THE FUTURE OF THE SAFETY NET IN NEW MEXICO

OBJECTIVE: DEVELOP CONSENSUS RECOMMENDATIONS FOR REDUCING THE NUMBER OF UNINSURED IN NEW MEXICO

Summary

Prior to the implementation of the Affordable Care Act (ACA), New Mexico had approximately 430,000 uninsured individuals, the highest rate in the nation except for Texas. New Mexico has one of the lowest percentages of employer-sponsored insurance in the nation as many of our small employers have not been able to afford to offer coverage.

While the ACA and Medicaid expansion have provided new coverage options for many New Mexicans, a large number of people remain uninsured and this situation will likely continue for several years. The initial projection for New Mexico Health Insurance Exchange (NMHIX) enrollment in 2014 was about 83,000; as of May 2014 approximately 34,000 had enrolled.

It may take several years for NMHIX enrollment goals to be reached. HSD reports that they have enrolled over 103,000 into Medicaid expansion as of 2014 and that of these enrollments approximately 50,000 previously had SCI or some other coverage such as Family Planning. Medicaid enrollments will phase in over time. In addition to those uninsured who are eligible for but not yet enrolled in the NMHIX or Medicaid, it is estimated there are between 50,000-100,000 New Mexicans that are undocumented and do not qualify for any coverage programs.

There will continue to be a large number of uninsured individuals in the state that will rely on safety net services which are shrinking as a result of implementation of the ACA. Uninsured individuals tend to go without needed health care until they are sicker and need more expensive services. Medical bills are the number one cause of bankruptcy in the U.S. The large number of uninsured individuals places financial burdens on providers and the health care system and also results in cost-shifting. New Mexico faces greater challenges than most states in reducing the number of uninsured, including reasons such as high poverty rates, rural challenges, and an absence of a "culture of coverage" (thousands of New Mexicans have never had health insurance).

Key stakeholders were brought together to discuss this issue and help develop strategic solutions. Information was provided in a background report on estimates of the uninsured, existing safety net[1] programs in New Mexico, and various strategies being utilized in other states. See Attachment 2 for that report.

An initial facilitated meeting of the stakeholders was held on May 7, 2014. See Attachment 2 for a summary of that meeting.

[1] For the purposes of this convening, the Health Care Safety Net is specifically defined to be: Services, facilities, and programs which help provide access to health care for uninsured or underinsured individuals.

The group came to consensus on the following:

- The large number of remaining uninsured is an issue that must be addressed.
- Specific strategies should be explored for 1) Enrollment and Outreach; 2) Retention; 3) Affordability/Subsidies.
- Strategies should not negatively impact the NMHIX enrollment.
- Special focus can be placed on Native American strategies due to the high percentage of Native Americans in New Mexico.
- Any tax impact on individuals should be carefully analyzed.

Workgroups and one-on-one meetings were held in June 2014 which generated the following recommendations:

Enrollment and Outreach

- NMHIX should partner with Walgreens (their motto is also "Be Well"). Walgreens has a box on their checkout cardswipe that asks if the consumer wants to know more about health insurance options. It is recommended that NMHIX work with Walgreens to see if when a consumer inputs their phone number that it will go to NMHIX and that NMHIX postcards should available at Walgreens for employees to give to consumers. A similar partnership is recommended with CVS, Walmart, and grocery stores.

- NMHIX should partner with companies/brokers selling auto insurance; this can help reinforce the mandatory requirement for health insurance.

- NMHIX should partner with MVD Express to have kiosks or other mechanisms for accessing NMHIX at MVD Express locations.

- NMHIX should make it easy to have Health Care Guides make appointments by phone or online when "roaming" places that there are many consumers, e.g. malls, other large events.

- NMHIX should develop toolkits for wide distribution, including with employers that don't plan to offer insurance so that employees can know their options, and for distribution through cities and counties to the general public. These toolkits should have much more specific information than the very general brochures developed by the NMHIX in the first open enrollment.

- NMHIX should have a single website. The multiple websites are confusing (BewellNM, NMHIX, healthcare.gov).

- Penalties should be highlighted in future messaging.

- Any new Requests for Information (RFIs) for outreach and education should not fund stand alone NMHIX events as they have not produced significant participation or good results in terms of enrollment. Outreach and education should be innovative and use approaches that reach large numbers of individuals in systematic ways rather than through events.

- NMHIX should explore using the "spitfire strategies" for social messaging. http://www.smartchart.org/content/smart_chart_3_0.pdf
  http://www.spitfirestrategies.com/tools/

- TV ads and other marketing should utilize real New Mexicans with testimonials with actual experiences with NMHIX, not actors. The health plans have done extensive testing and have found that real New Mexicans are far more effective throughout the state. TV ads should showcase both "success" stories with having health insurance as well as stories that illustrate the negative consequences of not having health insurance.

- For Young Invincibles, NMHIX should use Pandora, You Tube, Spotify, etc. for reaching this audience. More text strategies should be used for the younger population. Young Invincibles do not listen to the radio much. NMHIX should research what was done in the states with highest take-up by Young Invincibles.

- NMHIX should develop strategies to effectively reach consumers who are embarrassed/stigmatized by not having health insurance.

- NMHIX should ensure that there is a local point person in each county to coordinate outreach & enrollment efforts.

- Local templates should be developed for each county for community-based work on all strategies, e.g. retail, public agencies, cities, counties, etc., to ensure that every county of the state is flooded with information.

- NMHIX should work with large employers (e.g. Home Depot) and the Department of Workforce Solutions to see if a mailing can be done to every new part-time hire to let them know about coverage options.

- New Mexico Association of Counties should develop a database of all mailing lists that counties use to see what might be useful for NMHIX information, e.g. November property tax statements.

- NMHIX should explore whether there may be options for QHPs to directly enroll consumers perhaps through a partnership with NMPCA.

- Information should be provided to consumers on "What do you do now that you have health insurance?

- The provider community should develop strategies so that providers are more open to new patients.

Retention

- NMHIX should focus as much attention on retention in marketing strategies as on enrollment. PSA's with messages such as "Keep your health insurance benefits", "If you already have health coverage, make sure you keep it", etc. should be developed.

- Recommend generic messaging on retention that will apply to both Medicaid and NMHIX.

- NMHIX should also develop retention messaging for SHOP.

- Regarding Medicaid retention, a request should be made to HSD on whether there is sufficient capacity at ISD offices for ongoing required twelve-month recertifications given the large new volume of enrollments in Medicaid expansion. There may be ways to do more enrollments in the field with partners like NMPCA thereby freeing up ISD staff for recertifications. If there is a gap in recertification, it can cause significant problems with health plans and providers due to lack of continuity of care. During gap periods providers may be unsure of where to send claims. It would be useful to have data on the extent of gaps in coverage due to recertification logistics.

- Providers and Health Care Guides can be helpful in reminding consumers to recertify. Hospitals and clinics could ask patients every time they check in for a service to make sure to recertify. Private physicians could be helpful and perhaps GAMA and NMMS can help get the word out to physicians. Pharmacies could also be helpful in reminding patients.

- There needs to be direct messaging with clear instructions on how recertify for both Medicaid and NMHIX.

- Text strategies should be utilized more for retention.

- Recommend all MCOs and QHPs provide a flow chart on how recertification processes work.

- NMHIX and HSD should make available demographic data by county to know where to target retention messages.

- NMHIX should have only one website; the multiple websites for BewellNM, NMHIX, healthcare.gov is very confusing to consumers.

Affordability

Affordability is a significant issue for many low-income uninsured individuals. Strategies should continue to be investigated to address this issue. Some suggestions include:

- Focus groups should be held with individuals to determine affordability "price points" for the individual market.
- Focus groups should be held with small business owners to determine affordability price points" for the SHOP market.
- Hospital billing policies should ensure that there are appropriate incentives for uninsured individuals to enroll in coverage for which they are eligible. Hospital billing policies should be clearly explained to consumers as required by the ACA.
- Pilot projects could be pursued to test subsidy initiatives using funding sources allowed by CMS, including public entities, foundations, and tribes.

Next Steps

It is suggested that this report be transmitted to the NMHIX and HSD for consideration of the recommendations and that stakeholders continue to explore affordability solutions.

This report was prepared by Santa Fe Project Access and the activities of the project were carried out with funding from the Con Alma Health Foundation.

Attachment 1

The Magnitude of the Problem

Outlined below are the original estimates of enrollments into the NMHIX and Medicaid and estimates of possible NMHIX enrollment based on the data through March 2014.

Table 1: Initial Exchange Estimates

Projected Exchange Enrollment (Leavitt Partners estimate)

	2014	2015	2016	2017	2018	2019	2020
Individual	73,876	102,605	128,637	153,389	173,855	172,779	177,574
SHOP	8,681	16,147	20,296	28,751	33,890	33,896	33,859
Exchange	82,557	118,752	148,933	182,140	206,745	206,675	211,433

As of April 2014, approximately 35,000 people had enrolled in the NMHIX. The scenario below assumes a total of 50,000 will enroll by end of 2014 and that enrollments will increase substantially in subsequent years.

Table 2: Scenario for NMHIX Enrollment (unofficial estimate-scenario only)

	2014	2015	2016	2017	2018	2019	2020
Exchange	50,000	100,000	125,000	175,000	200,000	200,000	200,000

Table 3: Projected Medicaid Expansion Enrollment (HSD estimate as of April 2014)

Expansion	133,386	163,337	180,359	186,024	189,776	190,969	191,535

Table 4: Remaining Projected Uninsured

	2014	2015	2016	2017	2018	2019	2020
Baseline uninsured	430,000	430,000	430,000	430,000	430,000	430,000	430,000
Less: Medicaid expansion	(133,186)	(163,337)	(180,359)	(186,024)	(189,776)	(190,969)	(191,535)
NMHIX*	(50,000)	(100,000)	(125,000)	(175,000)	(200,000)	(200,000)	(200,000)
Adj. for previous SCI/etc.	50,000	50,000	50,000	50,000	50,000	50,000	50,000
Net projected uninsured	***296,614***	***216,663***	***174,641***	***118,976***	***90,224***	***89,031***	***88,465***

** Note that some of the individuals enrolled in the NMHIX had prior coverage; no data exists at this time on the number of those individuals.*

For the next several years it is projected that there will be large numbers of uninsured individuals—and this assumes substantial NMHIX enrollment.

Examples of Coverage Issues

There are a variety of types of issues that can result in an individual being uninsured. Here are some examples:

- Individuals who miss the open enrollment period for the NMHIX that ended March 31, 2014. These individuals, unless they have a qualifying life change event, will not be able to enroll in NMHIX coverage until fall 2014 and coverage will not begin until January 2015. (note: Individuals eligible for Medicaid can enroll at any time.)

- Many individuals at the lower income levels have found that even with the federal subsidies they cannot afford the premiums. A significant number of individuals are choosing to pay the penalty rather than enroll.

- Individuals who applied for Medicaid but were later determined ineligible may apply for the NMHIX outside of open enrollment periods, but they will have no coverage for the time period prior to enrollment in the NMHIX.

- Individuals who lose their job and initially elect COBRA coverage but then find it too expensive cannot enroll in the NMHIX until the next open enrollment period.

- Some individuals are caught in the "family glitch". Their spouse's employer offers coverage that is affordable (less than 9.5 percent of income) for the employee but is very expensive for the dependents. None of the family members would be eligible for a subsidy on the NMHIX.

- Some individuals on a J1 or J2 visa with incomes below 100% of the federal poverty level experienced technical difficulties with Exchange enrollment but are not eligible for Medicaid.

- It is anticipated that some individuals who enroll in bronze plans may find the deductibles and out-of-pocket costs to be prohibitively expensive and may choose to drop their coverage.

- A significant number of individuals who are eligible for Medicaid are not enrolled. For example, some estimate that there are 50,000 children in New Mexico that are eligible for Medicaid but not enrolled; some of whom are in mixed status families.

Safety Net Programs in New Mexico

For the purposes of this convening, the Health Care Safety Net is specifically defined to be: Services, facilities, and programs which help provide access to health care for uninsured or underinsured individuals. Below is information on some of the major safety net programs in the state.

Hospitals

New Mexico's hospitals are a key component of the safety net and are facing financing challenges. The ACA caused significant reductions in hospital funding and New Mexico's hospitals may face cuts as a result of SB 268 in the 2014 Regular Session which impacted county indigent fund financing and federal matching funds. While hospitals will eventually see increased funding as more people have NMHIX coverage or Medicaid, there will still be large amounts of uncompensated care for the remaining uninsured. Over the next several years, with continuing large numbers of uninsured, hospitals will face significant burdens of uncompensated care. See Appendix 1.1 from the New Mexico Hospital Association for additional information.

Counties

Counties are responsible for indigent care by statute in New Mexico. Changes to County Indigent Fund financing may reduce the availability of indigent care funding throughout the state. Some county revenues could possibly be leveraged to greater advantage to serve more individuals. Provisions in 2014 legislation to allow counties to pay premiums or assist with cost sharing for individuals were vetoed by the Governor. See Appendix 1.2 from the New Mexico Association of Counties for additional information.

New Mexico Medical Insurance Pool

The New Mexico Medical Insurance Pool ("the State Pool") was established by the Legislature in 1987 in order to provide access to New Mexicans who were unable to find affordable health insurance due to pre-existing medical conditions and other barriers to coverage. Before January 1, 2014, individuals qualified for the State Pool if they:

- Had a qualifying medical condition; or
- Had a rejection notice for comprehensive healthcare coverage; or
- Had a quote for, or in-force, a premium rate that is higher than the State Pool's qualifying rate; or
- Had a rider, waiver or limitation on current or offered coverage due to a health condition; or
- Are/will be involuntarily terminated from an individual plan because the carrier stopped selling such coverage in New Mexico; or
- Had moved to New Mexico and were covered by a High Risk Pool in another state; or
- Are currently covered by a plan under the NM Health Insurance Alliance and wish to transfer to the Pool; or
- Had reached the maximum allowable coverage limit of their current health plan; or
- Met HIPAA eligibility criteria (loss of group health coverage within the last 95 days.)

On January 1, 2014, the State Pool insured over 8,400 individuals. For the first time since the State Pool's inception, the majority of the State Pool's enrollees now have access to other options. State Pool enrollees have begun to take advantage of their new options, including the Marketplace and Centennial Care. As of April 18, 2014, enrollment had reduced to 6,677 enrollees. The State Pool's leadership expects that the majority of Pool enrollees will be transitioning to new coverage through an orderly process over the coming years. The parameters of the process and rate of transition will be shaped by a transition plan under development by the NMMIP's Board of Directors. See Appendix 1.3 for more information on the Pool, recent board decisions, and individuals who may still need coverage through a program like the Pool.

UNM Care

UNM Care is a coverage program for individuals in Bernalillo County with incomes up to 350 percent of the federal poverty level. UNM also operates a similar program in Sandoval County. UNM is attempting to convert as many patients as possible to Medicaid or the NMHIX. UNM is continuing UNM Care for individuals who get coverage through the NMHIX or other insurance so that the UNM Care program can serve as a secondary coverage and assist patients with out-of-pocket costs. At the end of March, out of the total of about 31,000 UNM Care patients, approximately 13,000 have been converted to Medicaid, about 3,300 have enrolled in the NMHIX. UNM Care is also continuing as a bridge program for individuals waiting on Medicaid eligibility or for individuals who have no other source of coverage.

Santa Fe Project Access

Santa Fe Project Access provided services to over 7,000 low income uninsured individuals in Santa Fe County in the past 10 years with a total of $30 million in care that was donated by providers and CHRISTUS St. Vincent Regional Medical Center. Project Access had its funding terminated in 2014 and the program is being discontinued as it was anticipated by the hospital that most patients would have access to coverage.

Project Access had provided for donations of services from providers to patients with serious medical problems that had no other options for care. SFPA was not for the purposes of preventive care or ongoing management of chronic disease. Over 200 physicians and providers volunteered to care for uninsured patients. Project Access was the only program of its kind in New Mexico; however, many programs like this exist around the country.

Other Safety Net Programs—New Mexico has a strong and extensive system of federally-qualified health centers and other clinics that have served as a major source of primary care for uninsured individuals throughout the state. The Indian Health Service provides services to Native Americans. Many other safety net programs exist throughout the state, many for specific populations or services.

Other Models

There are a variety of possible strategies to consider if New Mexico would like to pursue additional coverage and access options for individuals. Outlined below are some strategies for premium payments and models in other states.

Federal Options on Premium Payments

The U.S. Department of Health and Human Services ("HHS") has guidance regarding paying of premiums by 3rd parties. HHS has now discouraged hospitals and certain other third parties from paying patients' premiums or cost-sharing. HHS stated in its November 4, 2013 FAQ that it "has significant concerns with this practice because it could skew the insurance risk pool and create an unlevel field in the Marketplaces." If hospitals and other providers pay premiums for the sickest patients, HHS has expressed its concern that doing so will shrink the proportion of healthy patients so necessary to keep the insurance risk pool afloat.

HHS has clarified that the guidance does not apply to payments for premiums and cost sharing made on behalf of QHP enrollees by Indian tribes, tribal organizations, and urban Indian organizations. In fact, QHP issuers and state and federal insurance Marketplaces are encouraged to accept such payments.

State and federal government programs or grantees – specifically the Ryan White HIV/AIDS Program –may also pay premiums on behalf of their members who are eligible to purchase coverage through the Marketplaces.

Private, non-profit foundations may pay premiums and cost sharing for patients if the patients are selected based on defined financial status criteria. The patient's health status may not be considered, and the premium and any cost sharing payments must cover the entire policy year.

HHS has advised that any groups not specifically mentioned in the February FAQ should continue to avoid paying premiums or cost sharing on behalf of patients. Appendix 1.4 provides an example of an organization pursuing such premium assistance.

Washington State—Project Access Northwest

Project Access Northwest (PANW) is a seven year old Washington State based non-profit that exists to assure that low income patients receive appropriate and needed health care services by linking patients to needed appropriate donated specialty care services. This program is similar to other “Project Access” programs around the county like Santa Fe Project Access.

WA State passed legislation (RCW 43.71.030(3)) that allowed the Washington Health Exchange Board to establish policies that permit interested entities to pay premiums on behalf of qualified individuals purchasing insurance on the Exchange. *RCW 4.71.030(3) provides: The board shall establish policies that permit city and county governments, Indian tribes, tribal organizations, urban Indian organizations, private foundations, and other entities to pay premiums on behalf of qualified individuals.*

Based on this legislation, PANW started a pilot program in partnership with two local hospitals to sponsor the premiums for select low income people eligible for health insurance premiums in the Exchange. The pilot enrolled people thru the Open Enrollment period. Additionally, people may be enrolled based on life changing events through out the pilot period.

Eligibility criteria are:

- 138-400% Federal Poverty Level
- Eligible to purchase insurance in the Washington Health Benefits Exchange
- Family members of people above may, on a case-by-case basis, also be sponsored.

As part of the Premium Sponsorship process, patients agree to allow the Exchange to share all patient communications with PANW. Patients enter all necessary information in the Exchange and make an insurance plan choice. The Exchange determines the federal subsidy and remaining monthly premium.

Patients must choose a Silver-level insurance plan on the Exchange. They may then request to apply with PANW for Premium Sponsorship. PANW is notified of the request. PANW contacts each patient to determine eligibility and explain other aspects of the program. PANW pays all of the remaining premium for the individuals in the program. Patients are responsible for out-of-pocket costs. As of April 15, 2014 there were approximately 90 individuals in the pilot program.

Tribal Premium Sponsorship

The Affordable Care Act permanently reauthorized the Indian Health Care Improvement Act (IHCIA) which creates new opportunities for advancements and innovations in the Indian health system. Section 152 of IHCIA authorizes tribes, tribal organizations and urban Indian organizations to purchase health benefits coverage for Indian Health Service beneficiaries using appropriated health care dollars.

Currently, if beneficiaries need services provided outside the Indian health system, they are dependent on the Purchased/Referred Care program (formerly known as the Contract Health Service program). Historically, this program has been unable to meet the demand for services and two-thirds of the claims made under it are denied. Eligibility criteria are stringent and based on 72-hour notification, residency, and medical priority.

Section 152 enables tribes, tribal organizations and urban Indian organizations to purchase health benefits coverage for IHS beneficiaries. This may include coverage for service within a contract health service delivery area (CHSDA) or any portion of a CHSDA that would have otherwise been provided by CHS; coverage through a tribally owned and operated health care plan, a state or locally authorized or licensed health care plan, a health insurance provider or managed care organization, or a self-insured plan. The section permits that purchased coverage be based on the financial needs of the individual beneficiaries (as determined by the tribe(s) being served) and permits funds to be used to operate a self-insured plan.[2]

[2] http://www.ncsl.org/documents/health/IndHlthCareReauth.pdf

The implications of implementing this provision are significant. Tribes and tribal organizations can leverage existing resources by identifying individuals who would benefit from health coverage thus preventing the depletion of limited funds available through the Purchased/Referred Care program. Further, the increased opportunity to generate 3rd party revenue may result in recouping the entire cost of purchasing coverage for beneficiaries.

Nevada AccessHealth Medical Discount Plan

Nevada's AccessHealth Medical Discount plan is available for individuals not legally required to have health insurance coverage under the Affordable Care Act. Members receive care at greatly discounted rates from a network of nearly 2,000 doctors, hospitals and other healthcare providers throughout Nevada. They have over 300 primary care physicians and 700 specialists in the network. Services include everything except transplants. There are currently about 26,000 patients in the program and they are experiencing about 500 new patients per month.

Members choose a primary care physician from the network and membership also includes assistance from an assigned Care Coordinator to help manage care and services. Members are required to pay the discounted rate at the time of service. AccessHealth Medical Discount Plan is not a health insurance plan and does not meet government requirements for health insurance under the Affordable Care Act. It is a discount plan authorized in statute by the Dept. of Insurance in Nevada.

Members must live or work in the state of Nevada and have incomes below 300 percent of the federal poverty level. Only a photo ID is required, not birth certificates or social security numbers. Approximately 68 percent of the patients are employed.

Discounted services are provided through a statewide network of 2,000 providers.

Monthly Costs:	**Monthly Rate**
Each Adult – 19+	$35-$40 each
Each Child – up to 18	$10 each
Sample Services for Established Patients	**Fees for Service**
Primary care visit	$40-$45
Specialist office visit	$65-$70
Hospital – 10 day stay	$3,000 max / $400 day
Urgent Care	$70/visit
Pharmacy – year of cholesterol medicine	$84
Dental exam, x-rays and cleaning	$65-$75

Providers like the program because it lets them control the volume of Access patients they will see and because payments are upfront and not billed for. Providers also appreciate that patients are helping pay for their care and they believe it makes patients more responsible for their health. Patient care is highly coordinated with a medical home and Access tells patients what to take to appointments, where to go, how much money to bring, etc. After two no-shows or any non-payment for services, patients are permanently terminated from the program. These stringent rules result in very high compliance by patients.

There are program rules regarding ER usage so that patients do not get discounted ER rates unless they are admitted. They have a statewide contract with Walmart for drugs at 30% of cost. They have global rates for cancer treatment--chemotherapy ($5,000) and radiation ($3,000). They also operate a Patient Care Fund financed with grants and donations. This Fund is used for patients who have hardships in making payments.

They also operate a call center which acts as a one-stop clearinghouse to refer patients to appropriate programs (Access, Medicaid, Exchange, cancer programs, etc.). They receive about 4,000 calls per month. They believe many people who "opt-out" of the Nevada Exchange will still want to use Access, as well as undocumented individuals, and individuals who miss the open enrollment time frames.

TexHealthProgram

TexHealth Central Texas is a community based non-profit organization and licensed insurance agency located in Austin, Texas. The TexHealth program provides premium assistance to small businesses in Bastrop, Burnet Hays, Milam, Travis and Williamson counties. Originally a "3-share" model, TexHealth switched to a new model in 2013 to help small businesses and their employees with Exchange subsidies.

TexHealth reimburses one-third of the employee premium up to $120 per month. After the employer contribution, this can amount to a significant savings to the employee of 50% or more. Employers can choose from any group plan option and/or carrier they wish, or they can also shop on the Exchange for a plan that fits their needs. Business owners are eligible too if their income from the business does not exceed 400% of Federal Poverty Level or $46,680 per year.

It is available to small employers with between 2-50 employees who have not offered health insurance in the last 6 months. The program is partially financed by funding from the state Department of Insurance through a penalty fund. The program is currently small and limited to 500 members but TexHealth. The subsidy is available to employees only, not dependents. The chart below shows how the subsidy goes to offset the employee share of the premium.

Wage level (FT Hourly)	**Annual Income**	**Monthly cost of single plan**	**Employers pays 50% of premium**	**TexHealth subsidy ($375/3)**	**Employee's share**
7.40/hr.	$15,397	$375	188	120	68
8.28/hr.	$17,235	$375	188	120	68
$11.04	$22,980	$375	188	120	68
$16.57/hr.	$34,470	$375	188	120	68
$19.23/hr.	$40,215	$375	188	120	68
$22.38/hr.	$46,680	$375	188	120	68

In addition to the small business program, TexHealth is working on an *Individual Marketplace Premium Assistance Program* to help individuals and families qualify for state subsidy apart from the federal subsidy they receive on the exchange making healthcare even more affordable. The Texas Department of Insurance is reviewing their proposal at this time. Under their proposed model, the business owner will contribute an administrative fee to TexHealth to manage the subsidy for its employees who enroll in the individual marketplace.

Other Issues

Assessments/Financing—The NMHIX is considering a variety of financing mechanisms for ongoing funding of the NMHIX operations and is currently soliciting ideas and recommendations on this issue. There are a variety of policy issues that could be considered as such a mechanism is developed. The NMMIP is currently financed with an assessment/tax credit mechanism. As the NMMIP membership declines there may be an opportunity to explore overall assessment/financing strategies for both NMMIP and NMHIX to see if there might be ways to increase affordability for the uninsured.

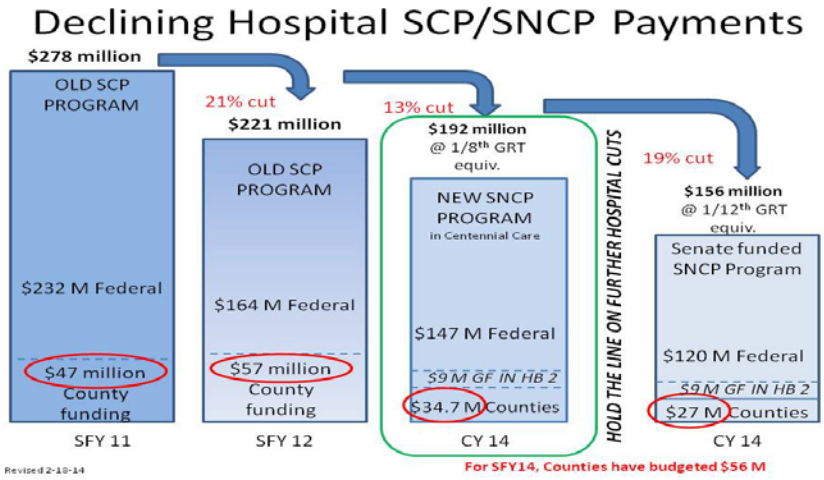
Enrollment Strategies—There may be ways to improve outreach and enrollment strategies for the NMHIX to improve enrollment. There may also be ways to accelerate Medicaid enrollment to reduce the number of uninsured.

Appendix 1.1

New Mexico's hospitals currently face myriad challenges at the state and federal level. The Centers for Medicare and Medicaid Services (CMS) continue to propose and implement new regulations which drive up reporting requirements and drive down reimbursement. For 2013, NM hospitals suffered about $16M in Medicare cuts, growing to $53M in 2014. At the State level, the blessing of Medicaid Expansion and new Centennial Care waiver are causing transition pains in the early stages of implementation.

Without a doubt, the biggest obstacle facing 29 of NMHA's 44 members is payment reduction resulting from the move from the Sole Community Provider (SCP) program to the new Safety Net Care Pool (SNCP) program under Centennial Care. Due to factors beyond the control of our members or the State Human Services Department (HSD), the transition from SCP to SNCP resulted in the severe cut of these supplemental payments intended to relieve the burden of hospital uncompensated care. Program dollars have declined from a peak of $270M to what we hope will be no lower than $192M. These resources will be allocated differently than under the previous SCP program; across the board, hospitals anticipate a "haircut" and some will be more closely shaven than others. The impact is particularly difficult smaller hospitals and public facilities. Recent passage of Senate Bill 268 safely ensures approximately $150M in hospital payments due to the 3:1 federal to state match. HSD and the Governor's Office are actively seeking the remaining $9-10M for a one year patch; if/when matched with federal dollars, SNCP hospitals will be allocated the full $192M in 2015.

All of the SNCP hospitals face difficult decisions. They are eliminating more services and staff. This impacts all hospitals and New Mexico's entire health care system as patients travel further to receive services. The elimination of local jobs will likewise hurt community economies. Based on the most recently available data, New Mexico hospitals had an annual employment impact (direct employees plus jobs created by the presence of those community employees) of 61,766 jobs adding $2.77B in compensation and $6.5B in economic activity statewide.



Appendix 1.2

Summary of Critical Elements of SB268 (Rodriguez)

- **Authorizes counties to fund the new state Safety Net Care Pool with the equivalent of a 1/12th county gross receipts tax (grt) increment.**

- **Counties may use public funds from any existing authorized revenue source to fund the new pool.**

- **The Board of County Commissioners is given new authority to enact a general purpose 1/12th or 1/16th increment , without referendum.**

- **The counties' obligation to fund the Safety Net Care Pool was to sunset in 3 years but Governor Martinez line-item vetoed this; the county's authority to enact the new grt increment will expire at the end of 3 years.**

- **Hospitals and the Human Services Department have specific mandates to report regularly to counties .**

- **The bill simplifies and adds flexibility to the County Indigent Act to help counties administer their programs more efficiently.**

- **Changes the name of County programs from "County Indigent Hospital Claims Fund" to Health Care Assistance Fund.**

New Mexico Association of Counties
Health Care Affiliate
March 30, 2014

Appendix 1.3

New Mexico Medical Insurance Pool

Additional Information on the NMMIP is provided below:

The Board has already taken action in two important areas that will likely increase the rate of transition.

- On January 24, 2014, the NMMIP's Board voted to suspend the list of qualifying medical conditions. This action works in concert with many of the reforms included in the ACA to significantly reduce the number of individuals who are eligible for the Pool as new enrollees. For example, because the ACA disallows the practice of individual underwriting, individuals are unlikely to be quoted a premium higher than the Pool's qualifying rate, which is 125% of the Pool's standard risk rate.

- On February 27, 2014, the Pool's Board voted to increase the Pool's premium rates by 23.8%, effective July 1, 2014, pending approval by the Superintendent of Insurance. Notice to enrollees of the proposed rate increase was sent immediately following the decision, so that enrollees could take advantage of the open enrollment period on the Marketplace if they chose to discontinue State Pool coverage. The anticipated effect of the rate increase is that it will serve as an additional reason for individuals to seek coverage in the Marketplace or Centennial Care.

A second program, the temporary Federal High Risk Pool ("the Federal Pool") was created in 2010 by the ACA to provide federal funds to cover individuals who had been rejected due to a pre-existing medical condition. On July 1, 2010, the New Mexico Human Services Department (HSD) in partnership with NMMIP contracted with the federal government (HHS) to operate the federal high-risk insurance pool program in New Mexico. The NMMIP oversees both the New Mexico State Pool and the Federal Pool.

The State Pool has a six-month pre-existing waiting period for people who meet certain eligibility criteria. The Federal Pool did not have the same waiting period, so most of the new enrollees from 2010-2013 selected the Federal Pool in order to begin insurance coverage immediately. Because of this important difference in the two programs, enrollment rose in the Federal Pool while enrollment in the State Pool remained fairly flat from 2010 through early 2013. This trend was observed until the Federal Pool ended new enrollment in March of 2013. Although the coverage for existing enrollees in the Federal Pool was initially planned to terminate on December 31, 2013, the federal government issued several extensions of coverage to ensure that no Federal Pool member would experience a gap in coverage when transitioning to new coverage. The Federal Pool is now expected to end on April 30, 2014. On January 1, 2014, the Federal Pool consisted of about 1300 individuals; as of April 2014 the enrollment has reduced to 80. The Pool is conducting personal outreach to each of these 80 enrollees to ensure that they have a plan in place for coverage following the end of the Federal Pool.

In the Pool's role as a major safety net program, the Pool's staff is often the first to uncover gaps in coverage. To date, some populations have anecdotally been identified by inquiries received to the office and in working with partner organizations. First, now that open enrollment has closed on the Marketplace and in the private individual market, those individuals who still need coverage and are not eligible for Centennial Care have virtually no options until January 1, 2015. As mentioned elsewhere in this report, county indigent funds may offer some support but the nature and funding of those funds is shifting.

Secondly, the affordability measure for employer-based plans is calculated based on the contribution of the employee for the purpose of Marketplace eligibility. If an employee's contribution toward a group plan is less than 9.5% of income, the plan is considered affordable and the employee and all eligible dependents are not eligible for subsidies on the Marketplace. However, some employers only contribute toward the cost of the employee's premium and not toward the cost of partner or family coverage, leaving the family with no option but to pay premiums that they may not be able to afford.

A third population consists of individuals who are under 65 years of age, disabled, and enrolled in Medicare Part A and B and are in need of a Medicare supplemental plan. These individuals currently have no option outside the Pool because the guaranteed issue provisions of the ACA do not extend to Medicare supplement or Advantage plans. The Pool plans to continue to offer coverage for this population until the issue is otherwise resolved. A fourth group of individuals needing affordable coverage options is the immigrant population. Immigrant eligibility for Centennial Care and the Marketplace is complex. Those that have a form of legal status may still not be eligible for premium subsidies on the Marketplace, and those who have not met the five-year residency requirement or other legal status requirements are not eligible for Centennial Care.

A final group of individuals are those who have encountered difficulties in applying for Centennial Care or the Marketplace. Typically, these individuals have been denied for one or both programs and have filed an appeal or a request for a fair hearing. While the outcome of their cases are being determined, these individuals have a short-term need for health coverage. The processing time can range from 45 to 90 days for these cases. This also includes individuals over 65 who are not eligible for Medicare, or are eligible for Medicare and can not afford the full Medicare premium, or have other complex Medicare eligibility issues.

Appendix 1.4

WSJ December 16, 2013
Insurers Fight Hospitals' Paying Premiums
Offers to Help Low-Income People Afford Coverage Could Undercut Economics of Law; Contradictory Guidance from HHS

A charity's plan to help people pay for coverage through new health-care exchanges has put it at the center of a high-stakes fight between the insurance and hospital industries that could pose a challenge to the economic underpinnings of President Barack Obama's health law.

A Better LA, a decade-old Los Angeles nonprofit, said last week it was signing up 50 low-income people for health plans in California's health-insurance marketplace. The charity, which said it has the blessing of the state agency overseeing the marketplace, will pay $50 to $100 a month to cover the share of the people's premiums not already financed by federal subsidies.

Those 50 people are at the vanguard of a push that could shift the balance between hospitals and insurers across the nation. Nonprofits, including some hospitals, say paying premiums would ensure coverage for people currently uninsured who can't afford even a small monthly payment for health insurance.

But insurers say they can't make a profit unless the health-insurance exchanges created by the Affordable Care Act draw a balanced mix of healthy and sicker customers. The law's rocky start, many insurers fear, has already skewed the mix toward people in worse health. Help from nonprofits or hospitals could speed the arrival of less healthy customers into the exchanges, outpacing the arrival of younger, healthier people who might not cross paths with hospitals.

One person set to get help from A Better LA is Renee Reaser, a 50-year-old in Lancaster, Calif. She has been uninsured since 2009 and has a monthly income of around $600 from running a community group teaching life skills to at-risk girls. Her husband, who also runs a community group, earns a little more, putting them slightly above the federal poverty level and making them eligible for tax credits to cover most of her premiums.

Ms. Reaser said she likely still couldn't afford her share of the premiums, in part because she is still paying off $1,900 in hospital bills after two emergency-room visits last year—for an asthma attack and what she was told was a mild stroke.

Rowan Vansleve, the charity's chief executive officer, said the initiative came from a donor who watched news reports on the health law and was struck by how little it would cost to pay some people's premiums.

A spokesman for Covered California, the state exchange, said the state didn't bar third-party payments, but that individuals should ask their own lawyers if the payment would violate any other statute or code.

Getting coverage for people with pre-existing illnesses is both an objective of Mr. Obama's health law and a priority for hospitals, which often must write off the cost of treating the uninsured. Many hospitals have already invested in signing people up.

Some want to go further and pay premiums for frequent patients, reasoning that their bottom lines would ultimately benefit. In the 25 mostly Republican-led states that aren't currently expanding their Medicaid

programs under the law, some people who fall below the poverty line don't qualify for any federal assistance and would likely need charitable help to afford coverage.

Hospitals making such payments would be fulfilling the law's mission of extending coverage to millions of Americans, said Melinda Hatton, the American Hospital Association's general counsel. "We thought it was the kind of thing the Affordable Care Act would really support and encourage," she said.

But such plans have drawn criticism. "It is a conflict of interest for hospitals and drug companies to pay patients' premiums and cost-sharing for the sole purpose of increasing utilization of their services and products," said Karen Ignagni, head of America's Health Insurance Plans, the health-insurance industry's trade group.

The group's general counsel, Joseph Miller, said laws regulating tax-exempt organizations could limit activities aimed at enriching themselves or another organization.

The federal government has provided apparently contradictory guidance. In late October, Health and Human Services Secretary Kathleen Sebelius wrote a letter to a congressman stating that she didn't consider plans sold through the insurance exchanges to be federal health-care programs, and so weren't subject to rules that prevent health providers from giving subsidies or rebates to enrollees.

But less than a week later, an HHS unit that is implementing the health law said it would "discourage" hospitals and other commercial entities from paying premiums. It asked insurers to reject such payments and warned that it would take further action if necessary.

"HHS has significant concerns with this practice, because it could skew the insurance risk pool and create an unlevel field," said the guidance issued Nov. 4. An HHS spokesman declined to comment further.

Hospitals are exploring whether to make payments on behalf of their patients, despite the ambiguities, said Dan Mendelson, chief executive of consultant Avalere Health.

Brian Massey, vice president for strategy at St. Vincent's Health System in Birmingham, Ala., an outpost of the Catholic nonprofit chain Ascension Health, said it was interested in paying premiums for people with incomes that fall below the level needed to secure federal subsidies. Under the law, the lowest earners were expected to enroll in Medicaid, the joint federal-state program for the poor, but Alabama chose not to expand its version.

The Tennessee Hospital Association said it was eyeing whether to create its own foundation to help its members do the same. "We're trying to work our way through that morass," said Craig Becker, president of the group. "We'd probably put some money up, and so would the hospitals, if we figure out we can swing it."

Attachment 2

Meeting Summary May 7, 2014

On May 7, 2014, 32 key health care stakeholders met to discuss the future of the safety net and potential solutions to the continuing large number of uninsured individuals in New Mexico. Convened by the Con Alma Health Foundation and Santa Fe Project Access, the meeting included review of a background document, discussions about possible solutions, and planning of next steps.

Summary of Presentations

New Mexico Health Insurance Exchange (NMHIX)
Mike Nunez gave a presentation about the status of the NMHIX. As of April 2014, a total of 32,062 individuals had been enrolled in a Qualified Health Plan. He noted that these individuals may have to be re-enrolled in the NMHIX in the fall as individuals transition from the federally-facilitated marketplace (FFM) to the NMHIX individual marketplace system. He noted that the NMHIX is working closely with the New Mexico Human Services Department (HSD) on Advance Premium Tax credit coordination and other system issues. NMHIX is working with the marketing firm BVK to make outreach and marketing strategies more "laser-like" rather than global outreach. NMHIX staff will travel to meet with the federal government on various issues the week of May 12 and to assess readiness to transition to a NMHIX individual IT system. Operational readiness is targeted for August 2014.

New Mexico Hospital Association
Jeff Dye provided information about hospital financing issues and noted that many hospitals are facing stability problems, particularly in the rural areas. Workforce issues are also a major challenge for hospitals. From the hospitals' perspective, the legislation regarding the Safety Net Care Program was not a compromise as hospitals will lose funding. He noted that there is still the potential for Medicare "fiscal cliffs" and that while Centennial Care expansion will eventually help hospitals there will need to be significant additional enrollment to reduce uncompensated care problems. He noted that they are working with the American Hospital Association to "redefine the H" and that there have been many quality improvement initiatives.

Counties
Liz Stefanics provided information about county indigent fund and safety net care financing. The counties had a meeting in Taos recently and many counties are not satisfied with the legislation passed in 2014 and will be challenging it. She noted that some counties are bankrupt and some don't have hospitals. Many counties also want to be able to have the flexibility to fund local programs. She anticipates that many counties will feel "budget shock" on this issue at the start of a new fiscal year on July 1.

New Mexico Medical Insurance Pool (NMMIP)

Debbie Armstrong provided information on the NMMIP. She noted that the eligibility for the NMMIP is now more restrictive and individuals can no longer qualify based on their medical condition. There is a question about whether the NMHIX closed open enrollment period can qualify an individual for entry into the NMMIP. However there is a six-month waiting period for the NMMIP. The NMMIP board does not want to just close the NMMIP at a set date and overwhelm the NMHIX enrollment or the off-Exchange market. To date the federal government has said that voluntary termination of NMMIP coverage does not qualify as a Special Enrollment Period event for the NMHIX. NMMIP membership has dropped from 8,500 to 6,500. She noted that NMMIP rates were recently raised as they were out of sync with the NMHIX. She noted that there are populations that will not qualify for the NMHIX such as individuals under 65 on Medicare with end stage renal disease and undocumented individuals.

Medicaid

Brent Earnest gave a presentation about the enrollment into Medicaid expansion. HSD is implementing the new ASPEN eligibility system. There has been a lot of enrollment due to the "woodwork" effect; previously eligible but unenrolled individuals have now been enrolled. This will have an impact on the state's budget. He discussed the administrative transfer process for individuals who had previously been covered by SCI or Family Planning and noted that approximately 63,000 of those individuals have been transferred to Centennial Care. HSD has hired additional permanent and temporary staff to work through the application surges. He noted that the FFM transfers had been sporadic and in "batches" rather than regular daily transfers; a total of 27,000 individuals have been transferred from the FFM to date. HSD has sent approximately 80,000 applications to the FFM. HSD estimates there are 40,000 children who are eligible for Medicaid but unenrolled and they estimate one-half of these children will be enrolled in 2014.

New Mexico Primary Care Association

David Roddy provided information (see Appendix 2.1) on the New Mexico Primary Care Association and the clinic system throughout New Mexico. The system saw 327,000 patients in 2013 and provided 1,289,146 total visits. New Mexico's clinics see double the rate of percent of population compared to the national average, seeing 16 percent of all New Mexicans. Major issues facing the clinics are workforce shortages, wage pressure, and reimbursement rates.

UNM Care

Steve McKernan provided information on UNM Care and noted that it is serving as supplemental coverage for individuals with NMHIX coverage or other commercial coverage or Medicare. UNM Care covers out-of-pocket costs so that an individual only pays the UNM Care level of co-pays. He noted that many UNM Care patients appear to have incomes too high to qualify for Medicaid expansion and that these individuals are also difficult to locate for enrollment. He noted that affordability is still a major barrier for the population with incomes between 138-200 percent of the federal poverty level.

Summary of Discussion

The group had an extended discussion about various enrollment, retention, and affordability issues.

- Michelle Welby noted that there were issues of enrollment retention and enrollment expansion and that different strategies were needed.
- Nandi Kuehn noted that there were two different populations to consider—those that can't afford coverage and those that do not qualify for coverage.
- Liz Stefanics noted that counties want to participate to help get more individuals covered and that local level strategies should be pursued. She also suggested new approaches to health literacy could be helpful, especially between now and the start of fall open enrollment.
- Debbie Armstrong noted that safety net programs are important but that programs should not be pursued that would negatively impact the NMHIX enrollment. She also noted that New Mexico would have the option of establishing its own Exchange with different rules in 2017.
- Martin Hickey noted that narrow networks were becoming more common among insurance products and that high out-of-pocket costs point to the need for affordability solutions for patients for both out-of-pocket costs as well as premiums. He also noted that for older patients the expenditures may be greater than the premiums. He also noted that patient-centered medical homes should be utilized to improve care and outcomes.
- Dolores Roybal noted that New Mexico's population over 65 was rapidly increasing and that this would also impact the health system. She also noted that the philanthropy sector was an important part of the system. Additionally, she emphasized the importance of community-based strategies on enrollment and outreach in rural communities, and for other underserved populations (e.g., Medicaid, low-income and others that experience the greatest health disparities). She also supported the expansion of the group to include other stakeholders (e.g., advocates and representatives from nonprofit organizations). She reported that Con Alma's focus was on rural, tribal and culturally diverse populations.
- Brent Earnest noted that less county funds will be transferred to HSD in the future and that this may provide opportunities for counties to do more with coverage options at the local level, including funds beyond county indigent funds. He also noted that retention was a big hurdle and that there will also be ramifications with penalties and tax season. He also raised the question of whether any premium assistance would be taxable income to an individual.
- Jeff Dye suggested that the three priority areas be 1) Retention; 2) Enrollment; and 3) Affordability/Subsidies.
- Charlotte Roybal suggested that additional stakeholders such as physicians and actual consumers be invited to participate.
- Tino Zamora noted that many long-term uninsured individuals are not accustomed to health insurance issues and that education is needed.
- Janix Barbusa expressed interest in more information about the Nevada discount program.
- David Roddy recommended the group explore premium assistance programs and assess issues such as legality, practicality, leveraging of county funds, etc.

- Robin Hunn asked what options there might be with additional Medicaid expansion but it was noted that a Basic Health Plan approach would require expanding between 138-200 percent of the federal poverty level and that there would be a State General Fund impact.

Consensus Recommendations

The group came to consensus on the following:

- The large number of remaining uninsured is an issue that must be addressed.
- Specific strategies should be explored for 1) Enrollment and Outreach; 2) Retention; 3) Affordability/Subsidies.
- Strategies should not negatively impact the NMHIX enrollment.
- Special focus can be placed on Native American strategies due to the high percentage of Native Americans in New Mexico.
- Any tax impact on individuals should be carefully analyzed.

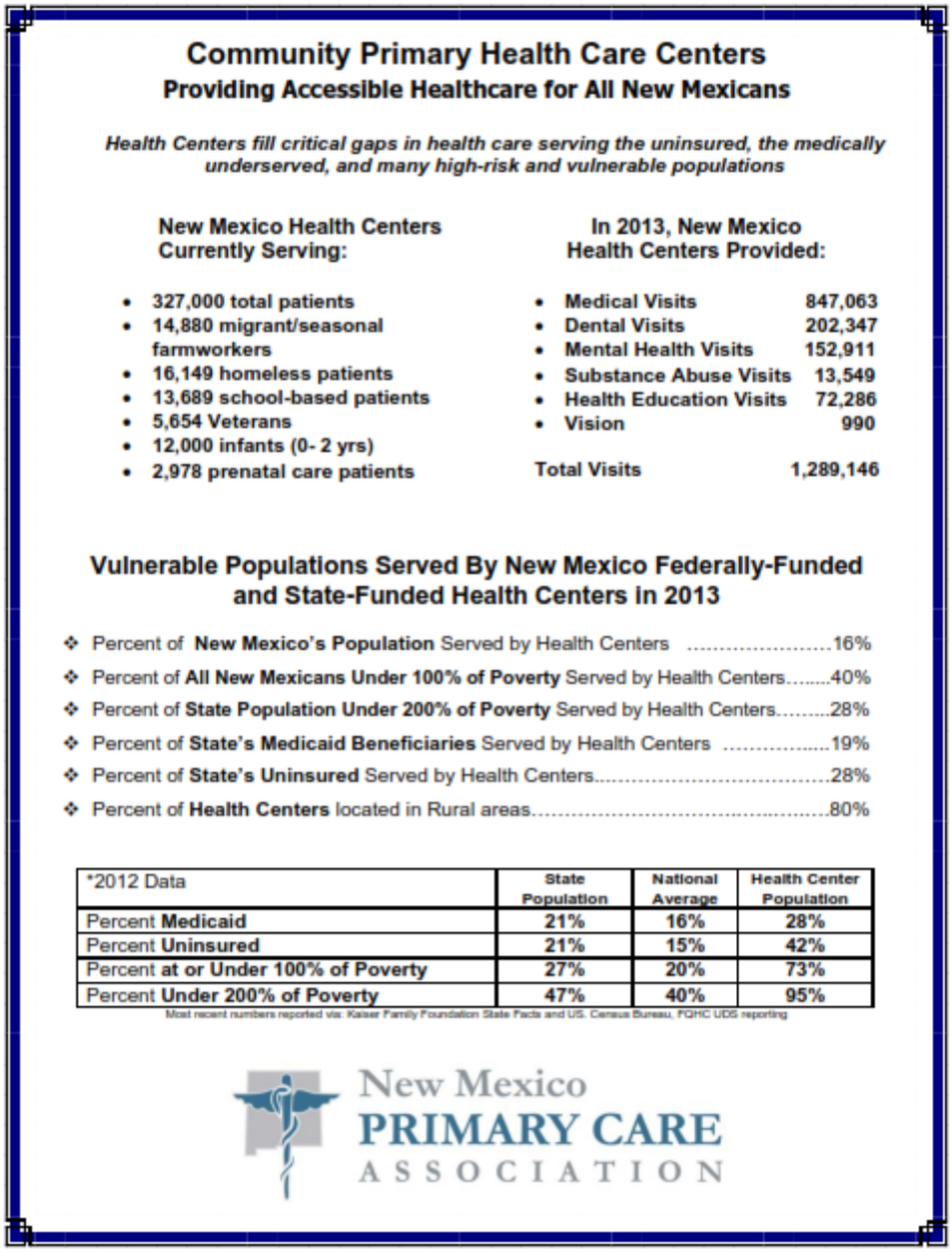
The group agreed to have Santa Fe Project Access provide technical and logistical support to establish work groups in the 3 priority areas. Robin Hunn will take the lead and convene the groups in the next few weeks. It was agreed that the larger group would reconvene to receive reports from the work groups.

Participants

Debbie Armstrong, New Mexico Medical Insurance Pool
Janix Barbusa, Independent Insurance Agent
Roxane Spruce Bly, Bly & Associates
Bob DeFelice, First Choice Community Health Care
Mike Donnelly, AARP
Jeff Dye, New Mexico Hospital Association
David Gaussoin, New Mexico Health Equity Partnership
Teresa Gomez, Futures for Children
Eileen Goode, New Mexico Primary Care Association
Shannon Groves, Blue Cross Blue Shield New Mexico
Martin Hickey, M.D., New Mexico Health Connections
Robin Hunn, Santa Fe Project Access
Kevin Kandalaft, UnitedHealthcare
Nandini Kuehn, First Choice Community Health Care
Eric Layer, Association of Commerce and Industry
Tony Martinez, Molinca Healthcare
Steve McKernan, UNM Hospital
Rodney McNease, UNM Hospital
Rachel O'Connor, Santa Fe County
Katelyn Quiroz, New Mexico Association of Counties
Debbie Rochford, New Mexico Primary Care Association
David Roddy, New Mexico Primary Care Association
Charlotte Roybal, Policy Connections West
Dolores Roybal, Con Alma Health Foundation
Fred Sandoval, Con Alma Health Foundation
Liz Stefanics, Santa Fe County

Reena Szcepanski, New Mexico Medical Insurance Pool
Renee Villarreal, New Mexico Community Foundation
Angela Vigil, New Mexico Health Connections
Michelle Welby, Molina Healthcare
Shas Yazhi, New Mexico Health Equity Partnership
Tino Zamora, Albuquerque Hispano Chamber of Commerce

Appendix 2.1



Community Primary Health Care Centers

Providing Accessible Healthcare for All New Mexicans

Health Centers fill critical gaps in health care serving the uninsured, the medically underserved, and many high-risk and vulnerable populations

New Mexico Health Centers Currently Serving:

- 327,000 total patients
- 14,880 migrant/seasonal farmworkers
- 16,149 homeless patients
- 13,689 school-based patients
- 5,654 Veterans
- 12,000 infants (0- 2 yrs)
- 2,978 prenatal care patients

In 2013, New Mexico Health Centers Provided:

• Medical Visits	847,063
• Dental Visits	202,347
• Mental Health Visits	152,911
• Substance Abuse Visits	13,549
• Health Education Visits	72,286
• Vision	990
Total Visits	1,289,146

Vulnerable Populations Served By New Mexico Federally-Funded and State-Funded Health Centers in 2013

- Percent of **New Mexico's Population** Served by Health Centers 16%
- Percent of **All New Mexicans Under 100% of Poverty** Served by Health Centers.....40%
- Percent of **State Population Under 200% of Poverty** Served by Health Centers.....28%
- Percent of **State's Medicaid Beneficiaries** Served by Health Centers 19%
- Percent of **State's Uninsured** Served by Health Centers.....28%
- Percent of **Health Centers** located in Rural areas.....80%

*2012 Data	State Population	National Average	Health Center Population
Percent **Medicaid**	21%	16%	28%
Percent **Uninsured**	21%	15%	42%
Percent **at or Under 100% of Poverty**	27%	20%	73%
Percent **Under 200% of Poverty**	47%	40%	95%

Most recent numbers reported via: Kaiser Family Foundation State Facts and US. Census Bureau, FQHC UDS reporting

New Mexico PRIMARY CARE ASSOCIATION

With strong federal and state support New Mexico's primary care safety net served 327,000 (nearly 1 in 6) New Mexicans in 2013. Over 160 Medical, dental, and school-based clinics provided over 1.2 million medical, dental, mental health and substance abuse visits. The clinics served 40% of all New Mexicans under 100% of the federal poverty and 135,000, or one in three, of New Mexico's uninsured.

The primary care safety net was fortunate to receive level state support for the 2014-15 state fiscal year as legislators and the Governor recognized that New Mexico's safety net will have to expand capacity if newly acquired health care coverage is to translate into access to quality comprehensive care. As health reform came to the state and the nation in 2014, primary care organizations recommitted to their mission of providing access to primary care for all New Mexicans.

The top challenge facing these organizations are retaining and recruiting clinical providers in an extremely competitive national marketplace. Organizations have reported increases of 15-25% in the salary expectations of physician and dentist recruits and up to 50% increases for Nurse Practitioners and Physician Assistants. A second but equally daunting challenge is maintaining financial viability. Implementation of electronic health records and efforts to develop and attain Patient Centered Medical Home accreditation have been expensive and up to this point have resulted in lower clinician productivity while not generating any offsetting revenues. At the same time many newly insured health insurance exchange patients have high medical deductibles and significant co-pays. Primary care clinics believe payment reform, particularly for primary care services is essential to insure access to the newly insured and remaining uninsured.

New Mexico's Community Primary Health Care Sites

Over 1.2 Million Visits Annually to over 320,000 of New Mexico's Most Vulnerable.

New Mexico PRIMARY CARE ASSOCIATION

List of Centers by County

BERNALILLO COUNTY
Albuquerque Health Care For the Homeless– ABQ
First Choice Community Health Care– ABQ
First Nation's Community HealthSource– ABQ
CATRON COUNTY
Presbyterian Medical Services– Reserve, Quemado
CHAVES COUNTY
La Casa Family Health– Roswell
CIBOLA COUNTY
Pine Hill Health Center– Ramah
Presbyterian Medical Services– Grants
COLFAX COUNTY
S. Central Colfax Special Hospital District– Angel Fire, Cimarron
El Centro Family Health Centers– Springer
CURRY COUNTY
La Casa Family Health– Clovis, Melrose
DE BACA COUNTY
De Baca Family Health Center– Fort Sumner
DONA ANA COUNTY
Ben Archer Health Center– Dona Ana, Hatch, Radium Springs
La Clinica De Familia– Anthony, Chaparral, Las Cruces,
San Miguel, Santa Teresa, Sunland Park
EDDY COUNTY
Presbyterian Medical Services– Artesia, Carlsbasd, Loving
GRANT COUNTY
Hidalgo Medical Services– Bayard, Cliff, Mimbres, Silver City
GUADALUPE COUNTY
El Centro Family Health Centers– Anton Chico
**Guadalupe County Clinic– Santa Rosa
HARDING COUNTY
EL Centro Family Health Centers– Roy
HIDALGO COUNTY
Hidalgo Medical Services– Animas, Lordsburg
LEA COUNTY
Jal Clinic– Jal
**Nor-Lea Hospital District– Hobbs, Lovington, Tatum,
Presbyterian Medical Services– Hobbs
LINCOLN COUNTY
**Carrizozo Health Center– Carrizozo
La Casa Family Health– Hondo
LUNA COUNTY
Ben Archer Health Center– Columbus, Deming
Presbyterian Medical Services– Deming
MCKINLEY COUNTY
Presbyterian Medical Services– Gallup, Ojo Encino, Thoreau

MORA COUNTY
El Centro Family Health Centers– Wagon Mound
Mora Valley Community Health Services– Mora
OTERO COUNTY
Ben Archer Health Center– Alamogordo
Presbyterian Medical Services– Chaparral, Cloudcroft, Tularosa
QUAY COUNTY
Presbyterian Medical Services– Tucumcari
**Village of Logan- Logan
RIO ARRIBA COUNTY
El Centro Family Health Centers– Coyote, Embudo, Espanola,
Truchas
La Clinica del Pueblo de Rio Arriba– Tierra Amarilla
Las Clinicas Del Norte– Abiquiu, El Rito
Presbyterian Medical Services- Espanola
ROOSEVELT COUNTY
La Casa Family Health– Portales
SAN JUAN COUNTY
Presbyterian Medical Services– Farmington
SAN MIGUEL COUNTY
El Centro Family Health Centers– Las Vegas, Ribera,
San Miguel
Pecos Valley Medical Services– Pecos
SANDOVAL COUNTY
El Pueblo Health Services– Bernalillo
Presbyterian Medical Services– Cuba, Counselor, Jemez
Valley, Rio Rancho, Torreon
SANTA FE COUNTY
First Choice Community Health– Edgewood
La Familia Medical Services– Santa Fe
Las Clinicas Del Norte– Pojoaque
Presbyterian Medical Services– Cerillos, Santa Fe
***Sangre De Cristo Community Health Partnership
**Women's Health Services– Santa Fe
SIERRA COUNTY
Ben Archer Health Center- Truth or Consequences
SOCORRO COUNTY
Presbyterian Medical Services– Magdalena, Socorro
TAOS COUNTY
El Centro Family Health Center– Penasco, Taos
Las Clinicas Del Norte– Ojo Caliente
Presbyterian Medical Services– Questa
TORRANCE COUNTY
Presbyterian Medical Services– Estancia, Mountainair
VALENCIA COUNTY
First Choice Community Healthcare– Belen, Los Lunas

** Non member, *** Health Center Partner/Member

Attachment 3

Meeting Summary

Enrollment and Outreach Work Group

June 3, 2014

Attendees:

Roxane Spruce Bly, Native American Professional Parent Resources
Shannon Groves, Blue Cross and Blue Shield of NM
Robin Hunn, Santa Fe Project Access
Beth Landon, New Mexico Hospital Association
Katelyn Quiroz, New Mexico Association of Counties
Debbie Rochford, New Mexico Primary Care Association
Reena Szczepanski, New Mexico Medical Insurance Pool

Discussion and Recommendations:

NMHIX should partner with Walgreens (their motto is also "Be Well"). Walgreens has a box on their checkout cardswipe that asks if the consumer wants to know more about health insurance options. However when this was tested recently the Walgreen employee knew nothing about health insurance in New Mexico. Recommend that NMHIX work with Walgreens to see if when a consumer inputs their phone number that it will go to NMHIX. Recommend having postcards available at Walgreens for employees to give to consumers. Recommend similar partnership with CVS, Walmart, and grocery stores. Blue Cross Blue Shield will provide contact information for Walgreens and Walmart.

NMHIX should partner with companies/brokers selling auto insurance; this can help reinforce the mandatory requirement for health insurance.

NMHIX should partner with MVD Express to have kiosks or other mechanisms for accessing NMHIX at MVD Express locations.

The new system NMPCA is developing for referrals/appointments with outward facing website capabilities should be very broadly shared with as many public and private organizations as possible, including retail. The web button/link should use bold graphics and easy to understand information.
It is effective to have the ability to make appointments by phone when "roaming" places where there is a lot of consumers, e.g. malls, other large events.

NMHIX should develop toolkits for wide distribution, including with employers that don't plan to offer insurance so that employees can know their options, and for distribution through cities and counties to the general public. These toolkits should have much more information than the general brochures developed by BVK.

The multiple websites are confusing (BewellNM, NMHIX, healthcare.gov). NMHIX should have a single website.

Penalties should be highlighted in future messaging.

The Department of Workforce Solutions should be contacted about a mailing insert regarding COBRA deadline of July 1.

Any new RFIs for outreach and education should not fund stand alone NMHIX events as they have not produced significant participation or good results in terms of enrollment. Outreach and education should be innovative and use approaches that reach large numbers of individuals in systematic ways rather than through events.

NMHIX should explore using the "spitfire strategies" for social messaging.
http://www.smartchart.org/content/smart_chart_3_0.pdf
http://www.spitfirestrategies.com/tools/

TV ads and other marketing should utilize real New Mexicans with testimonials with actual experiences with NMHIX, not actors. The health plans have done extensive testing and have found that real New Mexicans are far more effective throughout the state. TV ads should showcase both "success" stories with having health insurance as well as stories that illustrate the negative consequences of not having health insurance.

For Young Invincibles, NMHIX should use Pandora, You Tube, Spotify, etc. for reaching this audience. More text strategies should be used for the younger population. Young Invincibles do not listen to the radio much. NMHIX should research what was done in the states with highest take-up by Young Invincibles.

Some consumers are embarrassed/stigmatized by not having health insurance; mechanisms are needed to deal with this issue.

There should be a local point person in each county to coordinate outreach & enrollment efforts.

Local templates should be developed for each county for community-based work on all strategies, e.g. retail, public agencies, cities, counties, etc., to ensure that every county of the state is flooded with information.

NMHIX should work with large employers (e.g. Home Depot) and the Department of Workforce Solutions to see if a mailing can be done to every new part-time hire to let them know about coverage options.

New Mexico Association of Counties should develop a database of all mailing lists that counties use to see what might be useful for NMHIX information. Explore idea of sending out inserts in November property tax statements.

NMHIX should explore whether there may be options for QHPs to directly enroll consumers perhaps through a partnership with NMPCA.

Information should be provided to consumers on "What do you do now that you have health insurance?". Blue Cross and Blue Shield has extensive tools, many of which are unbranded.

The provider community should be more open to new patients; patients frequently feel unwelcome at provider offices.

Attachment 4

Retention Work Group

Meeting Summary

June 3, 2014

Attendees:
Jeff Dye, New Mexico Hospital Association
Robin Hunn, Santa Fe Project Access
Ken Reid, New Mexico Intertribal Community Services Council
Michelle Welby, Molina Health Care
Tino Zamora, Albuquerque Hispano Chamber of Commerce
Revea Gonzales, Albuquerque Hispano Chamber of Commerce and Health Care Guide

Discussion and Recommendations:

Retention will be a significant issue and should receive as much attention in marketing strategies as enrollment. PSA's with messages such as "Keep your health insurance benefits", "If you already have health coverage, make sure you keep it", etc. should be developed. Recommend generic messaging on retention that will apply to both Medicaid and NMHIX.

Retention messaging should also be developed for SHOP.

Regarding Medicaid retention, a request should be made to HSD on whether there is sufficient capacity at ISD offices for ongoing required twelve-month recertifications given the large new volume of enrollments in Medicaid expansion. There may be ways to do more enrollments in the field with partners like NMPCA thereby freeing up ISD staff for recertifications. If there is a gap in recertification, it can cause significant problems with health plans and providers due to lack of continuity of care. During gap periods providers may be unsure of where to send claims. It would be useful to have data on the extent of gaps in coverage due to recertification logistics.

Providers and Health Care Guides can be helpful in reminding consumers to recertify. Hospitals and clinics could ask patients every time they check in for a service to make sure to recertify. Private physicians could be helpful and perhaps GAMA and NMMS can help get the word out to physicians. Pharmacies could also be helpful in reminding patients.

There needs to be direct messaging with clear instructions on how recertify for both Medicaid and NMHIX.

Text strategies should be utilized more.

Recommend all MCOs and QHPs provide a flow chart on how recertification processes work.

It would be very helpful to have demographic data by county to know where to target retention messages. In the past, HSD produced a county report by MCO.

The multiple websites for BewellNM, NMHIX, healthcare.gov is very confusing to consumers; there should only be one website and/or consistency of how they are named.