CON ALMA HEALTH FOUNDATION

The Heart & Soul of Health in New Mexico

Achieving Equity in Health for Children and Families in New Mexico Through the Affordable Care Act

July 2016

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Robert Wood Johnson Foundation | Center for Health Policy at the University of New Mexico

UNM COLLEGE of POPULATION HEALTH

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The goal of this project is to ensure that people in low-income communities and communities of color have health equity — an equal chance to live healthy lives — as intended by the Affordable Care Act.

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The views expressed in this report are those of the authors and do not necessarily represent those of the RWJF Center for Health Policy, the University of New Mexico, collaborating organizations, or funders.

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ABSTRACT

The 2010 Patient Protection and Affordable Care Act (ACA) can help New Mexico achieve health equity by expanding access to care, bolstering public health and prevention programs, and improving the health-care safety net. A number of provisions under the ACA focus on reducing health disparities, particularly among racial and ethnic populations. This study provides a point-in-time snapshot of the progress in implementing ACA provisions aimed at advancing health equity for children and families living in New Mexico.

Drawing from multiple sources of evidence — census data, geo-mapping, 55 stakeholder interviews, and a comprehensive review of the literature and policy documents — this study:

(1) provides a baseline of children's insurance coverage needed for ongoing monitoring and tracking of progress toward health equity;

(2) reviews the health equity provisions in the ACA and highlights those New Mexico is implementing;

(3) researches and gathers information about the challenges of implementing specific provisions of the ACA focusing on health equity;

(4) summarizes implementation benchmarks and timelines; and

(5) provides solutions for moving forward to achieving health equity for children and their families.

EXECUTIVE SUMMARY

This report provides a point-in-time snapshot of the implementation progress and challenges regarding the Affordable Care Act (ACA) provisions aimed at advancing health equity for children and families living in New Mexico. Implementation research is of immense value in shining a light on the interface between what can be achieved in theory and what happens in practice. Drawing from multiple sources of evidence — census data, geo-mapping, 55 stakeholder interviews, and a comprehensive review of the literature and policy documents — implementation benchmarks, successes, and challenges are summarized and solutions offered for moving toward greater health equity together.

Equity matters for health.

- Equity assures that children most in need receive a fair amount of social support to achieve the same highest attainable standard of health as other children.
- To achieve health equity in New Mexico, social resources must be allocated according to need to ensure utilization by those at highest risk due to poverty, geographic isolation, and racial/ethnic disadvantage.

Coverage matters for New Mexico's children and families.

- From 2009 to 2013, the percent of uninsured children in New Mexico varied at state and county levels by race, ethnicity, age categories, family income, education level, and employment status.
- The baseline data supports the decision to continue enrolling children into the Marketplace.
- Medicaid and the Children's Health Insurance Program are an important safety net for many children and families.
- Children in families with unemployed or part-time workers rely on Medicaid.
- Public insurance coverage matters for children in families below 200 percent of the federal poverty level (FPL).
- Prior to the ACA, young adults aged 18–24 were more often uninsured than other age groups.
- American Indian/Alaska Native children are the most vulnerable with 22 percent uninsured, followed by Hispanic/Latino children and Native Hawaiian/Pacific Islanders, both at 9 percent uninsured.

The Affordable Care Act of 2010 includes a number of provisions designed to increase health equity.

- New Mexico is making some progress in accessing opportunities and resources to advance health equity, but more strategic efforts should be leveraged to maximize the impact of the following equity provisions under the ACA: Coverage Mandate; Medicaid/CHIP eligibility increase; Marketplace, Subsidies and Tax Credits; Employer Requirements; Children and Adolescents; Women's Health, Maternal and Child Health; American Indians/Alaskan Natives; Lesbian, Gay, Bisexual, Transgender Health; Latino Health; African American Health; Asian Pacific Islander Health; Immigrant and Refu-

gee Health; Rural and Frontier Health; U.S.-Mexico Border Health; Substance Abuse and Mental Health; Disability and Health; Community- and School-Based Health Centers; Data Collection; Health Disparities Research and Grants; Cultural and Linguistic Competency and Health Literacy; Workforce Diversity; Innovative Models of Care; and Safety Net.

New Mexico reached major benchmarks in implementing the ACA between 2008 and 2011.

- Governor Bill Richardson supported several health-care initiatives. Although his universal health-care proposal "HealthSOLUTIONS" failed to pass in 2008, a special legislative session resulted in a $22.5 million allocation to increase coverage for children not covered by the Children's Health Insurance Program (CHIP) or Medicaid.
- Governor Susana Martinez continued the planning process with funding from federal ACA implementation grants, and vetoed legislation (SB 35 and HB 370) to establish a Health Insurance Exchange, citing questions of ACA constitutionality that needed to be resolved.

2012

- The Supreme Court of the United States (SCOTUS) ruled 5-4 that the penalty for lack of insurance coverage was a constitutionally authorized tax rather than a mandate. The ruling included **the provision** that Medicaid eligibility expansion to 138 percent of the FPL was optional for the individual states and could not be disincentivized through federal funding sanctions.
- Public pressure on Governor Martinez to expand Medicaid included a statewide campaign led by advocacy organizations such as the New Mexico Center on Law and Poverty, Health Action New Mexico, Southwest Women's Law Center, labor unions, and many others.

2013

- Governor Martinez expanded Medicaid. Concurrently, the New Mexico Department of Human Services (HSD) obtained a Section 1115 Demonstration Waiver from the Centers for Medicare and Medicaid Services in order to implement the Centennial Care replacement for the state's outdated Medicaid program.
- The New Mexico Health Insurance Exchange (NMHIX) Act, which called for the establishment of the NMHIX as a nonprofit corporation, was passed just 187 days before the start of the first Open Enrollment Period on March 28, 2013.

2014

- The NMHIX Board hired a chief executive officer to provide direction over state operational efforts, information technology project oversight, staffing, targeted outreach, enrollment, and marketing.

2015 -2016

- New Mexico Marketplace Board of Directors voted to continue to lease the healthcare.gov platform for individual enrollment. Small business enrollment (SHOP) continues as a state-run health exchange.

- As of September 30, 2015, 44,836 (or 31 percent) of the eligible 133,000 individuals have enrolled in beWellnm, and more than 220,000 New Mexicans have enrolled in Medicaid.
- In February 2016, 54,865 persons enrolled in private plans through the marketplace. It is projected that 850,000 persons will be enrolled in Medicaid in 2016.

New Mexico is making progress, but continues to face challenges.

- From 2013 to 2015, the New Mexico uninsured rate dropped by 7.1 percent (from 20.2 percent to 13.1 percent).
- Culturally, linguistically, and geographically targeted strategies are ongoing priorities for achieving equity in health-care access under the ACA.
- An important aspect of outreach and enrollment described by many participants statewide was the use of community health workers.
- State implementation efforts have faced challenges, including a late start-up; leadership turnover; information technology problems; and inconsistent guidance and data from the Centers for Medicaid and Medicare Services.
- Many New Mexico residents cannot afford the cost of premiums or co-pays**.** Re-enrollment could be impacted by the cost of insurance coverage when deductibles, co-payments, and out-of-pocket expenses on top of premiums far exceed covered benefits.
- Health equity is not achievable for immigrant children because the ACA excludes undocumented immigrants from eligibility for Medicaid, and from purchasing insurance via the Marketplace.

Solutions for moving forward:

1) Create a culture of health coverage for all New Mexicans.

- Pursuing equity under the Affordable Care Act is rooted in a value of health care for all.
- Coverage is essential for all children. To that end, New Mexico should focus on assuring immigrant children and their families have access to health care.
- The NMHIX should focus on increasing awareness of the value of health insurance coverage among Native Americans and young adults, and foster a general cultural shift that recognizes the importance of health insurance coverage.

2) Prioritize community as a central force for achieving health equity.

- Across all geographic areas, sectors, and roles in implementing health reform, stakeholder participants consistently emphasized the importance of community as a central force in achieving health equity.
- Participants consistently called for more community inclusion in statewide health policymaking, and for the implementation process of the ACA to include more community input, validate and utilize local expertise, and build on community knowledge.

3) Make payment structures more equitable.

- Statewide, respondents offered a list of general financing solutions including: increasing payers so more people are insured; exploring opportunities for Native American tribes to purchase health coverage for members who have complex, high-cost health-care needs; maximizing the mil levy funds via the UNM hospital; providing incentives for workforce capitation costs; equalizing payer structures so that doctors and other providers working in communities receive reimbursements equal to doctors and providers working in hospitals; and regulating uniform hospital charges for the same procedures.

4) Expand on successful outreach and enrollment that is culturally and linguistically aligned with New Mexico's diverse communities.

- The NMHIX should build on the successes of school-based health centers, Native American Parent Professional Resources, and community health workers, and expand and diversify the types and locations of outreach and enrollment contracts to partnering organizations that are based in grassroots community networks.

5) Simplify eligibility and enrollment processes.

- The state should fully implement the Affordable Care Act by establishing a "no-wrong-door" policy, using funds to support cultural and linguistic strategies to reach out to and enroll children and their families in Medicaid and the Marketplace.

6) Build on best practices and support systems innovations.

- The ACA offers New Mexico an opportunity to design a health-care system that is outcomes-based, emphasizes preventative care, and minimizes hospitalizations.
- Across the state, there were several best practices that participants favored to support prevention and improved health outcomes, including community health workers, the home-visiting program, and school-based health centers.

7) Promote leadership and ensure accountability.

- In New Mexico, making inroads in health insurance coverage for children and families calls for responsive leadership and governance, on-going data collection, advocacy and coalition-building, intersectoral and intergovernmental collaboration, and culturally and geographically responsive outreach and enrollment strategies appropriate to the diverse communities in New Mexico.

8) Improve the collection of evidence for monitoring and tracking the progress of the ACA.

- The federal government (Centers for Medicare/Medicaid Services) and New Mexico Human Services Department should work in collaboration to collect and disseminate timely and quality data on enrollment numbers by race/ethnicity, language, and geography.
- Identify and support a single entity to take the lead in collecting state- and local-level data on enrollment and health insurance coverage for children.

9) Tackle the social determinants of health and achieve child health equity in all policies.

- Children's health is rooted in the social, economic, and environmental context in which they live.
- Local, state, and tribal policymakers must make children a priority in all policies, consider the development of a "children's agenda," and adopt a statewide campaign calling for a Better New Mexico.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA)[1] has three primary goals: expand access to health insurance; protect patients against arbitrary actions by insurance companies; and reduce costs. Additionally, the ACA can help New Mexico advance health equity by expanding access to care, bolstering public health and prevention programs, and improving the health-care safety net by providing funding that can be used to reduce inequities in access to care and adverse health outcomes by race, ethnicity, language, income, gender, sexuality, disability, and geography.

This report summarizes the findings of a policy implementation study aimed at assessing the progress of implementing the ACA and its impact on advancing health equity for children and families living in New Mexico.

Implementation research is of immense value in shining a light on the interface between what can be achieved in theory and what happens in practice. Drawing from multiple sources of evidence, this report:

(1) provides baseline data on children's insurance coverage at the state and county levels;

(2) compares the federal provisions supporting health equity under the ACA to what is actually happening in New Mexico;

(3) summarizes the timelines and benchmarks of activities; and

(4) describes the successes and challenges of implementing the ACA from the perspectives of stakeholders.

Solutions for moving forward include: creating a culture of health coverage for all New Mexicans; prioritizing community as a central force for achieving health equity; making payment structures more equitable; expanding on successful outreach and enrollment that is culturally and linguistically aligned with New Mexico's diverse communities; simplifying eligibility and enrollment processes; building on best practices and support systems innovations; promoting leadership and ensuring accountability; and improving evidence collection for monitoring and tracking the progress of the ACA.

RESEARCH METHODS

Using the mixed methods described below, this study broadens and deepens our understanding of real-world factors and how they impact implementation of the ACA in New Mexico. While Appendix A provides more details on the methodology, the following summary describes the overall design.

Approach

We used a policy implementation research approach to assess the progress in carrying out the activities of health reform in New Mexico. *"Policy implementation involves change in organizational practice, discretion by frontline workers, and complex decision-making in a context of formal policy ambiguity and uncertainty."*[2] Implementation research is crucial to improving our understanding of the challenges we face in rolling out health reform and what happens between the larger policy goals written and the real-world activities carried out by the various stakeholders involved in health reform. Implementation research is of immense value in shining a light on the interface between what can be achieved in theory and what happens in practice.

Literature review and policy scan

We conducted a comprehensive literature review of studies and reports assessing implementation of the ACA and health equity. We searched PubMed and Cochrane databases and nonpartisan research firms, government agencies, nonprofits, and foundations.[a] We also conducted a scan of New Mexico state policy reports and documents from governmental and nonprofit organizations and foundations.[b] Together, these searches included over 200 documents, reports, policy briefs, and publications. We conducted an additional literature review of reports, fact sheets, and research briefs summarizing the equity provisions in the ACA. Using over 35 sources, we created a side-by-side analysis of the federal provisions compared to New Mexico's activities in implementing these provisions (Table 1). Because not all the information was available on the internet, we also contacted content experts to supplement the web-based searches.

Census data and mapping

One of the goals of this study is to monitor and track the progress of implementing the ACA in New Mexico, and the impact on vulnerable children and families by race, ethnicity, and geography. Since no profiles exist of data at the sub-state level on children's coverage, the UNM team worked with the UNM Geospatial and Population Studies unit to extract county-level data from the U.S. Census into Excel data files, and worked with the UNM Center for Educational Policy Research to create chart packs and maps. Maps can be accessed at: https://public.tableau.com/profile/center.for.education.policy.research.university.of.new.mexico#!/vizhome/NewMexicoChildrenandHealthInsuranceCoverage_0/NewMexicoChildrenandHealthInsurancebyCount.

Interviews

Data collection and sampling: We conducted semi-structured interviews with 55 key informants in person and via telephone to gather their perspectives and experiences implementing the ACA in New Mexico. Enrollers, community health workers, health council coordinators, government officials, policymakers,

hospital administrators, insurance providers/carriers, advocates, and others involved in implementing the ACA participated in a 50-minute to one-hour interview between February and May of 2016. Drawing from the literature review, the interview guide was designed to elicit information regarding their roles in implementation of the ACA; awareness of ACA health equity provisions related to vulnerable children and families; successes and challenges encountered during implementation; leadership and partnerships; immigration provisions; and solutions. The Human Research Review Committee Human Research Protections Office of UNM Health Sciences Center approved the research design and interview methodology (HRRC#16-072).

Data analysis

We digitally recorded the interviews on a Mac/Yeti USB devise and transcribed them into text files that were de-identified and stored electronically in a password-protected computer database. The textual data from the transcribed interview notes (de-identified) were entered into the NVivo 10 software.[c] We used "open coding" to identify major themes by questions, followed by "focused coding" to assess variation and commonality across geographic areas of the state.

Geographic, demographic, and sector profile of participant stakeholders

The following geographic areas in New Mexico were represented in the final sample: Northern New Mexico — Taos, Rio Arriba, Union, Colfax, and Santa Fe counties; Central — Bernalillo, Valencia, and Sandoval counties; Eastern — Chavez, Roosevelt, and Quay counties; and Southern — Catron, Luna, Sierra, Otero, Doña Ana, Grant, and Hidalgo counties. The majority of participants reported that their sector affiliation was with nonprofit organizations (29), followed by federal, state, tribal, or county government (18); health councils (14); insurance enroller/navigators (14); community (13); schools (7); community health centers (7); hospitals (5); and legal advocacy/law (5). Fewer reported affiliation with insurance providers/managed care organizations (4); the business sector (4); and foundations (2). For detailed information on the sampling method and socio-demographic profile of the stakeholder participants, see **Appendix A.**

Strengths and limitations

While the financial resources for this study were limited ($79,000 from Con Alma and $20,000 from RWJF Center for Health Policy), the UNM team was able to call on the human resources and research assets of various university units. Graduate students were engaged in the project to build health services/health policy research capacities, and community-centered consultants were hired to provide rich expertise on the diverse policy landscape. The Con Alma team provided input and guidance into the research design, contributed technical expertise in producing translational research products, and led two statewide forums. Given the limited resources, the research itself was restricted to a qualitative policy analysis supplemented by demographic and geographic data. It was not the purpose of this study to assess consumer perspectives, determine the costs of health care, or review the utilization of health-care services.

a Examples include: Kaiser Family Foundation, Urban Institute, National Conference of State Legislatures, US Office of Health Reform, National Indian Health Board, Urban Institute, State Health Reform, Center on Budget and Policy Priorities, Commonwealth Fund, Mathematica Policy Research, National Indian Health Board, WK Kellogg Foundation, RWJ Foundation, Joint Center for Political and Economic Studies, PolicyLink, and National Centers for Medicare and Medicaid. We used a combination of search terms such as: health equity, health access equity, access to insurance coverage for racial/ethnic minorities, children's insurance coverage and the ACA, equity provisions in the ACA, and implementation research on the ACA.

b Examples include: NMHIX, Legislative Finance Council, Legislative Council, Human Services Department, Department of Health, NM Center on Law and Poverty, NM Voices for Children, Notah Begaye III Foundation, Con Alma Health Foundation, and Indian Health Services.

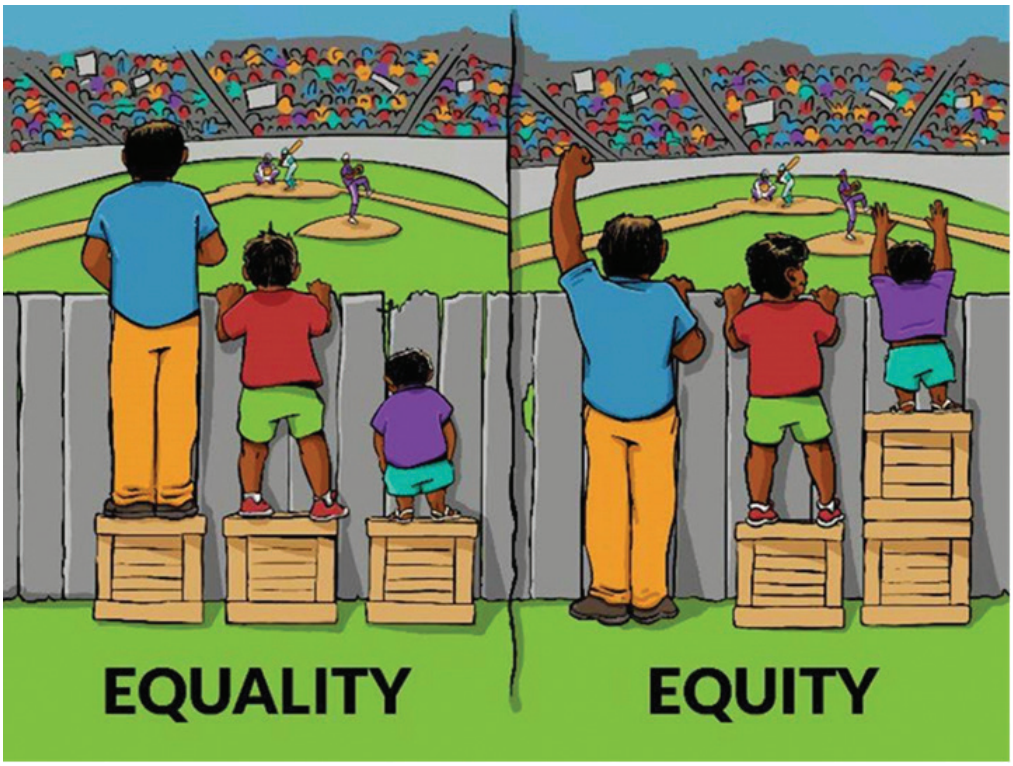
c NVivo qualitative data analysis software; OSR International Pty Ltd. Version 10, 2014.

EQUITY MATTERS FOR HEALTH

Inequities in health systematically put groups of people who are already socially disadvantaged — for example, by being poor, female, disabled and/or members of a disenfranchised racial, ethnic, or religious group — at further disadvantage with respect to their health — and health is essential to wellbeing and to overcoming other effects of social disadvantage.

Assessing health equity requires comparing health and its social determinants between more and less advantaged social groups. **FIGURE 1** illustrates the difference between equality and equity. Interventions aimed at giving all children the "same" amount of social support does not level the playing field for those children and families who have experienced historical social disadvantages. Rather, equity assures that the children most in need would get as much social support as necessary to achieve the same highest attainable standard of health as other children. These comparisons are essential to assess whether national and international policies are leading toward or away from greater social justice in health.[3] To achieve health equity in New Mexico, social resources must be allocated according to need to ensure utilization by those at highest risk due to poverty, geographic isolation, and racial/ethnic disadvantage.[4] The ACA can help New Mexico advance health equity by expanding access to care, bolstering public health and prevention programs, and improving the health-care safety net. The ACA created the opportunity to close the gap in health care inequities for vulnerable children and their families in New Mexico. Establishing a baseline of evidence on the status of insurance coverage for children at the state and local level is critical for assessing the progress in achieving health equity under the ACA.

FIGURE 1 - Equality vs. Equity



CHARTING *(IN)*EQUITY IN CHILDREN'S INSURANCE COVERAGE

Health insurance is the first basic step in accessing health care and promoting population health. Expanding health insurance coverage is critical to addressing the health-care needs of children, adults, racial/ethnic minorities, and medically underserved communities in New Mexico. Evidence of the adverse consequences of being uninsured demonstrates the important role that coverage plays in increasing timely, affordable, and quality health care. The harmful effects of lack of insurance include preventable illness, suffering — even death.[5]

Medicaid and the Children's Health Insurance Program (CHIP) are an important safety net for many children and families.

From 2009-2013, 45 percent of children in New Mexico were covered by Medicaid; 33 percent by employer-based coverage; and 12 percent by more than one or other types of coverage. Ten percent were uninsured (FIGURE 2).[d]

Figure 2: Health insurance coverage of children by type of coverage, New Mexico, 2009-2013

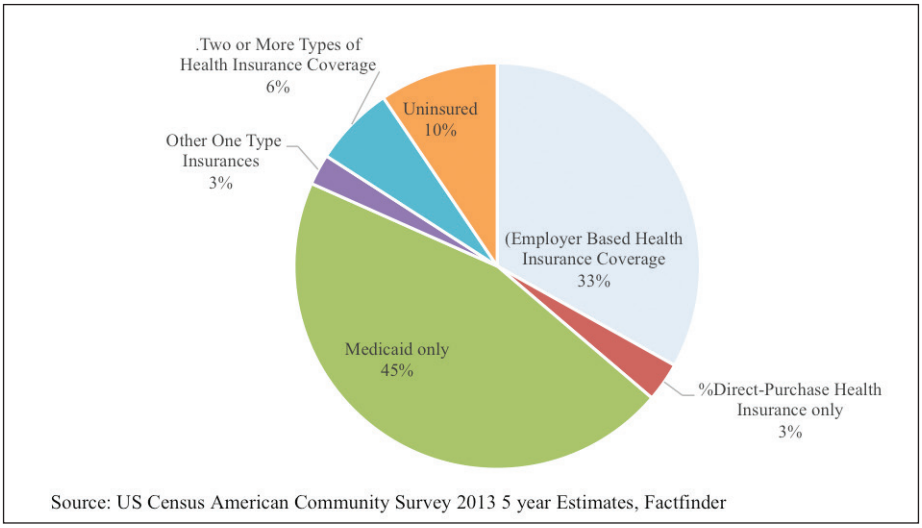
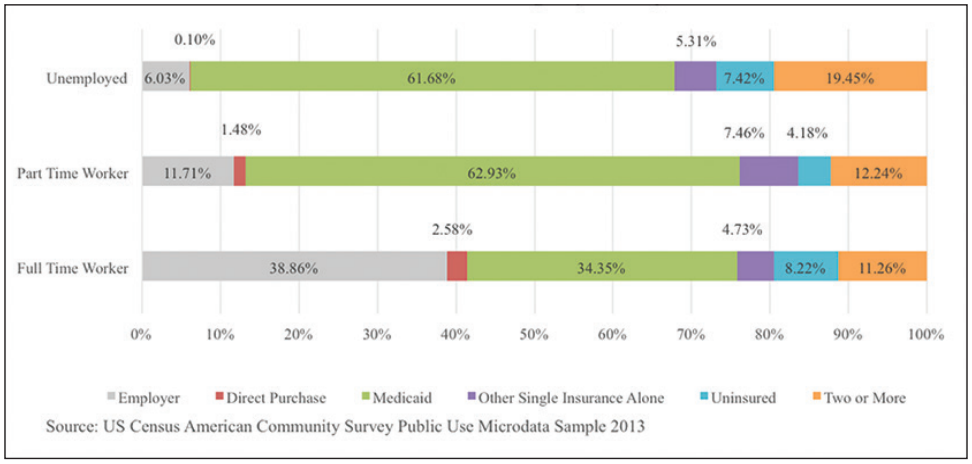


Figure 3: NM Children's health insurance coverage by family work status (employment), 2013



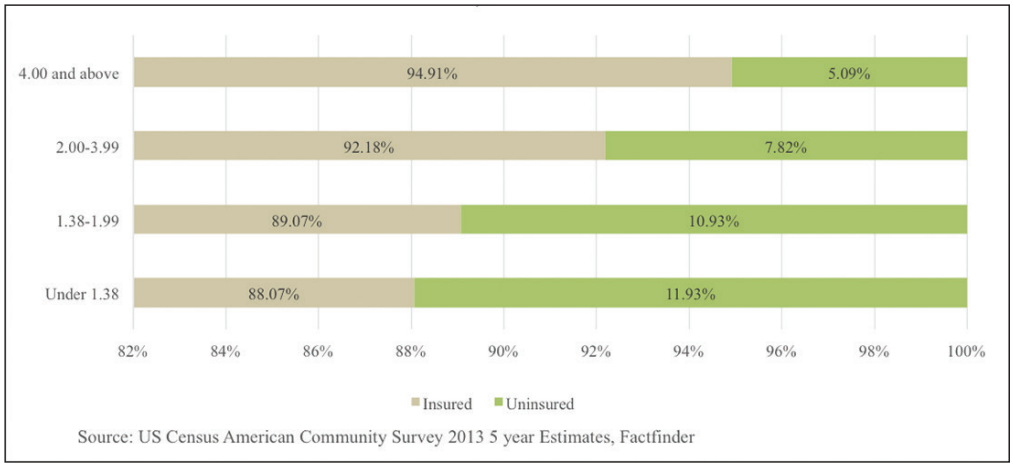
d NOTE: The five year estimates are the most reliable source of insurance coverage and these charts only include only part of the October 2013 data during which the New Mexico Insurance Exchanged launched the first open enrollment.

- For children in a home with part-time workers, 63 percent reported using Medicaid; 12 percent had employer-based insurance; and 4 percent were uninsured.
- For children in unemployed families, 62 percent used Medicaid and 7 percent were uninsured.
- For childrenor families employed full-time, 39 percent report being covered by employer-based insurance and 34 percent by Medicaid. Eleven percent were covered by two or more types of insurance.

Public insurance coverage matters for children in families below 200 percent of the federal poverty level (FIGURE 4).

- Of those qualifying for the Medicaid expansion at 138 percent of the FPL, 88 percent are insured and 12 percent are uninsured.
- Of those eligible for the Premium Tax Credits on their health insurance premiums at 400 percent of FPL, 95 percent are insured and 5 percent are uninsured.

Figure 4: Public insurance coverage matters for children in families below 200 percent of the federal poverty level, 2013



Young adults aged 18–24 were uninsured more often than other age groups prior to the Affordable Care Act (FIGURE 5)

- From 2009-2013, 39 percent of males and 32 percent of females between 18-24 were uninsured.
- For both boys and girls under the age of 18, approximately 10 percent are uninsured between ages 6 to 17, and 7 percent are uninsured under the age of 6. **(FIGURES 5 & 6)**

Figure 5: NM Children's health insurance coverage type by age group for females, 2009-2013

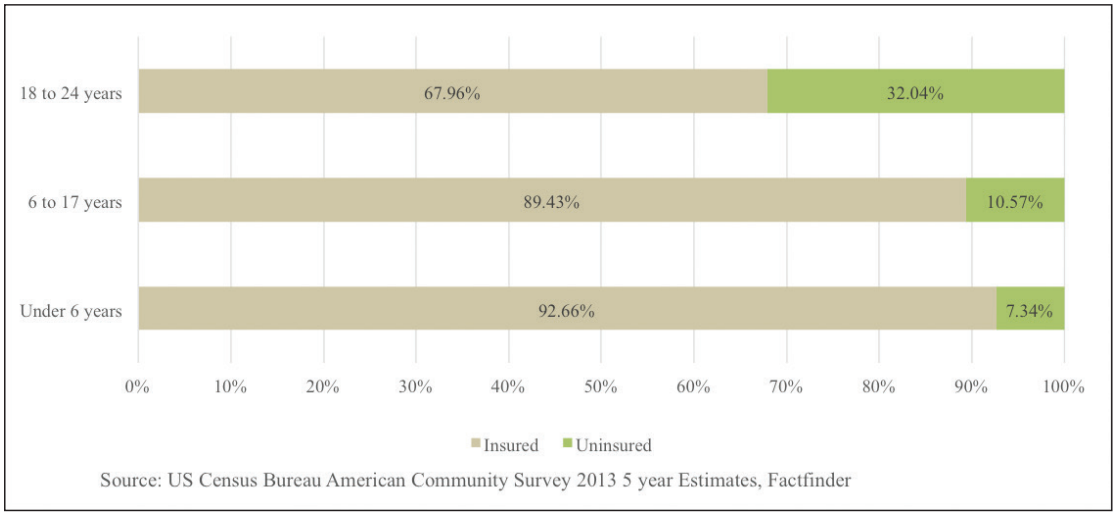
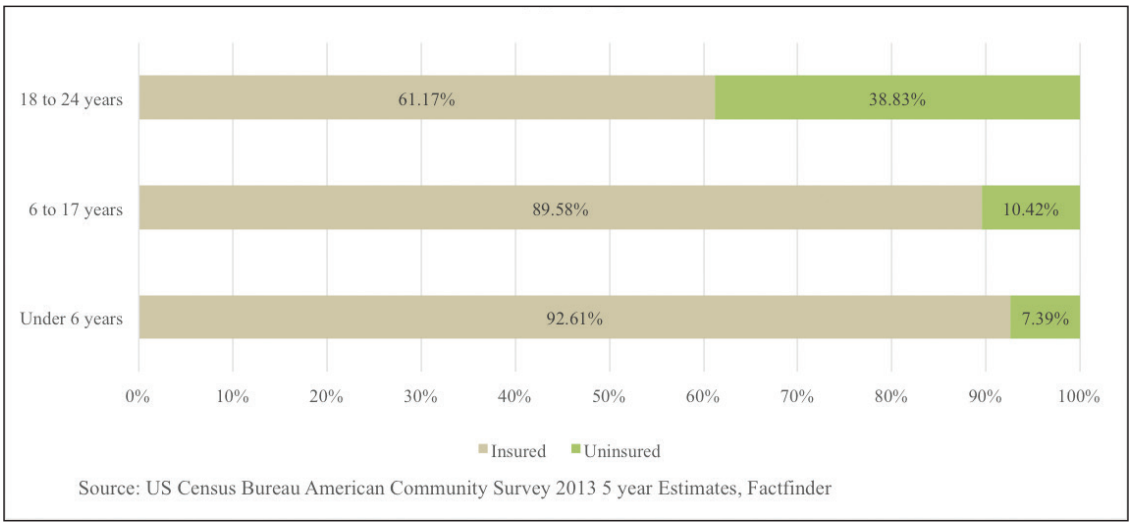
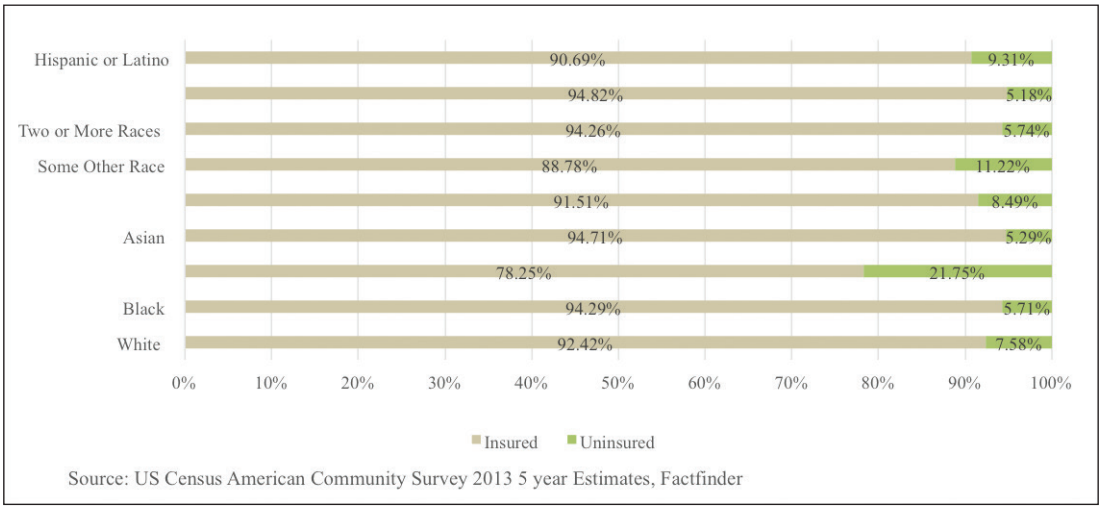


Figure 6: NM children's health insurance coverage type by age group for males 2009-2013



American Indian/Alaska Native children are the most vulnerable with 22 percent uninsured, followed by Hispanic/Latino children and Native Hawaiian/Pacific Islanders, both at 9 percent **(Figure 7)**.

Figure 7: Children's Health Insurance Coverage by Race and Ethnicity, 2009-2013



In homes where families report full-time employment, **FIGURE 8** shows 39 percent of children report coverage under employer-based insurance; 34 percent of children are covered under Medicaid; and 11 percent use two or more types of insurance. For children in homes with part-time workers, 63 percent report using Medicaid; 12 percent have employer-based insurance; and 4 percent are uninsured. For those children with families who are unemployed, 62 percent use Medicaid, and 7 percent are uninsured.

Figure 8: NM children's health insurance coverage by family work status (employment), 2013

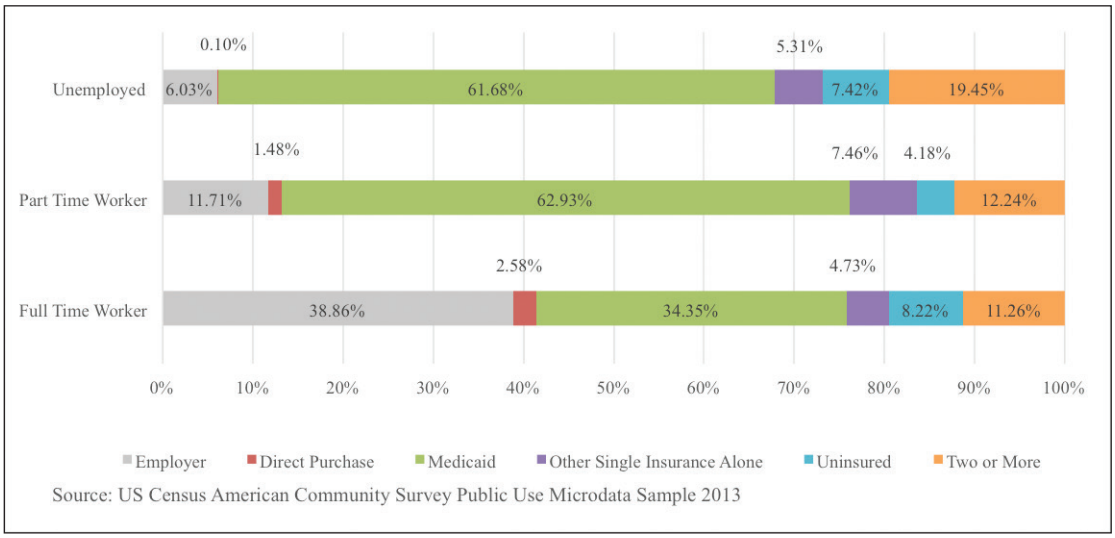
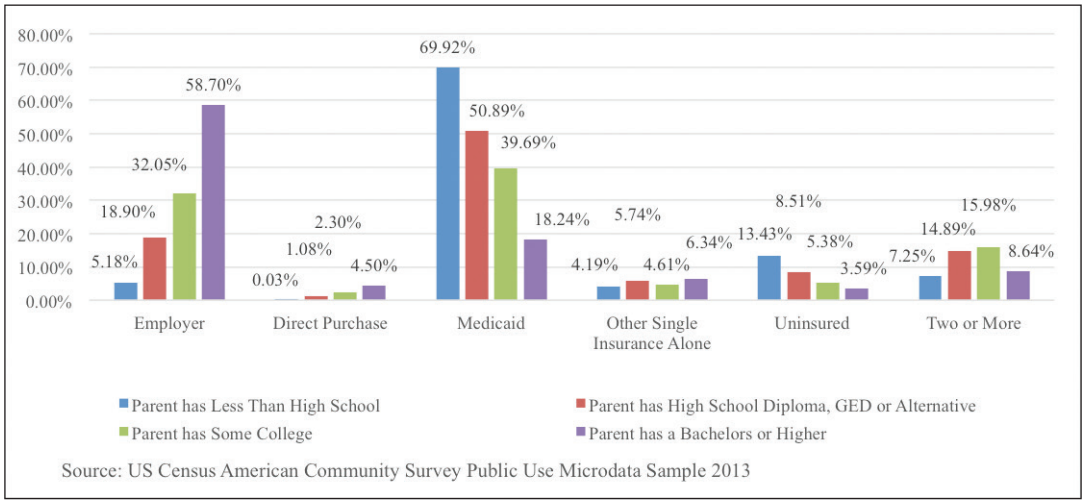


FIGURE 9 shows that for children covered under Medicaid, 70 percent of parents report having less than a high school education; 51 percent report a high school diploma or equivalent; 40 percent report some college; and 18 percent report a bachelor's degree or higher. For those children covered under employer-based insurance, 59 percent of parents report a bachelor's degree or higher, compared to 6 percent with less than a high-school education. For the children who are uninsured, 13 percent of parents have less than a high-school education; 9 percent have a high-school education or equivalent; 5 percent have some college education; and 4 percent have a bachelor's degree or higher.

Figure 9: NM children's insurance coverage by family education level (by parental education), 2013



Source: US Census American Community Survey Public Use Microdata Sample 2013

From 2009 to 2013, the percentage of uninsured children in New Mexico varied by race, ethnicity, age categories, family income and education level, and employment status. The baseline data supports the decision to continue to enroll children into the Marketplace and provides a snapshot why the Medicaid expansion was necessary. The following provisions under the ACA provide an opportunity for leveraging public and private funds aimed at advancing health equity and assuring that all children and families in New Mexico attain health and wellbeing.

HEALTH EQUITY PROVISIONS IN THE AFFORDABLE CARE ACT

The Affordable Care Act of 2010 includes a number of provisions designed to increase health equity, especially for children, young adults, and families.

TABLE 1 summarizes the ACA provisions that advance health equity, including those related to insurance coverage; Medicaid and the Children's Health Insurance Program (CHIP); Marketplace and subsidies; employer requirements and tax credits; children and adolescents; women's health; maternal and child health; American Indians/Alaskan Native health; lesbian, gay, bisexual, and transgender health; substance abuse and mental health; disability and health; community health centers; school-based health centers; data collection; health disparities research and grants; cultural and linguistic competency; workforce diversity; innovative models of care; and the safety net system. It also looks at what New Mexico has done in these areas to achieve health equity, highlights gaps that can be addressed during the next implementation stages of health reform, and provides a roadmap of opportunities to support future health policy implementation and systems change.

Table 1: Equity Provisions in the Affordable Care Act

	ACA PROVISIONS	IN NEW MEXICO
1. Coverage Mandate	• Most U.S. citizens and legal residents must obtain health insurance. • Plans must provide dependent coverage for children up to age 26. • Coverage cannot be rescinded nor lifetime limits imposed. • Tax penalties for those without coverage increase annually: 2.5% of annual income in 2016[6]	New Mexico committed to Medicaid expansion, January 2013. • Federal funding portion for pre expansion enrollees-70%[7] • Federal funding for expansion enrollees: 100% 2013-2016, decreasing to 90% by 2020[8] • 20.2% of New Mexicans were uninsured in 2013. • 13.1% uninsured as of June 30, 2015;[9] 233,000 uninsured: 47% Medicaid Eligible, 13% tax -credit eligible, 40% (93,200) ineligible[10]
2. Medicaid/ Children's Health Insurance Program (CHIP)	Medicaid Expansion • All non-Medicare eligible adults with incomes up to 138% FPL • 100% Federal funding through 2016, decreases to 90% by 2020 • Children's Health Insurance Program (CHIP): eligibility level must be maintained[11]	January 1, 2014: Centennial Care (CMS 1115 Demonstration Waiver) must be cost neutral over 5-year period).[12] • Eligibility: Undocumented immigrants excluded; 5 year hold for legal residents (NO hold for pregnant women and children); • FPL limits: Adults: 138% FPL; Pregnant women: 250% FPL; Children 240% FPL; CHIP 300% FPL[13] • 61.3% increase CHIP/Medicaid enrollees compared to National increase of 25.73% 2013-2015[14] • Total enrollees: 2013-560,000; 2016-850,000, projected July 2017-925,000[15] • Federal funds for new adults in Medicaid program: January, 2014 to March, 2016: $2,896,135,351 • Projected Medicaid budget shortfall through 2017: $86M with Federal match: $417M shortfall[16]
3. Marketplace & Subsidies	• Marketplaces must offer four options with range in premium, deductibles, copays, and benefits, including certain essential health benefits. • 80% of premiums must go to patient services. • Rate increases are subject to state review. • Premium and cost sharing subsidies are available for incomes up to 400% FPL.[17]	Marketplace (New Mexico Health Insurance Exchange) Established October 2013. Enrollment began January 1, 2014. • Funding: ACA Planning and Level I and Level II implementation Federal grants: $123M • Operated by private nonprofit: New Mexico Health Insurance Exchange; Federally-supported State-based Marketplace[18] • 54,865 enrolled as of Feb, 2016: 41% of qualified pool of 133,000[19] • 21% of eligible 18-34 year olds enrolled (US 28%); 34% of 55-64 year olds enrolled (US 25%)[20] • 22% qualified for subsidies. 74% qualified for tax credit[21] • 49% paid premiums of less than $100 per month after tax credits[22] • Per person enrollment cost with start- up costs included as of March 2014= $6,181[23]

4. Employer Requirements & Tax Credits	• Employers with more than 50 employees must provide coverage or face penalties. • No requirement for employers with fewer than 50 employees • Tax credits available for employers providing coverage with fewer than 25 employees • Small Business Health Options Program (SHOP) exchanges: Options for businesses with up to 100 employees	• New Mexico Small Business Health Options Program (SHOP), state-run platform • As of March 2015, there are 877 enrollees at amortized cost of $21,000 per person.[24] • The SHOP exchange needed $1.5 million in annual funding starting in 2015 when it had to begin operating without financing from the federal government. • In December 2014 the exchange board voted to impose a fee on all health insurance policies sold in the state of New Mexico in order to raise the funds needed for Be Well New Mexico's SHOP exchange in 2015 and beyond.
5. Children and Adolescents	• All states must complete a needs assessment to identify at-risk communities eligible to receive Title V Maternal and Child Health Block Grants. • Medicaid/private plans must include immunizations and preventive screenings with no cost sharing. • ACA provides $1.5 billion over five years for the Maternal, Infant, and Early Childhood Home Visiting Program.[25] • Other grant funded programs include: Training for oral health professionals Personal responsibility education Childhood obesity demonstration projects School Based Health Centers: capital and operational funding[26]	• Medicaid/CHIP Centennial Managed Care Plans include 26 preventive services for children and adolescents at no cost sharing.[27] • Dental coverage is included in some NM Marketplace plans.[28] • Six school based health centers (SBHCs) received over $2.6M capital funding in 2011.[29]
6. Women's Health, Maternal and Child Health	• Establishes Office of Women's Health • Medicaid/private plans required to include preventive screenings with no cost sharing: Well women visits per age guidelines Breast cancer education Diabetes prevention Sexually transmitted disease Mental health counseling/screening Contraceptive methods and counseling Breastfeeding support, supplies, and counseling Violence/abuse (HRSA Women's preventive guidelines)[30] Maternal, Infant Early Childhood Home Visiting Program (MIECHVP)[31, 32] Strong Start: Public awareness and grant funding to test evidence based prenatal approaches to reduce premature births in high risk mothers; reduce maternal mortality disparities and preterm low birth weight infants that affect low-income women and women of color, particularly African American women	• Funding for the Commission on the Status of Women eliminated by Governor Martinez (2010) • New Mexico SB 68 African American Infant Mortality Bill[e] funded by State 2014-2015 ($2K for pilot program Bernalillo County)[33] • MIECHVP funded through 2017: Bernalillo, Quay, Luna, McKinley, and Taos Counties; $8.4M total ACA grant funding • Tribal home visiting programs: 3,400 home visits to 248 families through 2013;[34] 370 families have received services through December 2015[35] • In the 2013 review of MIECHVP programs did not meet federal guidelines.[36] DOH Children, Youth and Families & UNM Center for Education Policy Research aligned MIECHVP with the existing state program and created an evidence-based model that met MIECHV requirements. • Taos Tiwa Babies: one of four MIECHV programs in US that met all USDHHS guidelines.[37] • Strong Start ACA funding-2 birth centers, positive outcomes include C-sections and preterm birth rates decreased to below national average.[38]
7. American Indians/ Alaskan Native Health	• The Indian Health Care Improvement Act is reauthorized and made permanent under the ACA • American Indians and Alaska Natives (AI/ANs) and other people eligible for services through the Indian Health Service, tribal programs, or urban Indian programs don't have to pay the fee for not having health coverage. • No cost sharing for members of federally recognized tribes with household income below 300% FPL • Limited cost sharing for members of federally recognized tribes regardless of household income or eligibility for premium tax credits when receiving healthcare services from or through an Indian healthcare provider. • Members of federally recognized tribes can enroll in Marketplace coverage any time of year. There's no limited enrollment period and they can change plans up to once a month. • Support for AI/AN mental health and substance abuse prevention programs.[39, 40]	• The federal government is obligated to provide healthcare services to Native Americans. Due to this obligation, Native American consumers have limited experience with health insurance and may be apprehensive about acquiring coverage. • MCO paperwork, pre-authorization requirements, and history of not sustaining providers in rural areas may discourage Native Americans from enrolling/seeking services through Medicaid. • Tribes as sovereign nations have the opportunity to build and expand health systems that meet their needs, including establishing FQHCs that serve neighboring rural communities. To date, specific tribes like Jemez and San Felipe Pueblos have opted to administer the funds and services. • SAMHSA grants to tribes 2015-2016 include: Laguna, Acoma, San Felipe, Santo Domingo, Acoma Pueblos, and Mescalero Apache tribes.[41]

e NOTE: The SB 68 African American Infant Mortality Bill is identified as a priority in the goals of the Con Alma project funded by W.K. Kellogg. See http://conalma.org/wkkf-2014/

8. Lesbian, Gay, Bisexual, Transgender (LGBT) Health	• LGBTQ Legally married same-sex couples are protected under the ACA regardless of what state they live in, even if those states do not recognize same-sex marriage.[42] • Protects LGBT patients from discriminatory practice based on their health status, such as being HIV positive • Does not place limits on medical coverage based on health status, such as monthly or annual limits on HIV medication • Many LGBT people will be protected from discrimination by federal statute on the basis of sex stereotyping or gender identity. • If a state has recently recognized same-sex marriage, newly married same-sex couples can undergo a special enrollment period to enter the healthcare marketplace and join a family insurance plan.	• Sexual orientation data collection for NM adults began in 2005 for the Behavioral Risk Factor Surveillance System and in 2013 for the Youth Risk and Resiliency Survey (YRRS).[43] • PCORI funded UNM for a partnership team, composed of LGBT community members, health science researchers, and healthcare providers; proposes to create the New Mexico LGBT Health Improvement Network. Funding supports two consecutive summits on LGBT health that include updates on a state-wide LGBTQ healthcare access survey and presentations such as "Rewriting our LGBTQ Health Stories: From Social Injustice to Heroes for Health" to "Stories of Trans* Health."
9. Latino Health	• Facilitate Insurance Enrollment including Medicaid expansion option for states and via the Marketplace.[44, 45] • 913,000 ages 18-26 now covered under their parents' plan • If all states took advantage of Medicaid expansion 95% of all Latino Americans would be eligible for Medicaid, CHIP or marketplace subsidies. • Even after health insurance creates opportunity for access, historical inequities and cultural barriers, including perception as to when a doctor's care is important may negatively impact appropriate use for this population. • Language barriers, confusing application processes which vary depending on status, concern about exposing family members who are undocumented are impediments • Supports expansion/implementation of *promotores de salud* (community health workers)	• Outcomes: Nov 1, 2015-Feb 1, 2016 Marketplace enrollment: Out of total 37,035 enrollees and re-enrollees self-reporting race/ethnicity 36% reported Latino. • DOH cultural competency recommendations include multilingual enrollment materials and website navigation. • The NMHIX provides Spanish-speaking messaging and outreach.
10. African American Health	• Facilitate Insurance Enrollment including Medicaid expansion option for states and via the Marketplace[46, 47] • 2.3 million AAs gained health insurance coverage • 500,000 ages 19-26 covered under parents' plan • If all states took advantage of Medicaid expansion 95% of all African Americans would be eligible for Medicaid, CHIP or marketplace subsidies • Section 2104: invest in historically black colleges and universities and minority- serving institutions • Improve availability of national health data disaggregated by race, ethnicity and gender • Support care delivery sites in underserved areas • Prioritize prevention and chronic care management	• Medicaid expansion/Centennial Care in place as of Jan, 2014 • Marketplace open Jan, 2014 Out of total 37,035 enrollees and re- enrollees self-reporting race 2% reported as African American • SB 69, 2014, African American Infant Mortality Program, $200K appropriation for 2014-15 • New Mexico Office of African American Affairs sponsors health care advocacy support programs: infant mortality and 90 day healthy body challenge. • New Mexico DOH equity report indicates major disparities: obesity, diabetes, chlamydia, homicide, hepatitis A. • Office of African American Affairs has an Infant Mortality Pilot Project at $50,000.[48]
11. Asian Pacific Island Health	• Facilitate Insurance Enrollment including Medicaid expansion option for states and via the Marketplace [49, 50] • 2 million uninsured will gain or be eligible for coverage by 2016 • 10% eligible for financial assistance e.g. tax credits • CDC data cited indicating 4.3M AAPIs now have access to preventive services • Language and cultural barriers limited ACA enrollment benefits	• Outcomes: New Mexico: Nov 1, 2015-Feb 1, 2016 Marketplace enrollment: Out of total 37,035 enrollees and re enrollees who self-reported race/ethnicity 0% reported as Pacific Islander, 4% reported Asian. New Mexico Asian Family Center offers free services: family/individual counseling, parenting education with cultural and language sensitivity, gambling and tobacco cessation, abuse and violence.
12. Immigrant and Refugee Health	• Lawfully and qualified present immigrants (including refugees) have limited federal coverage.[51, 52] • Undocumented immigrants have NO federal coverage. • Only those in a family who are applying for benefits are required to provide a Social Security number (SSN) and their immigration/citizenship status. • Refugees are noncitizens who, while outside the U.S. and their home country, were granted permission to enter and reside in the U.S. because they have a well-founded fear of persecution in their home country. Refugees are "qualified" immigrants and are "lawfully present" in the U.S.	• Approximately ten percent of uninsured people in New Mexico who are undocumented immigrants are ineligible for financial assistance under the ACA and barred from purchasing coverage through the Marketplaces. This group remains uninsured, though they will still have a need for health care services.[53] • These exclusions have a spillover impact on children in immigrant families who are U.S. citizens and otherwise eligible for coverage.

13. Rural and Frontier Health	The Affordable Care Act contained the following important building blocks that will significantly improve access to care in rural and frontier areas of the nation: • Resolve the workforce shortage crisis in rural areas; and eliminate long-standing payment inequities for rural providers.	• New Mexico has not received sufficient resources to monitor the outreach and enrollment in New Mexico's rural and frontier communities. • However, in certain areas of the state like Hidalgo/Grant Counties, efforts were leveraged to increase the work of CHWs through FQHCs to enroll) and efforts through NMHIX that contracted with AHECs for outreach. • New Mexico Health Care Workforce Committee, 2015 report[54] summarizes efforts in addressing shortages in rural and frontier areas of the state (see #22 below). • Residents in rural and frontier areas of the state are paying higher premium costs than their metro counterparts. Average adjusted premiums in rural counties are higher than in urban counties, with a widening gap in 2016 for both Marketplace types.[55]
14. U.S.-Mexico Border Health	U.S. Department of Health and Human Services launched the Spanish online enrollment tool CuidadoDeSalud.gov in early December 2013. This will impact Spanish speakers who live in the border area in New Mexico, where the Marketplace is run by the state but relies on the federal government for enrollment.	• Community Health Centers, Office of Border Health and Health Action New Mexico are working together to provide strategic outreach and enrollment strategies to Latino residents and Spanish speakers in the border region.
15. Substance Abuse and Mental Health	• ACA contains a number of provisions which achieve two goals with respect to mental health parity: (1) they expand the reach and applicability of the federal mental health parity requirements; and (2) they create an "essential health benefit" or mandated benefit for the coverage of mental health and substance abuse disorder services in a number of specific insurance financing arrangements.[56] • Parity, as it relates to mental health and substance abuse, prohibits insurers or health care service plans from discriminating between coverage offered for mental illness, serious mental illness, substance abuse, and other physical disorders and diseases. • Office of Minority Health focuses existing resources on Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources Services Administration (HRSA) to improve quality of services to minority group members. [57] • Support development of interdisciplinary mental health training programs [58]	• SAMHSA-Pre ACA and continuing mental and behavioral health grants in NM, including NA tribes, other communities, and organizations: in 2013-2014 funded $39M; 2014-2015 funded $33.5M; 2015-2016 funded $27.5M [59] • Demand for services has increased: Centennial Care includes mental/behavioral health coverage with additional services added: family support, respite, and recovery [60] • Most mental health professionals are located in urban areas[61] • Many social workers and counselors have not attained licensure necessary for private practice.[62] • NM does not have enough mental and behavioral health professionals to meet current needs or enough in training to meet future needs.[63] • ACA funding through HRSA: $2M for mental and behavioral health 2014/15[64]
16. Disability and Health	• Plans must cover treatment for pre-existing conditions from the first day of coverage. • Ensuring that minimum covered benefits include products and services that enable people with disabilities to maintain and improve function, such as rehabilitation and habilitation services and devices. • Improving training of physicians, dentists, and allied health professionals on how to treat persons with disabilities. • Requiring the Centers for Medicare and Medicaid Services (CMS) to collect data on beneficiaries with disabilities. • Increasing the federal share of Medicaid, known as the Federal Medical Assistance Percentage (or FMAP), for home and community based services. • Allowing states to offer additional services under the 1915(i) Medicaid HCBS Waivers State Plan Option.	• Individuals eligible for Medicaid through the expansion receive services under a limited benefit package. • Medicaid expansion members who meet the medically frail exemption as determined by the MCO are entitled to traditional Medicaid benefits (acute and ancillary only). • Medicaid expansion members who meet the medically frail exemption AND meet a nursing facility level of care (require assistance with two or more activities of daily living) are entitled to traditional Medicaid benefits and the Community Benefit package (home and community based services).

17. Community and School Based Health Centers	• Funding for construction and operation of school based health centers with high Medicaid/CHIP populations. • $11 billion for community health center construction from 2011-2016.[65, 66]	• Health center grantees in New Mexico have received $144,594,719 under the health-care law • Primary ACA benefit to FQHCs is a decrease in uninsured and increase in reimbursement eligible Medicaid expansion enrollees to help address need for larger clinical workforce and increasing pharmacy costs. • School Based Health Clinics (SBHCs): $2.6M in ACA capital improvement funding in 2011[67] • Fifty-six SCHCs in 26 counties currently trying different sustainability models, e.g. MCO partnership, direct Medicaid reimbursement [68] • Community Health Center funding: $144,594,719 • CMS Advance Primary Care grants in 2011-2013 for new and expanded services at 6 FQHCs; [69] $3,000 to $5,000 per month additional reimbursement per center based on additional pay ($6) per Medicare/Medicaid patient; PCMH level 3 certification was required; CMS ended program after 2 years citing lack of cost savings.
18. Data Collection	• Section 4302 of the ACA requires the USDHHS Secretary to create data collection standards for race, ethnicity, sex, primary language, and disability status. • USDHHS has implemented uniform data collection standards for National population health surveys. [70] • Collect and report demographic data, including race, ethnicity, sex, primary language, disability status, and rural/frontier locations • Collect and report Medicaid/CHIP disparities data • Collect and report work force diversity data • Provide technical assistance with data collection [71, 72]	• Health related data is contained in NM Department of Health (DOH) Information Based Indicator System (IBIS). • No significant data collection changes at DOH based on ACA • Federal data sources are limited to county level based on a restrictive patient privacy protocol resulting in limited racial and ethnic data availability to the state. • DOH and partner programs have increased geospatial analysis and public education and access to interactive data query systems. • DOH is improving hospitalization data analysis through geospatial enabling and inclusion of race in datasets. • NM Health Care Workforce Committee collects and reports data on age, race, ethnicity, sex, and geographic location of providers in New Mexico.[73]
19. Health Disparities Research and Grants	• National Institute on Minority Health and Health Disparities established under the National Institutes of Health • Data analysis to monitor trends in health-related disparities • Grant programs to reduce health disparities in rural/frontier areas • Patient Centered Outcomes Research Institute • Centers of Excellence funding increase [74]	DOH development of geospatial methods allows the larger population areas to be disaggregated into smaller units key to measurement of equity and the correlation of social determinants of health to health outcomes. • Project Extension for Community Healthcare Outcomes (ECHO) founded at UNM in 2003, funding contribution from ACA innovation grant • Project Access (neuro trauma: stroke, injury) founded at UNM, capital funding contribution from ACA innovation grant. • ECHO and Access create access to specialty care in rural areas to populations impacted by health disparities, enabling local providers/hospitals to maintain viability in local frontier communities. • University of New Mexico receives external grants from NIH/NIMHD and PCORI to study the problems and interventions to reduce health disparities and promote health equity including Community Based Participatory Research and funding of a New Mexico Center for the Advancement of Research, Engagement and Science on Health Disparities.[75, 76] • New Mexico State University is a recipient to health disparities research grants.

20. Cultural and Linguistic Competency and Health Literacy	• Culturally appropriate outreach to low-income populations • Plan information: coverage, co-pays, deductibles, out-of-pocket payments, and claims process must be written at a literacy level in "plain language." • Cultural competency curriculum development and training for primary care providers. [77] • Expand Community Health Worker (CHW) role: promote health literacy and facilitate culturally competent service delivery and follow up including insurance enrollment [78] • Title V, Subtitle A (amending existing laws and creating new law related to the health care workforce) of ACA establishes a statutory definition of "health literacy" consistent with Healthy People 2010. • Provisions touch on health literacy issues of research dissemination, shared decision-making, medication labeling, and workforce development. All four suggest the need to communicate effectively with consumers, patients, and communities in order to improve the access to and quality of health care.[79]	New Mexico Department of Health (DOH) cultural competency recommendations, per ACA 2015: [80] • Provide multilingual application materials; language appropriate website access and navigation • Community Health Workers (CHW) training and optional certification through DOH • Authorized SB58, 2014 Community Health Workers Act [f 81, 82] • CHWs have multiple roles in New Mexico, including patient education, home visits, follow-up appointment facilitation, and insurance enrollment.[83] • Sparse systematic interventions to address health literacy and fewer to none addressing health insurance literacy among New Mexico's diverse communities. However, there are various interventions that are single studies or initiatives such as Albuquerque area of Santa Barbara Martinez town intervention, "Health Literacy and Self-Efficacy in Hispanic Adults" (funded by the Clinical and Translational Science Center at the UNM Health Sciences Center).[84] • University of New Mexico Hospital established a Health Literacy Taskforce and position statement on health literacy in 2012. • New Mexico State University's Health Insurance Literacy Extension Project provides online 1-1 questions from the public and answers by an expert and is part of a national network supported by the ACA.[85] • NM Department of Health's Improvement Plan (2014) identifies health literacy as a need in NM.[86] • Generation Justice leads a Youth Health Literacy Project in collaboration with School Based Health Centers to improve the health and reduce health disparities of adolescents by improving their health literacy through social media.
21. Workforce Diversity	• Establish Workforce Advisory Committee • Increase diversity in all providers' groups: MD, DDS, nurses, and mental health • Increase MD residency training grants in FQHCs and in frontier or underserved areas • Expand training of and loans for all health care personnel in FQHCs and nurse managed clinics • Provide funding for National Health Services Corp • Expand Community Health Worker (CHW) training grants[87, 88]	New Mexico Health Care Workforce Committee, 2015 report: [89] • Workforce Committee collects detailed data regarding NM health care workforce socio-demographic and geospatial diversity indicators. • Significant provider shortage in most areas of the State; 32 out of 33 counties designated as health service provider shortage areas. • NM Below 2015 national benchmarks by: 145 PCPs, 197 APNs, 109 Psychiatrists, 43 OB/GYN, 73 dentists • State appropriated $36M for health-care workforce initiatives: 2015-2016
22. Innovative Models of Care	• Accountable Care Organizations (ACOs) • Patient Centered Medical Home support teams • CMS Innovation Center to reduce cost growth and increase quality. • Medical malpractice demonstration grants to evaluate alternatives to litigation. • Community–based collaborative care network program • National strategy for quality health care improvement.[90, 91]	• Project Extension for Community Healthcare Outcomes (ECHO) launched in 2003 by UNM physician; funded in 2011 by ACA Innovative Models of Care increases access to specialty treatment in rural areas using cell telephone technology; Replicated in 14 states. • Project Access: Capital funding Innovation grant using UNM neurosurgery as hub (stroke, traumatic brain injury treatment) 5 hospitals throughout NM now enrolled, 10 more in process. • State Innovation Model (SIM) cooperative agreement to NM DOH and NM HSD: $2M/2015. The plan to improve population health, enhance patient care experience and reduce health care costs based on local community input. • Community Transformation grant: $1.5M/ 2012 Healthy communities: Prevention plan for 14 communities.

f NOTE: The SB58, 2014 Community Health Workers Act is identified as a priority in the goals of the Con Alma project funded by W.K. Kellogg. See http://conalma.org/wkkf-2014/

23. Safety Net	• Expand insurance coverage to over 30 million individuals at no cost or subsidized by cost sharing based on income. • Reduce Disproportionate Share Hospital (DSH) payments by 75% ($18B between 2014 and 2020). • Recalculate hospital and FQHC payment subsidies based on future use by uninsured .[92] • Non-profit hospitals must: Conduct a community needs assessment every three years; Implement a strategy to meet the identified needs; Adopt a detailed financial assistance policy regarding free or discounted care; Limit charges to patients qualifying for financial assistance to the amount billed to insured patients; Determine eligibility for financial assistance before undertaking collection. A tax of $50,000 per year is imposed for failure to meet these requirements.[93]	• Uncompensated care has declined as uninsured NM adult population decreased from 18% (2013) to 13.1% (2015).[94] • Safety Net Care Pool per Centennial Care waiver is funded by counties based on Gross Receipts tax equivalency) Capped at $68.M annually. Applications by safety net hospitals for funds in 2015: $92M [95] • Centennial Care enhancements resulted in $142M to hospitals and a net income of $1.8M to FQHCs.[96] • Impact of decreased DSH funding per ACA unclear at this time. • Safety net need will not disappear in NM: 298,000 uninsured, of these 42,200 are ineligible for insurance based on immigration status.[97] • Medicaid EMSA and NM Medical Insurance Pool include coverage for undocumented; hospitals cover remainder • DOH Hospital Discharge Data web site in place 2018 will increase hospital pricing transparency.[98] • Model for Financial Assistance Policy (FAP) per ACA was developed by New Mexico Hospital Association (NMHA) follow up survey indicates implementation of FAPs by many NM hospitals. • Nonprofit hospital community needs assessments have been widely implemented and improve alignment of services with community needs.

1. Coverage Mandate. The ACA coverage mandate requires most U.S. citizens and legal residents to obtain health insurance or incur tax penalties. Insurance plans must provide dependent coverage up to age 26. Medicaid eligibility is expanded and cost-sharing Marketplace options are available. As a result, the percentage of uninsured New Mexicans has decreased from 20.2 percent in 2013 to 13.1 percent as of June 30, 2015.[62] Of the remaining 233,000 uninsured, 47 percent are Medicaid eligible, 13 percent are tax credit eligible, and 40 percent remain ineligible.[63, 64] Nationally, employer coverage decreases have been offset by individual coverage increases in the 7 percent range.[65] Limited employer enrollment through the Small Business Health Options Program (SHOP) may reflect this trend. Individual Marketplace enrollment has been modest in New Mexico and throughout the U.S. in comparison to Medicaid enrollment increases.

2. Medicaid/CHIP eligibility increase. Increases in Medicaid enrollment account for 90 percent of the gain nationally[65] and approximately 85 percent of the increase in New Mexico through 2014.[66] Total Medicaid/CHIP enrollment in New Mexico has grown from 560,000 in 2013 to 850,000 in 2016, and is projected to continue to increase. Medicaid expansion has been the greatest source of increased ACA-related revenue for providers in New Mexico, with over $2.8 billion in federal match for Medicaid expansion enrollees between January 1, 2014 and March 1, 2016. The state's current Medicaid funding shortfall, projected at $80 million, creates a threat to maintaining the federal match in 2017.[67]

3. Marketplace, Subsidies, and Tax Credits. The Affordable Care Act[99] required states to set up health insurance exchanges by October 1, 2013 as state-run Marketplaces by partnering with the federal government or by opting out, in which case the federal government would run the state's exchange. The New Mexico Health Insurance Exchange (NMHIX) runs a state-based exchange at www.bewellnm.com. Tax credits and subsidies are available through the Health Insurance Marketplace for families with incomes between 139 percent and 400 percent of the FPL. In 2015, for a family of four, income at 100 percent FPL was

$24,250; 133 percent was at $32,253; and $97,000 for 400 percent FPL. Private Marketplace plans offer a range in premiums, deductibles, co-pays, and benefits, but must include essential preventive services with no cost-sharing. Although the majority of enrollees have qualified for tax credits or subsidies, only 41 percent of the eligible pool has enrolled through February 2016. Those enrolling have been primarily older (34 percent ages 55-64) rather than younger (21 percent ages 18-34). Additional data regarding why individuals have not enrolled in Marketplace options, and increased accountability around the enrollment process, could provide the basis for policy adjustments to increase coverage rates, given the lag in enrollment and the associated cost per person of $6,181 as of March of 2014.

4. Employer Requirements. Employers with more than 50 employees must provide coverage or face penalties. There is no requirement for those with fewer than 50 employees. The Small Business Health Options Program (SHOP) offers options for businesses with up to 100 employees. As of March 2015, enrollment in New Mexico was 877 enrollees at a per person cost of $21,000. As with individual enrollment, additional information regarding why businesses are not participating could help guide future policy. ACA equity provisions increase coverage for those most impacted by the social determinants of health, including poverty, gender, race, and ethnicity. For example, African Americans, Latinos, women, LGBT individuals, and those from other minority groups have historically experienced equity gaps, as have those suffering from mental and behavioral health conditions. New Mexico has been the recipient of a variety of federal grants focused on equity gains.

5. Children and Adolescents. Programs specific to children and adolescents include Maternal, Infant, and Early Childhood Home Visiting Programs; Personal Responsibility Education; Childhood Obesity Demonstration Projects; oral health targeted activities for children with developmental disabilities; and funding for oral health personnel training. New Mexico has also received Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program funding at four Native American tribal locations, and for construction or capital improvements to six school-based health centers (SBHCs) in rural or other locations characterized by health disparities. In 2014, 55 percent of children in New Mexico lived in families with incomes below 200 percent FPL, and 29.5 percent were below 100 percent FPL. This makes these ACA-funded programs critical in the challenging effort to provide health equity for children.

6. Women's Health, Maternal, and Child Health. The ACA includes provisions for women's health and maternal and child health. Well-woman visits include age-appropriate preventive screenings to promote breast cancer awareness, diabetes prevention, and mental health screening, including violence and abuse. ACA guidelines emphasize reproductive health and the mother-child unit. Preterm birth has a $26 billion annual cost, results in increased mortality for mothers and babies, and lifelong developmental/health problems for children**.** Strong Start programs pilot three evidence-based models to address behavioral and psychosocial factors that may contribute to preterm, poor birth outcomes. Maternal health disparities are significant among African American women as compared to non-Hispanic white women. Reducing these disparities includes implementing comprehensive national data collection systems on maternal

deaths and preterm births; implementing maternity care performance measures and best practices; facilitating access to health services; and ensuring seamless insurance coverage.[100] Other programs specific to children and adolescents include Maternal, Infant, and Early Childhood Home Visiting Programs; Personal Responsibility Education; Childhood Obesity Demonstration Projects; Maternal, Infant, and Early Childhood Visiting programs; Strong Start for Mothers and Newborns Initiative; and oral health targeted activities for special populations (i.e., children with developmental disabilities).

7. American Indians/Alaskan Natives. The ACA permanently reauthorized the Indian Health Care Improvement Act, which includes a number of provisions that modernize the Indian Health Service and encourage tribes to assume management of their health programs and health systems. In addition, the ACA contains provisions that are designed to uphold the federal trust responsibility by excluding Native Americans from the requirement to obtain health coverage. Co-pays, deductibles, and other cost-sharing are waived for members of federally recognized tribes with a household income of up to 300 percent FPL who purchase qualified health plans through the Health Insurance Exchange. Despite this incentive, and because of the federal trust obligation, many Native Americans do not believe it is necessary to purchase health coverage and continue to rely on the Indian Health Service, Tribal 638 programs, and Urban Indian Health Programs for their care. The expansion of Medicaid has resulted in the enrollment of 35,159 Native Americans in the adult expansion category, with a total of 128,800 Native Americans enrolled in the Medicaid program as of April 2016. This has significant implications for the Indian health system in New Mexico due to the higher reimbursement rates paid to Indian Health Service and Tribal 638 providers.

8. Lesbian, Gay, Bisexual, Transgender (LGBT) Health. The ACA protects the health-care rights of LGBT couples and individuals, regardless of recognition of same-sex marriage within their state of residence. Federal statute protects LGBT people from discrimination based on sex stereotyping or gender identity, and the ACA includes unlimited medical coverage based on health status and treatment, including HIV medication. In New Mexico, sexual orientation data collection for adults began in 2005, and was expanded to include youth as part of the Youth Risk and Resiliency Survey in 2013. A Patient-Centered Outcomes Research Institute (PCORI)-funded grant to UNM has resulted in a partnership team comprised of LGBT community members, health-care researchers, and health-care providers with multiple goals, including establishment of a New Mexico LGBT Health Improvement Network.

9. Latino Health. Since the 1970s, Latino populations have been chronically uninsured. The ACA goals to make health insurance coverage accessible to all has made inroads nationally with 913,000 Latinos ages 18-26 now covered under their parents' plan. If all states took advantage of Medicaid expansion, 95 percent of all Latino Americans would be eligible for Medicaid, CHIP, or Marketplace subsidies. Even after health insurance creates opportunity for access, historical inequities and cultural barriers, including perception as to when a doctor's care is important, may negatively impact appropriate use for this population. Out of a total 37,035 enrollees and re-enrollees self-reporting race/ethnicity, 36 percent self-identified as Latino. The DOH cultural competency recommendations

include multilingual enrollment materials and website navigation, and NMHIX provides Spanish-speaking messaging and outreach. While Latinos comprise close to half of New Mexico's population, no state offices or organizations are solely dedicated to addressing the health inequities of this population.

10. African American Health. Under the ACA, 2.3 million African Americans gained health insurance coverage and 500,000 individuals ages 19-26 were covered under their parents' plan. In New Mexico, out of a total 37,035 enrollees and re-enrollees self-reporting race, 2 percent reported as African American. Other opportunities leveraged under the ACA include SB 69, 2014, the African American Infant Mortality Program, for which there was a $200,000 appropriation for 2014-15. Additionally, the New Mexico Office of African American Affairs sponsors health care advocacy support programs, including infant mortality and a 90-day healthy body challenge. The New Mexico DOH equity report indicates major disparities in this population, including obesity, diabetes, chlamydia, homicide, and hepatitis A. The Office of African American Affairs has an Infant Mortality Pilot Project funded at $50,000.[101]

11. Asian/Pacific Island Health. In New Mexico, out of total 37,035 enrollees and re-enrollees who self-reported race/ethnicity, none reported as Pacific Islanders and 4 percent reported Asian. The New Mexico Asian Family Center offers free services, including family/individual counseling; parenting education with cultural and language sensitivity; gambling and tobacco cessation; and abuse and violence prevention.

12. Immigrant and Refugee Health. Lawfully present immigrants and refugees have limited federal coverage. This group remains uninsured, though they still have a need for health-care services.[102] Undocumented immigrants are not allowed to purchase private health insurance at full cost in state insurance exchanges. Approximately 10 percent of uninsured people in New Mexico who are undocumented immigrants are ineligible for financial assistance under the ACA, and are barred from purchasing coverage through the Marketplaces. Additionally, undocumented individuals are not eligible for premium tax credits or lower co-payments; not exempt from the individual mandate; and not eligible for Medicare, non-emergency Medicaid, or CHIP. The undocumented do remain eligible for emergency care under federal law. Citizens, or lawfully present children of undocumented parents, are eligible to purchase from the state insurance exchanges; for premium tax credits and lower co-payments; and for Medicaid or CHIP. They also may seek non-emergency health services at community health centers or safety net hospitals. Only those in a family that is applying for benefits are required to provide a Social Security number and their immigration/citizenship status.

13. U.S.-Mexico Border Health. The ACA (of the United States) and the People's Insurance Program or *Seguro Popular* (of México) both focus on expanding access to care for their populations, but are rooted in two very different national policy goals.[103] In 2012, 55 percent of the U.S. border population was Latino, compared to 38 percent in the four U.S. border states and 17 percent nationally. According to the Pew Hispanic Center (2013), the 100 largest U.S. counties by Latino population contain 71 percent of all the nation's Hispanics. Half (52 percent) of those counties are in three states: California, Texas, and Florida.[104] Along with Arizona**,** New Mexico, New York, New Jersey, and Illinois, these eight states

contain three-quarters (74 percent) of the nation's Latino population. Thirty-one percent of the total U.S. uninsured population lives in four border states: Arizona, California, New Mexico, and Texas**.** The U.S. Department of Health and Human Services launched the Spanish online enrollment tool CuidadoDeSalud.gov in early December 2013. This will impact Spanish speakers who live in the border area in New Mexico, where the Marketplace is run by the state, but it relies on the federal government for enrollment. Community health centers, the Office of Border Health, and Health Action New Mexico are working together to provide strategic outreach and enrollment strategies to Latino residents and Spanish speakers in the border region.

14. Rural and Frontier Health. The ACA contains a provision to improve access to care, including resolving the workforce shortage crisis in rural areas and eliminating long-standing payment inequities for rural providers. New Mexico has not received sufficient resources to monitor the outreach and enrollment in rural/frontier areas of the state. However, in certain areas of the state, such as Hidalgo/Grant counties, efforts were leveraged to increase the work of CHWs through FQHCs for enrollment, and efforts through NMHIX that contracted with AHECs for outreach. The New Mexico Health Care Workforce Committee's 2015 report[105] summarizes efforts in addressing shortages in rural and frontier areas of the state (see #22 below). Residents in rural and frontier areas of the state are paying higher premium costs than their metro counterparts. Average adjusted premiums in rural counties are higher than in urban counties, with a widening gap in 2016 for both Marketplace types.[106]

15. Substance Abuse and Mental Health. The ACA incorporates the Mental Health Parity and Addiction Equity Act, which does not mandate coverage for mental and substance use disorders, but has financial requirements and treatment limitations and requires screening, brief intervention, and referral to treatment as the protocol for identification of substance use disorders through the integration into the electronic health records. Funding for mental and behavioral heath through SAMHSA and HRSA has totaled over $100 million since 2013; however, the continuity of programs is in jeopardy when federal project funding ends. Alignment between ACA and state programming has not been as successful in some areas. Although increased ACA emphasis on mental and behavioral health coverage is included in Centennial Care and Marketplace plans, the New Mexico Human Services Department froze Medicaid reimbursements in 2013 to 15 behavioral health providers accused of fraud. Although the allegations of fraud were disproven in 13 cases in February of 2016, and the final two exonerated in April 2016 by the New Mexico attorney general, a number of New Mexico mental health providers ceased operations, and three of the five Arizona companies brought in to provide services following state action against the New Mexico companies have pulled out of the state, exacerbating an existing shortage and leaving thousands without services.[70]

16. Disability and Health. The ACA mandates coverage for pre-existing conditions and ensures that benefits include products and services people with disabilities need to maintain and improve function. The federal Medicaid funding match (FMAP) for community- and home-based services has been increased. In addition, disability-related equity provisions require data collection by CMS related to disability beneficiaries, and provide grant funding for training of health-

care providers regarding health-care delivery specific to persons with disabilities. In New Mexico, Centennial Care provides a limited benefit package for all Medicaid-expansion eligible individuals with disabilities. Those individuals who are further designated as medically frail based on MCO criteria are entitled to full Medicaid benefits, and those who meet the criteria for medically frail and require additional assistance with daily living are entitled to the community benefits package of home- and community-based services.

17. Community- and School-Based Health Centers. The ACA allowance of $145 million for community health centers and $2.6 million in capital funding for school-based health centers are among the largest federal grants awarded to the states. The community health center funding allowed for the addition of staff and facilities. Health center grantees in New Mexico have received $144,594,719 under the health care law to offer a broader array of primary care services, extend their hours of operations, hire more providers, and renovate or build new clinical spaces. Of the $144,594,719 awarded to New Mexico, $2,634,479 was awarded to New Mexico health centers to help enroll uninsured Americans in the Health Insurance Marketplace. Overall, since 2013, New Mexico health centers used these funds to help more than 104,801 New Mexico residents with enrollment into affordable health insurance coverage, with 11,232 of those being assisted between October and December 2014. These investments ensure that health centers continue to be a trusted resource for assistance with enrollment in the Marketplace, Medicaid and CHIP in New Mexico.[107] New Mexico has built on the SBHC capital funding and provides operational funding for 50 school-based health centers.[68] Another example of state synergy is the Department of Health's alignment of state maternal and child home-visiting programs with the ACA guidelines, which resulted in funding for the Maternal, Infant Early Childhood Home Visiting Program.[69]

18. Data Collection. The ACA provisions specific to racial and ethnic equity include data collection and reporting by race, ethnicity, primary language, sex, and disability status. The New Mexico Department of Health and Human Services has developed uniform data collection standards to be used in population health surveys. DOH epidemiologists should continue analysis of existing databases to improve identification of ACA impacts on health-care access and use. New Mexico's diversity, characterized by a few urban areas and many sparsely populated rural areas, has created a complication between the ACA goal of data disaggregation specific to race and ethnicity, and federal regulations regarding privacy protection that affect frontier areas. Additionally, data from New Mexico's numerous Native American sovereign nations is proprietary, and is only included in U.S. Census Bureau zip code databases. Additional data tracking includes socio-demographic data, geographic location, and total number by health care provider type, collected by the New Mexico Health Care Workforce Committee, University of New Mexico (UNM), designated by the legislature in 2012 as responsible for workforce data collection and reporting.[71]

19. Health Disparities Research and Grants. The ACA establishes the National Prevention, Health Promotion and Public Health Council; the Prevention and Public Health Fund; the Clinical and Community Preventive Services Programs; Community Transformation Grants; the Office of Minority Health; and National Institute on Minority Health and Health Disparities. The ACA calls for chronic

disease programs targeting diverse populations, including oral health care and prevention. Clinical Preventative Services recommendations from the Institute of Medicine consist of FDA-approved prescription contraceptives, at least one annual well-woman visit, domestic violence screening, breast-feeding supports, HPV testing, and screening for sexually transmitted infection and gestational diabetes. The UNM-initiated telemedicine-based projects called ECHO (now replicated in a number of other states) and a program called Access have brought access to specialized care in rural areas via telemedicine. ACA innovation grants have contributed to the funding of these projects.

20. Cultural and Linguistic Competency and Health Literacy. The ACA calls for culturally appropriate outreach in the form of literacy level-appropriate information with regard to the details of Marketplace insurance plans. In addition, grant funding is identified for cultural competency training for health-care providers. The ACA outlines the CHW role with regard to providing culturally competent service, insurance enrollment facilitation, and promotion of health literacy. Improving health literacy is identified as an important aspect of improving communication, prevention, and health care utilization with patients and communities. New Mexico SB58, Community Health Worker Certification, and SB69, African American Infant Mortality Rate, became New Mexico state statutes in 2014. The CHW program aligns ACA workforce diversity with intervention at the community level by trusted community members in order to facilitate education, follow-up, and insurance enrollment at the one-on-one level, including home visits. The African American Infant Mortality Statute is an example of acknowledgment and intervention in a specific health disparity with a state-funded program.

Health insurance literacy has not been addressed to date through a culturally appropriate outreach effort; however, New Mexico State University is functioning as part of a national network supported by the ACA that fields questions from community members online and provides answers by an expert. The DOH has established health literacy as a need, and UNM initiated a Health Literacy Taskforce in 2012. Generation Justice is collaborating with school-based health centers to improve adolescent health literacy via social media. The Sandoval County Health Collaborative, consisting of educators and health-care providers, has initiated a pilot health literacy program for first graders in three elementary schools. In another important equity effort, New Mexico DOH has adopted ACA cultural competency guidelines and has been recognized nationally as a leader in training and optional certification, and defining an important role for CHWs in communities adversely impacted by the social determinants of health.[72]

21. Workforce Diversity. The ACA calls for increased workforce diversity within al health-care provider groups. In addition to provider diversity, the ACA focuses on financial incentives and training in Federally Qualified Health Centers (FQHCs), particularly in rural/frontier areas that have been historically underserved. In spite of federal loans and grants, and a 2015/2016 state appropriation for health care workforce initiatives, New Mexico continues to experience a significant provider shortage, particularly outside of urban areas. New Mexico is below national benchmarks in the areas of primary care providers, advance practice nurses, psychiatrists, OB/GYN, and dentists, and is not producing enough providers to fill the gap in the future. The shortage is even more significant given the large increase in Medicaid enrollment, including patients previ-

ously uninsured and with deferred health-care needs. Continued training and use of CHW along with expansion of telemedicine may be short-term offsets.

22. Innovative Models of Care. Innovative Models of Care are part of the ACA strategy to improve health-care quality, population health status, and reduce growth in health-care costs. In 2015, the New Mexico Department of Health and the New Mexico Human Services Department received cooperative agreement funding from the Centers for Medicare and Medicaid Innovation (CMMI) in Round 2 of funding for the national State Innovation Models (SIM) program. From 2015 to 2016, both state agencies led a process involving multiple, diverse stakeholders in both public and private sectors to design a specific state Health System Innovation (HIS) plan. Seven state summits were held, and seven core stakeholder committees contributed recommendations to the design. In addition, the state's tribal and county health councils contributed to the development of a statewide design that would increase equity of access to quality health care by helping to hold over 100 community-based discussion and feedback sessions. New Mexico's HSI design is intended to improve not only alignment of clinical, behavioral, and oral health care within patient-centered medical home models (PCMH), but to also assimilate local PCMHs into existing, broader-based collaborations of public health, social service, health equity and other community-centered stakeholders in Accountable Health Communities (AHC) to improve population health. Unfortunately, in 2015, the CMMI informed the 18 states and territories participating in Round 2 that the federal agency had changed its funding strategy, and that there would be no monies allocated for the testing and implementation of Round 2 SIM designs.

23. Safety Net. New Mexico has a broad safety-net program. Centennial Care, New Mexico's 1,115 Demonstration Waiver (Centers for Medicaid and Medicare Services), mandates a Safety Net Care Pool funded at the county level. The provisions of Centennial Care have resulted in increased revenue to New Mexico hospitals and FQHCs to date. By 2018, the New Mexico Hospital Discharge Data website, authorized in the 2015 legislative session, will increase hospital pricing transparency.[73] Health care for undocumented individuals is funded in part by Medicaid Emergency Medical Services for Aliens (EMSA) and the New Mexico Medical Insurance Pool. Individual hospitals pay the balance. New Mexico nonprofit hospitals are in the process of developing and implementing ACA-required community assessments and financial assistance policies. While New Mexico has made inroads in leveraging ACA equity provisions, there are opportunities for additional progress and innovative programming that addresses local community needs. Policy development and funding for programs at the state and county levels that increase access, supported by data that clearly indicates which ethnic, racial, and other minority populations have been served, will be increasingly important. Data regarding program outcomes, evaluated within an accountability framework, will be necessary for continued improvement and sustainability in order to provide a strong foundation for health care equity advancements in New Mexico.

IMPLEMENTATION BENCHMARKS AND TIMELINE

Figure 10 illustrates the parallel U.S. and New Mexico benchmarks and timeline in implementing the ACA. Prior to 2010, New Mexico had a long history of state health reform efforts, including several iterations of Medicaid reform, initiatives to tackle growing health-care costs, incremental legislation regarding insurance regulation, and behavioral health reform. Many of these efforts, while not directly coined as health equity measures, have been directed at making health care accessible, improving quality and making it more affordable for New Mexicans.

Since the passage of the ACA in 2010, two cases have been heard by the Supreme Court of the United States (SCOTUS). The first, *National Federation of Independent Business v. Sebelius*, included the challenge of legislative constitutional authority to impose a mandate for health-care coverage. In June of 2012, SCOTUS ruled 5-4 that the penalty for lack of insurance coverage was a constitutionally authorized tax rather than a mandate. Additionally, the ruling included that Medicaid eligibility expansion to 138 percent of the FPL was optional for the individual states and could not be disincentivized through federal funding sanctions.[108] In June 2015, in a second appeal, *King v. Burwell*, SCOTUS ruled health insurance tax credits are available in both federal- and state-operated exchanges.[109]

From 2008-2011, Governor Bill Richardson supported several health care initiatives. Although his universal health care proposal "Healthsolutions" failed to pass in 2008, a special legislative session resulted in a $22.5 million allocation to increase coverage for children not covered by CHIP or Medicaid.[110] In 2010, HB 12 (Health Insurance Service Reimbursement),[111] which limited insurance company profits, was signed into statute. In August 2010, Governor Richardson established, through executive order (2010-032), the Office of Health Care Reform (OHRC). The goal of the OHRC was to plan and establish policies for ACA implementation. A federally-funded planning grant of $1 million was used to gather pre-implementation input from diverse stakeholders.[112]

Upon taking office in 2011, Governor Susana Martinez continued the planning process with funding from the federal ACA implementation grants. Focus groups comprising diverse vulnerable populations as well as small businesses and general consumers were convened to identify barriers and opportunities to enrolling in insurance coverage. In 2011, Governor Martinez vetoed legislation (SB 35 and HB 370) to establish a Health Insurance Exchange, citing questions of ACA constitutionality that needed to be resolved.[113] Frustration among members of the legislature and the OHCR ensued, and the OHCR chairman and lifelong republican, Dr. Dan Dirksen, resigned in 2012**,** stating that "there had been a shift in policy and that he had lost the battle over 'policy approach and implementation' within the administration about the timeline for building a New Mexico health insurance exchange, which is meant to help more people obtain health insurance."[114]

Advocacy efforts for the state Medicaid expansion began in 2010 and ramped up through 2012. Public pressure on Governor Martinez to expand Medicaid included a statewide campaign led by advocacy organizations such as the New Mexico Center on Law and Poverty, Health Action New Mexico, New Mexico Voices for Children, Southwest Women's Law Center, labor unions, and many others.[115] Despite political cross-pressures from other Republican governors, in January 2013

Governor Martinez expanded Medicaid. Concurrently, the New Mexico Department of Human Services (HSD) obtained a 1,115 Demonstration Waiver from the Centers for Medicare and Medicaid Services in order to implement Centennial Care. This new Medicaid program, implemented in January 2014, sought to provide more comprehensive services to an increased number of Medicaid-eligible individuals while slowing the rate of Medicaid costs[116,117]

In 2013 the New Mexico Health Insurance Exchange Act, which called for the establishment of the New Mexico Health Insurance Exchange (NMHIX) as a nonprofit corporation, was passed just 187 days before the start of the first Open Enrollment Period on March 28, 2013. Following the passage of the act, a 13-member board of directors convened in April, just six months prior to the first open enrollment period on October 1, 2013. In August 2014, the NMHIX Board hired a chief executive officer who provided the direction over state operational efforts, information technology project oversight, staffing, targeted outreach, enrollment, and marketing.[118] Initially, the NMHIX marketplace was intended to be a state-run health exchange operating as a quasi-governmental, nonprofit public corporation charged with providing qualified individuals with improved access to health insurance.[119]

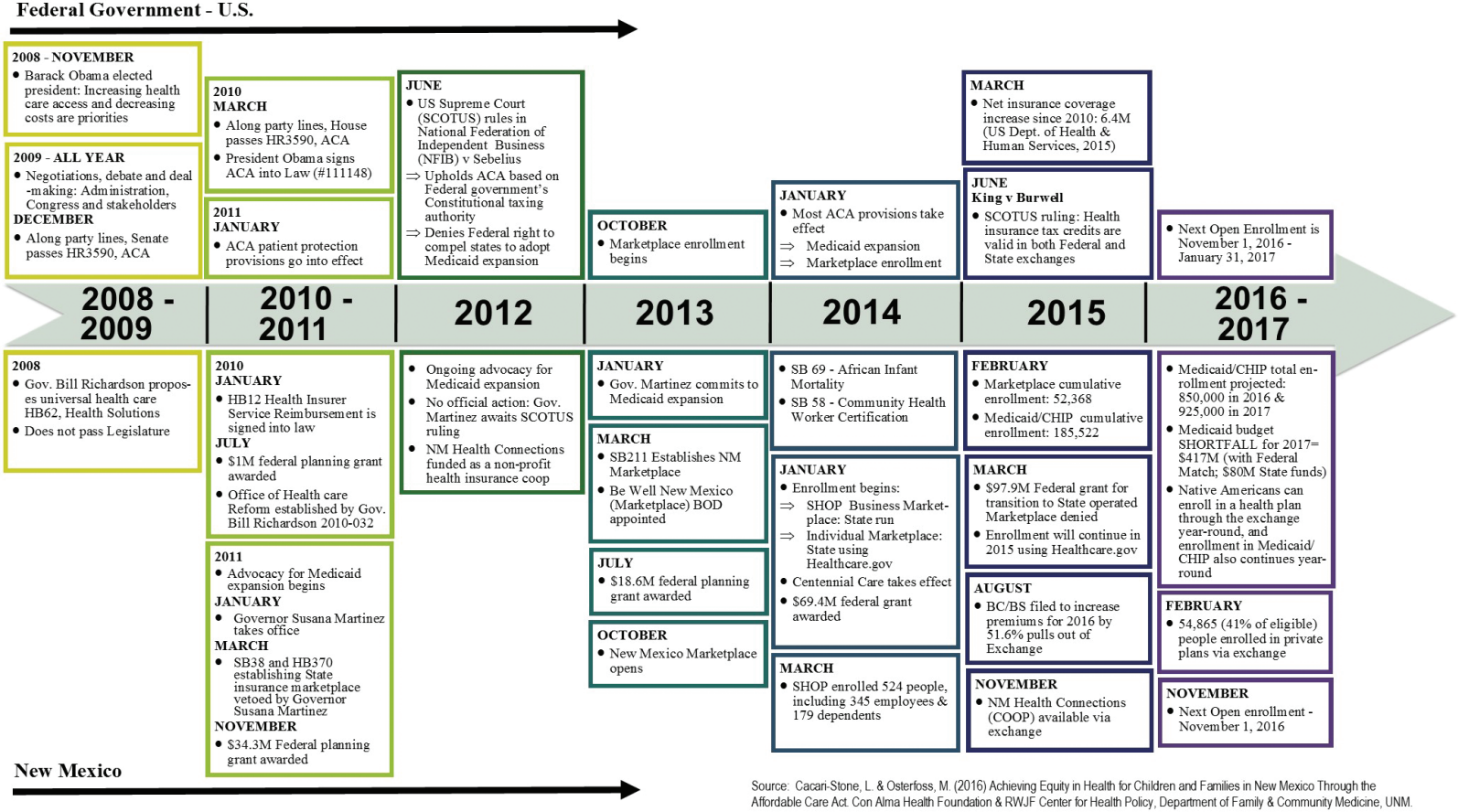
Between 2010 and 2014, New Mexico received $123.3 million in planning grants from the federal government to set up and run the state exchange. In June 2014, CMS notified the New Mexico Marketplace that the bewellnm portal needed to be organized as a "one-door" system rather than the existing "no-wrong-door" system in order to facilitate seamless enrollment in the private insurance Marketplace or Medicaid, based on eligibility.[120] The NMHIX Board requested a $98 million federal grant to modify the website and comply with the CMS request, while continuing to develop a state-operated Marketplace. In January 2015 this request was denied.[121] The denial referenced letters written by Secretary Sidonie Squier of the Human Services Department and Governor Martinez, who sharply criticized CMS for lack of clear guidance and for denying the request.[122]

In April 2015 the New Mexico Marketplace board of directors voted to continue to lease the healthcare.gov platform for individual enrollment. Small business enrollment (SHOP) continued as a state-run health exchange and the NMHIX continued to make concerted efforts to make bewellnm more attractive for small businesses.[123,124] According to a comprehensive evaluation conducted by the New Mexico Legislative Finance Committee, "the NMHIX has spent $85 million with limited benefits to taxpayers. Marketing was costly with low resulting enrollment, and the investments in Information Technology did not result in a full implementation of the exchange."[125]

The uninsured rate in New Mexico has dropped by 4.1 percent, which is much higher than the national reduction of 2.8 percent. In January 2014, of the 422,000 non-Medicare uninsured New Mexicans, 71 percent were eligible for financial assistance to obtain coverage through Medicaid or the NMHIX.[126] As of September 30, 2015, 44,836 or 31 percent of the eligible 133,000 individuals have enrolled in bewellnm, and more than 220,000 New Mexicans have enrolled in Medicaid.[127] In February 2016, 54,865 persons enrolled in private plans through the Marketplace, and it is projected that 850,00 persons will be enrolled in Medicaid in 2016.

Figure 10

Patient Protection and Affordable Care Act, (ACA) Implementation in the U.S. and NM 2008 - 2017



Source: Cacari-Stone, L. & Osterfoss, M. (2016) Achieving Equity in Health for Children and Families in New Mexico Through the Affordable Care Act. Con Alma Health Foundation & RWJF Center for Health Policy, Department of Family & Community Medicine, UNM.

ACA IMPLEMENTATION: SUCCESSES AND CHALLENGES

While **FIGURE 10** illustrates the temporal progression of the ACA in New Mexico, it is also important to understand how the processes of implementation developed over time from the perspectives of stakeholders most involved with that process. The following are key findings, synthesized from both the interviews and documents review, that highlight the major successes and challenges of implementation.

Uninsured rates have decreased: Medicaid expansion was the right thing to do. According to Gallup data, New Mexico's uninsured rate in 2013 was 20.2 percent, and had declined to 13.1 percent by the first half of 2015. In 2015, there were 233,000 uninsured residents and of those, 47 percent were eligible for Medicaid and 13 percent were eligible for premium subsidies in the exchange. As of mid-2015, the New Mexico exchange had just 44,307 people enrolled in private plans, and enrollment grew to nearly 55,000 by the end of the 2016 open enrollment period.[128] As of March 2016, 54,865 people enrolled in private plans (see **FIGURE 10**) through the New Mexico exchange during the 2016 open enrollment period, including renewals and new enrollees. That's an increase of nearly five percent over the 52,358 people who enrolled during the 2015 open enrollment period.

Overwhelmingly, participants noted that Medicaid expansion has been a successful health reform in New Mexico. An outreach director from the Albuquerque metro area explains: *"I think that Medicaid expansion, our governor accepting that, was a huge success, and that more people are enrolled. It's a huge success. I believe that health systems, for the most part, are taking this seriously."*

In southern New Mexico, a community action director highlighted the value of covering all people: *"I think the successes are that — to me, it was the right thing to do. To me, as an American, as being in a country that is so strong and so powerful and has so much money, we should not have people that are not covered by health care in this country."*

A health plan executive recognized New Mexico's success: *"Certainly, the uninsured rates have gone down; we have under 14 percent uninsured, but it should be in single digits. The second success is that more people do have health coverage and the impact it has had on our health delivery system is positive. For instance, our uncompensated care has plummeted, gone down."*

Most notably, the public health participants emphasized the critical role that Medicaid expansion plays in advancing population health. As a state health administrator explained: *"The benefit of expansion is not just that the health care improves it is that the public health system also improves."*

Culturally, linguistically, and geographically targeted enrollment strategies are ongoing priorities for achieving equity in access under the ACA.

The NMHIX is using various strategies for reaching and activating New Mexicans to seek coverage through bewellnm.com, including targeted awareness-building and marketing with Hispanic and rural populations and personal communication assistance in person, online, or via phone, and collaboration with experienced partners to conduct outreach.[129] Communication strategies include news releases, digital blogs, public service announcements, and custom media pitch-

es in English and Spanish. Outreach efforts as of October 2015 have included visits to 50 cities; 198 presentations to business owners; 39 presentations to faith communities; 11 events in higher education and two visits to K-12 schools (5,434 fliers); two tele-town halls reaching 2,876 attendees; 56 public events with general audiences; and the opening of enrollment centers in Farmington, Las Cruces, Gallup, and Santa Fe.[130]

Some of the most successful enrollment and outreach efforts in New Mexico have resulted from community-designed and community-based plans. The Native American Parent Professional Resources (NAPPR) and the Albuquerque Public School (APS) "boots on the ground" approach has made positive inroads in enrolling Native Americans and children. A health reform leader involved with statewide enrollment efforts stated: *"I think the fact that we were able to get several hundred people certified to do enrollment throughout the community health centers and with NAPPR in such a short period of time when we first started … it was truly amazing."* An APS enroller shared: *"At just one event we get several hundred people enrolled at one time and we do a lot of marketing for that event and a lot of call-outs. So having those events has been really impacting enrollment. We are also strategic about it. We have days around free and reduced lunch. So we do our events in areas we call high-impact areas. We know that there are more eligible families in certain areas. So we hold them there in those eligible areas."*

An important aspect of outreach and enrollment described by many participants statewide was the use of community health workers, also known as *promotores de salud*. Federally qualified health centers and primary care networks are utilizing community health workers to assist with enrollment and to help make sure there is a meaningful connection with eligible consumers. The CHWs have appropriate training and language skills, are trusted by the community, and are working with health-care providers to educate and mentor families through the application process.[131] A community health worker coordinator from the south shared: "I think the success is really the human resources invested in outreach, especially all the *promotoras*. They have been very patient and jump through all the hoops in order to do everything they need to do to get people enrolled and advocating for them well past the point of enrollment."

New Mexico is making progress, but continues to face challenges.
State implementation efforts have endured a number of challenges, including a late start-up, leadership turnover, information technology problems, and inconsistent guidance and data from the Center for Medicaid and Medicare Services.[132] Several state health reform leaders shared their concern that during the initial stages of implementation, the former cabinet secretary of the Human Services Department could have been more proactive in leading the process. One provider leader explained: *"Initially, Secretary Squier slowed down the state-based Marketplace process. We had a $34 million grant and the $100 million proposal to support outreach and education in the first year of operations, but it's hard to recover from missed opportunities and to get level support to carry it through. Early versions of it would have helped us reach Latino and Native American populations. New Mexico would have seen the largest decrease in uninsured in the country and it's hard to recover from getting way behind."*

Stakeholders from the south working in the Navajo area shared how the slow start-up impacted vulnerable families and communities. Initially, there were

delays in working out agreements with the Navajo Nation so that they could provide enrollment and education to the tribe. Community-based organizations stepped up to help, but contracts to do outreach and information to do enrollment were slow to come from the state. A community action leader from the south shared: *"As far as agencies, we were preparing for the implementation of ACA, it was very late and it was very rushed. There were a lot of unknowns in implementing ACA. We have a lot of vulnerable communities, so there were a lot of families that were missed in the educational piece of ACA."*

Stakeholders — from enrollers to health advocates and health administrators — noted that there were mixed opinions as to whether the process of decision-making and health reform implementation included sufficient community inclusion. Some participants felt there should have been more community inclusion in decision-making about current implementation efforts, and — especially in rural areas — participants described a gap between the goals of the ACA, governance of the ACA, and the lack of community inclusion. Other participants believed communities have been involved. A health advocate from Bernalillo shared: *"I think the other success is that there has been really good effort to involve and impact rural communities of New Mexico."*

While New Mexico has made successful inroads in decreasing the uninsured rate through the Medicaid expansion, stakeholders expressed concern that more needs to be done to improve enrollment into the Marketplace. One provider and health reform leader explained: *"Participation rate for those eligible for Medicaid is good and, in New Mexico, there's a lot of other eligible folks who could get assistance to pay and buy a health insurance plan, and that has been less than what I had hoped for! So, there hasn't been as a rigorous effort to help [people] get their families covered for those eligible; a lot of folks are not taking advantage of that. This hasn't gone as well as the Medicaid. You should do as well as in the Marketplace as those for up to 200 percent poverty level."*

In 2011, the New Mexico Office of Health Care Reform used a federal planning grant to commission a series of meetings with diverse consumers[7] across the state, and published reports that summarized the findings.[133] The reports highlighted a number of thematic barriers, including high deductibles/copays/out-of-pocket costs; lack of awareness on how and where to sign up; lack of literacy in health insurance and access and use of technology; legal status of family members; language/cultural barriers; and lack of trust in the health-care system and providers. Key concerns reported by consumers included the uncertainty of eligibility and the perception that associated costs for coverage puts a burden on families.[134] Understanding benefits and limitations of coverage related to treatment, access to treatment, and the claims process were additional concerns raised prior to implementation.

A state legislator explained the dilemma families still face today: *"It's still a matter of affordability. If you are deciding to put food on the table, shoes on your kids, or pay an insurance premium, right now you are healthy and could show up at the*

7 The reports summarized the findings from focus groups and interviews with diverse consumers including Small Employers in New Mexico; Toward an LGBT-Inclusive Approach to Health Care Reform Implementation; Recommendations for Establishing a New Mexico Health Insurance Exchange; Insurance Exchange Stakeholder Input: Sex and Gender Implications; Health Insurance Exchange Survey for Spanish-Only Speakers; and Young Adults and "Underemployed" Adults.

ER. But it is hard to justify doing that. So I still think it's an affordability issue and a full understanding of what [health insurance] is."

These concerns were reiterated at a Con Alma Health Foundation convening held in April 2015, over a year after the New Mexico Marketplace went into operation. Concern was also raised that re-enrollment could be impacted by the cost of insurance coverage when deductibles, copayments, and out-of-pocket expenses, on top of premiums, far exceeded covered benefits.[135] Results from the New Mexico Latino ACA and Health Survey strongly suggest that the costs associated with health care pose significant challenges to the already disadvantaged Latino community in New Mexico. Nearly a third (30 percent) reported that insurance was too expensive, compared to the much smaller percentages who said the problem was not being able to understand the paperwork (14 percent), or not being able to get assistance near home or work (20 percent).[136]

Related to this issue was the expressed need to address churning, which is a side effect of the Medicaid expansion and state-based exchanges under the Affordable Care Act. Churn is defined as the shifting into and out of eligibility for insurance affordability programs due to income changes. Because the line between Medicaid and Exchange eligibility is fine — 138 percent of the federal poverty level — New Mexico residents are expected to gain and lose eligibility, which in turn undermines continuity of care and raises costs.[8] A hospital CEO affirmed that: *"The biggest problem is eligibility and financing around the churn problem, the 138 percent to 220 percent of poverty levels. That is a gigantic problem that is going to manifest itself over the next two to five years. The federal government will have to address it one way or another or it will be an unholy mess for a lot of people with marginal incomes."*

Other studies have highlighted the social and structural barriers that have inhibited access to enrollment, especially among racial, ethnic, linguistic, and geographically diverse communities. For instance, lack of literacy and numeracy in target populations impedes a consumer's ability to make the best insurance choice or to sign up at all. This is especially prevalent for consumers with family incomes below 400 percent of FPL, with 6.1 percent self-rating as poor or fair literacy; 28.7 percent self-rating as poor or fair numeracy; and 20.1 percent self-reporting limited literacy and/or numeracy.[137] Findings from a survey conducted by Strong Families New Mexico emphasized the role of low health insurance literacy among applicants, compounded by other barriers including complicated forms, lack of or limited internet access, and website glitches. "This was especially common among Latinos who relied on navigators to translate complicated insurance terms and concepts like co-pay, deductible, and essential benefits. Often, these translators where not readily available in Spanish and most of the outreach was in English."[138] Other barriers included the time it takes to go through the enrollment process and fill out paperwork, the long distances involved in reaching people like farmers and ranchers, and persons with seasonal

8 Centennial Care Medicaid in New Mexico is now available to residents with incomes up to 138 percent of poverty. Higher guidelines apply for some populations. The following people are eligible in addition to the aged, blind, and disabled, and this chart includes monthly income limits as well as income as a percentage of poverty level: Adults with household incomes up to 138 percent of poverty; children with household income up to 240 percent of poverty are eligible for coverage through CHIP; for children age 0 to 6, the limit is 300 percent of poverty; and pregnancy-related services only, for pregnant women with household incomes up to 250 percent of poverty.

homes in rural and frontier communities such as the Navajo Nation.[139]

Stakeholder participants shared similar concerns about the complicated and confusing enrollment process, especially for limited-English speakers. For instance, an enroller in Northern New Mexico shared: *"I think we have a major gap in our Spanish-speaking-only populations. Not bilingual, but really the Spanish-only speaking populations. As much as we try to do outreach in both English and Spanish, I think across the board for health care, accessing health care, I think it is still very limited. We have a fully bilingual enrollment counselor at the hospital, and I am not certified, but I've worked with Spanish-speaking people. I've taken lessons in Spanish, but I'm not able to fully translate the health-care enrollment documents."*

Most notably, participant stakeholders emphasized that racial and ethnic populations, and especially people who are living in remote areas and/or do not have access to a computer or the internet, are still not getting enrolled into the Marketplace. A health council member from southeastern New Mexico shared: *"When we're a state that has a majority of people of color yet our enrollment still looks like 60 percent white, then that to me is a huge gap that I think speaks across all geographies — yeah, I think that has to be the biggest gap."*

Finally, it's important to note that while it was not a predominant discussion across the state, a handful of stakeholders expressed concern about how to improve behavioral and mental health, oral health and vision care under the ACA. A county health director expanded on this challenge: *"I think behavioral health, one of the big problems that I always had previously with health care is that it was like the head isn't part of the body because dental, vision, and psychiatry and mental health were never included. Some populations didn't have access to those services."*

Undocumented immigrants remain excluded from purchasing insurance coverage through the Marketplace. The ACA excludes undocumented immigrants from eligibility for Medicaid and from purchasing insurance via the Marketplace. As was the case before the ACA, legally documented immigrants who have resided in the U.S. for less than five years continue to be ineligible for Medicaid.[140] Key stakeholders involved at the federal and state level shared their belief that pulling undocumented immigrants out of the eligibility for the Marketplace was a pragmatic compromise in order to pass the health reform law. As a health reform leader explained: *"The ACA barely made it through Congress. If you added immigration reform, it was a pragmatic decision not to include undocumented immigrants. It's still not a rational argument, but it is still at the emotional partisan level."*

The exception to coverage for undocumented children is for the "Dreamers," those children who arrived in the United States when they were under the age of 16 and have assimilated to U.S. culture and been educated by U.S. school systems. While granted deferred action with regard to deportation, these individuals are specifically classified as ineligible for insurance coverage under the ACA.[141] To date, 25 states, including New Mexico, do provide Medicaid and Children's Health Insurance Program (CHIP) benefits to lawfully residing children without a waiting period. In a review of other states' health-reform activities, Illinois, New York, Washington, and California have extended coverage to undocumented children[142] based on projected downstream cost-savings, including decreases

in emergency department visits and labor force maintenance.[143] The California program, Health for All Kids, is projected to have an annual cost of $132 million and to extend coverage to 170,000 undocumented children.[144]

SOLUTIONS FOR MOVING FORWARD

1) Create a Culture of Health Coverage for All New Mexicans.

Stakeholder participants consistently expressed that the ACA created a cultural shift toward universal coverage for all in New Mexico. Across all regions of the state, many stakeholders shared a vision for universal coverage for all New Mexicans. A child advocate said: "*All kids should have the opportunity to get equal access to health care and that should be comprehensive — health, vision, dental, behavioral health and developmental health are especially important to kids. For kids it's not a matter of going when you are sick or injured, it's a matter of going for developmental care*."

There also was a shared sentiment that we haven't achieved the health-reform goal of universal coverage for all. A director of a free clinic noted: *"I hope the ACA really does it, it's really covering everybody and really going by their definition of universal health care for all. In that sense, the way it is right now it is not universal health care for all. To me, it's the 'all' that we know. It's covering everybody, being affordable, really affordable, so really not just advertising it, but actually doing it. So that people don't have this bad feeling about the ACA."*

In the southern and central areas of the state, participant stakeholders mentioned that health insurance coverage is the essential for all children, and that New Mexico should focus on ensuring immigrant children and their families have access to health care. One health council member from the border area stated: "*And of course, I don't know how, but New Mexico should address the issue with immigration, the undocumented immigrants, and the immigrants who are here legally. I don't know if we could work with Mexico better to ensure that their residents have access on their side of the border. I don't know; it's getting pretty complicated*."

Additionally, several stakeholders mentioned the importance of building more awareness among young adults and a general culture shift to value the importance of health insurance coverage. A state public health leader noted: *"Young people who fall within the gap after 26-35 who just don't see the value in having insurance."*

2) Prioritize Community as a Central Force for Achieving Health Equity.

Across all geographies, sectors, and roles in implementing health reform, stakeholder participants consistently emphasized the importance of community as a central force in achieving health equity. A state health administrator explained: *"I think it's all about community involvement, getting on the ground, talking to folks, getting information out there, and institutionalizing their involvement in this. I think that that can't be overstated. Because in the communities that we have worked in, we see … communities having an even bigger role in their health care system. The ACA is the platform for greater involvement. More community representation within institutions like the Health Insurance Exchange, even the*

Human Services Department. If we could get more community voices heard by the Human Services Department, I think that goes a long way."

Participants consistently called for more community inclusion in statewide health policymaking, and for the implementation process of the ACA to include more community input, utilize and validate local expertise, and to listen to communities and build on community knowledge. A community health benefits representative from an MCO stated: *"We need to continue to think of ways to be more community-driven and to continue to listen to community needs and bring it to the attention of our leadership and see how we can respond in a better way. For example, like if our communities are telling us we need substance abuse treatment, or that child abuse is a priority, or that behavioral health is a priority — making sure that that's at the table at the board and at the leadership meetings, and that we're responding internally through committees or task forces or whatever."*

3) Make Payment Structures more Equitable.

Overall, stakeholder participants expressed concern about the cost of health insurance and services, but few had specific solutions on how to fix these problems beyond calling for insurance reform. While there was no one solution offered, there was a variety of ideas on how to make the ACA more affordable for consumers, to continue to sustain providers so they can deliver quality care to consumers, and to push forth payment reform. One county program manager shared: *"I think payment reform is the next big issue to tackle with the ACA. To start to pay providers in a way that allows them to do the kind of work that the ACA appears to value. The linkages between the different entities and communities in the Accountable Health Community Model was exciting, and that should be supported."*

There was a perception among many stakeholders that the existing payer structures advantage the insurance companies over consumers and public providers. An enroller from northern New Mexico expressed concerned that: *"The health plans are still profiting quite a bit but they aren't really a part of the affordable care. They are still making their profits and within their budgets. I think that the government helping and the patient getting the lower costs is a start, but it's still the health plans that are making money and profiting."*

Statewide, respondents offered a list of general financing solutions, including increasing payers so more people are insured; exploring opportunities for Native American tribes to purchase health coverage for members who have complex, high-cost health care needs; maximizing the mil levy funds via the UNM Hospital; providing incentives for workforce capitation costs; equalizing the change in payer structures so that doctors and providers working in the communities receive equitable reimbursements with the doctors working in the hospitals; and regulating the uniformity of hospital charges for the same procedures.

4) Expand on Successful Outreach and Enrollment that is Culturally and Linguistically Aligned with New Mexico's Diverse Communities.

The NMHIX should build on the successes of school-based health centers (SBHC), the Native American Parent Professional Resources (NAPPR), and community health workers, and expand and diversify the types and locations of outreach and enrollment contracts to partnering organizations that are rooted in

grassroots community networks. Given the established lack of health insurance literacy, training should be extended to more "boots-on-the-ground" brokers and enrollers who are trusted, reliable and able to provide cultural and linguistic congruency to diverse New Mexicans. Geocoding and mapping should be a priority for the NMIX in order to reach the areas where there are gaps in coverage.

In the interviews and at a statewide convening on the ACA and equity in May 2016, participants expressed support of the SBHCs in reaching out to and enrolling children in Medicaid and the Marketplace, for their delivery of medical and behavioral health services, and for promoting comprehensive health services. An insurance provider declared: *"The most vulnerable kids are on Medicaid, and school-based health care is so important in our state."* Breakout groups at the statewide convening emphasized that SBHC are helpful for the entire family, and are good access points for the community.

Enrollment can be seen as a measurable proxy for access. Because children depend on their families to enroll, limited English language skills as well as literacy and numeracy challenges must be addressed.[145] An enrollment model should incorporate cultural and linguistic appropriateness while laying the groundwork for subsequent appropriate utilization of the health care system.[146] A 2015 Texas Institute of Health report reviewed information, guidance, navigation, and support for the previously uninsured in 17 states. The report emphasizes the need for enrollees to understand insurance costs and benefits, and how to maximize preventive health care after enrollment. An important question raised by the report is: How can an enrollment model facilitate health care equity by encouraging utilization that closes the gap in health outcomes?[147]

The New Mexico Human Services Department should facilitate, not hinder, enrollment into the ACA, as well as into other public health programs for vulnerable children and families (including Medicaid, CHIP, and SNAP). After the passage of the Children's Health Insurance Program in the mid-1990s through early 2000, the state of New Mexico partnered closely with community-based organizations to reach out to and enroll children. These efforts could easily be replicated in order to involve school-based health clinics (K-12) and two-year community and tribal colleges and universities.

5) Simplify Eligibility and Enrollment Processes.

A common theme among stakeholders, from enrollers to state administrators, was to simplify the enrollment process. A state government administrator explained: *"Something we should continue is to focus on making our eligibility processes and applications as simple and straightforward as they can be. This would be a benefit to everyone, for those with other inherent barriers, and with greater degrees of poverty. "*

A solution repeatedly suggested was to link the state Medicaid system with the NMHIX Marketplace enrollment process. The state should fully implement the Affordable Care Act by establishing a 'no-wrong-door' policy, and reinstating funds for outreach to enroll all children into Medicaid.[148] This requires that states must have a system where individuals and families can apply for health insurance coverage through a single entity, regardless the type of insurance they may ultimately enroll in (e.g., Medicaid, CHIP, Marketplace).[149] This would assure that consumers get to where they need to go as part of a "one-stop-shop" where the

exchange shares enrollment with Medicaid, and vice versa when applicants are likely to be eligible for the other program.

6) Support Health Systems Innovations that Promote Health and Access to Care.

Stakeholder participants considered the ACA an opportunity to design a health-care system that is outcomes-based, emphasizes preventative care, and minimizes hospitalizations. A public health leader shared: *"We are moving toward more value-based care. I think that's significant. When we talk about not generating money off of seeing patients and we talk about keeping healthy, and that you are rewarded basically for keeping people healthy, when we operate in a system more like that, we are successful. We have to have successful pilots demonstrating that the preventative approach works and provides a return on investment."*

Across the state, there were several best practices that participants favored in support of prevention and improved health outcomes, including community health workers and the home-visiting program. Unanimously, community health workers (*promotores de salud*) were touted as critical to achieving equity in health care access for under-resourced communities. However, many were concerned about not having sustainable financing mechanisms. Several participants recommended making community health workers a billable service under the insurance and Medicaid expansions.

In order to promote child development and health, many recommended that the New Mexico home-visiting program be expanded. A child policy expert explained: *"On practical level, I think one of the most beneficial programs for the healthy development of kids is home visits, and I'd like to see home visiting part of a benefits package. We can expand our home-visiting programs fourfold through a Medicaid model rather than a social development model. Medicaid could develop a requirement for the MCO's to deliver home-visiting services. We would see extraordinary results in a two-generation approach to breaking the cycle of poverty in New Mexico. In fact, the Legislative Finance Council and the legislature has backed this approach, but it has been vetoed by the governor; she doesn't want another mandate, and doesn't want bigger government."*

Federally Qualified Healthcare Centers, Indian Health Services, the Veterans Administration, public health clinics, and hospital emergency rooms have provided care to many of the state's uninsured. At the statewide ACA and Health Equity forum in May 2016, stakeholders recommended that the state, in collaboration with tribes and health-care organizations, continue to address the shortage of the health-care workforce. While stakeholders did not offer specific solutions, a 2013 report titled "Adequacy of New Mexico's Healthcare Systems Workforce"[150] provided the recommendations for addressing the health-care workforce shortage, including, but not limited to, passing legislation to expand state-funded family medicine residencies; increasing appropriations to loan repayment programs as opposed to loans for service programs; and ensuring the Department of Health has adequate resources to carry out its statutory responsibility to conduct workforce planning. In addition, the Medical Board should revisit the scope of practice for Physician Assistants to allow these professionals the same degree of independence that Nurse Practioners are allowed in the state. New Mexico's Behavioral Health Licensing Boards should expand the mental health masters

degrees that qualify for supervision and licensure, and streamline the requirements for mental health counselor reciprocity with other states.

In the 2015 New Mexico Health System Innovation (HSI) design, a workforce development and diversity stakeholder group, recommended the expansion of the community-based workforce, especially community health workers and community health representatives and emergency medical service personnel who also serve as links between communities and care providers, as a keystone of the design. The recommended HSI design also included strategies for enhancing use of tele-health systems to improve information sharing and workforce competencies, and increasing incentives or assets in rural areas for family members of practitioners.

7) Promote Leadership and Ensure Accountability.

Intersectoral leadership and responsive governance are needed across the executive, legislative, tribal, and local levels of government as well as in the private sector. The ACA provides an opportunity for leaders to rally around the needs and interests of New Mexico's diverse communities. Structural humility is needed in order to break down the resistance to working from the ground up rather than with top-down approaches to implementation. This may require time and commitment from key leaders to interface and dialogue directly with communities.

Several statewide leaders expressed the need for more accountability and for stakeholders to come together, especially around information about who is making decisions and where the funding is going. An executive director of a community-based organization serving children and families shared: *"I think a lot of agencies need to have a face, we need to have a name. We need to see who is managing or who is dictating our systems, especially for health care and services. If it is an entity, then that entity needs to have a face, and we need to hear what are their ideas. Let's go play together and do it together. Because right now everyone is fighting for their own interest!"*

8) Improve Evidence for Monitoring and Tracking the Progress of the ACA.

The federal government (Centers for Medicare and Medicaid Services) and New Mexico Human Services Department (NMHIX) should continuously improve collaboration in order to collect and disseminate timely and quality data on enrollment numbers by race/ethnicity, language, and geography. The ACA calls for data collection and reporting by race, ethnicity, and language. Currently, monitoring the implementation progress of the ACA is extremely limited by the lack of timely data at the sub-state level. In fact, when stakeholder participants were asked who, in New Mexico, is taking the lead in monitoring and tracking the ACA and its progress in achieving health equity, only one-quarter were able to describe a handful of community-based organizations (New Mexico Center on Law and Poverty, Health Action New Mexico, NM Voices for Children and NM Women's Law Center): the majority of respondents were not able to name a single entity that is taking the lead in analyzing pre- and post-progress in attaining equity in coverage for children and families.

The New Mexico Health System Innovation (HSI) design recommends that New

Mexico collect, analyze, and (under existing state guidelines) and share de-identified health care patient databases that are required to improve patient outcomes and to achieve significant cost savings. **Challenges to be addressed in the HSI design include the complexities** of patient data integration from various sources, statewide adoption and meaningful use of electronic health records (EHRs), integration of behavioral health data with physical health data, and the need for improved analytic capacity for clinical, claims, and population data.

To date, there is no single entity that has taken the lead in collecting state and local-level data on enrollment and health insurance coverage for children. The advocacy organizations **rely primarily** on national websites and various sources of data in order to extract coverage rates for children and families on a need-to-know basis. One state health reform leader shared: *"I wish there was an independent policy unit that held every institution's feet to the fire; we don't have that, I wish we did. We need a stand-alone review organization that says to the public, 'You should be doing this or that, or you should be submitting data on x, y or z.' No one is doing that as an independent arbiter of things."*

CONCLUSION

Tackling the Social Determinants of Health — Achieving Child Health Equity in All Policies

According to the 2015 Kid's Count data, New Mexico now leads the nation with the highest rate of child poverty. The state has seen a steady increase in the percentage of children living in areas where overall poverty is 30 percent or higher.

Achieving equity in health for children requires making children a priority in all policies.[151] According to a study conducted by New Mexico Voices for Children, "families with the lowest incomes pay the highest rates in state and local taxes."[152] Research demonstrates the negative impacts of family economic insecurity, food scarcity, substance abuse, mental illness, and teen pregnancy on child health.[153] Additionally, social disruption and adversity in childhood can result in lifelong physical and mental illness, including obesity, diabetes, smoking, drug use, depression, and cardiovascular disease.

Achieving child health equity requires New Mexico to expand beyond health care in order to address the social determinants of health. Children's health is rooted in the social, economic, and environmental context in which they live. Research demonstrates that improving population health and achieving health equity will require broader approaches that address social, economic, and environmental factors that influence health. The World Health Organization report on social determinants of health concludes that the health equity gap can be closed within a generation by focusing on the social determinants of health as well as access to health care for children.[154]

In order to achieve health equity, social resources must be available to all children and families in New Mexico. Thus, local, state, and tribal policymakers should address the social determinants of health, make children a priority in all policies, and consider the development of a "children's agenda" and adoption of a statewide campaign calling for a Better New Mexico.

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APPENDIX A: RESEARCH METHODS

Census data and mapping

One of the goals of this study is to monitor and track the progress of implementing the ACA in New Mexico and its impact on vulnerable children and families by race, ethnicity, and geography. Since no profiles exist of data at the sub-state level on children's coverage, the University of New Mexico team worked with the UNM Geospatial and Population Studies unit to extract county-level data from the U.S. Census into Excel data files, and to create chart packs and maps. The maps were developed by the Center for Education Policy Research and created in Tableau for public data use at:

https://public.tableau.com/profile/center.for.education.policy.research.university.of.new.mexico#!/vizhome/NewMexicoChildrenandHealthInsuranceCoverage_0/NewMexicoChildrenandHealthInsurancebyCounty

Data sources include:

American Community Survey (ACS), 2009-2013 five-year estimates

The ACS is an extensive annual statistical survey conducted by the U.S. Census Bureau. The ACS, which is sent to approximately 3.5 million U.S. households each year, contains questions previously asked in the long form of the decennial census, including questions about household member demographics, health insurance coverage, and household income. The ACS is currently available in one-year and five-year estimates. The five-year estimates are more stable and reliable than the one-year estimates, although the one-year estimates are more timely. Five-year estimates are used in this presentation.

ACS Public Microdata Sample (PUMS), 2013

The American Community Survey (ACS) Public Microdata Sample (PUMS) file contains a sample of untabulated record-level survey data about housing units and individuals within those housing units obtained through the American Community Survey. PUMS files allow data users to create custom tables not pre-tabulated by the U.S. Census Bureau. For example, in the ACS, insurance coverage by nativity and by household income is only available for all ages combined. The PUMS data allows for cross-tabulating children's health insurance coverage by nativity, as well as children's health insurance coverage by household income.

In this study, the 2013 PUMS estimates were used for children's insurance coverage by nativity and by household income. Five-year estimates are available for 2009 to 2013, but they were not used here due to changing New Mexico PUMS geographies during the period. Due to small sample sizes and large margins of error, PUMS data should be used with caution.

PUMS Margin of Error

Margin of Error (MOE) describes how close an estimate is to the true population value. Variability is primarily attributed to differences in samples. MOEs are expressed as the percent above or below an estimate that the true value could take. Ninety-percent margins of error were computed using the generalized variance method for health insurance described by PUMS Accuracy of the Data (2014).

Interpreting the Margin of Error

In the uninsured estimates by household income table below the margins of errors show the variation in which true values can occur. For example, the estimat-

ed percent of uninsured children in households in the Albuquerque PUMA with less than $25,000 household income is 9.4 percent. With a margin of error at +/- 8.5 percent, the actual percentage of uninsured children in households with less than $25,000 can range anywhere from 0.9 percent to 17.9 percent.

Interviews

We conducted semi-structured interviews with 55 key informants in person and via telephone to gather their perspectives and experiences with implementing the ACA in New Mexico. Enrollers, community health workers, health council coordinators, government officials, policymakers, hospital administrators, insurance providers/carriers, advocates and others involved in implementing the ACA participated in a 50-minute to one-hour interview between February and May 2016. The interview guide drew from the literature review and was designed to elicit information regarding roles in implementation; the ACA; health equity provisions and children; successes and challenges in implementation (design, governance, process); leadership and partnership; immigration provisions; and solutions to identified problems. The Con Alma ACA project team had input to the interview guide and the UNM team piloted the guide. The Human Research Review Committee, Human Research Protections Office, UNM Health Sciences Center approved the research design and interview methodology (HRRC#16-072).

Stakeholder mapping and sampling

From October through November 2015, Con Alma staff and consultants worked with the UNM team to map the key stakeholders involved with the implementation of the ACA in New Mexico. The UNM team created additional sampling lists from publicly available documents including the NMHIX contracts' database, which includes reports of the contract schedules from January 20, 2013 to January 31, 2016. A final sampling list was developed in a deliberate effort to gain a representative sample or subset of stakeholders in the state who have diverse roles in implementing the ACA and whose work is with diverse geographic regions .

Data collection and analysis

We recruited participants through an email invitation describing the study and conditions for interviewing. Once a participant agreed to be interviewed, an appointment was set up and a written consent and socio-demographic form were administered during the interview. We digitally recorded the interviews on a Mac/Yeti USB devise, and transcribed that material into text files that were de-identified and stored electronically in a password-protected computer database. The textual data from the transcribed interview notes (de-identified) were entered into the NVivo 10 software. (QSR International, 2012). NVivo software was used to code the data, first by questions and then to aid in the further coding of data into new themes. Two types of coding were used. First, "open coding" was used to locate the major themes raised by responses to questions. This was followed by "focused coding" across geographies, to determine which themes were repeated often and which ones were unique outliers.

Once the major themes and interpretations from the qualitative interviews were identified, the team consolidated these into a summary report and then com-

pared/contrasted that to the findings from the literature review, policy scan/analysis, side-by-side analysis of the equity provisions, data, and mapping of insurance coverage. This triangulation of data findings is a technique to enhance the validity and rigor of this research design.

Geographic, demographic and sector profile of participant stakeholders

The following geographic areas in New Mexico were represented in the final sample: Northern New Mexico — Taos, Rio Arriba, Union, Colfax, and Santa Fe counties; Central — Bernalillo, Valencia, and Sandoval counties; Eastern — Chavez, Roosevelt, and Quay counties; and Southern — Catron, Luna, Sierra, Otero, Dona Ana, Grant, and Hidalgo counties. The majority of participants reported that their sector affiliation is with nonprofit organizations (29), followed by federal, state, tribal, or county government (18); health councils (14); insurance enroller/navigator (14); community (13); schools (7); community health centers (7); hospitals (5); and legal advocacy/law (5). Fewer reported affiliation with insurance providers/managed care organizations (4); the business sector (4); and foundations (2).

The majority of participants were between the ages of 31-45 (40 percent) and 46-65 (41.8 percent); 7.3 percent were between 18 and 30, and six (or 10.9 percent) were over age 66. Most of the participants were female (76.4 percent, n=42); 21.8 percent were male (12); and one (1.8 percent) participant self-identified as gender non-conforming. The demographic form gave participants the option of selecting multiple race categories and ethnic identity, including no response. Of the participants, 56.4 percent self-reported as non-Hispanic White; 3.6 percent as African American; 9.1 percent as mixed race; 3.6 percent as American Indian/Alaskan Native; and 18.2 percent as other. Of the ethnicity self-identifier, 21.8 percent reported Hispanic and 16.4 percent reported Latino/Chicano/Mestizo. When asked, "What is the last grade in school that you completed?" the majority of participants had graduate or post-graduate education (49.1 percent); 29.1 percent had a bachelors degree; 10.9 percent attended a junior college; 3.6 percent studied at a technical school; and 1.8 percent had a high school diploma. Almost three-fourths of the participants spoke either English only (42.4 percent) or primarily English (28.8 percent), followed by bilingual (English/Spanish) at 13.6 percent. Only 5.1 percent reported speaking a language in addition to English.

CON ALMA HEALTH FOUNDATION

The Heart & Soul of Health in New Mexico

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