	- Decision on whether to fund state insurance mandates in excess of federal mandates using state dollars	Under review for future action
12/31/13	- Decision on interest in forming an interstate insurance compact	Under review for future action
Decision Points – Exchange		
DATE	**PROPOSED ACTION**	**Progress**
By 12/31/10	- Decision to create an Exchange and whether one Exchange or two; decision to create a New Mexico-only Exchange or join in a regional Exchange - Form planning group to develop Exchange; create work plan - Secure federal planning funds	Applied for Exchange Planning Grant on –July, 2010. HSD Awarded Planning Grant September, 2010 ($1,000,000) Stakeholder workgroups formed to guide health reform implementation: Medicaid, provider, employer, consumer, IT, Native American, and insurers.
9/10 & Ongoing	- Decision on where Exchange should be housed	Proposed legislation by LHHS (Appendix H)
9/10 & Ongoing	- Continue efforts to implement new state HSD Medicaid and other	HSD currently working on the Department's Income Support IT

	public programs' eligibility systems, as needed to comply with federal law; Issue RFP for new IT HSD eligibility system by Fall 2010	system (ISD2R). This system needs to be installed prior to the Exchange IT system.
1/1/12	Implementation of the Exchange	Pending legislation introduced and passed in 2011 session
1/1/14	Launch Exchange	
Decision Points—System and Payment Reform		
DATE	**PROPOSED ACTION**	**PROGRESS**
By 8/1/10	- Review all grants provided for under PPACA and group into state led and other grants - Develop a set of criteria to use in prioritization of grants; may require different criteria for different types of grants - Prioritize state led grants and assign responsible state agency for each grant to lead development	New Mexico has received over $47,000,000 in funding from the PPACA. See PPACA Funding Opportunities and Grant Tracking Section (page 45)
By 9/1/10	- Develop a strategy for state outreach to organizations, legislators, providers, tribes, urban Indians, and Indian Health Service around available grants and how	- Monthly meeting by Health Care Reform Leadership Meeting with public input. - Stakeholder groups established.

	they fit within state priorities.	- Contracts under negotiation with contractors to conduct public outreach, education and obtain input on Exchange planning. See Appendix I for contract list.
By 1/1/11	- Apply for Medicaid Health Home for Enrollees with Chronic Conditions Planning Grants - Apply for Medicaid Emergency Psychiatric Demonstration Project	Pending release of instructions
By Federal FY10	- Apply for funds from the Prevention and Public Health Fund	Pending release of instructions
Decision Points—Long Term Care		
DATE	**PROPOSED ACTION**	**PROGRESS**
By 7/1/11	- Conduct analysis of impact of amending state plan to expand home and community-based services - Determine percentage of Medicaid expenditures on home and community-based services - Determine additional state dollars for such expansion - Make decision on whether to	- Analysis in process

	amend State Plan	
By 8/1/10	- Conduct analysis of applying to be a Money Follows the Person state - Make decision on whether to apply for demonstration program	- Human Services Department applied for and received the Money Follows the Person Planning Grant ($200,000) - Demonstration proposal in process for submission January 7, 2011.
By 7/1/13	- Analyze state's existing spousal impoverishment benefit under the personal care option and home and community-based waiver programs - Develop a HCBS spousal impoverishment benefit if existing protections do not exist or are not adequate	Pending
By 12/31/10	- Ensure the state has a program contacting with Medicare Recovery audit contractors to identify, and recoup underpayments and overpayments	Pending
By 7/1/10	- Determine if the state will apply for the "Implementing the Affordable Care Act: Making it Easier for Individuals to Navigate their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and	Aging and Long-Term Services Department applied and was awarded funding: Medicare Improvement for Patients and Providers Grant - $371,358 Options Counseling Aging and Disability

	Access" funding opportunity	Resource Center Options Counseling and Assistance Programs Grant - $500,000
By 12/1/10	- Conduct analysis of impact of formula grants to the state's Adult Protective Services and Long-Term Care Ombudsman programs.	Pending release of instructions and formula grants
By 3/1/11	- Develop a consumer-oriented website that provides information about all nursing homes in the state, including their Form 2567 inspection reports, complaint investigation reports, plans of correction, and other information that the state and HHS consider useful to the public in evaluating care in individual facilities. - Develop a link between the New Mexico's consumer-oriented website and the federal Nursing Home Compare website to share - Develop a process to submit required survey information to CMS no later than the date on which they send it to the facility - Establish a long-term care facility complaint resolution process that	Under review by Department of Health

	ensures that legal representatives of residents and other responsible parties are not denied access to residents or otherwise retaliated against if they complain about the quality of care or other issues	
By 12/1/10	- Conduct a programmatic and fiscal analysis of the state's participation in the nationwide system to run background checks and screen for employees of long-term care providers. Determine if the state will continue participation in the program.	Department of Health in the process of applying for funding. PPACA Grant spreadsheets Appendix J
Decision Points—Native American Health		
DATE	**PROPOSED ACTION**	**PROGRESS**

Immediately and Ongoing	- As federal grant opportunities are announced, coordinate state and tribal applications to maximize funding to New Mexico in order to address Native American health needs and disparities. - As PPACA provisions are implemented, state agencies shall communicate, collaborate, and consult with tribes where mandatory or appropriate. - For state agencies, assess and include actions to implement Indian-specific provisions of the PPACA in their agencies' strategic and work plans.	Indian Affairs Department staff worked with Executive Agencies to identify impact of health reform provisions on tribes. See strategic plan matrices-Appendix B Tribal consultation conducted in November 9, 2010 Tribal-State workgroup meeting on December 16, 2010
By 9/1/10	- Establish an Indian Provision Health Care Reform ad hoc workgroup from the Tribal-State Workgroup created by HSD in order to ensure the adherence with and effective implementation of the Indian Provisions of the PPACA.	Tribal stakeholder workgroup established. Next meeting -December 16, 2010.
Decision Points—Education, Outreach and Communication Plan		
DATE	**PROPOSED ACTION**	**PROGRESS**
By 7/10 & Beyond	- Create a Vision for New Mexico	- Monthly meetings of Health

	Health Care Reform - Identify an Outreach, Education, Communication Team Lead as well as have an individual within each lead agency, and contacts within each Leadership Team state agency, to oversee consumer education and outreach, including education and outreach to tribal communities - Issue Progress Reports; Create a Timeline of grants, pilot projects and funding opportunities - Purchase of New Mexico Health Reform website domain names; Create email address for public input - Conduct Public Meetings; Develop Consumer Protection System; Provide resources for protection from fraud or abuse; Recommend protection complaint and appeals system; Recommend a consumer assistance entity or system	Care Reform Leadership Team with public input. - Stakeholder groups established (provider, employer, insurer, consumer, IT, Native American, and Medicaid) - Contracts under negotiation with contractors to conduct public outreach, education and obtain input on Exchange planning. See Appendix I for contract list.
By 12/30/10	- Determine if information regarding the federal Small Business Tax Credits should be included in the NM income tax form instruction packets, publications, TRD website, CRS packets and CRS workshops	Federal Government mailed instructions on how to apply and receive credit to all small employers in New Mexico

By 12/30/10 & Ongoing	- Determine if information regarding the individual and employer penalties for non-compliance should be included in the New Mexico income tax form instruction packets, publications, Taxation and Revenue Department (TRD) website, Combined Reporting System (CRS) packets and CRS workshops - Determine if information regarding insurance subsidies for individuals, families and businesses should be included in the New Mexico income tax form instruction packets, publication, TRD website, CRS packets and CRS workshops - Determine if TRD should educate parties about health law as it relates to the taxability of insurance subsidies tax credits and federal penalties	Pending

IV. Office of Health Care Reform and Leadership Team

On April 20, 2010, Governor Bill Richardson, by Executive Order 2010-012 (Appendix A), established the Health Care Reform Leadership Team in response to passage of the PPACA. The Leadership Team was charged with creating a strategic plan, and coordinating across state agencies that would oversee planning, development and implementation of federal health care reform in New Mexico. On July 1, 2010,

the Leadership Team sent to the Governor its report "Implementing Federal Health Care Reform – A Roadmap for New Mexico." Based on the report, on July 19, 2010, the Governor, by Executive Order 2010-032 (Appendix B):

- Charged the Leadership Team to continue in its mission to oversee the planning, development and implementation of health care reform in New Mexico;
- Expanded the membership of the Health Care Reform Leadership Team to include representation from the New Mexico Higher Education Department; Public Education Department; Department of Finance and Administration; General Services Department, Risk Management Division; Office of the Governor's Council on Women's Health; and the Workers' Compensation Administration;
- Created a New Mexico Office of Health Care Reform – administratively attached to the Human Services Department- authorized with decision-making authority and dedicated existing staff, including personnel from state agencies represented on the Leadership Team, to plan, coordinate, and administer implementation of federal health care reform while reporting to the Health Care Reform Leadership Team;

Leadership Team Members:

Chair: Human Services Department

Members: Aging and Long-Term Services Department; Children, Youth and Families Department; Indian Affairs Department; Department of Finance and Administration; Department of Health; Department of Information Technology; Department of Workforce Solutions; Taxation and Revenue Department; General Services Department; Governor's Office; Higher Education Department; NM Behavioral Health Collaborative; Office of the Governor's Council on Women's Health; Public Education Department; Public Regulation Commission Division of Insurance; and Workers Compensation Administration.

Meeting Schedule: 3rd Wednesday of every month, 10 am to noon.

Office of Health Care Reform Staff and Steering Group:

Given the upcoming transition to a new Administration, Secretary Falls requested the Office of Health Care Reform be led by classified employees to ensure a successful transition and continuity of implementation.

Staff

OHCR Transition Director: Emily Kaltenbach (Classified - Director of Policy and Planning at Aging and Long-Term Services Department)

Policy Coordinator: Ruby Ann Esquibel (Exempt –Human Services Department)

Management Analyst: Emma Bunkley (Classified - Human Services Department)

HSD Tribal Liaison: Priscilla Caverly (Classified - Human Services Department)

Legal Assistance: Melinda Silver (Contractor)

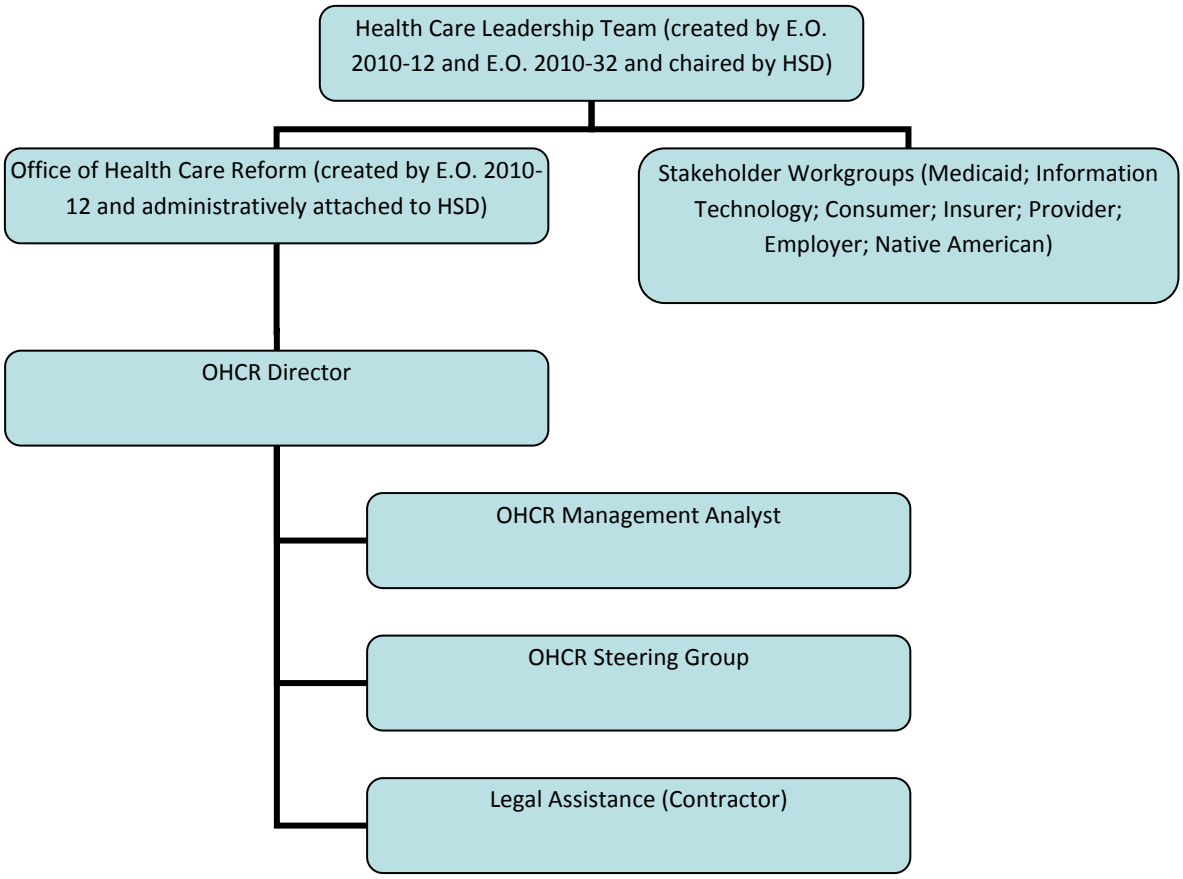
Steering Group Members

Department of Health: Penny Jimerson and David Quintana (classified)

PRC/Division of Insurance: Kimberley Scott (classified)

Indian Affairs Department: Sherrick Roanhorse (classified)

Human Services Department: Nicole Taylor, TANF (classified)


Health Care Leadership Team (created by E.O. 2010-12 and E.O. 2010-32 and chaired by HSD)
Office of Health Care Reform (created by E.O. 2010-12 and administratively attached to HSD)
Stakeholder Workgroups (Medicaid; Information Technology; Consumer; Insurer; Provider; Employer; Native American)
OHCR Director
OHCR Management Analyst
OHCR Steering Group
Legal Assistance (Contractor)

V. PPACA Funding Opportunities and Grant Tracking

Summary

To date, New Mexico has received 31 grants as part of the Patient Protection and Affordable Care Act (PPACA). These grants vary in type from exchange planning grants to infrastructure grants for community health centers.

The total dollars received for all grants throughout the State of New Mexico is $45,056,800 plus an additional $37 million the State will receive, over a three year period, to operate the Temporary High Risk Insurance Pool. The total amount of grant funds received by state agencies is $7,748,484. Listed below is a summary of all the grants received by the state agencies:

State Agency	Grant Name	Grant Amount
NM Department of Workforce Solutions	State Health Care Workforce Planning Grant	$150,000
NM Department of Health	State Personal Responsibility Education Program	$346,571
NM Department of Health	Emerging Infection Program: Enhancing Epi and Laboratory Capacity	$327,379
NM Department of Health	CDC Epidemiology Capacity/Emerging Infections Program Grant	$380,081
NM Department of Health	CDC Tobacco Quit Lines Grants	$60,340
NM Department of Health	Strengthening Public Health Infrastructure for Improved Health Outcomes	$199,877
NM Human Services Department	State Planning and Establishment Grants for Exchanges	$1,000,000

NM Human Services Department	Mental Healthcare Transformation Grant	$734,500
NM Human Services Department	Money Follows the Person Planning Grant	$200,000
Public Regulation Commission Division of Insurance	Health Insurance Premium Review (Cycle I)	$1,000,000
Public Regulation Commission Division of Insurance	Consumer Assistance Program Grants	$226,426
Aging and Long Term Services Department	Option A Medicare Improvement for Patients and Providers	$371,358
Aging and Long Term Services Department	Option B Options Counseling ADRC Options Counseling and Assistance Programs	$500,000
Children, Youth and Family Department	Maternal, Infant Early Childhood Home Visiting Program	$951,952
Public Education Department	FY1020 Support for Pregnant and Parenting Teens and Women	$1,300,000
As of December 8, 2010	Total PPACA for State Agencies	**$7,748,484**

Grant Tracking and Information Entry

Grant tracking is completed by the Department of Health's (DOH) Division of Policy and Performance. This is accomplished using an Access database, designed by the Department, to assist with grant tracking and reporting. In addition, DOH utilizes several federal PPACA websites and also relies on information provided by other members of the Office of Health Care Reform Steering Group to keep this information current.

On a daily basis, DOH updates its database with grant opportunities as they are released on the grants.gov website. They use the advanced search option and enter "Affordable Care Act" in the key word search section. They also search by agency "Department of Health and Human Services". By using these two search fields, DOH is able to more accurately pinpoint PPACA grants and eliminate hundreds of other grants that do not pertain.

DOH also uses the HHS.gov website. Under the "News Tab", they are able to identify most of the new grant award announcements including information on grantees and amounts that are awarded. This option allows DOH to track PPACA funding that outside entities (non-profits, private individuals or companies) have applied for or received.

Another website that is particularly helpful for grant tracking is the Federal Funds Information for States websites and list serves (ffis.org). This site emails information, almost on a daily basis, on PPACA and other grant opportunities that maybe of interest to state entities. Not only are grant announcements sent but other important information such as grant reporting and upcoming deadlines that one may miss on the federal websites.

Many members of the Steering Group also subscribe to federal agencies, as well as sub-agency's list serves. These list serves contain valuable information such as advanced notification of grant RFP's releases. When new information is identified, team members forward it to DOH to include in the grant tracking database.

Once a new grant is found the information is sent to the New Mexico Office of Health Care Reform. They then send the information out to their list serves throughout the state. The grant information is also sent to the Grant Tracking Team, who often knows of a particular state agency, non-profit, or individual that may be interested. The grant information is added to the master tracking sheet and entered into the database in order to make grant tracking reports easier to generate. This spreadsheet is updated on a daily basis and is released to the public on a weekly basis under the Human Services Department's Health Care Reform website.

Recommendations for Grant Tracking

Due to the complexity of the PPACA and grant funding mechanism associated with this Act, it is imperative to keep accurate records of the grants New Mexico agencies are applying for and receiving. Currently, state agencies that apply for PPACA funding, whether it is a competitive or formula grants, voluntarily report if they have applied for or received a grant. This makes it difficult to ensure that all grants and funding that is awarded is tracked appropriately. Utilizing an entity such as the Office of Health Care Reform, as a central entity for housing and reporting data on all PPACA grants, would help ensure accuracy of grant tracking and federal reporting for all state agencies.

See Appendix J for PPACA grant spreadsheets.

V. Native American Provisions

American Indians and Alaska Natives are celebrating passage of the historic health reform law, the Patient Protection and Affordable Care Act (PPACA), P.L.111-148. This law will improve the quality of health care and make it more accessible and affordable for all Americans, including American Indians/Alaska Natives. The Affordable Care Act also includes the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), which extends current law and authorizes new programs and services within the Indian Health Service. It is with great enthusiasm and anticipation that the New Mexico Office of Health Care Reform (OHCR) embarks on the health reform journey in partnership with the 22 Tribes, Nations, and Pueblos of New Mexico.

American Indian / Alaska Native Health Disparities

Health care delivery and access have been a focus of the New Mexico State Tribal Consultations due to several factors prevalent among American Indians/Alaska Natives (AI/AN), including but not limited to, lack of resources, geographic isolation, and health disparities. Compared with other Americans, AI/AN experience an overall lower health status and rank at, or near the bottom of other social, educational and economic indicators. AI/AN have a life expectancy that is four years less than the overall U.S. population and they have higher mortality rates involving diabetes, alcoholism, cervical cancer, suicide, heart disease, and tuberculosis. They also experience higher rates of behavioral health issues, including substance abuse, Compared to the general New Mexico population, AI/AN have higher rates of deaths relating to alcohol, deaths due to diabetes, homicide, motor vehicle deaths, pneumonia and influenza deaths, youth obesity, late or no prenatal care, and youth suicide. The state of New Mexico will strive to ensure with Tribes the accountability of resources, including a fair and equitable allocation of resources to address these health disparities.

Intergovernmental Coordination and Collaboration

New Mexico is the only state which has a Cabinet level Indian Affairs Department and is often hailed as a national model for state-tribal relations. New Mexico also enacted SB 196, the State-Tribal Collaboration Act, in 2009 that codified an effective and comprehensive structure to ensure positive government-to-government relations, effective collaboration and communication between tribal governments and state agencies and cultural competency in the provision of state services to Native Americans. Consultation and collaboration efforts have been most effective and meaningful when conducted before taking action that impacts Tribes and AI/AN. Most recently this has been particularly evident in State Tribal Consultations (STC) on Medicaid and health care reform.

The Human Services Department (HSD) has collaborated and worked closely with the Indian Affairs Department (IAD) to promote effective consultation, communication and collaboration between the Departments and the 22 Tribes, Nations, and Pueblos in New Mexico. These efforts have resulted in a positive government-to-government relationship built on mutually respectful relationships between the Secretaries of HSD, IAD and Tribal leadership. It is recommended that the Office of Health Care Reform (OHCR) continue to build on this relationship through conducting tribal consultations regarding health

care reform initiatives and policies that will impact AI/AN, and to create within the OHCR a Native American Ombudsman position in 2011 to address all Native American issues and Indian specific provisions of the PPACA.

- **Native American Ombudsman**: Recommend that a Native American Ombudsman position, located in the OHCR, be created in 2011 to address all Native American issues and Indian provisions of the PPACA, as well as provide education and outreach to tribal governments regarding the State's (Office of HCR) efforts to implement HCR.
- **State Tribal Consultation**: Conduct tribal consultation regarding health care reform initiatives and policies that will impact American Indians in order to ensure the adherence to federal requirements mandated and regulated by the U.S. Health and Human Services Department (HHS) and to honor our compliance with and commitment to the State – Tribal Collaboration Act SB 196.
- **Indian Affairs Department:** Ensure that the NM Indian Affairs Department continues to work closely with the Governor's Office, HSD, Office of Health Care Reform or other department tasked with implementing PPACA.
- **Native American HCR Steering Workgroup:** The Workgroup is responsible for advising and providing information to the Health Care Reform Leadership Team and the Office of Health Care Reform regarding the implementation of the Patient Protection and Affordable Care Act (PPACA).
- **Health Care Exchange & Separate Exchanges:** Create a mechanism to ensure that a state, non-profit or quasi state entity is required to adhere to the consultation provisions of the State-Tribal Collaboration Act.
- **HCR Outreach:** Communicate and coordinate with Indian Health Service/Tribes/Urban (I/T/U) on Native Americans' issues analysis, education, and data collection.
- **Express Lanes:** Work closely with Medicaid and the MAD NA Liaison to assure information, coordination and support is provided to the I/T/U Express Lane agencies.
- **Grant Opportunities**: Assure PPACA/IHCIA grant opportunities are communicated to I/T/U's and provide technical assistance when appropriate.
- **IT System**: Recommend that the scope of work for the IT firm that is contracted under the Work Plan include several specific tasks necessary to ensure the state adheres to the Indian provisions of the PPACA.

See recommendations defined in the Native American PPACA matrix (Appendix K)

As a result of the many provisions in the Patient Protection and Affordable Care Act and the reauthorization of the Indian Health Care Improvement Act, implementation will be a complex undertaking. Not all provisions can be implemented at once and some provisions will require additional work to implement. In the weeks and months ahead, national and statewide outreach efforts will provide

more education and information about the new law, plans for its implementation, and how it will impact Indian Country. In addition, Tribes will also be consulted on the implementation of PPACA.

In compliance and commitment to the New Mexico State-Tribal Collaboration Act (STCA), the Human Services Department and Indian Affairs Department have worked tirelessly to assure that the government-to-government relationship is nurtured and refined. With the establishment of the STCA in state statute, the intergovernmental relationship and the commitment between the state and Tribes to collaborate and communicate on issues of mutual concern has been strengthened. The continued support and involvement with the STCA and Tribal Workgroups are critical to the advancement of improved health care for Native Americans and the development of health care reform in the state of New Mexico.

Appendix L: ***IAD Presentation for Tribal Consultation – Indian Provisions of PPACA***

VI. Legislation

The Health Care Leadership Team believes that legislation should be introduced in the 2011 legislative session in two areas: (1) creation of Health Insurance Exchange and (2) modifications to the state insurance code

(1) Health Insurance Exchange.

The Patient Protection and Affordable Care Act ("PPACA") requires health insurance exchanges to be operational in each state by January 1, 2014. Authority is given to the states to operate their own exchanges. If a state fails to do so or chooses not to, the federal government will run an exchange in the state. States that elect to run their own exchange must demonstrate that is operational by January, 2013.

Under PPACA, an exchange is expected to supervise insurance-plan marketing and competition in the small-group and non-group markets; oversee the standardization of plan benefits and cost-sharing; bear some responsibility for restraining premium increases; and administer the distribution of tax credits for lower and middle income people who lack access to employer-sponsored coverage and who earn too much to be eligible for Medicaid.

Mandatory Provisions

If the state decides to establish its own exchange, there are certain federally mandated functions of the exchange that should be codified in statute. These functions include:

- Certify whether a health care plan meets the eligibility requirements to participate in the Exchange, based on criteria developed by U.S. Health and Human Services.
- Make eligibility determinations and provide assistance for participation in the Exchange, in catastrophic plans, to obtain premium tax credits and cost-sharing reductions, and to enroll in public programs such as Medicaid or CHIP.
- Gather income and tax information to make affordability determinations.

- Access or keep a database of employers and employees, which is needed to determine which employees drop coverage and to be able to communicate to employers when such an event occurs.
- Charge insurers user fees, or to otherwise generate money, to be a self-funded Exchange by January 1, 2015.
- Publish licensing and regulatory fees.
- Approve and deny premium increases.
- Collect and publish coverage transparency data.
- Provide enrollment periods as specified under PPACA.
- Monitor and enforce quality improvements required by the PPACA.
- Establish a navigator program, award grants from Exchange funds (cannot be derived from federal funds) to entities to carry out certain functions, and monitor and enforce the grants to ensure compliance with grant requirements.
- Collect and maintain adequate records regarding financial, enrollment and other data necessary for federal and state auditing and reporting requirements.

Further, PPACA has certain provisions specific to the Native American population in relation to the Exchange. These should also be codified in statute:

- For Native Americans with a household income of less than 300%:
  - No cost sharing, including premiums, deductibles and co-payments;
  - Must be enrolled in a "qualified health plan" through an Exchange;
  - "Native Americans" means members of a federally recognized tribe, pursuant to the Indian Health Care Improvement Act(IHCIA) and the section 4(d) of the Indian Self-Determination and Education Assistance Act (ISDEAA) definitions;
- For items or services under Indian Health Care Providers, under the Exchange, ALL Native Americans under 1402(d)(2) have eliminated cost sharing if the services or items are furnished directly by the I.H.S., a tribe, tribal organization, urban Indian organization, or through contract health services;
- Special monthly enrollment periods for Native Americans;
- Indian premium tax credits, reduced cost sharing, exemption from personal responsibility penalties should such penalties be imposed in state law; and

- A tribe or group of tribes have a wide range of options regarding Exchange participation. Individual tribal members have the flexibility to participate in any Exchange, which includes any state Exchange, a federal Exchange or other tribally operated plans. The tribes can create an independent Exchange or participate in other regional exchanges. Native American tribal members also have the option of enrolling in the federal employee health benefits program.

Decision Areas

Beyond the mandatory provisions, PPACA leaves discretion to the states on major aspects of the exchange. A decision should be made on the following questions and codified into stature accordingly:

i. What entity should operate the exchange?
   -Non-profit, state agency or quasi-governmental

ii. If quasi-governmental or non-profit, how is the exchanged governed?
   -Governing board and members thereof?
   -Staffing

iii. Should the small group and non-group exchanges be combined?
   -PPACA calls for an exchange for individual health insurance purchase and an exchange for small group purchase but gives the states the option to combine the two.

iv. What is the market role of the exchange?
   -Clearinghouse or active purchaser?

v. Should New Mexico Participate in a regional exchange with other states?

(2) Insurance code modifications

PPACA has various insurance reform measures that have gone into effect in 2010 or will go into effect in 2011. To bring state law in line with the federal mandates, legislation and/or regulation that does the following in needed:

- Prohibits annual and lifetime limits.
- Requires coverage of certain preventive services
- Extends adult dependent coverage through age 26 (current law is 25)
- Prohibits exclusions for preexisting conditions for children under 19
- Requires the provisions of certain information for insurers
- Enacts non-discrimination provisions regarding income and providers
- Change the medical loss ratio standards
- Adds minimum plan requirements to Patient Protection Act
- Creates health insurance consumer office and ombudsman
- Mandates premium rate disclosure and transparency
- Eliminates cost sharing for Indians under 300% FPL

VII. Public and Stakeholder Involvement

The Office of Health Care Reform and the Leadership Team have been dedicated to effectively communicate with its customers, advocates, legislators, federal partners, health care providers, small and large employers and other stakeholders as health reform progresses in an effort to educate and conduct outreach. These entities believe it is critical to ensure meaningful involvement of stakeholders in the implementation of the PPACA provisions.

All Leadership Team meetings provide opportunity for public input. In addition, seven stakeholder working groups have been established to provide input and recommendations to the OHCR and the Leadership Team. These groups are: Consumer; Insurer; Provider; Employer; Native American; Information Technology; and, Medicaid. These groups have met during the week of December 13th to establish a purpose statement; goals; and leadership team. Please see following pages for a list of working group members. See Appendix P for minutes of the stakeholder group's most recent meetings (the Tribal-State workgroup minutes are not included as they met after this plan was submitted).

In addition, utilizing the Exchange Planning Grant funds, the Office of Health Care Reform is in the process of establishing contracts (see below) with local contractors to provide professional services to design data gathering methods and facilitate, collect, analyze and report public input from various special population groups to inform the State's planners in the development of a health insurance Exchange.

Recommendations:

- Maintain involvement of, and coordination with: New Mexico's Congressional delegation; providers; insurers; health plans; consumers; advocacy groups; tribes, tribal organizations, and urban Indians; and other members of the public.
- Keep stakeholders informed and involved- continue the following Health Care Leadership Team Stakeholder/Working Groups: providers, Medicaid, insurance, consumer, health information technology, employers, and Native American. The purpose of these groups is to provide ongoing recommendations to both the Office of Health Care Reform and the Health Care Leadership Team.
- Establish a New Mexico Office of Health Care Reform website that will serve as the "go to" place for accurate information about the PPACA and contains, at a minimum, consumer information;

grant opportunities; funding applications and reports; Leadership Team and public meeting schedules and minutes; legislation; agency progress with implementation; key decisions that have been made; policy considerations and recommendations; and a timeline.

- Develop a comprehensive and cost-effective consumer protection and education plan that (1) promotes widespread consumer education as components of the PPACA are rolled out, (2) creates an independent consumer protection system with procedures and resources available for every county and tribal community, and (3) obtains funding through the PPACA to coordinate and advance consumer protection and education throughout New Mexico.