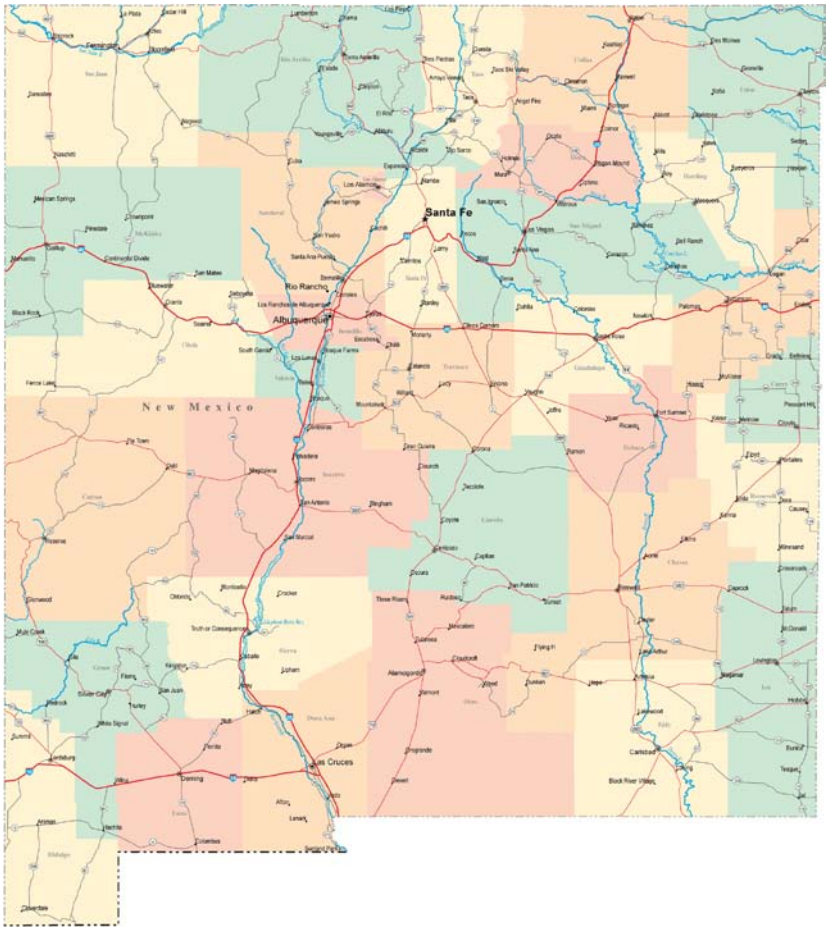
Implementing Federal Health Care Reform –

A Roadmap for New Mexico



STRATEGIC PLAN

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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, 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.

The Leadership Team, consisting of Secretaries from eight state agencies, New Mexico's Superintendent of Insurance, the CEO of the Behavioral Health Collaborative and a representative from the Office of the Governor, met three times in May and June 2010. Public input was received in all meetings and contributed to the recommendations in this report. In addition, all of the Leadership Team agencies completed an agency-specific matrix (see Appendices 3-12) describing issues they must address associated with implementation of PPACA. This strategic plan also includes a "Master Matrix" outlining the major PPACA provisions the state must address over the next four years of PPACA's implementation (see Appendix 1).

a. 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:

- **Expanding Medicaid Eligibility to 133 percent of the federal poverty level (FPL)**: Beginning in 2014, states will be required to make Medicaid available to all

people earning up to 133 percent FPL[1]. 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.

- **State-Based Health Insurance Exchanges**: 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.

- **Employer Mandates and Penalties**: Beginning in 2014, 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.

- **Individual Mandate**: 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.

[1] 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.

In addition to these elements, New Mexico must also focus on controlling costs to ensure affordability for businesses, enrollees and sustainability for all; enhancing quality to improve outcomes in public health, acute and long-term care; and maintaining access to coverage by supporting and increasing our state's health care workforce. As the state goes forth with initiating the implementation of federal health care reform, there are various Indian provisions outlined in the PPACA that must be noted and implemented in the state's plan in consultation with the Tribes.

b. Recommendations

The Leadership Team arrived at consensus regarding the following recommendations:

1. 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 rollout over the next several years as reforms are scheduled for implementation. As such, the Leadership Team recommends that the Leadership Team continue in its mission to oversee the planning, development and implementation of health care reform in New Mexico. The strategic plan outlined in this document will be updated as the federal government provides more guidance and direction on the provisions in PPACA. The Leadership Team will assure coordination across state agencies, report directly to the Office of the Governor, and be accountable for recommendations made to the Executive.

2. Expand 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. Additionally, it was recommended the Attorney General's Office be included in the membership of the Health Care Reform Leadership Team.

3. Create a New Mexico Office of Health Care Reform utilizing existing staff resources to plan, coordinate, and administer implementation of federal health care reform while reporting to the Health Care Reform Leadership Team. The Office of Health Care Reform would be based on the NM Office of Recovery and Reinvestment (NM ORR) model and assume many of the same responsibilities as

NM ORR does in the coordination of the America Recovery and Reinvestment Act (ARRA) stimulus funds. The role and responsibilities of the NM Office of Health Care Reform would include the following: (1) coordinate efforts across state agencies and various entities to ensure that the state applies for and obtains every dollar possible through the PPACA to benefit New Mexico; (2) assure that programmatic, demographic, and financial data analysis and reporting necessary to inform decision-making is coordinated across state agencies; (3) analyze and research future regulations and guidance from the federal government to inform policy-makers and assure accurate and complete compliance with the law; (4) assure coordinated efforts in the development of information technology systems and the exchange of data as required by PPACA; and (5) develop and oversee a coordinated plan to address consumer education and protection. The Office of Health Care Reform would be staffed by existing personnel from the state agencies represented on the Leadership Team.

4. Assure that the New Mexico Legislature is provided with information and updates on the recommendations and decisions of the Health Care Reform Leadership Team and the New Mexico Office of Health Care Reform including formal mechanisms for participation in meetings and/or joint meetings.

5. New Mexico should establish its own Health Insurance Exchange rather than using a federally operated Exchange. Recommendations to the Leadership Team were that New Mexico should develop an Exchange that assumes 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. While some states have developed Exchanges that merely serve as a market organization and distribution center for health care plans, it is recommended that New Mexico develop a strong Exchange that promotes competition between plans based on quality and price in a way that is transparent to consumers.

6. 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.

7. 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.

8. Continue to expand Health Information Technology and the establishment of Electronic Medical Records to meet the requirements of PPACA, reduce administrative costs, and improve health outcomes.

9. 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).

10. Brief the Governor on any recommendations for policy decisions and any changes to state statutes necessary to be submitted in the 2011 or subsequent Legislative Sessions.

11. 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.

c. Conclusions

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—due to the many tasks they must complete, and due to the extremely constrained financial and staff resources available to them.

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.[2] These ten areas are:

1. Be strategic with the health insurance Exchange.

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

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. Continued planning, implementation and oversight will be necessary to assure ongoing comprehensive implementation of health care reform over the next several years. This strategic plan represents the initial development of a roadmap that New Mexico will need to establish and modify as national health care reform is phased in over the coming years.

STRATEGIC PLAN

II. Introduction

In April 2010, Governor Richardson issued Executive Order 2010-012 establishing the New Mexico Health Care Reform Leadership Team to prepare for the implementation of health care reform passed by Congress and signed by the President. The Executive Order called for the Leadership Team to develop a strategic plan, coordinate across state agencies, and present recommendations to the Governor by July 1, 2010.

The strategic plan is to focus on the following:

- How state government will implement the new legislation including proposals for statutory and regulatory changes;
- An analysis of how federal legislation will impact the state budget;
- Identification of available funding sources;
- An analysis of available data necessary to prepare for implementation;
- An analysis of existing state agency capacities;
- A timeline for implementation that allows phase-in of reform and implementation of new systems; and
- A communications plan for stakeholders, the public and state agencies.

The Leadership Team consists of leaders of several state agencies, all of which play an important role in implementing national health care reform, with the Human Services Department Secretary appointed as the Chair of the Leadership Team. Other members include the Secretaries of the Departments of Health; Workforce Solutions; Taxation and Revenue; Information Technology; Children, Youth and Families; Aging and Long-Term Services; Indian Affairs; the Superintendent of the Division of Insurance, Public Regulation Commission; CEO of the Behavioral Health Collaborative; and a representative from the Governor's Office.

III. Background

In March 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Affordability

Reconciliation Act of 2010, legislation that makes major changes to the nation's health care system. National health care reform aspires to universal coverage, improved health care quality, strengthened public health and prevention, and cost containment by promoting shared responsibility among individuals, government, employers, health care providers, and insurers. Key elements include:

- An individual insurance mandate that requires individuals and families to purchase insurance if it is affordable for them;
- Expansion of the Medicaid program to all citizens and qualifying immigrants earning up to 133 percent of the federal poverty level (FPL) and federal tax credits to provide insurance subsidies for low- and middle-income earners up to 400 percent FPL;
- Requirements that larger employers provide coverage or pay an assessment;
- Incentives for small businesses to provide coverage to their employees;
- Cuts in the growth of Medicare payments to providers and new incentives to promote health care quality, care-coordination, and preventive 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 health care settings and the primary health care workforce;
- 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.

While the federal government, through the PPACA, retains control of the implementation of many of the public health and quality initiatives included in the law, national reform relies on states to carry out and monitor many of the major changes, particularly regarding the Medicaid expansion; new insurance market rules; promotion of quality, service delivery and payment reforms; and creating state-level insurance markets called Exchanges.

a. New Mexico's Role in Implementing Federal Health Care

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; determine responses to numerous grant and demonstration project opportunities; 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; and control growth in current and future costs.

b. Federal Health Care Reforms—What They Do Not Do

Federal health care reform does not directly change individual health behaviors nor directly confront some of the cost drivers in health care such as unhealthy eating habits and lack of physical activity. Federal reforms focus primarily on the responsibilities of the payers and providers, and less so on that of individuals.

IV. Administrative Activities

The federal government will provide significant support for states to implement health care reform, but state action and new expenditures will be required in some key areas. Additionally, there are many funding opportunities and tax credits available to New Mexico through the Patient Protection and Affordable Care Act (PPACA). These opportunities are available to state and other governmental entities; Indian tribes, tribal organizations, and urban Indian organizations; nonprofits; hospitals; medical practices; community health care centers; school-based health centers; businesses; medical providers; and in some cases, individuals. New Mexico should put a system in place that will assure that New Mexico takes full advantage of these opportunities.

a. Structure and Process

Implementing the health reform law will require significant attention and continued support of the Executive over the next several years. As the federal government begins to release draft regulations and shape the features included in the PPACA, new policy issues undoubtedly will arise. New Mexico has an initial structure in place within the Executive Branch through its Health Care Reform Leadership Team. The Leadership Team should continue with its purpose of overseeing the planning, development and

implementation of health care reform in New Mexico. As the federal government provides more guidance and direction on the provisions in PPACA, New Mexico's strategic plan will need to be updated and modified. The continuation of the role of the Leadership Team will assure the coordination across state agencies and comprehensive recommendations for implementation of the PPACA in New Mexico. The Leadership team should be expanded to include others in the Executive Branch that are impacted by the provisions of national health care reform. These agencies include the Higher Education Department; Public Education Department; Department of Finance and Administration; General Services Department, Risk Management Division; Worker's Compensation Administration and Office of the Governor's Council on Women's Health.

The Leadership Team should be augmented by the creation of an Office of Health Care Reform to direct implementation of health reform in an efficient, cost-effective and transparent manner. It is recommendation that this Office be established using the model of Governor Richardson's NM Office of Recovery and Reinvestment, which was created to promote the use of funding opportunities under the America Recovery and Reinvestment Act (ARRA). This model led to New Mexico being noted as one of the states cited as taking best advantage of the funds available through ARRA. As with ARRA, PPACA makes a multitude of funding opportunities available to the State. It is important New Mexico obtains every possible dollar available to the State through this legislation over the next four years. The NM Office of Health Care Reform would be responsible for staying current on funding opportunities in PPACA and assuring that state agencies, community partners and other entities apply and obtain these funds. In addition, the Office would support the Leadership Team through analysis of future federal regulations issued on the PPACA to update the strategic plan; assure that programmatic, demographic, and financial data analysis and reporting necessary to inform decision-making is coordinated across state agencies; analyze and research future regulations and guidance from the federal government to inform policy-makers and assure accurate and complete compliance with the law; assure coordinated efforts in the development of information technology systems and the exchange of data as required by PPACA; and develop and oversee a coordinated plan to address consumer education and protection. The Office of Health Care Reform would be staffed by existing personnel from the state agencies represented on the state Leadership Team.

New Mexico will need to consider a number of policy options throughout the implementation of the PPACA. Core areas where significant decision-making will need to occur in the short-term are: 1) Exchange governance and infrastructure, 2) Funding, 3) Insurance reforms, 4) Expansion of publicly funded coverage, and 5) Payment and system reform and related funding opportunities. As implementation activities begin it is possible that other planning questions will rise to the level of a major policy option.

b. Statutory and Regulatory Changes, Resource Allocation, Budgeting and Personnel Management

The state faces numerous other choices about whether to take action on specific policy matters throughout the implementation process during the coming years. These opportunities range from promoting workforce development, and wellness, public health and prevention programs to beginning the process of reforming the payment system and implementing innovative care delivery models. While New Mexico has a responsibility to take some actions due to new federal requirements, the state also has a unique opportunity to pursue its own path for reform given the flexibility provided under the PPACA.

Policymakers in New Mexico will face the following major policy questions in 2010 and beyond:

1. Will New Mexico establish a state health insurance Exchange that meets the federal requirements while serving the needs of the individuals, families, and businesses that use this marketplace or allow the federal government to do so? If New Mexico elects to run an Exchange, how will it do so?
2. Will New Mexico enforce the insurance market reforms, or allow federal regulators to assume these responsibilities? What legislation would be needed in New Mexico for the state to enforce insurance market reforms?
3. What strategic opportunities can the New Mexico Medicaid program take advantage of under the PPACA? How will the eligibility expansions, payment rules and benefit requirements impact the current program?
4. How will New Mexico coordinate its system for public program eligibility determinations with the Exchange given the new federal requirements?
5. What criteria and priorities will guide New Mexico's pursuit of grants, demonstration projects, and payment reform pilot programs offered through the PPACA?
6. What agency is coordinating what set of activities, and who is making the final decisions?
7. Do we need statutory changes in New Mexico? What changes need to be made to regulations and contracts?

This strategic plan will serve as an early roadmap which will need to be reexamined and updated as federal regulations implementing the PPACA are promulgated; it will also serve as a key document in the implementation of health reform in New Mexico, with

identified state agencies developing their own health reform work plans to direct specific activities identified here that fall within their responsibilities (*see Appendices 3-12*).

i. Decision Points—Administrative Activities

DATE	ACTION
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
By 11/10 & Ongoing	Determine state statutes requiring amendment/enactment
By 12/10 & Ongoing	Conduct fiscal analysis of PPACA in New Mexico
By 12/10 & Ongoing	Hold tribal consultation as needed to determine if legislation is required to reduce cost-sharing for individuals enrolling in qualified 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

V. New Mexico and the Financing of Health Care Reform

A central feature of the PPACA is the additional federal funding that will be available to support expansions in Medicaid coverage and to subsidize the purchase of private insurance for low and moderate-income people not eligible for public coverage.

a. Federal Financing of Reform

The federal health reform law dedicates more than $900 billion over 10 years to expand insurance coverage, implement new insurance rules and Exchanges, and support delivery system change. These costs are offset by savings in the Medicare and Medicaid programs and by new taxes on individuals and businesses. The Congressional Budget Office estimates that national health care reform will reduce the federal deficit by $124

billion over 10 years. New federal spending for Medicaid and CHIP, in the form of an increase in the rate at which the federal government matches state spending, and for insurance subsidies to help low- and moderate-income people afford coverage, will directly affect New Mexico's state spending on health coverage for its residents. Federal insurance subsidies for small businesses will also be available to urge small employers to offer coverage.

b. Revenue Provisions

Funding for federal health care reform comes in part from several new taxes and assessments on businesses and individuals, and in part from spending reductions in Medicare, largely by eliminating subsidies provided to insurance companies that run Medicare Advantage plans.

Medicare savings come from reductions in the growth in Medicare provider rates and the introduction of a productivity adjustment, which will provide an advantage to some providers and a disadvantage to others. The law restructures the Medicare Advantage program and reduces Disproportionate Share Hospital (DSH) payments under the Medicare and Medicaid programs. The law also increases the rebate that drug manufacturers pay to state Medicaid programs, with the incremental proceeds going to the federal government and reduced rebate revenues for states.

New Mexico is one of a few states that will benefit from the pharmacy rebate provision in the PPACA. Currently, the New Mexico Medicaid program does not collect pharmacy rebates from the drug manufacturers for managed care members. Under the PPACA, the Medicaid program will begin to collect rebates for managed care members. Part of these rebates will go to the federal government to help fund the programs and expansions contained in the PPACA; however, the remaining rebate dollars will stay in the State of New Mexico.

Revenue will also be generated through new taxes and fees on high-income earners and on certain health sector businesses such as pharmaceutical and medical device companies. The law levies taxes on health insurers, including an excise tax on high cost health plans that will phase in beginning in 2018. Individuals who earn more than $200,000 per year and couples who earn more than $250,000 will face a 0.9 percent increase in the Medicare payroll tax on income over that threshold and will owe a 3.8 percent tax on unearned income such as rents, investments, and dividends.

c. New Mexico Financing

The State Coverage Insurance (SCI) program provides subsidized health insurance premiums on a sliding scale for individuals and families with incomes up to 200 percent of the Federal Poverty Level (FPL). The SCI subsidies are funded by federal and state dollars.

Beginning in 2014, federal tax credits will subsidize the purchase of health insurance through the Exchange for individuals and families with incomes between 133 percent and 400 percent FPL. The credits are structured so that people at the low end of this range would be responsible for paying two percent of their income toward a premium; at the upper end, 9.5 percent. There are subsidies available to help people up to 250 percent FPL to pay their deductibles and copayments. For tribal populations, the PPACA prohibits cost sharing for Indians below 300 percent FPL enrolled through the Exchange in a qualified health plan in the individual market. Most people with incomes less than 133 percent FPL will be eligible for Medicaid, with enhanced federal funding.

The PPACA permits states to develop a Basic Health Plan for individuals with incomes between 133[3]-200 percent of the FPL instead of providing such individuals with federal subsidies to purchase health insurance. However, these individuals and all those below 400 percent FPL would be eligible for federal subsidies in the Exchange and creating a Basic Health Plan would establish another program that would need to be appropriately managed. New Mexico should consider whether it is interested in establishing a Basic Health Plan and what would be entailed to meet federal requirements. A notable feature is that the PPACA restricts the federal funds available for a Basic Health Plan to 85 percent of the premium and cost sharing subsidies that enrollees would have received if they were enrolled in a health plan through the Exchange. Under the PPACA, the Basic Health Plan would become effective in January 2014 at the same time as the Exchange.

Some current Medicaid and SCI enrollees will be eligible for the new federal tax credits. It may also be possible for New Mexico to shift some members with incomes between 133 percent and 200 percent FPL who are currently enrolled in Medicaid and SCI into a Basic Health Plan (if created in New Mexico) in the Exchange to leverage more federal dollars or simply to transition them to coverage in the Exchange. However, the impact on individuals currently covered through SCI would have to be evaluated as this could result in a significant change in their covered benefits. Additionally, the fiscal impact to the state would have to be evaluated and further analysis of PPACA Maintenance of Effort (MOE) provisions would have to be undertaken to determine the state's options.

[3] 133% FPL - $14,404 for an individual and $29,327 for a family of four (2009)

i. Supplementing the Federal Subsidy to Improve Benefits and Maximize Coverage

The federal premium tax credit is tied to the value of a specific benefit plan which has not yet been defined. While the federal plan must include preventive care and pediatric services, it is possible that the federally-specified benefits will not be as extensive as the benefits available in New Mexico today. To the extent that New Mexico currently has insurance mandates that are not included in the federal plan, or desires a richer benefit package for individuals and families purchasing coverage through the Exchange, some of the assessment might go toward supplementing the federal subsidy so that enrollees would not pay a larger share of their income than the federal law requires.

Some New Mexicans will be exempted from the requirement to have insurance because available options are too expensive given their family income levels. Assessment funds could be used for a state subsidy to help those who do not qualify for the federal tax credit to afford coverage. Additionally, American Indians are exempt from the shared responsibility payment or penalty for failure to comply with the requirement to maintain minimum health insurance coverage. The U.S. Health and Human Services Department (HHS) secretary will determine the required information in order for tribal members to qualify for such an exemption.

1. Decision Points – New Mexico and Financing of Health Care Reform

DATE	ACTION
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
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
1/11 & Ongoing	Enact legislation as needed to update Medicaid, SCI and other Insure NM! programs
2011 & Ongoing; Enact 1/14	Decision on whether to develop a Basic Health Plan and enactment of the Plan

VI. Expansion of Publicly Funded Benefits

The PPACA provides for the expansion of public programs through a combination of expanded Medicaid eligibility, enhanced federal match for Medicaid and CHIP, and the development of a subsidy program for the purchase of private insurance through an Exchange for individuals with incomes up to 400 percent of the federal poverty level (FPL).[4]

Specifically, the PPACA expands eligibility for Medicaid to all individuals under the age of 65 to 133 percent of the FPL beginning in 2014.[5] The cost of services for the expansion, or "newly eligible" population, will be fully federally funded in calendar years 2014-2016. Beginning in 2017, states will begin to pay a share of the new mandatory Medicaid expansion as follows: 95 percent FMAP in 2017; 94 percent FMAP in 2018; 93 percent FMAP in 2019; and 90 percent FMAP in 2020 and beyond.

It should be noted that states have received only preliminary guidance from the federal government regarding the definition of "newly eligible" individuals and final guidance on the matter has not been issued. The PPACA states that adults below 133 percent FPL will be considered "newly eligible" if on the date of December 1, 2009 they were (1) not eligible for full benefits under the state plan or waiver programs; (2) not eligible for benchmark coverage or benchmark-equivalent coverage; or (3) eligible but not enrolled (or were on a waiting list) for such benefits or coverage through a waiver under the plan that had capped or limited enrollment that was full. The Human Services Department (HSD) believes that it can successfully argue that included in the newly eligible population should be individuals who are SCI enrollees and those on the SCI waiting list under 133 percent FPL (because the SCI program does not meet the standards for full, benchmark or benchmark equivalent coverage), family planning wavier enrollees under 133 percent FPL, and other New Mexicans under 133 percent FPL.

New Mexico will also receive significant enhanced funding for children covered in the state's CHIP program up to 200 percent FPL, if it elects to keep them in the CHIP program from 2014-2019. These increases only take effect if the state maintains current eligibility levels for the Medicaid and CHIP program.

[4] The 2009 federal poverty level for an individual is $10,830 and $18,312 for a family of three.
[5] Medicaid covers children to 235% FPL through a combination of Medicaid and CHIP; parents to 200% FPL; and pregnant women to 185% FPL.

The PPACA also creates a new mandatory categorical eligibility for former foster care children, regardless of income, until the age of 26. This section is effective on January 1, 2014. While many states end eligibility for foster children at age 19, New Mexico has already expanded eligibility for foster care children up to the age of 21 but the PPACA will allow us to extend coverage even further.

While the expansions do not become mandatory until 2014, it is essential to immediately conduct analysis of the increases and decreases in federal revenue through the federal law and the long term impact on required state-funding for these expanded benefits. Once the analysis is complete, New Mexico has a number of options to consider. Examples of options include:

- Whether to allow childless adults into Medicaid prior to 2014 (at regular match);
- How to identify former foster children for enrollment in Medicaid if they are under age 26 but have already aged out of the foster care system;
- Determine what benefit package to offer the "newly eligible" population of adults up to 133 percent FPL.

i. Decision Points – Expansion of Publicly Funded Benefits

DATE	ACTION
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
By 71/13	Determine how New Mexico will identify former foster children to enroll in the Medicaid program and the associated costs of expansion
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.
Between 7/1/10 & 7/1/13	Determine the benefit package for the "newly eligible" population of adults up to 133% FPL.

VII. Insurance Reform

Although federal reforms include many of the 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 are allowed to come into a state and take over regulation to ensure compliance with national standards.

A key decision for New Mexico's policymakers will be whether to modify the state's laws to ensure that New Mexico's statutes meet the minimum standards set out in federal law. Generally, state insurance regulators can only enforce state insurance laws, not federal laws. Absent modifications to state insurance law, federal enforcement would be necessary.

In addition, PPACA recognizes that insurance markets vary and that states have chosen a variety of ways to protect consumers. PPACA preserves the right of states to continue to protect its consumers. Because federal law sets a minimum standard, states have flexibility to enact other laws and additional consumer protections.

Some key policy decisions that New Mexico will need to make immediately and before 2014 regarding the insurance market include:

- Whether to expand New Mexico's definition of the small group market from 50 employees to include businesses with up to 100 employees;
- Whether to merge the small group and individual markets;
- How to participate in the development of national standards, directly and through the National Association of Insurance Commissioners (NAIC);
- Whether to take an active role in enforcing the insurance market reforms, or allow federal regulators to assume these responsibilities;
- What revisions to make to New Mexico's insurance laws to meet the minimum federal requirements, including medical loss ratio standards, rate review, and a variety of other consumer protection standards;
- Whether to maintain or reduce the state's mandated insurance benefit requirements;
- Whether to participate in interstate insurance compacts, beginning in 2016, that would allow for the sale of insurance products across state lines.

a. Individual and Small Group Markets

A consideration under PPACA is whether to merge the non-group and small group markets. Merged markets can be beneficial if the financial impact on small businesses can be mitigated. The extension of the small group market to firms with 100 employees or fewer (up from 50 or fewer), coupled with the individual mandate and substantial financial subsidies to individuals and employer incentives, may provide enough of a buffer against increased risk to merge the markets without causing an increase in small group premiums.

New Mexico will need to consider the advantages and disadvantages of merging these markets in a reformed environment. PPACA also increases the threshold for large employer status from 50 to 100, effective in 2014, but allows states to opt out during 2014 and 2015. New Mexico will have to decide whether to allow the expansion to take effect immediately in 2014 or postpone implementation until 2016.

b. Medical Loss Ratio

As New Mexico does today, the PPACA requires health insurance plans to report medical loss ratios (MLR). Under the PPACA there is a minimum MLR of 85 percent in the large group market and 80 percent in the individual and small group market. New Mexico does not now regulate large group rates, and there are some differences between New Mexico's current MLR requirements and the federal definitions. These inconsistencies will need to be examined and the state will likely need to amend its laws to comply with the minimum MLR allowable to be consistent with the federal law. Where New Mexico's requirements are stricter than those required by PPACA, such as New Mexico's requirement of 85 percent minimum MLR in the small group market and the state's related definition of "direct health care services", the state may elect to keep the stricter requirement or lower it to be consistent with the federal legislation.

In addition to considering the minimum MLR, New Mexico will also need to consider how its current definition of MLR compares to the final regulation to be issued by the federal Department of Health and Human Services (HHS). The language used in the PPACA, which is the subject of a request for comments by HHS, is different from the definitions used in New Mexico. This makes the comparison between current New Mexico requirements and the new federal requirements more complex. The state may need to modify its process for monitoring a health insurer's premium rebates depending on the language of the upcoming federal regulations.

c. Premium Rate Review

The PPACA establishes a process for reviewing the reasonableness of health insurance premiums. New Mexico has decided there are further actions that can be taken by the Public Regulation Commission, Division of Insurance to enhance its review of rates and as such, the state is applying for 2010 grant funds contained in PPACA to review proposed health insurance premium increases.

d. Consumer Protection and Rating Standards

The PPACA establishes new federal minimum standards in a number of areas, including but not limited to protections for consumers with health conditions, expansion of dependent coverage, transparency in health insurance documents and communications, appeal processes, and limits on variations in premium rates. New Mexico needs to evaluate its insurance laws and to make changes as appropriate. If states do not enforce the federal requirements, the federal HHS is given the authority to step in and enforce the requirements.

e. New Mexico State Mandates

The PPACA requires states to evaluate the cost of their state insurance mandates that are not included in the Essential Benefit Plan that will be determined through federal regulation. Any person receiving federal tax credits for insurance through the Exchange will not be credited for benefits above this basic benefit plan.

Once the regulations are promulgated for the Essential Benefit Plan, New Mexico will need to determine whether or not it wants to fund any additional mandates through a state-only revenue source. An in-depth data analysis and fiscal impact report will be required to guide the State's decision in this area.

f. Interstate Insurance Compacts

The PPACA allows states, on a voluntary basis, to form "health care choice compacts" that allow insurers to sell policies in any state participating in the compact. As a starting point, New Mexico will need to determine whether it is interested in forming or joining a compact, and, if so, which states would likely be partners. Choice of state partners is a

key decision as, under the federal law, an insurer is required to follow some but not all state insurance laws by each of the states participating in the compact. The insurer is only required to follow all the state insurance laws for the state in which the insurer is domiciled. Federal regulations for interstate compacts will not be issued until 2013; with compacts beginning operations in 2016**.**

i. Decision Points – Insurance Reform

DATE	ACTION
Ongoing	Work with NAIC and HHS on development of federal insurance standards
By 11/10 & Ongoing	Review Insurance Code provisions and PRC/Division of Insurance rules for consistency with federal requirements
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
7/7/10	Apply for grant funding to enhance health insurance premium rate review
12/31/11	Decision on whether to fund state insurance mandates in excess of federal mandates using state dollars
12/31/13	Decision on interest in forming an interstate insurance compact

VIII. Health Insurance Exchange

The goals of the Exchange include promoting competition; simplifying shopping for insurance; enforcing consumer protections; standardizing consumer information; and centralizing enrollment. New Mexico already conducts some of the functions envisioned in an Exchange within the Insure NM! Call Center, New Mexico Health Insurance Alliance, New Mexico Medical Insurance Pool, and the Public Regulation Commission's Division of Insurance.

a. Operating an Exchange

The PPACA provides states with an option to develop and manage their own Exchange or to default to the federal government to operate the Exchange. States accepting responsibility for the Exchange must establish an American Health Benefit Exchange to serve individuals who receive tax credits as well as others who are purchasing insurance on their own. The law also requires states to establish a Small Business Health Option Programs (SHOP) for employers with fewer than 100 employees. States can opt to operate both of these pooling entities under a single Exchange. Unless state policymakers choose to have the federal government regulate insurance in New Mexico, the Public Regulation Commission Division of Insurance would be responsible for reviewing and approving the policy terms and premium rates for the insurance products and regulating the market conduct and financial condition of the insurers offering coverage through the Exchange, as it does for other insurance products.

In considering whether to operate an Exchange or to default to the federal government, there are a number of issues to consider, including:

- Coordination with other health coverage programs
- Capacity
- Flexibility
- Efficiency
- Uniqueness of market characteristics

New Mexico should consider managing our own Exchange for several reasons. It would likely be less complex to coordinate benefits and eligibility across all state programs if the Exchange operates in-state. Additionally, although federal standards for the state-level Exchanges will be determined, it may be desirable to customize an Exchange to best meet the needs of a state's residents. Relinquishing this responsibility to the federal government would likely create more work for agencies required to coordinate with the Exchange and may not provide enough flexibility regarding implementation issues that arise.

The purpose of the Exchange can vary from a simple market organizer and plan distribution center to a strong Exchange that drives market reform and consumer choices. New Mexico should consider implementing our own Exchange or joining a regional Exchange, and using that Exchange to help control the cost of the health care system. This could be accomplished in several ways such as limiting plans on the Exchange to those that stay within specified premium growth levels or requiring other

cost containment activities of the plans in order to achieve competition within the plans based on quality and price. By having the Exchange serve as a structured marketplace, New Mexicans will be able to readily identify premium differences and chose the plan that best fits their health and financial situation.

b. Eligibility Systems

The PPACA requires streamlined eligibility across the Medicaid, CHIP and subsidy programs, providing a seamless point of entry common to Medicaid and subsidized insurance. The PPACA includes new eligibility definitions for Medicaid that would make it more straight-forward as to who is eligible and who is not eligible. New Mexico must change its application and enrollment procedures for Medicaid to comply with the new requirements and meet the public's need for convenient and simple access to health care coverage. Moreover, the Human Services Department (HSD) current IT eligibility system can not accommodate procedures and data exchange that supports the concept of "one door" to health care coverage. HSD has been seeking to replace their 25 year old IT eligibility system and must move quickly to do so in order to comply with the requirements of federal health care reform. HSD's IT eligibility system must be able to share functions and data with the Exchange, provide web-based applications, and include functionality in the system that supports individuals moving back and forth between the Exchange and the Medicaid program while ensuring no loss of health coverage for these individuals.

Constructing this integrated eligibility capacity is a complex and potentially costly new requirement for states. However, health reform also presents opportunities and potential funding to improve outdated processes and information systems and to undertake an efficient and thoughtful information gathering process.

c. Potential for Development of a Regional Exchange

New Mexico could establish or join a regional Exchange. As with the initial question of whether New Mexico should administer an Exchange at all, considerations include coordination, capacity, flexibility, efficiency and similarity of market characteristics (i.e., demographics of those who will be purchasing through the Exchange, number and type of carriers and plans, employer offer rates, etc.).

The advantages of a regional Exchange include some economies of scale, in addition to some added portability that could result from having product availability across contiguous states. However, given the ambitious federal timelines, New Mexico would

have to move quickly to pursue a regional Exchange given the inherent challenges of working across states with multiple state agencies, if establishing a regional Exchange is desired. Another consideration is that federal start-up funds will be available to states and New Mexico should take advantage of this opportunity initially to build the needed infrastructure—including effective and seamless eligibility systems—for the overall reform activities. This option would not preclude some regionalization of certain aspects of the Exchange such as data sharing and opportunities for regional demonstration projects or grants.

d. Who Administers the Exchange

If New Mexico decides to implement its own Exchange, subsequent choices arise such as whether the state should establish one or more Exchanges and where to house the Exchange(s). New Mexico will want to consider its population demographics, carrier market share, provider networks, and capacity and resource requirements to determine whether one or more Exchanges are warranted. In addition, estimates of the numbers of individuals and businesses expected to enroll in an Exchange are important when considering whether to establish one or more Exchanges.

An Exchange needs the capacity to accomplish an extensive list of tasks—including (but not limited to) processing applications, confirming eligibility for tax credits, billing premiums, monitoring employer contributions, reconciling payments, developing and maintaining a website, payment of commissions, ongoing marketing and outreach, and developing and maintaining an electronic interface.

An Exchange will require significant interface with other state agencies including, at a minimum, New Mexico's Medicaid agency, the Public Regulation Commission Division of Insurance, and the New Mexico Taxation and Revenue Department.[6] In addition, New Mexico may choose to evaluate the capabilities of organizations that play an intermediary role in our state to determine whether they have some of the needed capabilities to operate various functions of the Exchange through a sub-contract.[7] These decisions will be critical in the short-term to meet federal deadlines for establishing the Exchange.

[6] The New Mexico Taxation and Revenue Department is likely to be involved in assisting the Exchange in verifying individual and small business eligibility for subsidies based on individual income and employer size.

[7] For example, in Massachusetts the Connector/Exchange subcontracts with an intermediary to provide sophisticated information technology needs without having to duplicate effort.

e. Funding to Support Development of the Exchange

One of the many funding opportunities included within the PPACA is federal support to states for the development of the Exchange. These federal funds become available within one year of the bill's enactment and continue through January 2015. The proposed Office of Health Reform should assure that an application for such funding is submitted for New Mexico, when funding becomes available. This opportunity will allow the state to conduct detailed analysis on the advantages and disadvantages of operating its own Exchange, joining a regional Exchange or defaulting to the federally-run Exchange by the required notification date to HHS of their intention to operate an Exchange by January 1, 2013.

f. Eligibility Determinations

The PPACA directs the U.S. Department of Health and Human Services (HHS) to establish a system that offers a single application for Medicaid, CHIP, and federal subsidies.[8] Further, the law requires applicants to have the option to apply for benefits and subsidies through a website that provides a comparison of available benefits across plans participating in the Medicaid program and the Exchange. The federal law requires that Medicaid and CHIP programs accept eligibility determinations made by the Exchange without any further determination. Likewise, the Exchange must accept eligibility determinations for subsidies made through Medicaid and CHIP. As noted earlier in this document, the Human Services Department will need to change its current application and enrollment procedures, as well as replace its outdated IT eligibility system, in order to meet the requirements of the PPACA and the expectations of the public.

Specific policy questions to be answered include:

- Will the current web-portal activity being undertaken by HSD, known as "YES – NM," accommodate the requirements under the PPACA for streamlined, on-line eligibility for subsidies and/or Medicaid accessible to all?
- Will the web-portal serve as the only entry into the system or will there be other methods for eligibility applications to be accepted (e.g., provide for a "no wrong door approach")?
- How quickly can the state's current eligibility system be replaced to provide for streamlined eligibility? What resources are needed? How will the state assure

[8] The PPACA provides states with the option to develop a Basic Health Plan for individuals between 133-200% FPL. If Ne Mexico opts to develop such an option, eligibility for the Basic Health Plan must also be included in this streamlining effort.

the new IT system is compatible with the Exchange when the standards for the Exchange have not yet been determined?

In addition to deciding where eligibility determinations are made, New Mexico will also need to analyze its current determination of eligibility to meet the new federal requirement that eligibility be based on modified gross income for nonelderly applicants. The PPACA provides a specific definition of Modified Adjusted Gross Income (MAGI), including an across the board five percent income disregard, and prohibits states from utilizing any other income disregards when determining eligibility, premiums and cost-sharing.

g. Longer Term Decisions Relating to the Exchange and Insurance Markets

In the longer term, the state will have the opportunity to consider the impact of the Exchange on health coverage generally and the insurance market specifically. Assuming the state determines it would like to maintain the federal health reform construct, the state also may want to consider whether the Exchange should become the state's insurance market or whether the state should continue to have a market outside of the Exchange.

Many of the first-order policy decisions outlined above should occur within a 6-month time frame. New Mexico will want to well prepare itself to respond to the federal government regarding start-up Exchange funds. Once the high-level decisions are made, New Mexico can begin to contemplate the myriad of smaller policy decisions inherent in getting the Exchange up and running.

i. Decision Points – Exchange

DATE	ACTION
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
9/10 & Ongoing	Decision on where Exchange should be housed

9/10 & Ongoing	Continue efforts to implement new state HSD Medicaid and other public programs' eligibility systems, as needed to comply with federal law; Issue RFP for new IT HSD eligibility system by Fall 2010
1/1/12	Action to create Exchange
1/1/14	Launch Exchange

IX. System and Payment Reform

Fundamental system reform that addresses behavioral health, public health, prevention and wellness, and how health care is provided, paid for and monitored is a key focus of the PPACA. New Mexico currently has a large number of public and private initiatives to improve the health of New Mexicans and the ways they receive and pay for health care. Several payment reform initiatives are underway including Medicaid's support for patient-centered medical home models and implementation of behavioral health care service agencies.

The initiatives of Governor Richardson, tribal governments, nonprofits, and businesses have taken to improve health care has put the state in a good position to take advantage of new opportunities in the health reform law. The PPACA takes a decentralized approach to promote payment and delivery system reform through funding for demonstration projects, pilot programs, and grants targeted to states, tribes, municipalities, medical schools, hospitals, nursing homes, and other providers. Many of these projects focus on areas that have been a priority for New Mexico.

a. Behavioral Health

The PPACA includes various provisions such as increased access and coverage, education and training grants for mental health service providers, and mechanisms for increased access to prevention services, which will significantly enhance services for mental illness and substance use disorders (MI/SUD) for millions of Americans.

Access: One of the key features of the PPACA includes guaranteed access to mental health and substance use disorder services at parity in major public programs to cover the uninsured and small businesses. The Wellstone-Domenici parity law mandates that insurance policies apply the same deductibles, co-pays, annual and lifetime limits, and other features equally to physical and mental health coverage. The provision of

immediate access to insurance for Americans who are uninsured because of a pre-existing condition will benefit MI/SUD individuals because these disorders are usually considered pre-existing conditions. Because Medicaid will cover single adults at higher income levels, behavioral health block grant dollars now spent on these individuals will be freed up to focus on recovery support services not paid for through Medicaid or other insurance benefit plans. Additionally, a significant number of youth with mental health and substance use disorders will benefit from the continuation of Medicaid coverage to former foster care children up to the age of 26 years old.

Coverage: Substance abuse has not been defined as a disability covered by Medicaid since the 1990s. However, individuals will receive treatment for substance abuse under PPACA, which is a significant expansion of substance abuse treatment. The expansion of Medicaid coverage to new enrollees will significantly impact individuals with MI/SUDs. Individuals with MI/SUD who are dually eligible for Medicaid and Medicare will no longer pay significant out-of-pocket expenses for medication because of the elimination of the Medicare Part D "donut hole." The PPACA provides for grants to community mental health programs for co-locating primary and specialty care. These programs will focus on adults with a mental illness and co-occurring substance use disorders. The continued expansion of home and community-based services will benefit individuals with MI/SUDs. The legislation allows state Medicaid programs to establish health homes for individuals with chronic illnesses. Grant programs have been created for school-based health clinics to provide mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, and in/out patient programs.

Prevention: Prevention is a key theme in PPACA. Under the Medicaid Rehabilitation Option, states will now be allowed to cover prevention services. PPACA allows for Medicare payments for annual wellness visits including assessments and recommendations to address mental health conditions or risks. Some screening activities to identify mental health and substance use conditions are included in a grant program for adults aged 55 to 64 years of age. Additionally, PPACA establishes a national public-private outreach and education campaign regarding prevention benefits.

Workforce: The Act establishes mental and behavioral health education and training grants to accredited programs for recruitment, education, and clinical training of students. This includes training programs for paraprofessional child and adolescent mental health workers. Grants are available to health centers, including community mental health centers, to expand primary care residency training. The Primary Care Extension Program recognizes the growing role of primary care providers and will support education of those providers about prevention and treatment of mental health

and substance use disorders. The PPACA also establishes grants and training opportunities specific to expanding provider capacity in tribal communities.

b. Preventive Care

Competitive grants are available for prevention and health promotion outreach to promote wellness, reduce health disparities and mitigate chronic disease through increasing access to services, creating healthy communities and providing support for innovation. Specific competitive grants are available for school-based health centers and oral health activities.

Competitive grants are also available for medical schools to provide preventive care training for medical residents; and to support non-profits, community-based organizations, and governments in promoting evidenced-based preventive health activities in local communities.

c. Wellness

Competitive grant funding is intended for a wellness program demonstration project; a preventive benefits outreach campaign; incentives to prevent chronic diseases through community transformation grants; demonstration projects to test providing at-risk populations individualized wellness plans; childhood obesity projects; and pilot projects to provide public health community interventions, screenings and referrals for individuals 55-64 years of age. A specific emphasis is to award competitive grants for diabetes prevention program model sites and to improve the collection of data for diabetes and other chronic diseases.

d. Health Disparities

The PPACA mentions the reduction of health disparities in numerous places and in order to aid the reduction of health disparities, the Public Health Service Act is amended to require any federally conducted or supported health care or public health program, activity or survey to collect and report data on race, ethnicity, sex, primary language and disability status for applicants, recipients or participants, and that the data be collected at the smallest geographic level possible for aggregation of the monitoring of trends in health disparities.

Standardized data collection requirements will be included in state plans for Medicaid and CHIP, and grants will be available for cultural competency training. The PPACA transfers the Office of Minority Health from the Office of Public Health and Science to the Office of the Secretary of HHS to prioritize and highlight the need to mitigate health disparities and improve minority health and the health care received by racial and ethnic minorities. Also under PPACA, each agency in the Health and Human Services Department is required to establish an Office of Minority Health. One of the consistent features of PPACA is reducing health disparities as part of the quality improvement in health care.

e. Quality and Efficiency

Competitive grants are authorized for institutions to adapt and implement models and practices, including the use of technology, that promote evidence-based quality and reductions in health disparities, and to states to develop quality measures and establish community health teams to support patient-centered medical homes.

Competitive grants are also available for pilot projects for emergency care and trauma systems; to enhance adult protective services provided by states and local units of government; and to implement complaint investigation systems optimizing the collaboration between local authorities, consumers and providers.

f. Expansion of Primary Care Health Care Settings and Workforce Capacity

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.

Some of the competitive grant opportunities include funding for development and operation of nurse-managed health clinics; funding to organize and administer primary care extension agencies to assist primary care providers implement medical homes and keep informed of best practices; and funding for community-based collaborative care networks.

Competitive grants will be available for comprehensive workforce development activities at the state and local levels including health care workforce assessment. Other

grants are available both to increase the health care workforce and to increase the capacity of institutions of higher education to train existing and future members of the health care workforce. Specifically, competitive grants are available for the support and development of primary care training programs including programs to improve clinical teaching and research; grants to plan, develop and operate training programs in the field of general, pediatric or public health dentistry; and grants to provide additional training to direct care workers employed in long term care facilities. Grants are also available for the training of allied health professional including alternative dental health care providers and community health workers.

g. Payment Reform

Competitive funding opportunities are included for demonstration projects on global and bundled payments, pediatric accountable care organizations, and planning grants for creating medical homes for people with chronic illness. This funding will provide important opportunities for public purchasers, including Medicaid and Medicare, to lead or participate in multi-payer payment reform efforts.

New Mexico will need to review all of the relevant opportunities in the law, quickly prioritize them and develop relationships with researchers and others in order to best meet the state's goals for improved quality and system reform. Because each of these grant opportunities will be of interest to various stakeholder groups, there will be pressure on the state to apply for as many as possible. However, given the fact that certain of these grants require some level of state matching funds or resource commitment and that the state has finite resources to implement, manage and monitor available opportunities, the proposed Office of Health Care Reform and the Health Care Reform Leadership Team should develop a recommended set of criteria, with input from the Senate Joint Memorial 1 Task Force, to follow in considering the application or support of such grants. Examples of appropriate criteria include:

- Priority in the New Mexico Comprehensive Statewide Strategic Health Plan
- Related initiatives underway in New Mexico
- Broad coalition of support
- Level of state funding required (lower is better)

In addition to developing a prioritization for grants that require the state to act as a lead, it is also important for New Mexico to develop an overall workforce development strategy to guide local organizations and health care providers on which grants are likely

to be of the most benefit to New Mexico and support statewide priorities. These funds begin coming available in 2010, and the first grant applications are due on July 19, 2010.

i. Decision Points—System and Payment Reform

DATE	ACTION
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
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 they fit within state priorities
By 1/1/11	Apply for Medicaid Health Home for Enrollees with Chronic Conditions Planning Grants
	Apply for Medicaid Emergency Psychiatric Demonstration Project
By Federal FY10	Apply for funds from the Prevention and Public Health Fund

X. Long Term Care

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. 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, according to the U.S. Census Bureau, 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 for services, limited resources and the growing preference for home and community-based services (HCBS). The long-term care opportunities presented in the national health reform legislation position the state to further enhance its long-term care system by creating funding

opportunities which enable seniors and people with disabilities to determine how and where they wish to live and create a long-term care safety net.

a. Medicaid Home and Community-Based Services

The importance of home and community-based services is explicitly stated in the legislation, "SENSE OF THE SENATE— Congress should address long-term services and supports in a comprehensive way that (1) guarantees elderly and disabled individuals the care they need; and (2) long term services and supports should be made available in the community in addition to in institutions."

The PPACA gives states the option to enhance access to home and community-based services through amending their state plans instead of through a waiver. Options to amend the New Mexico's state plan are included in the Community First Choice Option and through the amendment of Section 1915(1) of the Social Security Act.

- **Community First Choice Option:** New Mexico will have the option of amending the state Medicaid plan to provide home and community-based attendant services and supports to (1) consumers eligible for medical assistance under the state plan whose incomes do not exceed 150 percent FPL, or, if greater, to (2) consumers who meet their state's nursing facility clinical eligibility standards. New Mexico must meet certain requirements for the amendment to be approved, such as maintaining or exceeding the previous fiscal year's medical assistance expenditure levels in the first full fiscal year of the program's implementation and services will have to be offered statewide. A six percent point increase in the federal match for expenses associated with attendant services and supports.

- **Removal of Barriers to Providing Home and Community Based Services:** Amends Section 1915(i) of the Social Security Act to remove barriers to providing HCBS by giving New Mexico the option to provide more types of HCBS through a State Plan amendment. This option would prohibit New Mexico from setting caps on the number of individuals who receive coverage for the benefit, however, enables New Mexico to target benefits to individuals with selected conditions.

Other provisions supporting increased access to home and community-based services include the:

- **State Balancing Incentive Program** which gives selected states an increased FMAP of up to five percent based upon the state's Medicaid expenditures on home and community-based services. Since New Mexico already spends a considerable percentage of Medicaid expenditures on HCBS, the state will have to analyze eligibility for the increased FMAP.

- **Money Follows the Person Rebalancing Demonstration**: New Mexico will have the option to apply to be a Money Follows the Person (MFP) state. The MFP program is designed to give people the choice to transfer out of a nursing home back into the community while the funding supporting them in the nursing facility would shift to supporting them in the community. The MFP Demonstration Program would provide an enhanced Federal Medical Assistance Percentage (FMAP) rate for qualified services, which include HCBS services and demonstration services.

- **Protection for Recipients of HCBS against Spousal Impoverishment:** For five years, beginning on January 1, 2014, New Mexico will be required to apply spousal impoverishment rules to HCBS beneficiaries. The mandate will end December 31, 2019, at which point the current effective language of the statute will become effective again. New Mexico will need to review whether spousal impoverishment benefits already exist within the home and community-based waivers and personal care option of the state plan.

b. Coverage- CLASS Act

The PPACA creates a new voluntary public long-term care insurance program called the Community Living Assistance Services and Support (CLASS) Act. The program provides a cash benefit so that an individual can remain in the home and community longer. The Secretary of Health and Human Services will develop benefit levels and premiums. Benefits will vary by level of disability, with a minimum of $50 a day. Benefits include non-medical support services such as home modifications, transportation, homemaker services, etc. The program is financed through voluntary payroll deductions and will not have a lifetime or aggregate limit. Regulations are under development.

c. Elder Justice and Protection

The PPACA provisions increase protections, quality of service, and accessibility of information for the elderly and persons living with a disability. Among these provisions are the Elder Justice Act, the Nursing Home Transparency Act, and the Patient Safety and Abuse Prevention Act. The legislation enhances the coordination of abuse, neglect and exploitation prevention and enforcement efforts; establishes a nationwide system to run background checks and screens for employees of long-term care providers; develops new reporting requirements for long-term care facilities; and, establishes grant programs to enhance state adult protective services programs and the state long-term care ombudsmen program by expanding the capacity to respond to and resolve complaints regarding elder abuse and neglect.

d. Information, Referral and Assistance

Funding has been made available to make it easier for individuals to navigate through the long-term care system. Funding is available to New Mexico's Aging and Long-Term Services Department to enhance the Aging and Disability Resource Center's person-centered system of information, counseling and access. Through the grant program, New Mexico can apply for funding to: provide outreach and assistance to Medicare beneficiaries on their Medicare benefits including prevention; use additional funds through a competitive process to provide Options Counseling on health and long-term care; and develop transition models that integrate the medical and social service systems to help older individuals and those with disabilities remain in their own homes and communities after a hospital, rehabilitation or skilled nursing facility visit.

i. Decision Points—Long Term Care

DATE	ACTION
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 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
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
By 12/31/10	Ensure the state has a program contacting with Medicare Recovery audit contractors to identify, and recoup underpayments and overpayments
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 Access" funding opportunity
By 12/1/10	Conduct analysis of impact of formula grants to the state's Adult Protective Services and Long-Term Care Ombudsman programs.
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 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.

XI. Native American Health

The Patient Protection and Affordable Care Act applies to American Indians as these individuals participate in the U.S. health care system and may utilize sources of health care other than the Indian Health Service, such as private or employer-sponsored health insurance, Medicare, Medicaid, community health centers, and the Veteran's Administration. The PPACA provides American Indians and Alaska Natives more choices to:

- Use the Indian Health Service (eligible individuals);
- Purchase affordable health care coverage; and/or
- Access coverage for eligible individuals through other sources such as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

The PPACA affects Indian Tribes as they may purchase insurance for their employees or their members and can benefit from more affordable options and reduced costs. Additionally, the Indian Health Service and its hospitals and clinics are enhanced under the PPACA due to various provisions that expand coverage or improve the quality of health care for all Americans, including underrepresented minorities.

The Patient Protection and Affordable Care Act contains provision specific to American Indians, which will benefit these individuals, tribes, and Indian health facilities. For example:

- American Indians who purchase health insurance on the individual market through an Exchange do not have to pay co-pays or other cost-sharing if their income does not exceed 300 percent FPL.[9]
- Members of American Indian tribes are exempt from individual responsibility assessments.
- The value of health services/benefits from Indian Health Service (IHS) funded health programs or Tribes will be excluded from an individuals' gross income so it cannot be taxed starting with benefits and coverage provided after the date of enactment.
- For individuals who have Medicare drug coverage (Part D), spending by IHS, Indian tribes or tribal organizations, or urban Indian organizations will count towards the annual out-of-pocket threshold in the Part D "donut hole" as of January 1, 2011.

[9] 300% FPL - $66,000 for a family of four in 2010 ($83,000 in Alaska)

As the state implements health care reform initiatives, tribal consultation will be a component of the state's process regarding policy/statutory development and other health care reform initiatives that will affect tribal populations.

Furthermore, the Indian Health Care Improvement Act, which authorizes Congress to fund health care services for American Indians through IHS, was originally approved by Congress in 1976 and last reauthorized in 2000. The PPACA makes the reauthorization of this law permanent and authorizes new programs within IHS to ensure that IHS is more equipped to meet its mission to raise the health status of American Indians to the highest level. For example, the Indian Health Care Improvement Act includes:

- Authorization for new and expanded programs for mental and behavioral health treatment and prevention;
- Expanded authorization for long-term care services, including home health care, assisted living and community-based care;
- New authorization for development of health professional shortage demonstration projects;
- Expanded authorization for funding of patient travel costs;
- New authorization for demonstration projects for innovative health care facility construction;
- New authorization for the provision of dialysis services;
- Improvements in the Contract Health Services program, which pays for referrals;
- New authorization for facilitation of care for Indian veterans; and
- New authorization for urban Indian health programs.

i. Decision Points—Native American Health

DATE	ACTION
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.
By 9/1/10	Establish an Indian Provision Health Care Reform ad hoc workgroup from the State-Tribal Workgroup created by HSD in order to ensure the adherence with and effective implementation of the Indian Provisions of the PPACA.

XII. Education, Outreach and Communication Plan

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 care reform progresses in an effort to educate and conduct outreach to the many different groups affected and interested. This can and should be done through several different processes organized through the Office of Health Care Reform.

1. Create a Vision – New Mexico will need to develop a coherent vision to guide the work and coordinate the tasks so that everyone is working toward the same goals and engage a broad range of stakeholders.

2. Develop a Consumer Education, Outreach and Communication Team – The State of New Mexico should have a lead person within the Office of Health Care Reform as well as contacts within each state agency to oversee the consumer education and outreach issues raised by the Affordable Care Act.

3. Engage the Public in Policy Development and Implementation – The public remains confused about how health reform will affect them. New Mexico must develop a clear approach to achieving effective information flow between the public and the state to weigh in on options before one is chosen, and to provide information back on how things are going so they can be improved.

    a. Develop a New Mexico Health Care Reform website that will serve as the "go to" place for accurate information about the Patient Protection and Affordable Care Act.
    b. Keep Stakeholders Informed and Involved – Issue progress reports to the Legislature, the public and other stakeholders on agency progress in

implementing aspects of health reform, including at a minimum, key decisions that have been made, key decisions that remain, and policy considerations and recommendations. These progress reports should continue, at a minimum, through June 2014 when most of the reform activities will be implemented.

c. Timeline Update – Keep the public informed with accurate information as different elements of the law are phased in. This timeline would include potential grants, pilot projects and other funding opportunities available under the Act.
d. Conduct Public Meetings – While websites play an important role in getting information out to the public, it is important to recognize New Mexico's cultural and rural situation. Public meetings are essential to get the word out to all of New Mexico's citizens.
e. Encourage Public Input – Communication is a two-way street. Set up an e-mail address and mailing address for the public to submit opinions, suggestions or questions about policy recommendations.

4. Develop Consumer Protection System – Educating the public is only the beginning—protecting the public from misinformation, confusion, and potential fraud must also be addressed. HHS has identified five principles of an effective health care integrity strategy including the following.[10]

    a. Enrollment: Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment or reenrollment in the health care programs.
    b. Payment: Establish payment methodologies that are reasonable and responsive to changes in the marketplace and medical practice.
    c. Compliance: Assist health care providers and suppliers in adopting practices that promote compliance with program requirements.
    d. Oversight: Vigilantly monitor the programs for evidence of fraud, waste, and abuse.
    e. Response: Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

[10] Testimony of Lewis Morris, Chief Counsel, OIG/HH, before the House Committee on Ways and Means, Subcommittees on Health and Oversight, 15 June 2010.

5. Developing an effective consumer protection system requires consumer education regarding consumers' rights and responsibilities under the Affordable Care Act.

    a. Create a special webpage on the New Mexico Health Care Reform website for consumer protection.
    b. Provide resources, such as brochures and other written materials in different languages for those who do not have easy access to the internet.
    c. Make recommendations on how to coordinate existing consumer protection complaint and appeals systems within government agencies.
    d. Make recommendations on the creation and support of a (non-government or government) consumer assistance entity or system.

i. Decision Points—Education, Outreach and Communication Plan

DATE	ACTION
By 7/10 & Beyond	Create a Vision for New Mexico 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
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
By 12/30/10 &	Determine if information regarding the individual and employer

Ongoing	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

New Mexico's policies and implementation practices will largely determine whether the new federal health reform law translates into more affordable coverage and access to health care services for people in New Mexico. The state will play a particularly important role with respect to Medicaid expansion, the creation of an insurance Exchange(s), and the new market rules for insurance. The decision of whether or not to create an Exchange looms as one of the most important and consequential one for states. To achieve effective implementation, New Mexico will need a coherent vision to guide its work, for which this Strategic Plan, *Implementing Federal Health Care Reform—A Roadmap for New Mexico*, serves as an important beginning step.

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Kaiser Family Foundation
Families USA
Robert Wood Johnson Foundation
National Association for State Units on Aging
SCAN Foundation
Indian Health Service
National Indian Health Board

Issues	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Administrative Activities					
Grant Prioritization	NM will need to develop criteria and process to help prioritize efforts to obtain and support federal funding available through grants available through PPACA (whether or not state must serve as the lead). Establish a policy that will minimize grant competition within the state and between state agencies.	- Review grants and bucket into groups that delineate opportunities for states to apply for grants and opportunities for other stakeholders to apply for grants; determine which grants require state or other matching funds - Develop a set of criteria to assist in prioritization of grant opportunities that state will lead or support - Based on criteria, prioritize grants for which state agency must be lead - Assign grant development to appropriate state agencies - Develop a set of criteria to prioritize state support for non state-led grants	Leadership Team; Steering-Program Workgroup	Provide state matching funds	8/10
Evaluation	Plan for evaluation of major policy changes	- Determine with Leadership Team and Workgroups, and SJM1 Task Force how to evaluate health reform and its impact on NM; - Determine which agencies and/or organizations will perform evaluation of key policies and reforms; - Agencies to establish measures and begin collecting baseline data.	Leadership Team; Steering-Program Workgroup	Provide money for evaluation and/or authorize agencies to seek outside funding	11/10
Monitor Federal Activities	Review federal activities related to health reform on ongoing basis for impact on NM activities	- Serve as liaison to federal government and clearinghouse for federal issues - Review federal regulations, bulletins and other information about interpretation of PPACA provisions - Inform state agencies of activities - Coordinate NM response to federal requests for input -Consult with and engage appropriate state agencies	Leadership Team	Inform	Ongoing

Status Reports	Provide ongoing status reports to Leadership Team and Legislature on progress in implementing health reform activities	Develop a template for ongoing status report to be utilized by state agencies; - Update weekly summary reports and submit to Leadership Team	Leadership Team; Steering-Program Workgroup	Inform	Weekly; and as requested by Legislature
Monitor Federal reporting requirements	Track reporting requirements as they become available and transmit to appropriate agencies.	- Currently there are no reporting requirements for healthcare reform. According to Section 2717 these requirements will be established at a later date or as needed.	Leadership Team; Steering-Program Workgroup	Inform	Ongoing
Access					
Temporary High Risk Pool Program	Monitor implementation of temporary high risk pool program	- Monitor implementation of high risk pool (to be implemented in 7/10) - Consult with NMMIP	HSD; NMMIP	Inform	7/10
Reinsurance fund for retirees ages 55-64	Obtain reinsurance funds for state-funded retirees	Apply for reinsurance funds (ASAP as funds on first come, first serve basis) -Analyze impact of state funds on state budget and provide Legislature with information - Educate private employers regarding availability of money; - Consult with DWS on outreach	Dept. of Finance & Admin; IBAC Agencies; DWS	Inform; May allow for reduced state money	7/10
Medicaid					
Medicaid drug rebate	Consider changes to the state Medicaid drug formulary	- Analyze fiscal impact of changes to federal Medicaid rebate law identify potential changes to Medicaid drug formulary; - Analyze fiscal impact of proposed changes to state Medicaid drug formulary - Amend state regulations or sub-regulatory materials - Provide appropriate notice to beneficiaries and providers	HSD	Inform; if financial loss may require new state money	8/10
Medicaid	Decide whether to expand	Conduct financial analysis of	HSD	Statutory change required to	8/10

expansion prior to 2014	eligibility for childless adults up to 133% FPL prior to availability of enhanced FMAP in 2014.	expansion prior to 2014, including determination of whether any state funds are available to fund early expansion		change coverage level to 133% for childless adults; would require additional state funds	
Medical provider acquired infections	Ensure that state rules prohibiting payment for never events is inclusive of provider acquired infections as contained in PPACA	- Confirm that federal rules on prohibiting payment for provider acquired infections are consistent with NM's current rules prohibiting payment -Incorporate hospital acquired condition exclusion in DRG payments, consistent with Medicare DRG methodology.	HSD		1/11
Home and community based services	Consider adopting federal options to enhance home and community based service state plan options	Analyze impact of adding state plan option for these benefits through either a 1915 (k) and/or 1915 (i) waiver, including determination of population to be included and potential fiscal implications (both with and without enhanced federal funding) - If decide to utilize option, a number of next steps (draft state plan amendment; ensure sufficient community services; define population and extend new services; provide proper notice and rights of appeal (etc) - Consider extent to which NM qualifies for enhanced funding based on current balance of long term care Services - Analyze fiscal and administrative impact of the new spousal impoverishment requirements -Analyze impact of applying for Money Follows the Person demonstration grant.	HSD; ALTSD; BHPC	Would require statutory change; may require new state funds	Various dates beginning 10/10
Payment and	Consider applying for grants	- Prioritize payment and delivery	Leadership Team;	HSD with	Various

delivery system reform	to assist with delivery system and payment reform in NM: pilot program on Medicare payment bundling, global payment demonstration, Pediatric ACO demonstration, grants for health homes for chronically ill patients.	system reform opportunities and develop criteria with Advisory Council on Health Systems Development to be used in deciding which grants to pursue; -Determine partnerships for grant opportunities - Consider where state can be a lead vs. play a supporting role - Draft or assist leads in drafting of grants and by providing letters of support	HSD; BHPC; ALTSD; DOH; CYFD	Leadership Team	dates; programs begin in 9/10
Provider payments: DSH and primary care payments in Medicaid	Project potential net effects of increased federal revenue in 2013-14 and loss of federal revenue from reduced DSH allotments; consider options for redirecting additional funds.	Consider impact of increased rates to NM providers through Medicaid (both short term and when enhanced funds end - Consider impact on psych IMD DSH - Confirm that NM is protected from DSH reductions based on waiver - Develop transition plan if reductions go in place when waiver period ends	HSD; BHPC	Inform; Provide additional funds as necessary	10/11
Provider rates	Increase Medicaid rates for primary care to 100% of Medicare where applicable; 100% federal funding of incremental cost in 2013-14.	- Determine difference between current rates and Medicare rates; - Make appropriate changes in MMIS to pay primary care providers 100% of Medicare; - Develop report showing difference in state developed rates and 100% of Medicare; Consider implications of existing PCCM, PCMH payments. - Submit claim for difference to CMS based on rules to be developed	HSD	Legislative authority to provide higher payment rate and plan for sunset of federal dollars	1/13
Federal Medicaid expansion to 133% FPL	Expand Medicaid eligibility to 133% FPL; adjust Insure NM eligibility and enrollment accordingly.	- Amend Medicaid statute and regulations to allow for increased enrollment; - Provide notice to individuals enrolled in Insure NM that have opportunity to move to Salud - Make eligibility systems changes	HSD	Statutory change	1/14

		(including to decision trees and notices)			
Insurance Reforms					
Web-based insurance marketplace	Participate in designing federal and state websites and web-based capacity for Exchange and insurance market to help consumers identify affordable coverage options.	- Division of Insurance to continue to work with NAIC on input into federal website, with input from Medicaid. - Exchange to design state specific website to provide detailed information on specific NM coverage options in Exchange	PRC/Division of Insurance; HSD; DOIT	Inform	12/10
Small business tax credits	Inform and educate small employers about the availability of tax credits to subsidize insurance coverage for employees.	- Develop fact sheets on availability of tax credits - Hold forums with small businesses to help understand tax credit opportunity (ongoing through 2014)	PRC/Division of Insurance; DWS; TRD	Inform	8/10 (ongoing)
Conform NM insurance rules to new federal rules	Review and amend insurance laws and regulations to conform with PPACA	- Review differences in federal law and state law for all insurance changes in federal law - As necessary, draft legislation and regulations conforming to federal law - Educate insurers on new requirements, including reporting requirements	PRC/Division of Insurance	Amend statutes to conform to federal law	Various dates; begins 9/10
Medical Loss Ratios	Insurers that fail to maintain adequate medical loss ratios will be required to provide rebates; monitor insurers to ensure compliance	- Develop a method to oversee and monitor insurers activities	PRC/Division of Insurance; Leadership Team	May require amending of NM' MLR statute	1/11
Co-Op Plans	Oversee possible development of private, non-profit, member-run Consumer Operated and Oriented Plan (CO-OP).	- Bring together stakeholders for discussion of development of CO-OP - Consider pros/cons of development of such a CO-OP; - Consider regulatory and legislative changes necessary to allow for operation of new COOP	PRC/Division of Insurance; Leadership Team	Review statutory authority for COOP to operate in NM and ensure licensing	1/13
Standardize systems for eligibility and enrollment,	Disseminate and start to enforce standardized rules for the simplification of insurance records in the areas of	- Educate NM providers and insurers on federally developed standardized rules to administratively simplify insurance records	PRC/Division of Insurance; HSD; Workers Comp Admin	Require insurers & Medicaid to be involved	Various dates

claims and payment	eligibility/enrollment, claims/payment, encounter, and authorization.	- Include Medicaid and worker's comp insurers to ensure consistency across all interactions with providers			
Individual and employer mandates; penalties for non-compliance	Raise awareness of start of individual and employer mandates and penalties beginning 2014.	- Determine potential mandate exemptions for individuals and employers (e.g., unaffordable coverage or provision of free choice voucher) - Develop fact sheets and FAQs to educate individuals and businesses about responsibilities under law - Consider conducting media campaign to promote enrollment to meet the mandate - Coordinate outreach and education activities with other ongoing outreach and education efforts	DWS; TRD; PRC/Division of Insurance		1/14
New federal insurance rules and protections	Implement new reforms at the state level: • Limit out-of-pocket spending below 400% FPL • ESI waiting period no longer than 90 days • Add federal-contracted multi-state plans to Exchange; NM may want to require additional benefits (at state cost) • Consider merging individual and small group markets	- Evaluate existing laws for consistency with federal requirements - Develop regulations for insurers to comply with federal rules - Develop method within Exchange and Medicaid to ensure out-of pocket maximums are tracked and complied with - Consider whether NM will include state mandated benefits (at state cost) - Consider merging individual & small group market	PRC/Division of Insurance; HSD; State Exchange	Statutory changes; decision on state mandated benefits & merging of individual and small group markets	Various dates; mostly 1/14
Health Insurance Exchange					
Setting up a state Exchange	Pursue planning grant for developing Exchange and SHOP; identify state and/or nonprofit agency to house Exchange.	- Apply for grant funds to help develop Exchange - Work with Leadership Team, Workgroups, SJM1 Task Force and Legislature to identify state agency or other nonprofit to house Exchange - Consult with PRC/DOI and HSD	Leadership Team; SJM1 Task Force; Workgroups; HSD; PRC/DOI; DOIT	Review and approval; Enact enabling legislation	12/10
Insurance	Consider state tax implications	Review federal changes to determine	TRD; DWS; DOIT	Potential legislative	12/10

subsidies for individuals, families, and businesses	of federal insurance subsidies	whether cause automatic changes to state taxes - Based on review, identify if need to make changes to law either to extend same subsidy to state taxes or to not extend it		change	
Building a state Exchange	Begin planning structure and functions of Exchange	- Identify key functions of Exchange - Determine changes to current personnel needs in transition to an Exchange - Work collaboratively with Medicaid on how eligibility and subsidy payment will work	Leadership Team; SJM1 Task Force; Workgroups; HSD; PRC/DOI; DOIT	New statutory language authorizing an Exchange	10/10
State Exchange	Launch the state Exchange and begin offering minimum essential coverage to individuals and small businesses.	- Begin operations effective Jan 1, 2014 - Provide outreach and education of Exchange offerings - Provide coverage for insurance with assistance of subsidies to both individuals and businesses -Coordinate with Medicaid - Consult with PRC/DOI and assure plans sold through the Exchange comply with NM insurance rules	State Exchange; HSD; DOIT	Monitor; receive status reports	1/14
Outreach, Education and Consumer Protection					
Educate all parties about health law	Inform the public and key stakeholders about policy changes and other reforms.	- Develop fact sheets and FAQs for all stakeholders (e.g., consumers, providers, businesses, insurers, etc) to clearly explain law and its implications - Hold forums across the state to assist in understanding of new law - Continue to provide outreach and education, particularly regarding eligibility for subsidies & tax credits; as well as potential for penalties	Leadership Team; ALTSD; HSD; DOH; CYFD; DIA; BHPC		8/10
Prevention and Wellness					
Wellness program grants	Develop a centralized office to ensure appropriate wellness	- See structure and function of NM's Office of Health Care Reform	Leadership Team; DOH and all Executive Agencies		

	and prevention grants are applied for.	- Track all grants and the funding received. - Ensure appropriate federal reporting			
Wellness program grants for small businesses	Raise awareness among small employers of grants (through 2015) to establish comprehensive wellness programs	- Develop materials describing availability of grants to small businesses - Participate with small business advocacy organizations in development of forums - Inform small employers or coalitions of small employers of ability to receive grant funding to develop a tool kit to assist businesses with establishing wellness programs or availability of tool kit developed through health reform staff	Leadership Team; HSD; DWS; DOH; CYFD; ALTSD; DIA		1/11
Wellness incentives	Raise awareness among employers of the option to provide employees with rewards in the form of reduced premiums based on participating in a wellness program.	- Develop materials describing options for employers to reduce premiums based on participation in wellness - Participate with business advocacy organizations in development of forums for businesses to describe opportunity -Eliminate co pays in public programs for preventive services and apply increased match.	PRC/Division of Insurance; HSD; DWS; State Exchange; DOH; CYFD; ALTSD		1/13
Wellness through the Exchange	Consider applying to conduct a Wellness Demonstration project that applies rewards in the individual market; evaluate whether NM's existing wellness initiatives are consistent with new wellness options.	- Work with insurers to consider Wellness Demonstration in individual market; - Based on current practices and potential changes, determine whether to develop a demonstration project to reward with premium incentives	State Exchange; DWS; DOH; PRC/Division of Insurance; HSD; ALTSD; CYFD		1/14
Quality					
Health Care Disparities	Maintain focus on reducing health care disparities	- Ensure disparities are considered in quality improvement activities, measurement, and evaluation	DOH; HSD; BHPC; ALTSD; CYFD; DIA; NMMRA	Inform; Gather information from legislators as to what is needed in each of	3/12

		- Explore new and innovative ways to combat these problems. -Ensure that the Culturally and Linguistic Appropriate Services (CLAS) standards are enforced throughout the state. - Enhance collection and reporting of data, including access and treatment data for people with disabilities -Ensure that health literacy is a part of this process. As one method of promoting wellness in one part of the state may not work in another part of the state.		their Districts. To combat health inequities.	
Medical malpractice	Consider applying for demonstration grant to develop alternatives to medical malpractice rules and engage in possible tort reform to reduce provider practice of defensive medicine	- Work with key stakeholders (physicians, hospitals, and trial attorneys to develop a coalition to apply for demonstration grant - Consider if state can be a lead vs. play a supporting role - Assist leads in drafting of grants and by providing letters of support	HSD; DOH; PRC/Division of Insurance; Trial Court; Medical Society; Hospital Association; New Mexico Health Care Association	Provide legislative authorization for medical malpractice demonstration projects	
Hospital Readmissions	Support New Mexico hospitals and community-based organizations in applying for Community-Based Care Transitions Program funding.	-Identify hospitals with high readmission rates - Work with key stakeholders to apply for funding	DOH, HSD, ALTSD	Inform	1/11
Long Term Care					
CLASS	Raise awareness among individuals and employers of the opportunity to save for the eventual need for long term supports using payroll deductions in the Community Living Assistance Services and Supports (CLASS) program.	- Develop/distribute information to individuals and businesses about CLASS; - Promote CLASS at public forums and events -Conduct financial analysis on impact of CLASS on Medicaid long term care costs - Consult with PRC/DOI	ALTSD; HSD; DOH; DWS; TRD	Inform	1/11

		- Consult with Risk Management Division			
Information, Referral and Assistance	-Develop programs to assist individuals and families navigate the long-term care system	-Consider applying for funding to enhance and expand the state Aging and Disability Resource Center -Consider applying for funding to assist individuals apply for low-income subsidy programs -Develop a consumer outreach campaign to educate on Medicare changes	ALTSD	Inform	7/10
Elder Justice & Protection	- Enhance the state's system to protect against adult abuse, neglect and exploitation - Provide public information re: New Mexico nursing homes so individuals can make informed choices	- Consider applying for federal formula and demonstration grants -Analyze impact on Adult Protective Services and state's Long-Term Care Ombudsman program. -Advocate for funding to be appropriated -Establish a public website with information on all nursing homes in the state, including survey reports, complaint investigations, and plans of correction.	ALTSD, DOH	Inform	1/11
See Medicaid Section for Medicaid Long-Term Care Provisions					
Native American Health					
Indian Health Care Improvement Act	Consider amendments to Indian Health Care Improvement Act	- Review Indian Health Care Improvement Act, which is reauthorized & amended in the PPACA - Consider impact of amended requirements on American Indians residing in NM -Consider whether any corresponding changes are needed in NM state law	DIA; Tribes & Pueblos; IHS; Leadership Team & its departments	Inform	8/10

APPENDIX 2

Timeline for Implementation of the Patient Protection and Affordable Care Act

2010

- Access to Insurance for Uninsured Citizens with a Pre-Existing Condition through a Temporary High Risk Pool Program.
- Small Business Health Insurance Credit.
- No Discrimination Against Children with Pre-Existing Conditions.
- Relief for Seniors Who Hit the Medicare Part D "Donut Hole."
- Prohibits Dropping Coverage When People Get Sick or rescission of coverage plans.
- Eliminating Lifetime Limits on Insurance Coverage.
- Regulating Use of Annual Limits on Insurance Coverage, cap to be determined by HHS.
- Covering Preventive Health Services by exempting from cost sharing.
- Improving Preventive Health Benefits by requiring Medicaid to cover tobacco cessation for pregnant women.
- Extending Coverage for Young Adults through age 26 on parents' plans.
- Bringing Down the Cost of Health Care Coverage by limiting Medical Loss Ratios.
- Reducing the Cost of Covering Early Retirees by creating a temporary reinsurance program.
- Holding Insurance Companies Accountable for Unreasonable Rate Hikes by creating grants to support states with premium rate reviews.
- Reducing Barriers to Providing Home & Community-Based Services in Medicaid.
- Strengthening Community Health Centers by providing funds to build new and expand existing centers.
- Strengthening the Primary Care Workforce by expanding funding for scholarships & loan repayments for practitioners working in underserved areas.
- Improving Consumer Information through the Web where consumers can identify affordable coverage options in their State.
- Expanding the Adoption Credit & Adoption Assistance Program via refundable tax credit.
- Expanding Educational Funds to Strengthen the Health Care Workforce; Providing Tax Relief for Health Care Professionals with State Loan Repayment.
- Improving Consumer Assistance with grants to States to establish ombudsman.
- Improving Public Health Prevention Efforts by establishing a Prevention & Public Health Fund.
- Allowing States' Medicaid Programs to Cover individuals up to 133% FPL and receive current FMAP

2011

- Discounts in the Medicare Part D "Donut Hole."
- Improving Medicare Preventive Health Coverage by providing free preventive services.
- Increasing Reimbursement for Primary Care Practitioners by providing bonuses in health professional shortage areas.
- Providing Options for Long-Term Care Insurance to be financed by voluntary payroll deductions.

- Establishing the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries following hospital discharge.
- Establishing greater financial parity between Medicare Advantage (MA) and traditional Medicare coverage while better aligning MA payments with the local costs of coverage.
- Establishing a Community First Choice Option allowing States to offer home & community based services to disabled individuals through Medicaid rather than institutional care.
- Strengthening Health Care Quality targeting Medicare, Medicaid and CHIP.
- Establishing an Independent Payment Advisory Board to extend the solvency of Medicare & lower health costs.

2012

- Encouraging Integrated Health Systems with payments incenting accountable care organizations (ACOs).
- Linking payment to Quality Outcomes by establishing a value-based purchasing payment system.
- Reducing Avoidable Hospital Readmissions by implementing penalties for hospitals with the highest readmission rates.
- Reducing Paperwork & Administrative Costs by implementing electronic exchange of health information.

2013

- State must demonstrate is it ready to implement the Health Insurance Exchange
- Improving Preventive Health Coverage by creating incentives for Medicaid to cover evidence-based preventive services with no cost sharing.
- Encouraging Provider Collaboration by establishing a pilot program on payment bundling for improved patient care coordination.
- Increasing Medicaid Payment for Primary Care Doctors equal to 100% of State's Medicare rates.

2014

- Implement Health Insurance Reforms that prohibit carriers from issuing coverage based on health status and limiting rating.
- Eliminate Annual Limits on Coverage.
- Ensure Coverage for Individuals Participating in Clinical Trials.
- Implement Health Insurance Exchanges in each State for the individual and small group markets to facilitate comparison shopping, plan enrollment and issuance of tax credits and subsidies.
- Ensure Choice through a Multi-State Option by providing at least two multi-State plans offered through the Exchange.
- Provide Premium Tax Credits and Cost-Sharing Reductions available through the Exchanges to help people at 100-400% FPL obtain affordable coverage.
- Create Free Choice Vouchers for workers who qualify for an affordability exemption to the individual responsibility policy to take their employer contribution and purchase an Exchange Plan.
- Mandating Individuals obtain Affordable Coverage or pay a fee to offset the cost of caring for the uninsured.

- Increasing Medicaid Eligibility to 133% FPL for all under 65 with 100% federal funds for first 3 years.
- CHIP Funding in FY14-FY15 for Children not eligible for Medicaid.
- Implementing a Tax Credits for Small Business up to 50% of employer contributions; up to 35% for nonprofits.
- Implementing Quality Measure Reporting programs in various hospitals and inpatient rehabilitation and psychiatric facilities to move towards value-based purchasing.

Appendix 3
Aging and Long-Term Services Department's Health Care Reform Issue Matrix

Long-Term Care Reform Provisions	Implementation Dates	Options/Decisions	Funding Opportunity	Indian Provisions
MEDICAID-Home and Community-Based Services				
Money Follows the Person Rebalancing Demonstration: Effective 30 days following enactment, Money Follows the Person is extended through September 30, 2016. This section modifies eligibility requirements by reducing the institutional residency period to not more than 90 consecutive days and by eliminating the state's flexibility in setting this residency period themselves. Currently, states set this requirement within Deficit Reduction Act's guidelines, which require that individuals reside in a facility for not less than 6 months, and not more than 2 yrs. (Section 2403)	30 days following enactment through September 30, 2016	CMS will post a grant solicitation in late July to www.grants.gov to offer States not currently participating the opportunity to apply for an MFP Demonstration Program Grant through a competitive award process.	The MFP Demonstration Program provides an enhanced FMAP rate for qualified services, which include HCBS services and demonstration services. This rate is equal to taking the published FMAP for a State, subtracting it from 100 percent, and dividing the total by half, and adding that percentage to the published FMAP.	
Community First Choice Option: Gives states the option, beginning October 1, 2011, of amending their state Medicaid plans to provide home and community-based attendant services and supports to (1) consumers eligible for medical assistance under the state plan whose incomes do not exceed 150% FPL, or, if greater, to (2) consumers who meet their state's nursing facility clinical eligibility standards. Available services include Activities of Daily Living task assistance, electronic service backup systems, and training on the management of attendants. Permissible services include transition costs from the facility to the community based home setting, and additional, qualifying, individual needs. The state must meet certain requirements for their amendment to be approved, such as maintaining or exceeding their previous fiscal year's medical assistance expenditure levels in the first full FY of the program's implementation. The services authorized under this section will be evaluated based on data provided to the HHS Secretary by the states. (Section 2401)	October 1, 2011: States will have the option to provide home and community based services to qualifying individuals under Medicaid	Analyze impact of adding state plan option including determination of population to be included and potential fiscal implications - If decide to utilize option, a number of next steps (draft state plan amendment; ensure sufficient community services; define population and extend new services; provide proper notice and rights of appeal (etc)	Participating states will receive a 6% percentage point FMAP increase.	
Protection for Recipients of HCBS against Spousal Impoverishment: For five years, beginning on January 1, 2014, states will be required to apply spousal impoverishment rules to HCBS beneficiaries. The mandate will end December 31, 2019, at which point the current effective language of the statute will become effective again. (Section 2404)	2014-2019: States must apply spousal impoverishment rules to HCBS beneficiaries	Determine if NM already provides this benefit	Unknown	
State Balancing Incentive Program: Effective October 1, 2011 – September 30, 2015, selected states will receive an increased FMAP of 5% or 2% with respect to medical assistance expenditures for non-institutionally-based long-term services and	October 1, 2011-September 30, 2015	Determine if NM is eligible— NM most likely not eligible to apply as the State spends at least	States may receive an enhanced FMAP for certain expenditures	

supports provided under the state Medicaid program. States whose Medicaid expenditures on home and community based services equal less than 25% of their total Medicaid LTSS are eligible for the 5% increase; states whose LTSS Medicaid expenditures on home and community based services equal less than 50% of their total Medicaid LTSS are eligible for the 2% increase. States must agree to make structural changes within 6 months including: no wrong door single-entry-point system; conflict-free case management services; core standardized assessment services. The HHS Secretary shall select participating states from among the applicants. (Section 10202)		50% of Medicaid funds on HCBS.		
Reform Provisions	Implementation Dates	Options/Decisions	Funding Opportunity	Indian Provisions
MEDICARE				
Medicare Advantage Plans: Medicare Advantage payments will freeze in 2011. In 2012, the benchmarks will be reduced, and the payments will be set to different percentages of fee-for-service rates. These payments will vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas. Beginning in 2011, this restructured payment system will be phased in over three years in most areas, with longer phase-in periods in other areas, depending on the level of payment reductions. Beginning in 2014, the plans will be required to spend at least 85% of revenue on medical costs or activities improving quality of care. Special Needs Plans are extended until 2014. (Section 3201)	2011: Medicare Advantage payments will freeze, and a phased-in restructured payment system will be in effect.	Analyze the impact on NM Medicare beneficiaries.	N/A	
Closing the "Donut Hole": Phases out the donut hole by plan year 2020. In plan year 2010, which began January 1, all Medicare beneficiaries who reach the donut hole will receive a $250 rebate to help cover costs. Low-income recipients are not eligible for the rebate. (Section 3315)	2010-2020	Education of NM Medicare Beneficiaries	N/A	
Medicare Coverage Gap Discount Program: Drug manufacturers will be required to provide a 50 percent discount to Part D beneficiaries for brand name drugs and biologics purchased during the coverage gap. The applicable discount will be treated as a true out of pocket cost. The discounts will apply to prescription drug and MA-PD plans, not to Title XIX state plans. As such, the PDP sponsors and MA organizations, not the states, will be responsible for providing necessary information to the manufacturers. (Section 3301)	Shall apply to covered part D drugs dispensed on or after July 1, 2010	Education of NM Medicare Beneficiaries	N/A	

Elimination of Part D Cost Sharing for selected non-institutionalized Dual Eligibles: Makes cost-sharing for full benefit dual eligible individuals receiving HCBS equal to the cost-sharing for those receiving institutionalized care. Effective no earlier than January 1, 2012. (Section 3309)	January 1, 2012	Education of NM Medicare Beneficiaries	N/A	
Community-Based Care Transitions Program: This section creates a new five year, $500 million HHS program that will begin January 1, 2011. Selected hospitals with high readmission rates and qualifying community-based organizations will receive funding to provide improved care transition services to high risk Medicare beneficiaries. (Section 3026)	January 1, 2011: The program takes effect	-Identify hospitals with high readmissions rates -Gather stakeholders to analyze impact	Funding for selected hospitals and qualifying community-based organizations.	
Reducing avoidable hospital readmissions: This provision directs CMS to track national and hospital-specific data on the readmission rates of Medicare participating hospitals for certain high-cost conditions that have high rates of potentially avoidable hospital readmissions. Starting in 2011, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20% if a patient with a selected condition is re-hospitalized with a preventable readmission within seven days, or by 10% if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days. (Section 3025)	2011: Hospitals with high readmission rates will face penalties	-Identify hospitals with high readmissions rates -Gather stakeholders to analyze impact	Potential reduction in Medicare payments to certain hospitals.	
Expansion of the Recovery Audit Contractor (RAC) Program: By December 31, 2010, states must have programs contracting with Medicare Recovery audit contractors to identify, and recoup where necessary, underpayments and overpayments with respect to services. (Section 6411)	December 31, 2010: States must have in place RAC programs	Determine which HHS Dept. to take lead	N/A	
Option for Low-Income Subsidy (LIS) recipients: Increase in the number of zero premium plans by changing the way that low income "benchmark" amounts are calculated and allowing plans with premiums that are a "de minimis" amount above the benchmark to waive premiums for LIS recipients. The new law also requires, effective January 1, 2011, that the LIS eligibility of an individual whose spouse dies be extended by one year. (Sections 3302-3305)	Plan year 2011	Education of NM Medicare Beneficiaries	N/A	
New Annual Coordinated Election Period (AEP) for Part D and Medicare Advantage: Starting in the Fall of 2011, the AEP will begin Oct. 15 and end Dec. 7. The change is designed to give beneficiaries more time to consider their options. (Section3204)	2011	Education of NM Medicare Beneficiaries	N/A	
AIDS Drug Assistance Program (ADAP) and Indian Health Services (HIS) Costs in TrOOP Calculation: Costs incurred by the ADAP and IHS will count toward true out-of-pocket costs (TrOOP) incurred by Part D Enrollees. (Section 3314)	2011 Plan year	Education of NM Medicare Beneficiaries	N/A	Indian Health Services (HIS) Costs in TrOOP Calculation: Costs incurred by IHS will count toward true out-of-pocket costs (TrOOP) incurred by Part D Enrollees.

Independence at Home Demonstration Program: The HHS Secretary shall conduct a demonstration program to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes. (Section 3024)	The demonstration program shall begin no later than January 1, 2012.		Payments to primary care teams	
Medicare Hospice Concurrent Care demonstration project: Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs. The demonstration program under this section shall be conducted for a 3-year period. The HHS Secretary shall select not more than 15 hospice programs at which the demonstration program under this section shall be conducted. Such hospice programs shall be located in urban and rural areas. (Section 3140)			Funding to Hospice programs	
Medicare Senior Housing Plans: Makes permanent Medicare Advantage Senior Housing Facility Demonstration Plans. These plans serve individuals living in a continuing care retirement community by providing primary care services and transportation to offsite providers. (Section 3208)	The amendment made by this section shall take effect on January 1, 2010, and shall apply to plan years beginning on or after such date.			
Coverage of Preventative Services: Only proven preventative services will be covered and cost-sharing for preventative services in Medicare will be eliminated, effective January 1, 2011. Medicare payments for certain preventative services will be increased to 100%. Medicare beneficiaries will have access to a comprehensive health risk assessment and a personalized prevention plan. Within six months of enactment, qualified health plans must provide minimum coverage without cost-sharing for certain preventative services. (Section 2713)	Within six months of enactment: Qualified health plans must provide minimum coverage without cost-sharing for certain preventative services January 1, 2011: Cost-sharing for preventative services will be eliminated.	Education of NM Medicare Beneficiaries		
Dual Eligibles: A new office, the Federal Coordinated Health Care Office for Dual Eligible Beneficiaries, within the Centers for Medicare and Medicaid services (CMS) will be established to more effectively integrate Medicare and Medicaid benefits and to improve coordination between the federal	March 1, 2010: the Federal Coordinated Health Care Office	Education of NM Medicare Beneficiaries Examine how the ALTSD		Enhanced Medicare and Medicaid Program Integrity Provisions: Requires that the

government and states. By January 1, 2011, the Center for Medicare and Medicaid Innovation within CMS will be established to, in part, test innovative payment and service delivery models to reduce program expenditures while simultaneously preserving or enhancing the quality of care furnished. The Center allows states to test and evaluate models for fully integrating care for dual eligibles within the state, as well as payment reform models for the medical care residents of the state, including dual eligibles. Payment models will be implemented on a nationwide basis, with exceptions for states demonstrating that such implementation would not be feasible or appropriate to the health care delivery system of that state. (Sections 2601-02;3021) No earlier than January 1, 2012, cost-sharing will be eliminated for dual eligibles receiving home and community-based services whom would otherwise be institutionalized. (Section 3309)	for Dual Eligible Beneficiaries will be established January 1, 2011: the Center for Medicare and Medicaid Innovation will be established January 1, 2012: Cost-sharing for certain dual eligibles will be eliminated	Senior Medicare Patrol Program's is linked to Integrity Provisions.		Integrated Data Repository of the CMS shall include, at minimum, claims and payments data from certain programs including IHS and the Contract Health Services Program. Also requires the Secretary to enter into agreements with individuals of certain agencies, including the IHS Director, to share and match data in the record system of the respective agencies with data in the HHS system for the purposes of identifying potential fraud, waste, and abuse. (Section 6402)
Medicare Part B				Section 2902: Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics. Makes permanent reimbursement for all Medicare Part B services furnished by Indian Health Service hospitals & clinics.
Reform Provisions	Implementation Dates	Options/Decisions	Funding Opportunity	Indian Provisions
ELDER JUSTICE & PROTECTION				

Elder Justice Act: -Federal formula grants will be made available to states to support adult protective services for adults lacking decisional capacity and victims of abuse, neglect and/or exploitation. -Demonstration grants will be available to develop innovative methods of elder abuse detection or prevention. -A national Elder Justice Coordinating Council and Advisory Board on adult abuse, neglect and exploitation will be established. -Funding will be made available to support Long-term Care Ombudsman Programs dedicated to protecting the rights of individuals living in long-term care institutions.(Sections 6701-6703)	FY11-FY15	Advocate for funding to be appropriated.	Yes—funding to ALTSD Adult Protective Services Division and Long-Term Care Ombudsman Program	
Nursing Home Transparency: -Public disclosure of nursing home owners, operators, and others who provide management, financing, and services to nursing homes will be required. -Public information on "Nursing Home Compare" website will be improved, including staffing data; links to facilities' survey reports and plans of correction; summaries of complaints against facilities; a standardized complaint form; and adjudicated criminal violations. -A consumer rights information page on "Nursing Home Compare" will be established, including services available from the long-term care ombudsman . -Complaint handling will be improved, including a standardized form for filing complaints with the survey agency and ombudsman. -Residents' legal representatives and other responsible parties will be protected from retaliation when they complain about quality of care. -60-day advance notification of facility closure and authorization to continue Medicaid payments pending relocation of all residents will be required. -Dementia care and abuse prevention in nurse aide training programs will be made available. (Sections 6101-6114)	2011	States will be required to maintain a website with information on all nursing homes in the state, including survey reports, complaint investigations, and plans of correction.		
Reform Provisions	Implementation Dates	Options/Decisions	Funding Opportunity	
LONG-TERM CARE COVERAGE				

Community Living Assistance Services and Support (CLASS) Act: The CLASS Act is a national voluntary long-term care insurance program. After 5 years of contributing to the program, should a person require services in the future, the fund would provide a lifetime benefit averaging $50/day depending on the needs of the person. Benefits include non-medical support services such as home modifications, transportation, homemaker services, etc. Services are intended to maintain the beneficiary's personal and financial independence and ability to remain in the home and community longer. The program is financed through voluntary payroll deductions and will not have a lifetime or aggregate limit. (Sections 8001-02)	The program is intended to start in 2011	Regulations are pending. NM needs to analyze financial and administrative impact of state employees choosing to enroll	N/A	
OTHER PROVISIONS IMPACTING LONG-TERM SERVICES				
Train workers in geriatrics and long-term care: grants to eligible entities to enable such entities to provide new training opportunities for direct care workers who are employed in long-term care settings such as nursing homes, assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, and home and community-based settings. (Section 5305)	2011-13		Potential funding to entities training direct caregivers	
Workforce Promotion: Amends the OAA to establish a Personal Care Attendant Workforce Advisory Panel to examine workforce issues. The Panel will formulate a report on core competencies for home care aides which will result in an AoA directed three year, four state demonstration projects. This section promotes family caregiver support as it modifies the appropriations for the Family Caregiver Support Program by increasing its funding to $250 million for each fiscal year from 2011 – 2013. (Section 3210)	2011-13	Analyze if NM is eligible to receive Family Caregiver Support Program funds	Potential funding through the Family Caregiver Support Program	
Healthy Aging, Living Well: CDC to award grants to states or tribes to carry out 5-year pilot projects that include public health community interventions, screenings, and clinical referral activities for persons 55-64. (Section 4202)	2010-14	Consider applying when funding opportunity is available	Potential funding to states or tribes	Indian tribes are eligible entities with states.
Community Transformation Grants: CDC to award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, and address health disparities. (Section 4201)	2010-14	Consider applying when funding opportunity is available	Potential funding to state, local, community-based organizations	Indian tribes are eligible entities.
Expansion of ADRCs: Funding to expand state ADRC's—authorizes $10 million in additional support. (Section 2405)	Funding opportunity released: Due July 30th, 2010	Consider applying	Potential funding to ALTSD - $10,000,000 - 2010 through 2014	
Extension of Medicare Improvement to Patients and Providers Act (MIPPA): Additional funding to support Low-Income Subsidy	Funding opportunity released: Due July 30th,	Consider applying	Potential funding to ALTSD	Funding for Title VI Native American Programs-

Outreach and Enrollment. (Section 3306)	2010			support to elders for the Low Income Subsidy program (LIS), Medicare Savings Program (MSP), Medicare Part D, Medicare prevention benefits and screenings and in assisting beneficiaries in applying for benefits. AoA will provide a grant of $1,000 to each Older Americans Act Title VI Native American program.
The Early Retiree Reinsurance Program: provide financial relief for employers so retirees can get quality, affordable insurance. The Affordable Care Act provides $5 billion in financial assistance to employers to help them maintain coverage for early retirees age 55 and older who are not yet eligible for Medicare. Employers can use the savings to either reduce their own health care costs, provide premium relief to their workers and families or a combination of both. • Employers who are accepted into the program will receive reinsurance reimbursement for medical claims for retirees age 55 and older who are not eligible for Medicare, and their spouses, surviving spouses, and dependents. • Health benefits that qualify for relief include medical, surgical, hospital, prescription drug, and other benefits that may be specified by the Secretary of Health and Human Services, as well as coverage for mental health services. • The amount of this reimbursement to the employer plan is up to 80% of claims costs for health benefits between $15,000 and $90,000. Claims incurred between the start of the plan year (often January 1) and June 1st are credited towards toward the $15,000 threshold for reimbursement. However, only medical expenses incurred after June 1, 2010 are eligible for reimbursement under this program. (Section 1102)	HHS will begin the Early Retiree Program on June 1, 2010, in advance of the June 21 start date required by the Affordable Care Act, allowing more claims to qualify for reinsurance payments for plans this year. The program ends on January 1, 2014 when early retirees will be able to choose from the additional coverage options that will be available in the health insurance exchanges.	ALTSD to provide education of staff and constituents; Can the NM Retiree Health Care Authority be accepted into the program?	Both self-funded and insured plans can apply, including plans sponsored by private entities, state and local governments, nonprofits, religious entities, unions, and other employers.	

The information contained in this report has been gathered from multiple sources including: The White House; The National Association for State Units on Aging; AARP; Families USA; Medicare Rights Center; National Senior Citizens Law Center; and the Natl. Consumer Voice for Quality LTC

Appendix 4
Behavioral Health Collaborative's Health Care Reform Issue Matrix

Behavioral Health Collaborative Matrix of Provisions	Implementation Dates	Options/ Decisions	Funding Opportunity
Expanded Coverage			
Expands Medicaid to 133% FPL – an estimated 200,000 new enrollees, of which 1/3 could have MI/SUD service needs. Makes premium & cost-sharing credits available to individuals and families with incomes between 133%-400% FPL. Focus grant dollars for recovery support services not paid for through insurance benefit plans. Changes in Medicaid to assist youth to maintain coverage in times of transition. Expands possibility of home & community-based services for individuals with mental illness & substance use disorders (MI/SUD).			Medicaid Health Home for Enrollees w/ Chronic Conditions: Planning Grant - $25 million maximum per state with state contribution required. Begins Jan. 1, 2011) Medicaid Emergency Psychiatric Demonstration Project: Establishes program for emergency psychiatric demonstration project to provide incentive payments to certain institutions for mental disease. Appropriates $75 million for fiscal year 2011 for three year period.
Identify Benefit Package			
Increased Medicaid funding of mental health & substance abuse services. Allowing states to cover prevention services under Medicaid Benchmark coverage for adults will likely be similar to NM's State Coverage Insurance (SCI) but with modifications including removal of the $100,000 annual claims maximum. Establishes a "Medicaid Emergency Psychiatric Demonstration."	2010		
State Exchanges			
Creates state-based Health Benefit Exchanges through which individuals not eligible for Medicaid & not offered employer-sponsored insurance can purchase coverage. Creates separate Exchanges -Small Business Health Options Programs [SHOP] -through which small businesses can purchase coverage. Increased commercial insurance funding of mental health and substance abuse services. Allows SAMHSA block grant & grant dollars to be focused on recovery support services not paid for through insurance benefit plans.	2014		
Implementation of Behavioral Health Parity			
Parity required in essential benefits plans offered through Exchanges. Employer mandate requires parity in private health plans. DHHS Parity Regulation – implementation of interim final rule. Comments & research on scope of services, non-quantitative treatment limitations, common deductibles. Medicaid parity regulation still to come.	Effective April 5th; applies to plan years beginning on or after July 1, 2010; comment period through May 3		
Accountable Care Organizations (ACOs) & Relationship to NM's Core Service Agencies (CSAs)			
Programs to expand "medical homes" to include behavioral health. School-based health clinics to provide mental health & substance			

use disorder assessments, crisis intervention, counseling, treatment. States that develop health homes must "consult & coordinate" with SAMHSA regarding the prevention & treatment of MH/SUD. Increased patient-centered health research. Training grants for behavioral health workforce. Training on MH/SUD for Primary Care Extender.			
Health Information Technology (HIT)/Health Information Exchanges (HIE)/Electronic Health Records (EHR)			
SA/MH provider capacity to utilize electronic health records, including access to federal assistance. Behavioral health outcomes & data using health information technology – standards needed. Privacy/confidentiality of MH/SA treatment information, while supporting integration of health & behavioral health care. Common National Outcome Measures (NOMS) across funding streams for state mental health, substance abuse & Medicaid agencies. FY 2011 Budget: $4 million new in the Office of the National Coordinator (ONC) for Behavioral Health HIT			
Federally Qualified Health Centers (FQHCs) and Relationship to CSAs' and FQHCs' Behavioral Health Standards			
Behavioral health/primary care integration. Numbers & distribution of practitioners with aging workforce. Support for recovery coaches peer and paraprofessional or non-traditional workers. Evidence-based practices adoption. Recovery in core competencies and curriculum for education of all practitioners and workers. Will require changes to NM Practice Acts (i.e., LMSWs, etc.) and other impacts on workforce in NM. FY 2011 Budget: $25 million to HRSA for behavioral health in FQHCs.			Prevention and Public Health Fund: $250 million in Federal Fiscal Year 2010 for prevention from the new Fund dedicated to four critical priorities – 1. Community and Clinical Prevention, 2. Public Health Infrastructure, Research, and 3.Tracking, and Public Health Training.

Appendix 5
Children, Youth, and Families Department's Health Care Reform Issue Matrix

Relevant Reform Provisions by CYFD Division	Implementation Dates	Options/Decisions	Funding Opportunity
PROTECTIVE SERVICES DIVISION (PS)			
Income Eligibility for Nonelderly determined using the MAGI & development of "equivalent income test" except for individuals eligible for Medicaid through another program, SSI, Child Welfare, or another program that establishes Medicaid eligibility external to the Medicaid agency.	January 1, 2014	Consider opportunity to expand coverage to non-Title IV-E Adoption; consider opportunity to fund title IV-E and non-Title IV-E kinship guardianship as allowed by the *Fostering Connections to Success and Increasing Adoptions Act of 2008*.	
Mandatory Coverage for Former Foster Care Children: Establishes a new categorical eligibility group of individuals who are under age 26 who were in foster care and enrolled in Medicaid on the day they turned 18. Limited to children who aged out of foster care as of the date of enactment or later.	January 1, 2014	Expands "Chafee" Medicaid through age 25 (currently through age 21). Currently, PS completes the eligibility determination; would continue to do so with expanded population. Consider how to address foster care alumni from other states seeking coverage.	
Prohibits Pre-Existing Conditions Exclusions for Children: Increases the number of medical support orders that can be effectively enforced.		Has the potential for impacting children adopted from foster care using adoptive parents' private insurance if private insurance has an exclusion or pre-existing conditions clause.	
Parents above certain income required to provide minimum essential health care coverage for their children or pay a fine.		Consider how this plays out for non IV-E adopted kids with severe pre-existing conditions – would this create a disincentive to adopt? Would be critical that insurance company restrictions on limiting coverage were enforced.	
Increase Medicaid Reimbursement for Primary Care: Requires Medicaid payment rates to primary care physicians for primary care services to be no less than 100% of Medicare payment rates in 2013 and 2014.	2013-2014	Impacts access to care issues faced by PS clients. Currently, based on lower reimbursement rates for Medicaid than other insurance plans, clients are placed on waiting list so as to be able to serve clients covered by alternative plans.	100% federal funding for the incremental costs to states to meet the requirement
Prevention and Public Health Fund: Established to increase funding for programs authorized by the Public Health Service Act for prevention, wellness, and public health activities including prevention research and health screening such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits and immunization programs.	FY 10-15	Affects populations served by PS: In-Home Services, Foster Care, Adoptions, and Youth Services.	Yes – funds are to HHS
Oral Healthcare Prevention Activities: b) School-based sealant programs; c) oral health infrastructure cooperative agreements to establish oral health leadership and program guidance, oral health data collection and interpretation, a multi-dimensional delivery system for oral health and implement science-based programs to improve oral	FY 10-14	Affects populations served by PS: In-Home Services, Foster Care, Adoption, and Youth Services.	Yes – B&C funds available to States and territories, Indian tribes or tribal organizations

health; d) updating national oral health surveillance activities—1) PRAMS – updating and improving oral healthcare in PRAMS to be reported by the State including mandatory measurements; 4) increase participation of State in the National Oral Health Surveillance System from 16 states to all 50 states, territories and DC.			
Health Workforce, Grants to Promote the Community Health Workforce: Grants to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.	FY 10-14	Affects PS: CFSR Systemic Factor finding of nonconformity for service array. Finding partially based upon determination that there is insufficient service array in rural NM.	Yes – State, public subdivision of State, Public Health Department, FQHC
Personal Responsibility Education: Allotments to states to educate adolescents in both abstinence and contraception for the prevention of pregnancy, STs and adulthood preparation subjects.	FY 10-14	Affects populations served by PS: Youth in custody of the state. Aligned with Transition Services requirements authorized by Chafee Foster Care Independence Act.	If a state does not submit an application for FY10 or 11, State will no longer be eligible and State allotment will be awarded to local organizations and entities
Expansion of Adoption Credit and Adoption Assistance Programs: - Increases the credit from $10,000 to $13,170. - Includes guidelines for an annual cost of living adjustment. - Extends the EGTRRA - Economic Growth Tax Relief Reconciliation Act - sunset from Dec 2010 to Dec 2011. Among other things, the EGTRRA increased the adoption tax credit first introduced in 1996, and while the EGTRRA made the credit itself permanent, the increased amount it authorized sunsets when the Act sunsets	July 1, 2010	CYFD is required by the *Fostering Connections to Success and Increasing Adoptions Act of 2008* to notify adoptive parents that the adoption credit exits (done at the time of renewal of adoption agreement). Nothing new for CYFD to do; CYFD does not prepare taxes or file on behalf of individuals. The credit increase may lead to increased stability for adoptive parents.	None – credit goes directly to adoptive parent
EARLY CHILDHOOD SERVICES (ECS)			
Maternal, Infant, and Childhood Home Visiting Programs: Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s) to promote improvements in maternal and prenatal, infant and child health, parenting related to child development outcomes, and reductions in child abuse, neglect and injury. Indian Provisions: Sets asides 3% of funding for I/T/Us, tribal entities preferred.	FY 10-14	CYFD lead, DOH support. Affects populations served by PS: CPS investigation and In-Home Services could identify client families eligible for home visitation. First step with grant: Assess home visiting in NM; second step, create strategic plan to improve it. Actions on Indian Provisions: DHHS has issued separate grant for the 3%, for which CYFD is not eligible; see http://www.acf.hhs.gov/grants/open/foa/view/HHS-2010-ACF-OFA-TH-0134, CYFD can provide TA to	Formula; paperwork due 7/9/10

		tribes/tribal entities at their request and share information from the CYFD proposal including State data. CYFD can also partner with Tribes/tribal entities in a collaborative Tribal-State program.	
JUVENILE JUSTICE SERVICES (JJS)			
Establish a process to allow individuals to apply for, enroll in, and renew their enrollment in Medicaid through a website. The website must be linked to the Health Insurance Exchange and CHIP.	January 1, 2014	Affects population: Clients in reintegration centers with access to a website could apply for Medicaid.	
Accept Medicaid and CHIP eligibility determinations made by the exchange, and enroll individuals determined eligible by the exchange without any further determination.	January 1, 2014	Possible service impact: Need to look at transition services for clients leaving JJS facilities.	
Health Workforce, Training in Family, General Internal, General Pediatrics and Physician Assistantship Grants or contracts to: a)Support and development of primary care training programs including developing and operating programs for physicians planning to teach in family medicine, general internal medicine or general pediatrics and programs for physician assistant training b) capacity building in primary care – establish, improve, maintain to improve clinical teaching and research or integrate academic administrative unites to enhance interdisciplinary recruitment, training and faculty development	FY10-14	Could potentially benefit JJS recruiting for medical staff.	Yes, accredited public or nonprofit private hospitals, schools of medicine or osteopathic medicine, academically affiliated physician assistant training programs
YOUTH AND FAMILY SERVICES (YFS)			
Community-Based Collaborative Care Networks: Grants to community-based collaborative care networks to : Assist low-income individuals to access and use health services, enroll in a health coverage program, obtain a regular primary care provider or medical home; Provide case management and care management; Perform health outreach using neighborhood health workers; Provide transportation; Expand capacity including through telehealth, after-hours service or urgent care; and Provide direct patient services.	FY11-15	Affects services: YFS works with field staff to provide primary care providers for JPO clients with no medical care.	Yes, Community-based collaborative networks (defined p 852)
Create state based Health Insurance Benefit Exchanges.	2010	Affects services: Better Medicaid coverage for clients, less reliance on CYFD General Fund (GF).	Increased FMAP for "newly eligible individuals"
Medicaid Coverage for Former Foster Care children	January 1, 2014	Affects services: Better Medicaid coverage for clients, less reliance on CYFD GF.	
Money Follows the Person Rebalancing Demonstration: Effective 30 days following enactment, Money Follows the Person is extended through September 30, 2016. This section modifies eligibility requirements by reducing the institutional residency period to not more than 90 consecutive days and by eliminating the state's flexibility in setting this residency period	30 days following enactment through September 30, 2016	Affects services: Better Medicaid coverage for clients, less reliance on CYFD GF.	Yes, if additional funding opportunities come available

themselves. Currently, states set this requirement within Deficit Reduction Act's guidelines, which require that individuals reside in a facility for not less than 6 months, and not more than 2 yrs.			
Parents Above Certain Income Required to Provide Minimum Essential Health Care Coverage for Their Children or Pay a Fine: Parents will be motivated to obtain insurance regardless of a court order for the NCP to do so. This may raise legal questions in relation to court ordered medical support obligations if the parents pay a penalty, but continue not providing health insurance		Affects services: Better Medicaid coverage for clients, less reliance on CYFD GF.	
Parents Who Claim a Child as a Dependent for IRS Must Prove Coverage for Child or Face Tax Penalty (Some Exemptions Exist): Parents will be motivated to obtain insurance regardless of a court order for the NCP to do so. This may raise legal questions in relation to court ordered medical support obligations if the parents pay a penalty, but continue not providing health insurance.		Affects services: Better Medicaid coverage for clients, less reliance on CYFD GF.	
Medicaid Eligibility Expansion: Expands Medicaid to 133% FPL for all individuals without regard to categorical eligibility. 5% income disregard. Definition of newly eligible (19-64 who are not eligible for Medicaid on the date of the bill's enactment).	January 1, 2014	Affects services: Better Medicaid coverage for clients, less reliance on CYFD GF.	Provides 100% FMAP for newly eligible individuals from 2014 – 2016. In 2017, FMAP for newly eligible individuals decreases to 95% and continues to decrease every year until 2020, when it will remain at 90%
Presumptive Eligibility: States have the option to allow for PE for individuals up to 133% FPL; and states may permit any hospital participating in Medicaid to determine PE for all Medicaid categories.	January 1, 2014	Affects population: Faster Medicaid eligibility for JPO clients.	
Mandatory Coverage for Former Foster Care Children: Establishes a new categorical eligibility group of individuals who are under age 26 who were in foster care and enrolled in Medicaid on the day they turned 18. Limited to children who aged out of foster care as of the date of enactment or later.	January 1, 2014	Affects services: Better healthcare coverage for clients, less reliance on CYFD GF.	
Health Insurance Exchange: The state is required to establish a health insurance exchange that, among many things, (1) facilitates the purchase of qualified health plans; (2) provides for the establishment of a Small Business Health Options Program (SHOP Exchange) that is designed to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the state; and 3) individuals can use to apply for Medicaid, CHIP, and tax credits for individual coverage through the exchange. The exchange must be a governmental entity or a nonprofit entity that is established by a state.	No later than January 1, 2014	Affects services: Better healthcare coverage for clients, less reliance on CYFD GF.	Funding is available to establish the exchange but the exchange must be self-sustaining within one or two years
Benefit Package: Allows states to cover prevention services under Medicaid Benchmark coverage for adults; will likely be similar to NM's State Coverage Insurance (SCI) but with modifications including removal of the $100,000 annual claims maximum.	2010	Affects services: Better healthcare coverage for clients, less reliance on CYFD GF.	Increased Medicaid funding of mental health & substance abuse services.

			Increased commercial insurance funding of mental health and substance abuse services Allows SAMHSA block grant and grant dollars to be focused on recovery support services not paid for through insurance benefit plans
Parity: Parity required in essential benefits plans offered through Exchanges. Employer mandate requires parity in private health plans. DHHS Parity Regulation – implementation of interim final rule. Comments & research on scope of services, non-quantitative treatment limitations, common deductibles. Medicaid parity regulation still to come.	Effective April 5th; applies to plan years beginning on or after July 1, 2010; comment period through May 3	Affects services: Better healthcare coverage for clients, less reliance on CYFD GF.	
IDENTIFIED FOR FURTHER STUDY BY CYFD FOR IMPACT ON CYFD SERVICE POPULATION			
Presumptive Eligibility: States have the option to allow for PE for individuals up to 133% FPL; and states may permit any hospital participating in Medicaid to determine PE for all Medicaid categories.	January 1, 2014	Further study.	
Community-Based Care Transition Program: Provides funding for improved care transition services to high-risk Medicare beneficiaries. Certain hospitals identified by the Secretary as having high readmission rates, and community-based organizations that have arrangements with them to provide care transition services, will be eligible. (Sec. 3026)	January 1, 2011 for 5 years.	Further study.	$500 million, 2011-15
FQHCs and relationship to CSA and FQHC BH standards: Behavioral health/primary care integration. Numbers & distribution of practitioners with aging workforce. Support for recovery coaches, peer and paraprofessional or non-traditional workers. Evidence-based practices adoption. Recovery in core competencies and curriculum for education of all practitioners and workers.		Further study.	$25 million to HRSA for behavioral health in FQHCs.
Mental Health Parity: Community mental health centers may be medical home.		Further study.	Funds are provided to states for planning and development.
Oral Healthcare Prevention activities: b) school-based sealant programs; c) oral health infrastructure cooperative agreements to establish oral health leadership and program guidance, oral health data collection and interpretation, a multi-dimensional delivery system for oral health and implement science-based programs to improve oral health; d) updating national oral health surveillance activities – 1) PRAMS – updating and improving oral healthcare data in PRAMS to be reported by the State including mandatory measurements; 4) increase participation of States in the National Oral Health		Further study.	

Surveillance System from 16 states to all 50 States, territories and DC.			
Support , Education and Research for Postpartum Depression: Grants to provide services to individuals with a postpartum condition and their families.	FY 10-12	Further study.	Yes, state or local government, Recipient of 330 grant, hospital, community-based organization, ambulatory care facility, community health center
Support for Pregnant and Parenting Teens and Women: A State may use amounts received under a grant from section 10212 to make funding available to eligible institutions of higher education to enable the institution to establish, maintain or operate pregnant and parenting student services. A State may also make funding available to eligible high schools and community service centers to establish maintain or operate pregnant and parenting services. A State may make funding available to its Attorney General to assist Statewide Offices in providing intervention services for eligible pregnant women who are victims of domestic violence, sexual violence, sexual assault or stalking. Technical assistance and training to governmental, law enforcement, tribal government, court staff , other professionals working in legal, social service and health care settings, nonprofit and faith-based organizations.	FY 10-19	Further study.	Yes, to states for distribution to educational institutions, state attorney generals and professions working with victims of domestic/sexual violence
Design and Implementation of Regionalized Systems for Emergency Care: 4 multiyear competitive contracts or grants to support pilot projects that design, implement and evaluate innovative models of regionalized, comprehensive and accountable emergency care and trauma systems.	FY 10-14	Further study.	Yes, States, Indian tribes
Nurse-Managed Health Clinics: Grants to fund the development and operation of nurse-managed health clinics.	FY 10-14	Further study.	Yes for Nurse-Managed health clinics providing primary care to underserved or vulnerable populations, and associated with a school, college, university or department of nursing, a federally qualified health center or independent nonprofit health or social services agency
Community-Based Collaborative Care Networks: Grants to community-based collaborative care networks to : Assist low-income individuals to access and use health services,	FY 11-15	Further study.	Yes, Community-based

enroll in a health coverage program, obtain a regular primary care provider or medical home; Provide case management and care management; Perform health outreach using neighborhood health workers; Provide transportation; Expand capacity including through telehealth, after-hours service or urgent care; and Provide direct patient services.			collaborative networks (defined p 852)
Co-locating Primary and Specialty Care in Community-Based Mental Health Settings: Grants and cooperative agreements to eligible entities to establish demonstration projects for the provisions of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.	FY 10-14	Further study.	Yes, Qualified community mental health programs

Appendix 6
Department of Health's Health Care Reform Issue Matrix

Health Care Reform Provisions	Implementation Dates	Options/Decisions	Funding Opportunity	Indian Provisions
Public Health				
Sec. 2713 Coverage of Preventive Health Services: Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.	Within 6 months of the enactment of the Act	Provide information or assistance PRC and/or HSD with legislative/rule changes		
Sec. 2301 Coverage for Freestanding Birth Center Services: Provide separate payment to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center.	Take effect the day the Act is enacted, unless state legislation is required for this change to become effective.	If not already required in NM and funding allows, work with HSD to provide information and outreach to NM's birth centers and midwives about this new opportunity		
Sec. 2303 State Eligibility Option for Family Planning Services: Allows the State's to provide a family planning services option through Medicaid and allow for presumptive eligibility for these services.	Take effect the day the Act is enacted.	If not already required in NM and funding allows, work with HSD to provide information and outreach to family planning providers		
Sec. 2703 State Option to Provide Health Homes for Enrollees with Chronic Conditions: A state may submit a state plan amendment to allow for the payment of home health services to each eligible individual's with chronic diseases.	January 1, 2011	If not already an option in NM and funding allows, work with HSD to submit a state plan amendment		
Sec. 511 Maternal, Infant, and Early Childhood Home Visiting Programs: Submit an additional needs assessment that identifies specific data related to maternal and child health and the quality and capacity of existing programs for early childhood home visitation in the state for FY11.	No later than 6 months after the Act is enacted	DOH, CYFD and others develop a needs assessment as outlined in the Act. Apply for grant when guidance is available.	Grants for early Childhood Home Visitation programs	Indian Tribes, Tribal Organizations, Urban Indian organizations are eligible for these grants.
Sec. 513 Personal Responsibility Education: Allotments to States to educate adolescents in both abstinence and contraception for the prevention of pregnancy, STIs and adulthood preparation subjects	FY10-FY14	If a State does not submit an application for FY10 or 11 the state will no longer be eligible and the state's allotment will be awarded to local organizations and	Yes	

		entities		
Sec. 4002 Prevention and Public Health Fund: Establishes a fund in DHHS to increase funding over FY08 levels for prevention, wellness, and public health activities including prevention research and health screenings, such as Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits and immunizations.	FY10- FY15	Apply when guidance available	Yes – funds are distributed through HHS	
Sec. 4101 School-based health centers: Establish a program to award grants to eligible entities to establish and operate school-based health centers.	FY10-FY14	Apply when guidance available	Yes – funds are distributed through HHS	
Sec. 399LL-1 Research-based Dental Caries Disease Management. Demonstrate the effectiveness of research-based dental caries disease management activities.	TBD	Provide technical assistance to IAD and eligible tribal entities, if requested	Yes – funds are distributed through HHS	IHS, Indian tribal, and urban Indian trauma centers are eligible for these grants.
Sec. 399LL- 2 Authorization of Appropriations for Oral Healthcare Prevention Activities: b) school-based sealant programs c) oral health infrastructure cooperative agreements to establish oral health leadership and program guidance, oral health data collection and interpretation, a multi-dimensional delivery system for oral health and implement science-based programs to improve oral health d) updating national oral health surveillance activities – 1) PRAMS – updating and improving oral healthcare data in PRAMS to be reported by the State including mandatory measurements 4) increase participation of States in the National Oral Health Surveillance System from 16 states to all 50 States, territories and DC	FY10-FY14	Apply when guidance available and/or provide technical assistance to eligible tribal entities, if requested	Yes – funds are distributed through HHS	Indian tribes, tribal organizations and urban Indian organizations are eligible for some of these funding opportunities
Sec. 4107 Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid: Require coverage and removal of cost-sharing for counseling and pharmacotherapy for cessation of tobacco use by pregnant women.	October 1, 2010	Provide information or assistance to HSD if requested. When coverage option is available educate clients about opportunity.		
Sec. 4108 Incentives for Prevention of Chronic Diseases in Medicaid: Award grants to states to carry out initiatives to provide incentives to Medicaid beneficiaries who help individuals with 1) tobacco cessation, 2) control or reduce weight, 3) lower cholesterol, 4) lower blood pressure, or 5) prevent or control diabetes.	January 1, 2011	Provide information or assistance to HSD if requested	Yes	Indian tribes may enter into these incentives with the state.
Sec. 4201. Community Transformation Grants: Award	FY10-FY14	Apply when guidance	Yes – funds are	Indian Tribes are

competitive grants for the implementation, evaluation and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities and develop a stronger evidence-base of effective prevention programming.		available and/or provide technical assistance to eligible tribal entities, if requested	distributed through HHS	eligible for these grants
Sec. 4202 Healthy Aging, Living Well: Evaluation of Community-based Prevention and Wellness Programs for Medicare Beneficiaries: Award grants to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.	FY10-FY14	Apply when guidance available and/or provide technical assistance to eligible tribal entities, if requested		Indian Tribes are eligible for these grants.
Sec. 4204 Immunizations: Authority to purchase recommended vaccines for adults; and establish a demonstration program to award grants to improve the provision of recommended immunizations for children, adolescents and adults.	FY10	Apply when guidance available	Yes – funds are distributed through HHS	
Sec. 4206 Demonstration Project Concerning Individualized Wellness Plans: Establish pilot program to test the impact of providing at-risk populations who utilize community health centers funded under Section 330 of Public Health Service Act an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.	TBD	Encourage one of the 330 clinics serving American Indians, African-Americans or Hispanics to apply	Yes – funds are distributed through HHS	
Sec. 4207 Reasonable Break Time for Nursing Mothers: Amend the Fair Labor Standards Act to 1938 to require an employer to provider for reasonable time and location for an employee who is breast feeding to express milk for her nursing child for 1 year after the child's birth.	TBD	Ensure NM's statues are incompliance with new section of the Fair Labor Standards Act		
Sec. 4306 Childhood Obesity Demonstration Project: Funds otherwise not appropriated in the Treasury are appropriated to carry out this subsection.	FY10-FY14	Apply when guidance available	Yes	
Sec. 5102 State Health Care Workforce Development Grants: Establish a competitive workforce development grant program to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels.	FY10 and subsequent fiscal years	Apply when guidance available but includes matching requirements	Yes – funds are distributed through HRSA	
Sec 5103 Health Care Workforce Assessment: Award grants/contracts for 1) collecting, analyzing and reporting data regarding programs under Title V, and 2) providing technical assistance to local and regional entities on the collection, analysis	FY10-FY14	Apply when guidance available and provide information or assistance to the State workforce	Yes – funds are distributed through HRSA	

and reporting of data.		investment board		
Sec. 776 Public Health Workforce Loan Repayment Program: Establish the Public Health Workforce Loan Repayment Programs to assure an adequate supply of Public Health professionals to eliminated shortages in Federal, State, local and tribal public health agencies.	FY10-FY15	Educate potential students of repayment opportunities.		Individuals who plan to work with tribal public health agencies would be eligible for this repayment program.
Sec. 5205 Allied Health Workforce Recruitment and Retention Programs: Assure an adequate supply of Allied Health professionals to eliminated shortages in Federal, State, local and tribal public health agencies or in settings where patients might require health care services.	FY10-FY15	Educate potential students of repayment opportunities.		Individuals who plan to work with tribal public health agencies would be eligible for this repayment program.
Sec. 330A Grants to Nurse-Managed Health Clinics: Fund the development and operation of nurse-managed health clinics.	FY10-FY14	Encourage any clinics associated with UNM or FQHC to apply		
Sec. 5304 Alternative Dental Health Care Providers Demonstration Projects: Award grants to 15 eligible entities to establish training programs to train or to employ alternative dental health care providers (community dental health coordinators, dental hygienists, primary care physicians, dental therapists, and dental health aides) in order to increase access to dental health care services in rural and underserved communities.	Not later than 2 years after the date of enactment and conclude not later than 7 years after the date of enactment	Enter into discussion with potential partners, only 15 grants available.	Yes, Institution of higher education, a public-private partnership, A federally qualified health center, state or county public health clinic, public hospital or health system	An Indian Health service facility or tribe or tribal organization is eligible for these grants.
Sec. 5311 Nurse Faculty Loan Program: Provide loan repayment to individuals willing to serve as a full-time facility member of an accredited school of nursing for at least four years.	FY10 –FY16	Work with NM Health Resources and Schools of Nursing to educate potential candidates	Yes – funds are distributed through HRSA	
Sec. 5313 Grants to Promote the Community Health Workforce: Award grants to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.	FY10-FY14	Apply when guidance available	Yes	
Sec. 399W Primary Care Extension Programs: Award competitive grants for establishment of State or multi-state level	FY10-FY14	Apply when guidance available. Partnership	Yes	

Primary Care State Hubs to organize and administer Primary Care Extension Agencies to assist primary care providers to implement patient-centered medical homes and keep informed of best practices.		between DOH, HSD and a state school that trains primary care providers is required.		
Sec. 5601 Spending for Federally Qualified Health Center: Additional grants are authorized for Community Centers to contract with a federally certified rural health clinic, a low-volume hospital, a critical access hospital, a sole community hospital or a Medicare-dependent share hospital for the delivery of primary health care services available at the clinic or hospital to individuals who would otherwise be eligible for free or reduced cost care at the community health center.	FY10-16 and thereafter	Apply when guidance available	Yes	
Sec. 7101 Expanded Participation in 340B Program: Expand the types of covered entities eligible to receive discounted prices from the 340B Program.	Effective for drug purchases after January 1, 2010	Educate potential health care providers of the new benefits		
Sec. 10212 Support for Pregnant and Parenting Teens and Women: A State may use amounts received under a grant from section 10212 to make funding available to eligible institutions of higher education to enable the institution to establish, maintain or operate pregnant and parenting student services. A State may also make funding available to eligible high schools and community service centers to establish maintain or operate pregnant and parenting services. A State may make funding available to its Attorney General to assist Statewide Offices in providing intervention services for eligible pregnant women who are victims of domestic violence, sexual violence, sexual assault or stalking; Technical assistance and training to governmental, law enforcement, tribal government, court staff , other professionals working in legal, social service and health care settings, nonprofit and faith-based organizations	FY10-19	Provide technical assistance and information to educational institutions, state attorney general and professions working with victims of domestic/sexual violence when guidance available	Non-federal match of 25% of funding amount – can be in-kind	
Sec. 340 H Community-Based Collaborative Care Networks: Grants to community-based collaborative care networks to: 1) assist low-income individuals to access and use health services, enroll in a health coverage program, obtain a regular primary care provider or medical home; 2) Provide case management and care management; 3)Perform health outreach using neighborhood health workers; 4) Provide transportation; 5)Expand capacity including through telehealth, after-hours service or urgent care; and 6) Provide direct patient services.	FY11-FY15	Provide technical assistance and information to the Community-based collaborative	Yes	
Epidemiology				

Sec. 1204 Competitive grants for Regionalized Systems for Emergency Care and Response: 4 multiyear competitive contracts or grants to support pilot projects that design, implement and evaluate, innovative models of regionalized, comprehensive and accountable emergency care and trauma systems.	FY10-FY14	Apply when guidance available and/or provide technical assistance to eligible tribal entities, if requested	Yes	Indian Tribes are eligible for these grants.
Sec. 3506 Trauma Care Centers and Service Availability: Establish 3 programs to award grants to qualified public, non-profit IHS, Indian tribal, and urban Indian trauma centers.	FY10-FY15	Provide technical assistance to eligible tribal entities, if requested	Yes	IHS, Indian tribal, and urban Indian trauma centers are eligible for these grants.
Sec. 1281 Trauma Grants to States: To provide trauma centers with funding to support physical compensations in trauma-related specialties where shortages exist and to enhance and expand trauma services.	FY10-FY14	Apply when guidance available	Yes	
Sec. 4301 Research on Optimizing the Delivery of Public Health Services: Provide funding fir research in the area of public health services and systems.	TBD	Apply when guidance available	Yes – funds are distributed through HHS	
Sec. 3101 Data Collection, Analysis, and Quality: Any federally conducted or supported health care or public health program, activity or survey collect and reports 1) race, ethnicity, sex, primary language, and disability status, 2) data at the smallest geographic level, and 3) sufficient data to generate statistically reliable estimates.	Two years after enactment of the Act.	Modify all surveys, contracts and provider agreements to include these requirements		
Sec. 2821 Epidemiology-Laboratory Capacity Grants: Award grants to 1) strengthen epidemiologic capacity to identify and monitor the occurrence of infectious diseases and other conditions of public health importance, 2) enhance lab practice as well as system to report test orders and results electronically, 3) improve information systems including developing and maintaining an information exchange, and 4) develop and implement prevention and control strategies.	FY10-FY13	Apply when guidance available and/or provide technical assistance to eligible tribal entities, if requested	Yes – funds are distributed through HHS	Tribal jurisdictions and academic centers that assist eligible tribal health departments are eligible for these grants
Sec. 2009 Program for Early Detection of Certain Medical Conditions Related to Environmental Health Hazards: Award competitive grants for the purpose of: 1) screening at risk-individuals and 2) developing and disseminating public information and education.	FY10 – FY14	Apply when guidance available and/or provide technical assistance to eligible tribal entities, if requested	Yes	A facility of IHS is eligible to apply
Sec. 10407 Better Diabetes Care: Prepare a National Diabetes Report Card ion a biennial basis to include trend analysis for Nation and for each states on improving diabetes care c) Improvement of Vital Statistics Collection to improve collection of data for diabetes and other chronic certificates including re-	2 years after the enactment of this act	Vital Records to determine changes in order to meet new requirements.	No	

engineering of vital statistics systems.				
Sec. 399V-3 National Diabetes Prevention Program: Award grants for community-based diabetes prevention program model sites	FY10-FY14	Apply when guidance available and/or provide technical assistance to eligible tribal entities, if requested	Yes	Tribal organizations may apply for these grants
Scientific Laboratory				
Sec. 2821 Epidemiology-Laboratory Capacity Grants: see information under Epidemiology heading				
Facilities				
Sec. 2701 Adult Health Quality Measures. Development of a core ser of health care quality measures for adults eligible for benefits under Medicaid.	Recommended measures develop by 1-1-11; Dissemination of measures by 1-1-12; Standard reporting developed by 1-1-13; First report to Congress 1-1-14.	Work with HSD and the federal government to develop standardized format for reporting these quality measures.		
Sec. 3004 Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs: Reduce update rate by 2% for failure to report required data. Section also outlines the quality measures required.	Starting rate year 2014	Review requirements and adjust collection and reporting mechanisms if needed.		
Sec. 6114 National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes: Award two competitive grants for demonstration projects 1) for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement, and 2) for the development of best practices in Skilled nursing facility and nursing facility for the use of information technology to improve resident care.	Not later than 1 year after enactment of this act and not to exceed 3 years	Apply when guidance available	Yes	
Developmental Disabilities				
Sec. 2401 Community First Choice Option: Gives states the option, beginning October 1, 2011, of amending their state Medicaid plans to provide home and community-based attendant services and supports to (1) consumers eligible for medical assistance under the state plan whose incomes do not exceed 150% FPL, or, if greater, to (2) consumers who meet their state's nursing facility clinical eligibility standards. Available services include Activities of Daily Living task assistance,	October 1, 2011: States will have the option to provide home and community based services to qualifying individuals under Medicaid	Work with Medicaid to Amend State Plan	Participating states will receive a 6% percentage point FMAP increase.	

electronic service backup systems, and training on the management of attendants. Permissible services include transition costs from the facility to the community based home setting, and additional, qualifying, individual needs. The state must meet certain requirements for their amendment to be approved, such as maintaining or exceeding their previous fiscal year's medical assistance expenditure levels in the first full FY of the program's implementation. The services authorized under this section will be evaluated based on data provided to the HHS Secretary by the states.				
Licensing, Certification and Oversight				
Sec. 6111 Civil Money Penalties: Amends the Social Security Act to make changes related to Civil Money Penalties and deficiencies.	Take effect 1 year after the date of enactment of this Act	Need to determine effects of these changes on state statue or regulations.		
Sec. 6113 Notification of Facility Closure: Amends the Social Security Act to requirements of notification when closing a facility.	Take effect 1 year after the date of enactment of this Act	Need to determine effects of these changes on state statue or regulations.		
Sec. 6201 Nationwide Program for National and State Background Checks on Direct Patient Access Employees or Long-Term Care Facilities and Providers: Establish a program to identify efficient and effective procedures for long-term care facilities and providers to conduct background checks.	FY10-FY12	Need to determine effects of these changes on state statue or regulations.	Yes	
Sec. 2042 Adult Protective Services Functions and Grant Programs: Provide grants to enhance adult protective services provided by States and local units of government.	FY11-FY14	Work with ALTSD to apply when guidance available	Yes	
Sec. 2046 Protecting Residents of Long-Term Care Facilities: Award grants to state survey agencies that perform surveys of skilled nursing facilities or nursing facilities to implement complaint investigations systems that promptly prioritize complaints respond to complaints, with optimum effectiveness and timeliness and optimize the collaboration between local authorities, consumers and providers.	FY11-FY14	Work with ALTSD to apply when guidance available	Yes	
Health IT				
Sec. 1561 Health Information Technology Enrollment Standards and Protocol: Develop interoperable and secure enrollment standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Federal Secretary.	No later than 180 days after enactment of the Act	DOH's Information Technology Division and Vital Records need to participate in the implementation of these standards in New Mexico.		

Appendix 7
Department of Information Technology's Health Care Reform Issue Matrix

Department of Information Technology	Implementation Dates	Options/Decisions	Funding Opportunity
Insurance Reform			
Web-based insurance marketplace	12/10	Create state-specific website for informing consumers on insurance offerings	
Health Insurance Exchange			
Creates state-based Health Benefit Exchanges through which individuals not eligible for Medicaid & not offered employer-sponsored insurance can purchase coverage. Requires single portal and enrollment for Exchange and Medicaid. Set up insurance subsidies.	12/10	Decision on Exchange operator. Technical assistance required if state entity operates the Exchange. Interface technical support for connection with Medicaid. Assist TRD with rapid implementation of tax changes.	
Outreach, Education and Consumer Protection			
Educate consumers and others on health reform	Ongoing.	Leverage distance and web-based education tools.	

Appendix 8
Department of Workforce Solutions' Health Care Reform Issue Matrix

Workforce Development Opportunities	Implementation Dates	Options/Decisions	Funding Opportunity
For all grant opportunities additional information on due dates, eligibility, funding levels, mandatory and desired criteria, and scoring systems will be included when the Solicitation for Grant Opportunities are released by the various federal departments			
Sec. 5204, Public Health Workforce Loan Repayment Program. Participants receive up to $ 35,000 per year of service	2010 - 2015	Lead Agency: suggest HED/DOH*	Eligible: Graduates or enrollees in a public health or health professions degree or certificate program
Sec. 5206, Training program for mid-career public health professionals, $ 60 million for 2010	2010	Lead agency: suggest DOH	Eligible: Accredited educational institution with courses in public or allied health, those employed in public or allied health positions (federal, state, local, tribal)
Sec. 5314, Address workforce shortages in state and local health departments in epidemiology and laboratory science, $39.5 million per year	2010 - 2013	Lead Agency: suggest HED*	CDC program
Sec. 5403, Funding for health professionals from underprivileged or underrepresented minority backgrounds seeking careers in underserved areas or health disparity populations, coordination with workforce system required, high school program desired 50% matching funds (non-federal) needed 2010 $60 million for students from disadvantaged backgrounds	2010-2014	Lead Agency: Suggest HED/PED* Locate matching fund source	Federal gov't loan repayment & scholarships Eligible: school of medicine, operators of an area health education center
Sec, 5205, loan repayments for allied health professionals employed in public health agencies, in areas of health professional shortages, or serving underserved populations, $30 million	2010	Lead Agency: Suggest HED/PED/DOH*	Federal loan repayment Eligible: Full time allied health professionals in a federal, state, local or tribal public health agency or working in medically underserved areas
Sec 5203, loan repayments for pediatric subspecialists employed in public health agencies, in areas of health professional shortages, or serving underserved populations, $30 million each year, up to $35,000 per year for 3 years	2010-2014	Lead Agency: Suggest HED/DOH*	Federal loan repayments Eligible: Physician entering or in accredited pediatric subspecialty, residency or fellowship & those with specialized

			training or experience with child and adolescent mental health
Sec. 5405, Primary Care Extension Program, to educate primary care providers on preventative medicine, health promotion, chronic disease management, mental health services, and evidence based therapies, $120 million If program is successful there may be continuing federal monetary support	2011-2012	Lead Agency: Suggest DOH*	States with a HUB (consists of Dept of health, state Medicaid program, state entity administering Medicare, health professional schools)
Sec. 5303, support and develop dental training programs and provide financial assistance to students and loan repayment for dental faculty, $30 million	2010-2013	Lead Agency: Suggest HED*	Eligible: Schools of dentistry, public or nonprofit hospitals, nonprofit entity
Sec. 5308, accredited nurse midwifery programs can receive advanced nurse education grants		Lead Agency: Suggest DOH	Eligible: midwife programs accredited by the American college of nurse midwifes
Sec. 5310, nursing school faculty eligible for loan repayment and scholarships	2010	Lead Agency: Suggest HED*	Federally funded Eligible: Employed by accredited school of nursing
Sec. 5311, loan repayment program for nurses who pursue careers in nursing education, $ up to 10,000 per year	2010-2014	Lead Agency: Suggest HED*	Federally funded Eligible: Employed by accredited school of nursing
Sec. 5203, loan repayment for providers of pediatric medical, surgical, mental and behavioral services or child and adolescents mental and behavioral services working in an area of professional shortage or medically underserved area, $ 30 million per year, up to $ 35,000 per year	2010-2014	Lead Agency: Suggest HED*	Federally funded Eligible: Entering or receiving training in an accredited pediatric subspecialties, residency or fellowship
Grant Opportunities with workforce development component	Implementation Dates	Options/Decisions	Funding Opportunity
Sec. 5313, to have community health workers promote/educate/refer persons towards positive health behaviors and outcomes in medically underserved areas, collaboration encouraged with academic institutions and the one-stop delivery system	2010-2014	Lead Agency: Suggest DOH*	Eligible: Public or nonprofit entity, including subdivisions of a state, public health departments, free health clinic, hospitals
Sec. 5606, grants to health care providers who treat a high percentage of medically underserved or special populations			
Sec 5102, Competitive health care workforce development program for planning and activities for coherent and comprehensive health care workforce development strategies, $150,000 max for planning	2010	Lead Agency: suggest DWS/DOH	Eligible: State workforce board (w/ specific

grants (requires 15% matching funds), $150 million 2010 implementation (requires 25% matching)		Need additional members to state workforce board appointed Locate matching funds (state, federal, business, nonprofit, institutes of higher education)	membership criteria) Implementation eligibility requires receipt of a planning grant or completed requirements of that grant
Sec. 5403, community based training and education grants for area health education centers targeting individuals seeking careers in the health professions from urban and rural medically underserved communities, collaborate efforts with One-stop system, $250 thousand minimum grant, matching non-federal funds of 50% needed	2010-2014	Lead Agency: Suggest HED/DWS* Locate matching funds	Eligible: States, Indian tribes or organizations, institutes of higher education, local workforce board, apprenticeship program
Sec. 5301, primary care training grants to plan, develop and operate training or teaching programs for family medicine, general internal medicine, general pediatrics, $125 million	2010-2014	Lead Agency: Suggest HED*	Eligible: Public and non-profit hospitals, schools of medicine, academic affiliated physician assistant training programs
Sec. 5508, new or expanded primary care residency programs at teaching health centers, $25 million 2010, $ 50 million 2011 and beyond (max of $ 500,000 for 3 years)	2010 – 2012	Lead Agency: Suggest HED*	
Sec. 5305, Geriatric Education and training to create fellowship programs, $10.8 million per year	2011-2014	Lead Agency: Suggest HED/DOH*	Eligible: geriatric education centers
Sec. 5404, expands uses of nursing diversity grants to include associates degrees, bridge or degree completion, or advanced degrees in nursing, pre-entry preparation, advanced education preparation and retention		Lead Agency: Suggest HED*	Public health service grants
Sec. 5309, grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention		Lead Agency: Suggest HED/DOH	Eligible: Accredited schools of nursing, health care facilities
Sec. 3510, reauthorizes a demonstration program to provide patient navigator services within communities to assist overcoming barriers to health services			
Sec. 5507, demonstration grant program to provide aid and supportive services to low-income individuals to obtain education for occupations in the health care fields		Lead Agency: Suggest PED/HED/DWS*	
Sec. 5316, HHS grant for a training demonstration program to allow graduates of nurse practitioner program to pursue careers as primary care providers, each great to not exceed $600,00 per year	2011-2014	Lead Agency: Suggest HED/DOH*	
Sec. 5304, demonstration programs to train or employ alternative dental health care providers in rural and other underserved	2010-2014	Lead Agency: Suggest DOH/HED*	Eligible: Institutes of higher

communities, $4 million per grant			learning, public/private partnerships, FQHC, Indian health services facility, gov't clinic, public hospital
Sec. 5306, grants to schools for development or expansion of training programs, $8 million for social work, $12 million for graduate psychology, $ 10 million for professional child and adolescent mental health, $5 million for paraprofessional child and adolescent work	2010-2013	Lead Agency: Suggest HED*	Eligible: Institutes of higher education, state licensed mental health profit and nonprofit organizations,
Sec. 5302, new training opportunities for direct care workers providing longer term care, $10 million per year	2011-2013	Lead Agency: Suggest DOH*	Eligible: Accredited Institute of higher learning
Sec. 5504, continuing education for health care professionals, priority for primary care	2010	Lead Agency: Suggest DOH	Eligible to apply: State & local gov't, Health schools, Public and non-profits
Sec. 5507, development of core training competencies and certification programs for personal and home care aids, $85 million per year	2010-2014	Lead Agency: Suggest DOH*	Eligible to apply: State, Indian Tribes, Indian Organizations, Higher Education, Local Workforce Board, Apprenticeship program
Other Provisions from the 5/20/10 DWS PowerPoint slide	Implementation Dates	Options/Decisions	Funding Opportunity
Sec. 1513 & Sec. 10106. Employer (> 50 employees) penalties if employee obtains a premium credit for no or poor insurance options available, Appears to be federally enforced Potential leads: PRC, TRD, HSD, Worker's Comp, DWS	2014	If states are to enforce a lead agency is needed, key issues: 1)Employer size 2) Access to Insurance database 3) Knowledge of law and insurance policies 4) Hearings, subpoenas, binding/suggested orders? 5) monthly penalty assessments = monthly hearings? 6) Appeals – admin/court 7) Legislation will be needed whoever is lead	
Tax Credits	2010 2014	Not a DWS issue other than providing information to businesses. If tax credits are related to	

		businesses than IRS/TRD. If related to educational loans than HED and DOH.	
Health Care Professional Workforce Issues (see above section)	2010 - 2014	If Grant Opportunities, will work with DOH, HED and PED on grant submissions. Can make statistical & economic data available to provider applications Some grants will need the state workforce board to apply, governor may need to appoint additional members to meet the mandatory membership criteria If loan repayments not a DWS issue other than passing information to prospective health care professionals	
Payroll Deductions of Coverage and Long term Insurance		Not a DWS issue, deductions of business taxes are IRS/TRD	
Outreach to employers and employees, non-profits, chambers, ACI, Health Care Professionals		DWS can add health care bullets to the employee rights information pamphlets and posters from wage & hour	
Field Offices		Can provide direction to potential monetary assistance for health care opportunities to those seeking services, will need to create handouts & other informational materials on workforce opportunities	
Sec. 4207, Fair Labor Standards Act amended to require break time and locations for breastfeeding mothers to express milk – no money damages only > 50 employees		Need to decide if NM wants to amend its wage and hour law to add this. If not enforcement will be by private right of action under the federal law.	

* Materials outlining monetary assistance and debt repayment options available for health care careers should be created for general distribution in PED/HED guidance offices, workforce centers and elsewhere

Appendix 9
Human Services Department's Health Care Reform Issue Matrix

INCOME SUPPORT DIVISION

Income Support Division Matrix of Provisions	Implementation Dates	Options/Decisions	Funding Opportunity
Create state based Health Insurance Benefit Exchanges. Native American Provisions: § 1311(c)(6)(d) Affordable Choices of Health Benefit Plans – Enrollment Periods: Exchange is required to provide for special monthly enrollment periods for Indians. Actions: Computer Enhancement/ Regulatory Promulgation/ MAD Legislation Native American Provisions: § 1402(d)(1) No-Cost Sharing for Indians With Income At or Below 300% of FPL Enrolled in Coverage Through a State Exchange: Prohibits cost sharing for Indians below 300% of the FPL enrolled in any qualified health plan in the individual market through an Exchange. Actions: Computer Enhancement/ Regulatory Promulgation / MAD Legislation Native American Provisions: § 1411(b)(5)(A) Procedures for Determining Eligibility for Exchange Participation, Premium Tax Credits, and Reduced Cost-Sharing and Individual Responsibility Exemptions: An individual seeking an exemption from the individual mandate due to their status as an Indian must provide such information to the Secretary as prescribes to qualify for the exemption. Actions: Computer Enhancement/ Regulatory Promulgation / MAD Legislation Native American Provisions: § 2901(a) No-Cost Sharing for Indians with income at or below 3005 FPL enrolled in coverage through a State Exchange.	2010	Implementation of online exchange	Increased FMAP for "newly eligible individuals".
Expansion of Public Programs			
Expand Medicaid to all non-Medicare eligible individuals under age 65 with incomes up to 133% FPL based on the MAGI	January 1, 2014	Rule Promulgation, Modified Eligibility System	
Income eligibility for nonelderly determined using the MAGI & development of "equivalent income test" except for individuals eligible for Medicaid through another program, SSI, Child Welfare, or another program that establishes Medicaid eligibility external to the Medicaid agency	January 1, 2014	Rule Promulgation, Modified Eligibility System, to only count MAGI towards Medicaid eligibility and not other programs.	
Medicaid Coverage for Former Foster Care children	January 1, 2014	Rule Promulgation, Modified Eligibility System	
Medicaid & CHIP Enrollment Simplification			
Establish a process to allow individual's to apply for, enroll in and renew their enrollment in Medicaid through a website. The website must be linked to the Health Insurance Exchange and CHIP. Native American Provisions: § 2901 (b)Facilitate Enrollment of Indians under the Express Lane Option: Facilities operated by the IHS and Indian, Tribal and Urban Indian facilities would be added to the list of agencies that could serve as an "Express Lane Agency" under § 1902(e)(13 of the Social Security Act. Actions: Data Transfer Agreements w/ IHS and I/T/U's	January 1, 2014	Rule Promulgation, Modified Eligibility System, online application	
Accept Medicaid and CHIP eligibility determinations made by the exchange, and enroll individuals determined eligible by the	January 1, 2014	Rule Promulgation, Modified Eligibility System,	

exchange without any further determination.		online application	
MEDICAID-Home and Community-Based Services			
Money Follows the Person Rebalancing Demonstration: Effective 30 days following enactment, Money Follows the Person is extended through September 30, 2016. This section modifies eligibility requirements by reducing the institutional residency period to not more than 90 consecutive days and by eliminating the state's flexibility in setting this residency period themselves. Currently, states set this requirement within Deficit Reduction Act's guidelines, which require that individuals reside in a facility for not less than 6 months, and not more than 2 yrs.	30 days following enactment through September 30, 2016	Apply for Money Follows the Person Grant if opportunity is made available *Rule promulgation & training for new eligibility requirements.*	Yes, if additional funding opportunities come available
Protection for Recipients of HCBS against Spousal Impoverishment: For five years, beginning on January 1, 2014, states will be required to apply spousal impoverishment rules to HCBS beneficiaries. The mandate will end December 31, 2019, at which point the current effective language of the statute will become effective again.	2014-2019: States must apply spousal impoverishment rules to HCBS beneficiaries	Determine if NM already provides this benefit	Unknown
MEDICARE			
Elimination of Part D Cost Sharing for selected non-institutionalized Dual Eligibles: Makes cost-sharing for full benefit dual eligible individuals receiving HCBS equal to the cost-sharing for those receiving institutionalized care. Effective no earlier than January 1, 2012. Native American Provisions: Medicare Part D Improvements for Prescription Drug Plans & MA-PA Plans Including Costs Incurred by AIDS Drug Assistance Programs and IHS in Providing Prescription Drugs Towards the Annual Out-of-Pocket Threshold under Part D: Amends the Social Security Act to allow IHS, Indian tribe or tribal organization, and urban Indian program spending to count toward the Medicare Part D out of pocket threshold, or coverage gap. Medicare Part B Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics: Makes permanent reimbursement for all Medicare Part B services furnished by Indian Health Service hospitals & clinics. Actions: Legislation	January 1, 2012: Cost-sharing for certain dual eligibles will be eliminated	Education of NM Medicare Beneficiaries *Training for ISD eligibility workers*	N/A
ELDER JUSTICE & PROTECTION			
Nursing Home Transparency: Public disclosure of nursing home owners, operators, and others who provide management, financing, and services to nursing homes will be required. Public information on "Nursing Home Compare" website will be improved, including staffing data; links to facilities' survey reports and plans of correction; summaries of complaints against facilities; a standardized complaint form; and adjudicated criminal violations. A consumer rights information page on "Nursing Home Compare" will be established, including services available from the long-term care ombudsman . Complaint handling will be improved, including a standardized form for filing complaints with the survey agency and ombudsman. Residents' legal representatives and other responsible parties will be protected from retaliation when they complain about quality of care. 60-day advance notification of facility closure and authorization to continue Medicaid payments pending relocation of all residents will be required. Dementia care and abuse prevention in nurse aide training programs will be made available.	2011	States will be required to maintain a website with information on all nursing homes in the state, including survey reports, complaint investigations, and plans of correction. *Training on the use of the website for ISD eligibility staff.*	

CHILD SUPPORT ENFORCEMENT DIVISION (CSED)

Child Support Enforcement Division Matrix of Provisions	Implementation Dates	Options/Decisions	Funding Opportunity
Prohibits Pre-existing Condition Exclusions for Children			
Increases the number of medial support orders that can be effectively enforced	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Limits Waiting Periods to 90 Days			
Eliminates drawn-out follow-up periods with employers on the National Medical Support Notice	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Qualified Health Plans Must Offer Child Only Plan			
Could result in more non-custodial parents (NCPs) able to afford insurance if they do not want to pay for themselves as well as the child	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Insurance Rate Increases Subject to Process Review Justification			
Could result in fewer NCPs and employers being priced out of coverage	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
HHS Secretary Defines "Essential Health Benefits" to Include Coverage of Preventative Services and Immunizations			
More, if not, insurance plans will meet the minimum standards to be considered "acceptable coverage" under the NM MMSA.	January 1, 2010	Wait for rules to be promulgated; enforce	None for CSED
Establishes Qualified Health Plans Under the American Health Benefit Exchange with Essential Benefits and Limitations on Deductibles			
More medical insurance obligors will have affordable insurance available to them that then can be enforced.	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
States Given the Flexibility to Establish Basic Health Plans for Non-Medicaid, Lower-Income Individuals			
Parents who currently do not qualify for Medicaid and who are not otherwise covered will be able to obtain other coverage; if the nature of this is private rather than public, such availability would make medical orders enforceable.	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
States Will Establish American Health Benefit Exchanges to Help Small Employers and Individuals Obtain Coverage			
More medical insurance obligors will have affordable insurance available to them that then can be enforced	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Tax Credits Available for Individuals Between 100-400% FPL to Enable Them to Enroll in the Exchange			
More medical insurance obligors will have affordable insurance available to them that then can be enforced	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Tax Credits Available to Business With Fewer than 25 Workers For Up to 50% of the Premium Cost			
More businesses will be able to offer obligors insurance through their employment	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Most Individuals Will Be Responsible for Maintaining Essential Coverage or Pay Penalties			
By avoiding federal penalties, individuals will be more likely to comply with their court obligation for dependent coverage	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Employers With More Than 200 Employees Must Enroll FT Employees in Coverage			
More employers will seek group insurance availability for their employees resulting in more obligors with enforceable insurance	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED

Large Employers Must Report to IRS the Names of Covered Employees and Provide Proof of Coverage to Employees			
If the data were made available to IV-D agencies, it might serve as proof of compliance with court order for medical support	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Employers of 50 or more Employees With at Least 1 Employee Receiving Premium Assistance Tax Credit Required to pay $2,000 per Credit-Receiving Employee			
More employers will seek group insurance for their employees resulting in more obligors with enforceable insurance	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Parents Above Certain Income Required to Provide Minimum Essential Health Care Coverage for Their Children or Pay a Fine			
Parents will be motivated to obtain insurance regardless of a court order for the NCP to do so. This may raise legal questions in relation to court ordered medical support obligations if the parents pay a penalty, but continue not providing health insurance	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Parents Who Claim a Child as a Dependent for IRS Must Prove Coverage for Child or Face Tax Penalty (Some Exemptions Exist)			
Parents will be motivated to obtain insurance regardless of a court order for the NCP to do so. This may raise legal questions in relation to court ordered medical support obligations if the parents pay a penalty, but continue not providing health insurance.	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Expands Medicaid Eligibility up to 133% FPL with Gradually Reducing Federal Support			
More dependents in child support cases will become eligible for Medicaid; some judges or hearing officers may be reluctant to establish or enforce medical support against obligors whose dependents are covered by Medicaid	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
CHIP Program Expanded			
More dependents in child support cases will become eligible for CHIP; some judges or hearing officers may be reluctant to establish or enforce medical support against obligors whose dependents are covered by CHIP	January 1. 2014	Wait for rules to be promulgated; enforce	None for CSED
Cafeteria Plans established for small businesses, including self-employed individuals; incentives to employers for contributing to such plans			
More small employers may be offering affordable insurance to their employees who may have medical support obligations	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Employers Who Make Contributions Toward Employee Coverage also Required to Provide Optional Vouchers for the Purchase of Qualified Health Plans Through Exchanges			
The administration of the National Medical Support Notice may be more complicated for both the state and employers by this provision	January 1, 2014	Wait for rules to be promulgated; enforce	None for CSED
Reasonable cost of health care coverage determined to be 8% of income			
CSED currently uses 5% of income as the test for reasonableness when determining whether medical insurance should be provided by NCP for the child(ren)	January 1, 2014	Wait for rules to be promulgated; review CSED definition of "reasonable" related to medical insurance coverage for child(ren)	None for CSED

OFFICE OF INSPECTOR GENERAL (OIG)

Office of Inspector General Matrix of Provisions	Implementation Dates	Options/Decisions	Funding Opportunity
Office of the Inspector General Matrix of Provisions: Conducts audits and investigations regarding allegations of health care fraud pertaining to HSD programs, contractors, and clients. OIG	TBD	Continue present operations while planning for expansion based on	None at this time.

functions include hearings to resolve disputed issues of eligibility or receipt of services and collection operations for the recovery of improper payments.		new federal or state health care reform requirements and available funding.	

INFORMATION TECHNOLOGY DIVISION (ITD)

Information Technology Division Matrix of Provisions	Implementation Dates	Options/Decisions	Funding Opportunity
Create state based Health Insurance Benefit Exchanges.	2010	Implementation of online exchange	Increased FMAP for "newly eligible individuals".
Health Insurance Exchange:			
A Health Insurance Exchange (HIE) information technology system must be implemented to support the exchange.	January 1, 2014	A decision must be made as to which organization will run the HIE and host the HIE system	Unknown
Clients must be screened for Medicaid eligibility before being sent to the exchange. The HIE system must be part of or interface with the HSD's eligibility system.	January 1, 2014	Determination of who will host the HIE system is needed. If HSD hosts the system, HIE can be added on to the eligibility system. If other organization hosts the HIE system, significant alterations may be required to the HIE system and HSD's eligibility system to allow the systems to interface.	Unknown
HSD's eligibility system will require significant modification or replacement to accommodate or interface with the HIE system. HSD's current eligibility system is 27 years old and is not suitable to interface with modern systems such as an HIE system	January 1, 2014	HSD is in the process of replacing the current eligibility system. Options for the replacement systems include the ability to host an HIE system.	$25 million is currently allocated to the replacement of HSD's eligibility system.
Application web portal is required to interface with HSD's eligibility system and the HIE system to apply for benefits. The rule requires that client's be able to apply for benefits through a single application to determine eligibility for Medicaid and HIE benefits.	January 1, 2014	HSD has a web portal that can perform this function. Some modification to the portal will be required.	Unknown
Medicaid eligibility			
Medicaid eligibility applications will significantly increase. Significant modification to or replacement of the existing eligibility system will be required to handle the increased volume.	January 1, 2014	HSD to issue an RFP for a replacement system.	$25 million is currently allocated to the replacement of HSD's eligibility system.

MEDICAL ASSISTANCE DIVISION (MAD)

Medicaid Health Reform Provisions	Implementation Dates	Options/Decisions	Funding Opportunity
Medicaid Eligibility Provisions			
Medicaid Eligibility Expansion: Expands Medicaid to 133% FPL for all individuals without regard to categorical eligibility. 5% income disregard. Definition of newly eligible (19-64 who are not eligible for Medicaid on the date of the bill's enactment).	January 1, 2014	Need clarification from CMS on who will be considered newly eligible. Must be able to track newly eligible individuals and those who are	Provides 100% FMAP for newly eligible individuals from 2014 – 2016. In 2017, FMAP for newly eligible individuals decreases to 95% and continues to decrease

		eligible under criteria in effect at passage for purposes of applying differential FMAP rates and meeting new annual reporting requirements.	every year until 2020, when it will remain at 90%.
Modified Adjusted Gross Income (MAGI): States must use MAGI to determine eligibility for most Medicaid categories; eliminates income disregards; establishment of equivalent income test; excludes certain groups from MAGI.	January 1, 2014	Need to map current categories of eligibility to categories eligible under MAGI. Threshold income using MAGI cannot be less than effective level that applied on date of enactment. Must assure coverage during transition to MAGI by establishing an equivalent income test.	
Basic Health Program State Option: States may create a Basic Health Program for uninsured individuals with income from 133% - 200% FPL.		Option in lieu of individuals receiving premium subsidies for coverage in the exchange. Individuals would not be eligible for subsidies in the exchange. States must have competitive process to enter into contracts with one or more standard plans; provide at least federally determined essential health benefits; and ensure that individuals do not pay more than they would in the exchange.	States would receive 95% of federal premium and cost-sharing subsidy funds that would have been paid through the exchange.
Presumptive Eligibility: States have the option to allow for PE for individuals up to 133% FPL; and states may permit any hospital participating in Medicaid to determine PE for all Medicaid categories.	January 1, 2014	State option requires policy decision.	
Annual Reporting on Eligibility: Annual reports required on Medicaid enrollment. States must break out different eligibility categories and populations and identify newly enrolled individuals and a description of outreach activities.	January 1, 2015	Must be able to track newly eligible individuals and those who are eligible under criteria in effect at passage.	
Mandatory Coverage for Former Foster Care Children: Establishes a new categorical eligibility group of individuals who are under age 26 who were in foster care and enrolled in Medicaid on the day they turned 18. Limited to children who aged out of foster care as of the date of enactment or later.	January 1, 2014	If the individual also qualifies on the basis of the Medicaid expansion, the individual will receive state plan services (including EPSDT) rather than benchmark coverage.	
CHIP: Extends reauthorization of CHIP for two years through	September 30, 2015		For the years 2016

September 30, 2015.	(CHIP extension) and October 1, 2016-2019 (match rate increase)		through 2019, states will receive a 23% match rate increase subject to 100% cap.
Enrollment: Process for individuals to apply for, enroll in, and renew their enrollment in Medicaid through a website; accept Medicaid/CHIP determinations made by the exchange; conduct outreach and enrollment efforts to vulnerable populations.	January 1, 2014		
Exchange Provisions			
Health Insurance Exchange: The state is required to establish a health insurance exchange that, among many things, (1) facilitates the purchase of qualified health plans; (2) provides for the establishment of a Small Business Health Options Program (SHOP Exchange) that is designed to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the state; and 3) individuals can use to apply for Medicaid, CHIP, and tax credits for individual coverage through the exchange. The exchange must be a governmental entity or a nonprofit entity that is established by a state.	No later than January 1, 2014.	Decision needed on which governmental agency or state-established entity will be the exchange. Decision needed on whether the exchange will include both the individual and small employer exchange or whether they will be separate exchanges. Major IT development and planning needed.	Funding is available to establish the exchange but the exchange must be self-sustaining within one or two years.
Long-Term Care Provisions			
Hospital-Acquired Conditions: Prohibits federal payments for Medicaid services related to hospital-acquired conditions and adjusts Medicare payments. (Sec. 2702 and 3008)	2011	Amend CoLTS MCO contracts to include language to not pay for these conditions. Also add to not pay for "never events"/"adverse events".	Savings to be identified.
Medicaid Drug Rebate Percentage: The minimum drug rebated level is increased from 15.19% to 23.1% for most brand name products and from 11% to 13%$ for generics. The Medicaid prescription drug rebate is extended to Medicaid managed care organizations for generic and brand name drugs. (Sec. 2501)	2010	Amend CoLTS MCO contracts for Medicaid only payments. Analysis needed to identify cost-savings.	Any savings that accrue from the incremental increase in the minimum base rebate levels and additional rebates on new formulations of existing drugs accrue 100% to the federal government only. Federal and state supplemental rebates negotiated above 23.1% on brands will be split with states according to the regular state FMAP.
Community-Based Care Transition Program: Provides funding for improved care transition services to high-risk Medicare beneficiaries. Certain hospitals identified by the Secretary as having high readmission rates, and community-based organizations that have arrangements with them to provide care transition services, will be eligible. (Sec. 3026)	January 1, 2011 for 5 years.	Consult CoLTS MCOs whether they will pursue on their Medicare side and coordinate with Medicaid.	$500 million, 2011-15
National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes: Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and	Implementation no later than 1 year after enactment (of law?), for a period not to exceed 2	Consult CoLTS MCOs and NM Health Care Association. Discuss on-line abstracts and other	

nursing facilities that are involved in the culture change movement and 1 for the development of best practices in skilled nursing facilities for the use of HIT to improve care. (Sec. 6114)	years.	initiatives.	
Providing HCBS Changes to 1915 (i) Option: Extends the HCBS state plan option available under section 1915(i) to individuals eligible for HCBW services under a wavier approved under other authorities (1915 (c), 1915 (d), 1915 (e) and 1115), but only for individual whose income does not exceed 300% of SSI. Note: since this is a SPA no waiting lists allowed. (Sec. 2402)	Effective October 1, 2010. CMS to promulgate regulations	Further analysis needed to identify advantages of pursuing this option.	
State Balancing Incentive Payment Program: Provides enhanced federal match to states that make structural reforms in order to expand non-institutionally-based Medicaid long-term services and supports. States must agree to make structural within 6 months in the following areas: • No wrong door/single entry point system • Conflict free case management services • Core standardized assessment instruments	Increased payments available between October 1, 2011 and September 20,2015	Consult CoLTS MCOs on opportunity and availability of MCO resources to write proposal.	2% point FMAP increase available
Community-First Choice Option: States may opt to provide home and community-based attendant care services and supports to Medicaid beneficiaries through a SPA authorized under section 1915 (k)	October 1, 2011	Consult CoLTS MCOs on opportunity and availability of MCO resources to write proposal.	6% point FMAP increase available for SPA for services provided through this option
Money Follows the Person Rebalancing Demonstration: Effective 30 days following enactment, Money Follows the Person is extended through September 30, 2016. This section modifies eligibility requirements by reducing the institutional residency period to not more than 90 consecutive days and by eliminating the state's flexibility in setting this residency period themselves. Currently, states set this requirement within Deficit Reduction Act's guidelines, which require that individuals reside in a facility for not less than 6 months, and not more than 2 yrs.	30 days following enactment through September 30, 2016	Determine whether to apply for Money Follows the Person Grant if opportunity is made available	Enhances FMAP for 1 year. Funding level for demonstrations increased from 2.25 billion through 2016 , bringing demonstration's total funding to $4 billion.
Protection for Recipients of HCBS against Spousal Impoverishment: For five years, beginning on January 1, 2014, states will be required to apply spousal impoverishment rules to HCBS beneficiaries. The mandate will end December 31, 2019, at which point the current effective language of the statute will become effective again.	2014-2019: States must apply spousal impoverishment rules to HCBS beneficiaries	Analysis needed to identify any cost implications.	Unknown
Medicare Advantage Plans: Medicare Advantage payments will freeze in 2011. In 2012, the benchmarks will be reduced, and the payments will be set to different percentages of fee-for-service rates. These payments will vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas. Beginning in 2011, this restructured payment system will be phased in over three years in most areas, with longer phase-in periods in other areas, depending on the level of payment reductions. Beginning in 2014, the plans will be required to spend at least 85% of revenue on medical costs or activities improving quality of care. Special Needs Plans are extended until 2014.	2011: Medicare Advantage payments will freeze, and a phased-in restructured payment system will be in effect.	Analyze the impact on NM Medicare beneficiaries.	N/A
Elimination of Part D Cost Sharing for selected non-institutionalized Dual Eligibles: Makes cost-sharing for full benefit dual eligible individuals receiving HCBS equal to the cost-sharing for those receiving institutionalized care. Effective no earlier than January 1, 2012.	January 1, 2012: Cost-sharing for certain dual eligibles will be eliminated	Education of NM Medicare Beneficiaries. Analyze any cost implications for Medicaid.	N/A
Dual Eligibles: A new office, the Federal Coordinated Health Care Office for Dual Eligible Beneficiaries, within the Centers	March 1, 2010: the Federal Coordinated	Education of NM Medicare Beneficiaries.	

for Medicare and Medicaid services (CMS) will be established to more effectively integrate Medicare and Medicaid benefits and to improve coordination between the federal government and states. By January 1, 2011, the Center for Medicare and Medicaid Innovation within CMS will be established to, in part, test innovative payment and service delivery models to reduce program expenditures while simultaneously preserving or enhancing the quality of care furnished. The Center allows states to test and evaluate models for fully integrating care for dual eligibles within the state, as well as payment reform models for the medical care residents of the state, including dual eligibles. Payment models will be implemented on a nationwide basis, with exceptions for states demonstrating that such implementation would not be feasible or appropriate to the health care delivery system of that state. No earlier than January 1, 2012, cost-sharing will be eliminated for dual eligibles receiving home and community-based services that would otherwise be institutionalized.	Health Care Office for Dual Eligible Beneficiaries will be established January 1, 2011: the Center for Medicare and Medicaid Innovation will be established January 1, 2012: Cost-sharing for certain dual eligibles will be eliminated	Identify options available for increased Medicare and Medicaid service and payment coordination through the new office.	
Nursing Home Transparency: Public disclosure of nursing home owners, operators, and others who provide management, financing, and services to nursing homes will be required. Public information on "Nursing Home Compare" website will be improved, including staffing data; links to facilities' survey reports and plans of correction; summaries of complaints against facilities; a standardized complaint form; and adjudicated criminal violations.	2011	States will be required to maintain a website with information on all nursing homes in the state, including survey reports, complaint investigations, and plans of correction. Identify coordination needed between HHS state agencies.	
Community Living Assistance Services and Support (CLASS) Act: The CLASS Act is a national voluntary long-term care insurance program. After 5 years of contributing to the program, should a person require services in the future, the fund would provide a lifetime benefit averaging $50/day depending on the needs of the person. To promote a high rate of program participation, individuals whose employers agree to participate in premium withholding will automatically be enrolled, while retaining the right to opt-out of the program at any time.	The program is intended to start in 2011	Regulations are pending. Analyze Medicaid fiscal impact and ensure coordination with Workforce Solutions.	N/A
Train workers in geriatrics and long-term care: Grants to eligible entities to enable such entities to provide new training opportunities for direct care workers who are employed in long-term care settings such as nursing homes, assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, and home and community-based settings.	2011-13	Consult CoLTS MCOs to identify if any of their providers intend to apply.	Potential funding to entities training direct caregivers
Workforce Promotion: Amends the OAA to establish a Personal Care Attendant Workforce Advisory Panel to examine workforce issues and promote the direct care workforce. The Panel will formulate a report on core competencies for home care aides which will result in an AoA directed three year, four state demonstration projects to evaluate the Panel's findings. This section promotes family caregiver support as it modifies the appropriations for the Family Caregiver Support Program by increasing its funding to $250 million for each fiscal year from 2011 – 2013.	2011-13	Analyze if NM is eligible to receive Family Caregiver Support Program funds	Potential funding through the Family Caregiver Support Program
Community Transformation Grants: CDC to award competitive grants to State and local governmental agencies and community-based organizations for the implementation,	2010-14	.Consider applying when funding opportunity is available, If yes, consult	Potential funding to state, local, community-based organizations

evaluation, and dissemination of evidence-based preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, and address health disparities.		CoLTS MCOs for resources to help apply.	
Behavioral Health Provisions			
Benefit Package: Allows states to cover prevention services under Medicaid Benchmark coverage for adults; will likely be similar to NM's State Coverage Insurance (SCI) but with modifications including removal of the $100,000 annual claims maximum.	2010		Increased Medicaid funding of mental health & substance abuse services. Increased commercial insurance funding of mental health and substance abuse services. Allows SAMHSA block grant and grant dollars to be focused on recovery support services not paid for through insurance benefit plans.
Parity: Parity required in essential benefits plans offered through Exchanges. Employer mandate requires parity in private health plans. DHHS Parity Regulation – implementation of interim final rule. Comments & research on scope of services, non-quantitative treatment limitations, common deductibles. Medicaid parity regulation still to come.	Effective April 5th; applies to plan years beginning on or after July 1, 2010; comment period through May 3	Need clarification regarding what services parity will apply to	
ACOs and relationship to CSAs: Programs to expand "medical homes" to include behavioral health. School-based health clinics to provide mental health and substance use disorder assessments, crisis intervention, counseling, treatment. States that develop health homes must "consult and coordinate" with SAMHSA regarding the prevention and treatment of MH/SUD. Increased patient-centered health research. Training grants for behavioral health workforce. Training on MH/SUD for Primary Care Extender.			
HIT/HIE/EHR: SA/MH provider capacity to utilize electronic health records, including access to federal assistance. Behavioral health outcomes & data using health information technology – standards needed. Privacy/confidentiality of MH/SA treatment information, while supporting integration of health & behavioral health care. Common National Outcome Measures (NOMS) across funding streams for state mental health, substance abuse & Medicaid agencies.			$4 million new in the Office of the National Coordinator (ONC) for Behavioral Health HIT
FQHCs and relationship to CSA and FQHC BH standards: Behavioral health/primary care integration. Numbers & distribution of practitioners with aging workforce. Support for recovery coaches, peer and paraprofessional or non-traditional workers. Evidence-based practices adoption. Recovery in core competencies and curriculum for education of all practitioners and workers.		Will require changes to NM Practice Acts (i.e., LMSWs, etc.) and other impacts on workforce in NM.	$25 million to HRSA for behavioral health in FQHCs.
Rate-Related Provisions			
Increase Medicaid Reimbursement for Primary Care: Requires Medicaid payment rates to primary care physicians for primary care services to be no less than 100% of Medicare payment rates in 2013 and 2014.	2013 - 2014		100% federal funding for the incremental costs to states to meet the requirement.
Medicaid DSH Payments: Reduces federal Medicaid DSH payments, with HHS to determine the methodology of the	2014		

reduction.			
Hospital-Acquired Conditions: Prohibit s federal payments for Medicaid services related to hospital-acquired conditions and adjusts Medicare payments.	2011		
Medicaid Drug Rebate Percentage: The minimum drug rebate level is increased from 15.1% to 23.1% for most brand name products, and from 11% to 13% for generics. The Medicaid prescription drug rebate is extended to Medicaid MCOs for generic and brand name drugs.	2010	Amend MCO contracts for Medicaid only payments. Analysis needed to identify cost savings.	Any savings that accrue from the incremental increase in the minimum base rebate levels and additional rebates on new formulations of existing drugs accrue 100% to the federal government only. Federal and state supplemental rebates negotiated above 23.1% on brands will be split with states according to the regular state FMAP.
Program Integrity/Quality Provisions			
Establishment of Medical Homes: States receiving funding for this model must include a system for tracking avoidable hospital readmissions and calculating savings from improved chronic care coordination and management.	January 1, 2011	Medicaid state plans will be required to meet specific monitoring, evaluation and reporting requirements. Must have a plan for incorporating the use of HIT to improve service delivery and coordination. Need to evaluate impact on reducing hospital admissions, ER visits and nursing home admissions.	Increased FMAP of 90% for the first two years that the state plan is in effect. Payments will be adjusted based on beneficiary risk scores so that higher payments are made to higher risk beneficiaries.
CHIPRA Quality Measurement: Core health quality measures for adults and children covered by Medicaid and CHIP.	January 1, 2011	Program to develop, test and validate emerging and innovative evidence-based measures for Medicaid/CHIP. Regulations will be promulgated no later than two years after the program's establishment and annually thereafter.	
Value-Based Purchasing of Health Care Services – Long-Term Care: Minimum of five indicators, including acute myocardial infarction, heart failure, pneumonia, certain surgical procedures, and health-care associated infections.		Variations in standards will be implemented each fiscal year, with 60 days' notice before each performance period will begin (Sec. 3001).	
Health Care Acquired Conditions: Prohibits federal payments to states for Medicaid services related to health care acquired conditions and never-events.	January 1, 2012	MMIS is being modified to capture the 'Present on Admission' indicator in conjunction with HIPAA 5010 (also required 1/1/12).	

Data Collection: Requires data collection on health disparities, including race, ethnicity, sex, primary language and disability status for applicants, recipients and participants.			
Quality Reporting: States required to report annually on state-specific quality measures for Medicaid-eligible adults; and on information collected through external reviews of the quality of care provided to Medicaid-eligible adults.	January 1, 2014	Requires states to develop annual reports to include: total enrollment and new enrollment of beneficiaries; Medicaid enrollment data stratified into categories; and state-specific enrollment processes and outreach programs.	
Incentives for Collaborative Care: States must develop a system for tracking avoidable hospital readmissions and calculating savings resulting from improved chronic care coordination and management.	October 1, 2010		Funds are provided to states for the planning and development ($25 million). Requires state match.
Mental Health Parity: Community mental health centers may be medical home.		States are required to collaborate with SAMHSA. Extends full Medicaid benefits to individuals receiving HCBS. Allows states to target a specific population (e.g., people with mental illness)	Funds are provide to states for the planning and development.
National Correct Coding Initiative: Mandatory use of national correct coding initiatives (NCCI). Awaiting direction from CMS.	March 1, 2011 (to incorporate NCCI methodologies)	States must identify methodologies of the NCCI and identify initiatives. States must make their MMIS methodologies compatible with Medicare's NCCI. Must report to Congress.	
Funding & Pilot Demonstrations			
State Option to Provide Health Homes for Enrollees with Chronic Conditions: Allows Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a medical home.	January 1, 2011	State Plan must include: Payment methodology the state will use; Methodology for tracking avoidable hospital readmissions and calculating savings; Proposal for use of HIT in providing health home services; and Participation of providers in reporting requirements.	Provides 90% FMAP for applicable services for the first 8 fiscal quarters the SPA is in effect. Secretary may award states planning grants to develop SPAs (which will require state contribution). Total amount of planning grants will not exceed $25 million.
Demonstration Project to Evaluate Integrated Care around a Hospitalization: Allow states to use bundled	January 1, 2012 – December 31, 2016	Up to 8 states will be selected.	

payments for episodes of care that include hospitalization and for physician services during hospitalization.		Hospitals will have to establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in or have access to those settings.	
Medicaid Global Payment System Demonstration: Participating states will adjust payments to eligible safety net hospital systems or networks from fee-for-service to global capitated payment.	FY 2010 – FY 2012	Up to 5 states will be selected.	
Pediatric Accountable Care Organizations Demonstration Project: Allows participating pediatric medical providers organized as accountable care organizations to share in cost-savings at a level to be determined by the Secretary of HHS, if they meet performance and cost-savings targets.	January 1, 2012 – December 31, 2016	Providers in the selected states must commit to participate for no less than 3 years. NM may not have the infrastructure to do this.	
Medicaid Emergency Psychiatric Demonstration Project: Provides Medicaid payments to psychiatric institutions for adult enrollees who require stabilization of an emergency condition	October 1, 2011 – December 31, 2015 (Possibility of extension/national expansion based on results of report to Congress in 2013)	Projects will be conducted for 3 consecutive years.	$75 million for FY 2011 Will pay states their FMAP quarterly for the services provided.
Medicaid Preventive Services: Provides FMAP incentive payment to states that eliminate cost-sharing requirements for Medicaid clinical preventive services that have been recommended by the USPS task force and for vaccines for adults.	January 1, 2013	1 percentage point increase in FMAP for states that eliminate cost-sharing for preventive services and vaccines for adults.	
Incentives for Prevention of Chronic Diseases in Medicaid: Grants to states to carry out initiatives to provide incentives to Medicaid beneficiaries who participate in an evidence-based program that is designed to help with tobacco cessation, weight, cholesterol, diabetes prevention or management, blood pressure or co-morbidities; and who demonstrate changes in health risk and outcomes.	January 1, 2011, or sooner, depending on when the Secretary of HHS develops program criteria; lasts 5 years.	States can partner with providers, community-based organizations, or other entities to establish programs. Programs run for at least 3 years.	$100 million for 5 years, available until expended.
CHIP Obesity Demonstration Program: Extends funding for the childhood obesity demonstration program established under CHIPRA.	FY 2010 – FY 2014		Direct appropriation to HHS/CMS totaling $25 million.
CHIP Outreach Grants: Extends and increases funding for a program to award grants to states and other eligible entities to improve outreach and enrolment in the CHIP program, as established under CHIPRA.	FY 2014 – FY 2015	MOE on state funding for outreach and enrollment activities, based on state spending in the FY preceding FY of the grant award.	Direct appropriation for $140 million for FY 2009 – FY 2015.

Appendix 10
Indian Affairs Department's Health Care Reform Issue Matrix

Recommendations Provided by Tribal Entities Regarding the Implementation of Health Care Reform Initiatives	
Submitted by the Bernalillo County Off-Reservation Native American Health Commission, the Pueblo of Laguna Health Committee, the Navajo Nation, and the Navajo Area Indian Health Service.	
The State of New Mexico should adhere to the following guiding principles as they develop a strategic plan to implement the provisions of federal health care reform: • Promote and support the culture and core values of American Indians. • Maximize eligibility, enrollment, coverage, and public financing of health care for American Indian consumers. • Streamline processes and remove barriers to ensure that the New Mexico Indian health care programs will benefit from new funding opportunities and initiatives.	
Individual Mandate	Recommendations for the State: • Work closely with HHS to develop as many mechanisms as possible to identify individuals who are American Indian and exempted from tax penalties for failing to maintaining qualified health coverage. No single mechanism will adequately identify the number of American Indians who are eligible for the exemption. • Influence HHS to define American Indian as CMS has done while implementing ARRA.
Employer Mandate & Tax Implications	The employer mandate applies to Tribes and tribal enterprises. Further, there are tax implications related to coverage and exemptions for Tribally-provided coverage. Tribes must fully understand the implications of these provisions. Recommendations for the State: • Who can assist with this effort? Could the Indian Affairs Department partner with the Indian Law Center to do this?
Health Insurance Exchange	Recommendations for the State: • Influence CMS and/or the Consumer Information and Insurance Oversight to interpret "cost-sharing" to include premiums. We consulted with national experts who stated that the Senate staff indicated that the intent was to exempt American Indians under 300% FPL from premiums, deductibles and copayments. • Ensure that Indian Health Service, tribal, and urban Indian health providers are included in the plans' networks to prevent consumers from

	having to switch. • Ensure that information about unique Indian provisions is conveyed to American Indian consumers who access coverage through the Exchange. The State must seek input from American Indian consumers regarding the best way to inform consumers of the unique Indian provisions. • Reliance on web-based mechanisms to access health coverage information and determine eligibility will not adequately meet the needs of individual American Indian consumers. The State must seek innovative and aggressive education, outreach, and enrollment strategies, e.g. multiple navigators in the off-reservation community. • American Indians have historically resisted purchasing health insurance coverage. Despite the incentives and unique benefits created by the passage of federal health care reform, it will require a significant shift in attitude to entice Indian consumers to purchase coverage. If the State receives any federal dollars to support education and outreach regarding the benefits of health insurance coverage or the Exchange, these funds must be used to support aggressive outreach in American Indian communities.
Simplify & Integrate Eligibility Systems	Recommendations for the State: • Ensure that the technological capacity exists to develop an integrated eligibility system for Medicaid, the Exchange, and other public benefits programs. • Work closely with the Indian Health Service and the Urban Indian Health Program to develop the capacity to enter into "express lane" agreements.
Expand Indian Health Care System Capacity	Recommendations for the State: • Ensure that provisions within the law designed to expand the Indian health workforce are upheld by State agencies that may require licensed providers and/or entities. • It is imperative that the State ensure that any federal dollars received to expand and strengthen the health care system is distributed equitably to strengthen the off-reservation health care system. • Work closely with the Off-Reservation Commission to designate local "essential community providers" and include them in any plan networks. It is critical that we avoid the complexity and confusion that results when community providers are not included in the network and consumers are struggling to choose between plans or forced to switch providers.
Benefit Design	Recommendations for the State: • We do not have the technical capacity or expertise to make informed recommendations regarding the design of benefits. We urge the State to hire a consultant with a strong background in American Indian health system development and financing to assist with this effort. • Benefit design should support the elimination of health disparities and

	ensure access to culturally competent care.
Focus on the Dually Eligible	Recommendations for the State: • Work closely with off-reservation community members to design a community-based, coordinated care program that meets the needs of individuals who are dually eligible for Medicare and Medicaid. • Actively seek input and guidance directly from beneficiaries, e.g. New Mexico Indian Council on Aging.
NM Strategic Plan	Recommendation for the State: • In addition to the participation of the Secretary of Indian Affairs, tribal representatives to be included in the Leadership Team subcommittee.
Provisions that Require Tribal-State Collaboration, Communication and Consultation & Recommended Method of Consultation	Recommendation for the State: • Use and expansion of the State Agency Collaboration, Communication and Consultation Policies to develop provisions in the implementation of PPACA Titles I, II, IX, and X.
Medicaid Redesign	Recommendations for the State: • Continue State collaboration with New Mexico's Indian tribes and that tribal subcommittees consider specific tribal health care issues be incorporated into policies and processes. • Review current data regarding Medicaid and uninsured populations that may be most impacted by the new law; this includes reviewing data on New Mexico Medicaid enrollees and the Contract Health Service population served by the Indian Health Service.
Other Topics	Additional State-Tribal Items of Discussion: • Expansion of the Medicaid population; • Health manpower assessments; • Information systems data interface; and • Administrative issues such as enrollment, billing and eligibility determination, and review of the benefits package and coordination of benefits.

Appendix 11

Public Regulation Commission Division of Insurance's Health Care Reform Issue Matrix

PRC Responsibilities for implementing health care reform provisions:	Effective Date	Next Steps	Funding Opportunity and State Legislation
Annual and Lifetime Limits	Six-months after the enactment	HHS determination of essential benefits	Legislation/Rule-Making or Revision
Rescissions	Six-months after the enactment	Currently in NM State Law	None
Coverage of Preventive Health Services	Six-months after the enactment	HHS Guidance	Legislation/Rule-Making or Revision
Extension of Adult Dependent Coverage		Insurance Bulletin #2010-02 HHS Regulatory Guidance Issued	Legislation/Rule-Making or Revision
Preexisting Condition Exclusions	Six-month after the enactment for under 19 years of age	Accepts grandfathered individual market plans	Legislation/Rule-Making or Revision
Uniform Explanation of Coverage Documents and Standardized Definitions	Standards developed within 12 months	HHS/NAIC/Insurers, Consumers, HC Professionals, Patient Advocates and Qualified Individuals Working Group	Legislation/Rule-Making or Revision
Provision of Additional Information	Six-months after the enactment	State Insurance Superintendent and HHS	Legislation/Rule-Making or Revision NMSA 1978 §59A-57-8
Prohibition on Discrimination Based on Salary	Six-months after the enactment	Fully-insured plans (State) HHS developing Rules	Legislation/Rule-Making or Revision
Ensuring Quality of Care	Two-years after enactment	HHS Guidance with Stakeholder and HC expert input	Legislation/Rule-Making or Revision
Bring Down the Cost of Health Care-MLR	1/1/2011	NAIC – Dec 31, 2010 establish uniform definitions & methodologies for calculating measures	Legislation Revision of HB 12
Appeal Process	Six-months after enactment	Labor & HHS Guidance External Review – PRC	Grievance Rule Revision
Patient Protections PCP Designation to Allow Pediatricians, Emergency Care Services w/o Prior Approval & OBGYN	Six-months after enactment	Insurance Division Plan Review and Filing Requirements	Legislation & Rule Change Related to Pediatrician Requirement

Services as PCP			
Health Insurance Consumer Assistance Offices and Ombudsmen	Date of enactment	Insurance Division and Other State Agencies Pending HHS regulation	Funding Opportunity TBA Legislation/Rule-Making or Revision
Ensuring Consumer Get Value for Their Dollars – Review of Unreasonable Premium Rates & Disclosure	2010 Plan Year	HHS & State Insurance Division	State Funding Opportunity Legislation & Rule Revision
Temporary Reinsurance Program for Early Retirees	90-days after enactment	Secretary of HHS	Provide $5 Billion to Fund Program
Web Portal to Identify Affordable Coverage Options	7/1/10	Insurance Division Submitted Request Information Multi-state agencies	

Appendix 12
Taxation and Revenue Department's Health Care Reform Issue Matrix

	Reform Provisions& (Possible)TRD Direct Responsibility	Implementation Dates	Options/ Decisions	Funding Opportunity	Agency/ Program/ Contact	Date Grant Applied For	Grant Amount	Federal Website
1	**2010 - 2014 Small Business & Nonprofit Tax Credits**	2010- 35% **federal tax** credit of insurance costs (for employers w/ fewer than 25 employees) & up to 25% for small non-profits Starting in 2014- credit increases to 50% of employer contributions; up to 35% for non-profits	Determine need for state legislative or regulation changes. No impact identified for TRD at this time. Follow federal interpretations and monitor other states.	N/A	TRD/Audit and Compliance Division/Phillip Salazar	N/A	N/A	N/A
2	**CHIP-eligible children**	Post 9/30/2015: eligible children may receive tax credits if state allotment insufficient to meet CHIP funding needs						
3	**Premium Tax Credits and Cost-sharing reductions**	2014: makes premium tax credits and cost-sharing reductions available through Exchanges to help people obtain affordable coverage. Premium credits available to people with incomes above 100% and below 400% of poverty who are not eligible for or offered other qualified coverage.	The Premium tax credits will likely be in the form of a tax credit on the 1040. These are most often after FAGI. Will not affect state tax form as statute currently stands. As it now stands no IT impact to TRD. Will continue to monitor the federal interpretations and what other states are doing. **Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans: (Special Rules for Indians)** Any individual Indian enrolled in any qualified health plan through the Exchange whose household income is less than 300% of					

			the federal poverty line (FPL) shall be treated as an eligible insured. Eliminates all cost-sharing for Indians under 300% of the federal poverty level enrolled in any individual market insurance plan offered through the Exchange. Action: Legislation **Special Rules for Indians, items or services furnished through Indian Health Providers**: If an Indian beneficiary enrolled in a qualified health plan is furnished an item or a service directly by IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, no cost-sharing under the plan shall be imposed under the plan for such item or service, and the issuer of the plan may not reduce the payment to any such entity for services or items. Action: Legislation **No-Cost Sharing for Indians With Income At or Below 300% of FPL Enrolled in Coverage Through a State Exchange**: Prohibits cost sharing for Indians below 300% of the FPL enrolled in any qualified health plan in the individual market					

			through an Exchange. Action: Legislation					
4	**Health Care Professional Tax Credits**	2010: excludes from taxable income payments made under any State loan repayment or loan forgiveness program intended to increase the availability of health care services in underserved or health professional shortage areas. Effective for amts. received by an individual in taxable years beginning after 12/31/08.	May result in amended tax returns for 2009 No impact identified to TRD at this time. Continue to research what other states are doing and monitor.		TRD/RPD/Gale Kessler			
5	**Excise Tax**	2018: implementation of excise tax on insurers of employer-sponsored "Cadillac Health Plans"	Identify who has enforcement/collection authority Requires PRC to identify those insurers and collaborate w/ TRD					
6	**Increase of adoption tax credit and adoption assistance exclusion**	2010: The tax credit/assistance exclusion are increased by $1,000, makes the credit refundable and extends the credit through 2011. Effective for tax years beginning after 12/31/09.	No impact identified to TRD at this time. Continue to research what other states are doing and monitor.		TRD			
7	**Limiting Insurance Executive Compensation**	2013: Limits the deductibility of executive compensation under the tax code for insurance providers it at least 25% of the ins. provider's gross premium income from health business is derived from health ins. plans that meet the minimum creditable coverage requirements. The deduction is ltd to $500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services, for or on behalf of, a covered health insurance provider. Effective with respect to services performed after 2009.	No impact identified for TRD at this time. Continue to research what other states are doing and monitor.		TRD/RPD/Gale Kessler			

8	**Individuals must acquire health coverage or pay a tax penalty unless exemptions from mandate apply**. Exemptions include tribal members, individuals with low incomes who are not required to file taxes, those incarcerated; undocumented immigrants, those w/o coverage for less then three months, those who do not have "affordable" offer of coverage through Exchange or their employer.	Penalties: 2014: $95/adult family member & ½ that amt for each child up to max of $285 per family or 1% of taxable household income 2015: $325 or 2% of taxable household income 2016: $695 up to max of $2085 or 2.5% of taxable household income	Who has enforcement/collection authority? Penalties on the federal form generally do not affect Federal AGI. No impact identified for TRD at this time. Continue to research what other states are doing and monitor. We should continue to monitor the federal interpretations and what other states are doing Indian Provision as indicated in first column. Action: Legislation		TRD			
9	**Penalties to employers of 50+ if any employee receives Health Coverage Tax Credits to purchase insurance through the Exchange or Payment of Penalty whether or not employers Offer Coverage**	2014: Employer subject to fee for every FT employee regardless of how many employees receive tax credit up to a capped amount	Employers w/ less than 50 employees are exempt from penalties. Does TRD have any notification obligations to employers on receipt of returns?		TRD/Legal Services Bureau/Ida M. Luján 505/827-0574 Leadership Team's Legal Work Group			
10	**System Changes**	TBD	If system changes are necessary then definition of scope, analysis and thorough documentation of the required changes will be needed to adequately plan, develop and implement changes.		TRD/IT			

11	**Form Changes**	TBD			TRD/RPD Gale Kessler			
12	**Reporting to Fed**	N/A	N/A	No	TRD/Audit and Compliance Division/Phillip Salazar	N/A	N/A	N/A
13	**Outreach to Businesses, Employees, Individual Taxpayers, Nonprofits, Health Care Professionals, Insured/Uninsured, Medicaid & Other State Agency Partners**	Start in July 2010	How to promote Health Care Tax Reform: Mailing inserts Workshops Posters in offices Info on TRD website Info in filer's kits Professional organizations-CPAs, etc Other agencies Press releases & marketing	Unknown if federal funding available	TRD/Audit and Compliance Division/Phillip Salazar			
14	**Staffing**	TBD	Potential need for IT staff, RPD staff, Project Management and Tax Research staff		TRD			

Appendix 13
Indian Health Service's Indian Health Care Improvement Act Provisions Matrix

Indian Provisions in P. L. 111-148 (Non-IHCIA Titles Only)

Following table provides the **INDIAN SPECIFIC PROVISIONS** of the Patient Protection and Affordable Care Act (Affordable Care Act), P. L. 111-148.

TITLE 1 – QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS		
Subtitle D – Part II – Consumer Choices & Insurance Competition Through Health Benefit Exchanges		
Section	**Title**	**Summary**
1311(c)(6)(d)	Affordable Choices of Health Benefit Plans – Enrollment Periods	Requires the HHS Secretary to require an Exchange to provide for special monthly enrollment periods for Indians.
Subtitle E – Affordable Coverage Choices for All Americans		
Part I – Premium Tax Credits and Cost-Sharing Reductions **Subpart A – Premium Tax Credits and Cost-Sharing Reductions**		
Section	**Title**	**Summary**
1402(d)(1)	Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans: Special Rules for Indians	Any individual Indian enrolled in any qualified health plan through the Exchange whose household income is less than 300% of the federal poverty line (FPL) shall be treated as an eligible insured. Eliminates all cost-sharing for Indians under 300% of the federal poverty level enrolled in any individual market insurance plan offered through the Exchange.
1402(d)(2)	Special Rules for Indians, items or services furnished through Indian Health Providers	If an Indian beneficiary enrolled in a qualified health plan is furnished an item or a service directly by IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, no cost-sharing under the plan shall be imposed under the plan for such item or service, and the issuer of the plan may not reduce the payment to any such entity for services or items.

1402(d)(3)	Special rules for Indians-(3)Payment	HHS shall pay to a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan as a result of subsection 1402(d).
Subpart B – Eligibility Determinations		
Section	**Title**	**Summary**
1411(b)(5)(A)	Procedures for Determining Eligibility for Exchange Participation, Premium Tax Credits and Reduced Cost-Sharing, and Individual Responsibility Exemptions	An individual seeking an exemption from the individual mandate due to their status as an Indian must provide such information as the Secretary prescribes to qualify for the exemption.
Subtitle F – Shared Responsibility for Health Care **Part I**		
Section	**Title**	**Summary**
1501 adds Section 5000A(e)(3)	Requirement to Maintain Minimum Essential Coverage	Exempts members of Indian tribes from the shared responsibility payment, or penalty, for failure to comply with the requirement to maintain minimum essential coverage.
TITLE II – ROLE OF PUBLIC PROGRAMS		
Subtitle K – Protections for American Indians and Alaska Natives		
Section	**Title**	**Summary**
2901(a)	No-Cost Sharing for Indians With Income At or Below 300% of FPL Enrolled in Coverage Through a State Exchange	Prohibits cost sharing for Indians below 300% of the FPL enrolled in any qualified health plan in the individual market through an Exchange.
2901(b)	Payer of Last Resort	I/T/U providers are the payers of last resort for services provided to Indians by I/T/U for services provided through such programs.

2901(c)	Facilitating Enrollment of Indians under the Express Lane Option	Facilities operated by the Indian Health Service (IHS) and Indian, Tribal, and Urban Indian facilities (I/T/Us) would be added to the list of agencies that could serve as an "Express Lane agency" under sec. 1902(e)(13) of the Social Security Act.
2902	Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics	Makes permanent reimbursement for all Medicare Part B services furnished by Indian Health Service hospitals & clinics.
Subtitle L – Maternal and Child Health Services		
Section	**Title**	**Summary**
2951	Maternal, Infant, and Childhood Home Visiting Programs	Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Sets asides 3% of funding for I/T/Us, tribal entities preferred.
2953	Personal Responsibility Education	Creates grant programs to educate adolescents on abstinence and contraception. Includes a 5% set aside (out of $65 million per year) for grants to Indian Tribes and Tribal Organizations.
TITLE III – IMPROVING THE QUALITY AND EFFECIENCY OF HEALTH CARE		
Subtitle A – Transforming the Health Care Delivery System **Part II – National Strategy To Improve Health Care Quality** **Data Collection, Public Reporting**		
Section	**Title**	**Summary**
3015	Collection and Analysis of Data For Quality and Resource Use Measures	Authorizes the Secretary to award grants or contracts to eligible entities to support efforts to collect and aggregate quality and resource measures. IHS and tribal health programs are eligible entities.
Subtitle D – Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans		
Section	**Title**	**Summary**

3314	Including Costs Incurred by AIDS Drug Assistance Programs and IHS in Providing Prescription Drugs Towards the Annual Out-of-Pocket Threshold under Part D.	Amends the Social Security Act to allow IHS, Indian tribe or tribal organization, and urban Indian program spending to count toward the Medicare Part D out of pocket threshold, or coverage gap.
Subtitle F – Health Care Quality Improvements		
Section	**Title**	**Summary**
3501	Quality Improvement and Technical Assistance and Implementation	Grants funded under the program authorized in this section will identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services. Eligible entities include Federal Indian Health Service programs, health programs operated by tribes, and tribal organizations, Provision includes specific language around cultural competence.
3502	Establishing Community Health Teams to Support Patient-Centered Medical Home	Indian tribes and tribal organizations (per IHCIA Sec. 4) are eligible entities for a grant program to establish community-based interdisciplinary, inter-professional teams to support primary care practices, including OB-GYN, within hospital service areas.
3504	Design & Implementation of Regionalized Systems for Emergency Care	Authorizes Secretary to award competitive grants for pilot projects for innovative models of regionalized & comprehensive emergency care and trauma systems. Indian tribes (per IHCIA Sec. 4) or multi-tribal govt. partnerships are eligible entities.
3505	Trauma Care Centers and Services Availability	Authorizes three program awards to qualified IHS, tribal, and urban Indian trauma centers to assist in defraying substantial uncompensated care costs and to further the core missions of such trauma centers.
TITLE IV – PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH		
Subtitle A – Modernizing Disease Prevention and Public Health Systems		
Section	**Title**	**Summary**
4001	National Prevention, Health Promotion and Public Health	Assistant Secretary for Indian Affairs will be part of the council and the council will establish a process for continual public input from Indian tribes & tribal organizations.

	Council	
4003	Clinical & Community Preventive Services - Community Preventative Services Task Force	Directs the Community Preventive Services Task Force to review scientific evidence on effectiveness, appropriateness, & cost-effectiveness of clinical prev. services, and develop recommendations for delivery of population-based prevention intervention services by wide range of programs including government public health agencies (IHS), Indian tribes, tribal organizations & urban Indian organizations.
4004	Education and Outreach Campaign Regarding Preventative Benefits	Includes Indian health programs as providers to which health promotion and disease prevention information consistent with national priorities should be distributed for dissemination for a prevention and health promotion outreach and education campaign.
Section	**Title**	**Summary**
4102	Oral Healthcare Prevention activities	Four parts. Part 1) requires the Secretary to ensure that AI/ANs are targeted in activities for oral health care prevention education campaign. Part 2) makes I/T/Us eligible for grants for dental programs. Part 3) requires grants be award to I/T/U providers—but does not set the number of grantees. Part 4) Indian tribes and tribal organizations (per IHCIA sec. 4) along with states are eligible entities for the new CDC Oral Health Care Infrastructure Cooperative Agreements.
Subtitle C – Creating Healthier Communities		
Section	**Title**	**Summary**
4201	Community Transformation Grants	Authorizes CDC competitive grant awards for implementation, evaluation & dissemination of evidence-based community preventive health activities to reduce chronic disease rates, address health disparities, and develop a stronger evidence-base of effective prevention programming. Indian tribes are eligible entities.
4202	Aging Healthy; Living Well; Evaluation of Community-based Prevention and Wellness Programs for Medicare Beneficiaries	Authorizes CDC grant awards to carry out 5-year pilot programs to provide public health community interventions, screenings, & where necessary clinical referrals for individuals who are between 55 and 64 years of age. Indian tribes are eligible entities with states.
Subtitle D – Support for Prevention and Public Health Innovation		
Section	**Title**	**Summary**
4302 adds section 3101	Understanding Health Disparities: Data Collection,	Makes data analyses of federally conducted or supported health care or publicly health program or activity available to IHS and epidemiology centers funded under the IHCIA.

	Analysis, and Quality	
4304	Epidemiology-Laboratory Capacity Grants	Authorizes the establishment of a CDC grant program to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by epidemiology capacity, enhancing lab practices, improving IT systems, and implementing control strategies. Tribal health departments are eligible entities.
TITLE V – HEALTH CARE WORKFORCE		
Subtitle A – Purpose and Definitions		
Section	**Title**	**Summary**
Sec.5002	Health Work Force – Definitions	Defines 'allied health professional' and includes employees of tribal public health agency as eligible to meet the definition.
Subtitle C – Increasing the Supply of Health Care Workforce		
Section	**Title**	**Summary**
5204	Public Health Workforce Loan Repayment Program	Authorizes new loan repayment program to assure adequate supply of PH professionals to eliminate critical public health workforce shortages in Federal, state, local, tribal and other public health agencies. Tribes are eligible as well as UIOs in HPSA areas.
5205	Allied Health Workforce Recruitment and Retention Programs	Amends authorization for a loan repayment program to allied health professionals employed at public health agencies or in settings providing health care to patients, including acute care facilities, ambulatory care facilities, residences, and other settings located in Health Professional Shortage Areas, Medically Underserved Areas, or serving Medically Underserved Populations. Tribes are eligible as well as UIOs in HPSA areas.
5206	Grants for States and local programs	Amends authorization for scholarship programs for mid-career public and allied health professionals employed in public and allied health positions at the Federal, State, tribal, or local level to receive additional training in public or allied health fields. Tribes are eligible as well as UIOs in HPSA areas.
Subtitle D – Enhancing Health Care Workforce Education and Training		
Section	**Title**	**Summary**

5304 adds Sec 340G	Alternative Dental Health Care Providers Demonstration Project	Authorizes grant program for 15 eligible entities to establish demo programs to establish training program to train and employ alternative dental health care providers. Eligible entities include IHS facility or health facility operated by a Tribe, Tribal organization, or urban Indian organization.
Subtitle E – Supporting the Existing Health Care Workforce		
Section	**Title**	**Summary**
5405 adds Section 399W	Primary Care Extension Program	Authorizes program to provide assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed techniques, to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors. The Secretary is required to consult with federal agencies including IHS.
Subtitle F – Strengthening Primary Care and Other Workforce Improvements		
Section	**Title**	**Summary**
5507	Demonstration Projects to Address Health Professions Workforce Needs	HHS Secretary, in consultation with Secretary of Labor, is to award demonstration project grants designed to give eligible individuals the opportunity to obtain training and education in high demand health care fields. The Secretary must award at least 3 grants to eligible entity that is an Indian tribe, tribal organization or tribal college or university.
5508	Increased Teaching Capacity—Teaching Health Centers Development Grants	Authorizes grant program for teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs. Entities eligible include health centers operated by an I/T/U provider.
Subtitle G – Improving Access to Health Care Services		
Section	**Title**	**Summary**
5601	Spending for FQHCs	Authorizes appropriations for grants to Federally Qualified Health Centers.
TITLE VI – TRANSPARENCY AND PROGRAM INTEGRITY		

Subtitle E – Medicare, Medicaid, and CHIP Program Integrity Provisions

Section	Title	Summary
6402	Enhanced Medicare and Medicaid Program Integrity Provisions	Requires that the Integrated Data Repository of the CMS shall include, at minimum, claims and payments data from certain programs including IHS and the Contract Health Services Program. Also requires the Secretary to enter into agreements with individuals of certain agencies, including the IHS Director, to share and match data in the record system of the respective agencies with data in the HHS system for the purposes of identifying potential fraud, waste, and abuse.

TITLE IX – REVENUE PROVISIONS

Subtitle B – Other Provisions

Section	Title	Summary
9021	Exclusion of Health Benefits Provided by Indian Tribal Governments	Excludes the values of health benefits provided or purchased by the Indian Health Service, tribes, or tribal organizations from gross income.

TITLE X – STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle B – Provisions Relating to Title II

Part II – Support for Pregnant and Parenting Teens and Women

Sections	Title	Summary
10211 & 10212	Definitions & Pregnancy Assistance Fund Establishment	Amends definition of "State" to include tribes in a provision that authorizes the HHS Secretary to award competitive grants to States (Indian tribe or reservation included in definition of 'state') to assist pregnant and parenting teens and women.

Note: This document is intended as an informational summary and reference – please refer to the final law for more information and clarification.