

MINUTES
of the
SECOND MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

July 18, 2007 — New Mexico Highlands University, Las Vegas, New Mexico
July 19-20, 2007 — Taos Convention Center, Taos, New Mexico

The second meeting of the Legislative Health and Human Services Committee was called to order by Senator Dede Feldman, chair, on Wednesday, July 18, 2007, at 1:20 p.m. at New Mexico Highlands University in Las Vegas, New Mexico.

Present

Sen. Dede Feldman, Chair
Rep. Danice Picraux, Vice Chair (7/18)
Sen. Rod Adair (7/19, 7/20)
Rep. Keith J. Gardner (7/19, 7/20)
Rep. Joni Marie Gutierrez
Sen. Steve Komadina (7/18, 7/19)
Sen. Mary Kay Papen
Rep. Gloria C. Vaughn

Absent

Advisory Members

Rep. Ray Begaye
Rep. Nora Espinoza
Rep. Daniel R. Foley
Rep. Miguel P. Garcia
Rep. Roberto "Bobby" J. Gonzales
Rep. John A. Heaton
Sen. Gay G. Kernan
Rep. Rick Miera
Sen. Gerald Ortiz y Pino
Rep. Jeff Steinborn (7/20)
Rep. Mimi Stewart
Sen. David Ulibarri

Sen. Sue Wilson Beffort
Rep. Jose A. Campos
Sen. Clinton D. Harden, Jr.
Sen. Timothy Z. Jennings
Sen. Linda M. Lopez
Rep. Antonio Lujan
Rep. James Roger Madalena
Rep. Luciano "Lucky" Varela

(Attendance dates are noted for those members not present for the entire meeting.)

Staff

Raul Burciaga
Beverly Jimmerson
Jennie Lusk
Tim Crawford

Wednesday, July 18

Senator Feldman opened the meeting by addressing the audience and explaining a form that has been developed for public comment on the Mathematica report. She reminded everyone that the Legislative Health and Human Services Committee (LHHS) will not be hearing funding requests this year, as they are referred to the Legislative Finance Committee (LFC). The LFC contact is Robin Shaya.

Regarding the committee's afternoon agenda and public testimony, the chair clarified that the committee would hear from proponents of each plan, but that the models are not exactly what Mathematica studied. The Mathematica modeling required certain assumptions in order to make comparisons using a common baseline. The chair then offered a summary of the Health Partnership Act, referenced in the last committee meeting. The act, introduced by Senator Jeff Bingaman, would enable states like New Mexico to increase health coverage through grants. He endorsed the concept of individual state action. Representative Begaye commented that it would be important for the governor's staff to attend LHHS meetings. Senator Feldman expressed the committee's appreciation that Mike Batte, commissioner of insurance, and Rubyann Esquibel from the Human Services Department (HSD) were in attendance.

Other States' Health Care Reform Efforts

Laura Tobler from the National Conference of State Legislatures (NCSL) gave an overview on other state health care reform strategies to cover the uninsured and to improve care and outcomes, after giving an overview of national and state expenditures and pointing out that New Mexico's uninsured rate is higher than the national average. California, Minnesota, Illinois and Pennsylvania are working on universal model initiatives, as are Kansas and Colorado. Ms. Tobler said all of the models address four main topics, all of which have a concurrent focus on cost: (1) reduce the number of uninsured; (2) focus on quality initiatives; (3) focus on appropriate care for people with chronic diseases; and (4) focus on prevention and wellness initiatives.

Reducing Uninsured

Some states are addressing changes to the existing market, called "Exchanges" or "Connectors". Massachusetts uses a quasi-governmental connector, run by a multidisciplinary board, to answer the question, "What is affordable coverage?" It has worked with insurers to develop a plan that costs under \$200 per month. Washington state is working on a similar, though employer-based, model. Rhode Island and Missouri use a "cafeteria" plan that allows buy-in with pretax dollars. Massachusetts merged the small and individual markets for its insurance reform and mandated insurance coverage. However, a waiver is offered if insurance costs are 6% or more of income. Massachusetts is monitoring coverage through its state income tax and is considering other methods such as driver license renewal for enforcement. Hawaii is the only state with a waiver under the federal ERISA statute, since its program was adopted before ERISA became effective in 1974. Under ERISA, states are limited in the ways they may intervene in insurance matters for multistate employers. Massachusetts imposed a low

assessment to get buy-in for health coverage, and will charge every employer that does not offer health care \$295 per year. Vermont is doing the same at \$395 per year, hoping that the penalty is so low it will survive a challenge under ERISA. Six states are considering involving the employer through a payroll tax, but Ms. Tobler opined that a payroll tax is a risky method, since one case has found such a tax to be an illegal "influence" on multistate employer insurance. Ms. Tobler recommended Pat Butler, a consultant, as the nation's best expert on health benefits and ERISA.

Some states are attempting strategies to help small employers. For example, Montana has a tobacco tax to subsidize health insurance; Healthy New York Reinsurance Program targets small business; and Cover Tennessee is subsidized with public funds. States such as New Mexico have looked at insurance coverage with state help, but found they were not getting sufficient enrollment. Because young adults (19-30) are the fastest-growing population of the uninsured, a widely used strategy is to keep children on their parents' insurance. New Jersey allows children to remain on their parents' policies up to age 30, but many states have found that parents consider this method too expensive. Every state is attempting to leverage SCHIP dollars as high as possible in order to cover more poor people. Massachusetts has gone up to 400% of the federal poverty level (FPL) for children. Some states have tried to increase choice through "Consumer Directed Health Care" (CDHC) — health savings accounts high deductible health plans, but Ms. Tobler recommended against these methods because they are not effective in reducing the number of uninsured significantly, despite the fact that six states have passed laws focused on these methods. Pennsylvania has designed a broad-based reform plan, but passed bills that institute the plan incrementally, a tactic Ms. Tobler approved.

Focus on Quality Initiatives

Ms. Tobler emphasized the need to focus on quality and to focus outcomes in order to yield lower costs. She offered to be a resource on these initiatives and suggested that New Mexico legislators examine Minnesota and Maine reforms.

Focus on Management of Chronic Disease

Ms. Tobler reminded committee members that 5% of the population constitutes the greatest expense, and 10% of the sickest account for 65% of expenses. Vermont worked with Ken Thorpe, a consultant on chronic disease management programs, on ways to lay out a plan that includes all providers and that makes chronic disease management a statewide priority. The state has a chronic disease grant program for local communities to work for dollars, and NCSL believes chronic disease management can have a significant impact on communities. The Vermont bill, "BluePrint for Health", is on the web.

Focus on Prevention and Wellness

In the past, prevention or wellness programs were simply administered by state health departments with legislative appropriations. Now, legislators are seeking ways to

encourage the private market and employers to be involved in wellness. States are using incremental legislation to decrease disease. Wellness programs involve personal responsibility, and many states offer incentives to encourage Medicaid clients to quit smoking or lose weight. Kentucky has set up an account for health-related services not otherwise covered. West Virginia is taking away benefits from Medicaid recipients if they do not take preventive steps to improve their health. In Rhode Island, "WellCare" focuses on evidence-based care in the most appropriate setting.

Access to Services

A major problem to states is dealing with access to services. Pennsylvania has talked about changing the scope of practice for nurse practitioners and is also looking at doctors, nurses and physician assistants. Community Health Centers (formally known as Federally Qualified Health Centers, or FQHCs) have been a real success. Some are self-sustaining for their other revenue or costs. Indiana and Nebraska use tobacco settlement funds to support the centers. California, Colorado, Wisconsin and Washington earmark a portion of tobacco taxes. New Jersey uses a hospital assessment fund for support of FQHCs.

There are many challenges to resolving problems of access to services. The lack of doctors in rural areas has caused 45 states to create loan repayment programs for doctors, encouraging them to practice. Some of those states pay more than others. Washington will help develop marketing plans to get people to become doctors there. Transportation is a huge problem in rural areas, especially for chronic disease. Minnesota has prioritized people on Medicaid, such as those who need to get to a dialysis center, in order to resolve the transportation problem. Affordability is a challenge as well. Access to records can be difficult, and a movement emphasizing coordination of information is beginning, though much information technology generally available has not been integrated into the health reform discussion.

Incentives drive the system, Ms. Tobler said. Purchasing pools as a whole do not work. They may work for administrative efficiency, for state expense or for administrative costs; otherwise, purchasing pools alone are not successful strategies. Purchasing pools *plus* a mandate is better. The most successful pool, in California, was in existence for 14 years until it closed recently because it was not getting the enrollment to keep it open. States that have been working toward reform for a long time are better at getting things done with bipartisan efforts. Ms. Tobler also stressed that incremental change is the best approach because small changes are easier to get through committees and signed.

The chair recognized Ms. Esquibel from HSD for information on New Mexico enrollment in available programs. Ms. Esquibel stated that for the State Employee Insurance Program (SEIP), there are about 6,000 enrollees (in part because crowd-out provisions are part of the equation) and that, thus far, there is no critical mass to create

the pool of enrollees. People who enroll for the SEIP are moved into New Mexico State Coverage Program (SCI).

University of New Mexico — Health Policy Institute

Deborah McFarland and Carlos Cisneros from the New Mexico Health Policy Center, created by a Robert Wood Johnson Foundation award of \$18.5 million to New Mexico, spoke to committee members about the new foundation center. The donation that created the center is the largest gift made by the foundation to a university. The funders' goal was to fund an Hispanic university with a Ph.D. program and a medical school. As Latinos are very underrepresented in New Mexico and in health policy, the foundation is planning to prepare students and professionals who will participate at the national level. Such representation will change national discussion about health disparities. The foundation has currently funded nine students and nine or 10 projects. The first doctoral candidates have just begun their programs. The center may be useful for legislative proposals and exploring issues. The center is designed to be national center, able to recruit underrepresented students who want an interdisciplinary degree in health sciences.

Health Security Act

Mary Feldblum, executive director, Health Security for New Mexicans Campaign, stated that 128 organizations and 25 cities and counties passed resolutions in support of the Health Security Act, one of three health coverage proposals analyzed in the Mathematica study. She explained the process for developing the proposal: in the past two-and-a-half years, her organization conducted over 600 presentations and workshops to ask what the health plan should look like and how to deal with rural and provider issues. Dr. Feldblum suggested there are three choices for single payer insurance: a single payer bill passed both houses in California, but was vetoed by Governor Schwarzenegger; a self-insurance pool of persons under 65 in Wisconsin is being considered by that state's Senate; and in New Mexico, the model being considered is more like a co-op. She stated the Health Security Act (HSA) is New Mexico's homegrown, homespun system. It would cover almost all persons except federal and military employees and tribes. Approximately 1.6 million New Mexicans would be in the health risk pool with freedom to choose a doctor and hospital, including across state lines. In any new plan that includes state employees, services can be no less than what is offered; therefore, HSA will include current benefits at a minimum.

The HSA would be administered by a commission that includes consumers and providers from around the state. It would not have to go through state personnel or state procurement, but records and books would be subject to scrutiny. The HSA would be funded by existing state dollars. Counties would decide how to use their indigent funds. Premiums would be based on income up to a cap and would cover auto insurance and workers' compensation. The employer contribution would also be capped. Legislation

would need to provide for a phased approach, including an analysis of cost as the first step.

Health Choices Plan

Celia Ameline, representing New Mexico Health Choices, described the Health Choice Plan.

To fix the private insurance market and to make it a better, more affordable market, Ms. Ameline recommended creating a large purchasing pool (called "the Alliance") with a mix of personal dollars, government dollars and employer contributions. All programs would meet the minimum for state participation and all participants would have a choice of benefits and providers and the option to purchase expanded benefits.

For Version 1, developed in 2005, vouchers for low-income families were included, but the plan was considered too problematic. (All further notes refer to Version 2.)

Version 2 requires less public funding and a greater role for employers. It has a neutral impact on employers and employees; funding comes mostly from public funds and mandated basic adult coverage, with a small portion comes from voluntary spending (i.e., upgraded coverage). Estimated employer responsibility would be \$210-\$260 per month per full-time employee. The estimated employee cost is \$40.00-\$60.00 per month.

The Health Choices Plan avoids ERISA issues, encourages consumer responsibility and uses health information technology efficiencies to incorporate administrative savings for the Alliance and for providers. The plan provides guaranteed coverage and community rating. Now, high-risk participants pay more and low-risk participants pay less. With Version 2, everyone would have to be insured at the same rate.

Health Coverage Plan

Mr. Burciaga briefly described the history of the Health Coverage for New Mexicans Committee (HCNM), the third plan studied by the Mathematica consultants. He explained that the Health Coverage Plan would increase coverage eligibility to 300% of FPL and employers would be required to make a "fair-share" payment for each employee if they do not offer a health insurance plan.

Overview of Study Conducted by Mathematica Policy Research, Inc.

Mr. Burciaga gave the audience a brief summary of the Mathematica study.

Public Comment

Carol Pierson spoke about the changes in England when that country changed to universal health care and stated that everyone's fears were resolved positively within a year of England's shift to universal care.

Dr. Robert Pierson said that everyone should have health care regardless of preexisting conditions. Care should be driven by service and needs, not for profit. He stated that in Medicare, costs are 3-4% of the total bill.

Lee Ina stated he was in the movie "Sicko" as a health care whistleblower and expressed impatience at the state's doing more studies. According to him, Mathematica is saying the same thing people already know: HSA, or universal health, will save money; and one cannot reform health care with a profit motive in the mix.

Pat Lehan explained her background as a social worker currently at New Mexico Highlands University and as executive director of the Peace and Justice Center in Las Vegas. She is uninsured and wants a model on a co-op plan like HSA. Ms. Lehan lived in Belgium for five years and there, when something went wrong, one went to the doctor and got incredible care, she said. She supports a plan that is universal, culturally appropriate and comprehensive.

Terry Riley stated that he went to a recent Health Care for All meeting at Unitarian Church, a standing-room-only meeting of approximately 200 people. The group discussed a summary of the Mathematica report. Mr. Riley stated that 27% of the health care expenses in New Mexico go to health insurance companies, but Medicare administrative costs constitute only 2.8%. He considers the discussion to be not only about the uninsured, but also about those with insurance whose lives have been endangered or shortened by for-profit insurance company decisions.

George Boersig, a Bernalillo resident, stated that common sense says HSA is the best choice because it has the lowest cost and an independent governing board; consolidates programs; covers all New Mexicans, including homeless persons and the unemployed; and creates a single risk pool. Such a plan will reduce expenditures by billions of dollars.

Charlotte Roybal is among those who are traveling throughout the state to community forums about health care for all. She said selecting a health plan is important for people. She stated that Mathematica did not cover health care delivery but instead reported on costs. She said there is still work to do. She expressed several principles that must be incorporated: universal coverage requires universal oversight; and there is need for accountability, transparency about profits and oversight of the insurance industry. In the short term, 52% of people eligible to be enrolled are not enrolled, so the enrollment process is not user friendly. She suggested getting rid of autoclosure and looking into an

auto-enrollment system. Finally, she encouraged the committee to look at the ideas in Oregon's SB 329.

The meeting recessed at 7:30 p.m.

Thursday, July 19

Behavioral Health Background

Senator Feldman and Mr. Burciaga briefly reviewed the state's history in selecting and administering a behavioral health program. Senator Feldman reminded committee members that the committee had held hearings for approximately two years before making a change in 1999, attempting to address issues such as the closure of residential treatment centers and juveniles who were not getting treatment. The committee brought in experts from the Bazelon Center for Mental Health Law and from Colorado's county-based mental health programs, among many others. Senator Jeff Bingaman and Representative Heather Wilson got involved and the federal Centers for Medicare and Medicaid Services (CMS) finally acceded to the state's request to withdraw behavioral health services from the waiver and managed care model. Administrative costs, which had run as high as 75% would now be limited to 18%. At that point, the administration changed in Washington. When the Richardson administration came in, the New Mexico governor assigned a "GAP" analysis to determine where health care needed to be improved. The result was that it became painfully obvious that there is very little health care in rural communities. There was no coordination of services statewide, so the behavioral health collaboratives came into being as experts in local resources. For juveniles, correctional facilities were virtually the only facilities where adequate mental health services were provided for children. Much has changed. The process has been bipartisan.

Programmatic Efforts for Behavioral Health in New Mexico

Deputy Secretary Katie Falls and the new "behavioral health czar", Linda Roebuck, both of the Human Services Department (HSD), outlined new program efforts to address behavioral health issues. Ms. Roebuck outlined several priorities of the department, among them children, adolescent transition, children's services purchasing, consumer-driven services, an anti-stigma and a wellness campaign for those with behavioral health needs, family involvement, substance abuse (to be added to the department's Medicaid plan in the fall), transportation, tribal involvement, teen suicide rates, the problem with having jail-based crisis management, post traumatic stress disorder (PTSD) and aging.

The czar discussed the children's clinical home pilot for residential care referrals, attempting the to stop overuse of residential care. There was a lack of continuity for child care for children with behavioral health referrals, and services were delivered across systems. With pilot sites now in place for the transition from detention facilities, some 10 providers are expanding to include children returning from residential care. A

clinical home promotes family involvement, continuity of care and crosses departmental systems. Currently 100 children have been assigned a clinical home, and the department anticipates having data on the pilot programs in time for the next legislative session.

This year, \$570,000 was appropriated for a pilot PTSD project serving returning military personnel and their families, including those in the National Guard. HSD is working with Bob Mayer on telehealth services to help expand this project, which is located in Sandoval County.

Committee members asked a battery of questions, including the plan for expanding services for returning veterans to other counties, coverage of all adults on Medicaid through 100% of the federal poverty level and consequently adding another 20,000 persons to the Medicaid rolls in the current year and reasons for starting pilot projects in select cities rather than rolling them out simultaneously in several cities.

Ms. Roebuck said HSD is working with ValuOptions to address areas of concern with a focus on persons in a "special relationship" with the state, such as children in state custody. Senator Komadina asked that Ms. Roebuck send the committee further information on the six areas of concern. In response to another of his questions, Pam Galbraith of Value Options said that, by contract, ValuOptions is able to make 15% for "overhead" the second year, and a percent less per subsequent year. However, for large federal grants, there is no administration fee, and for special appropriations, no administrative fee is allowed. Ms. Galbraith said she would send the performance information on profit or administrative fees to the committee for the first two years. Further, there is a fee-for-service fee of \$5.00 per member per month. She added that ValuOptions buys some services from its parent company because it is cost-effective to do so. The ValuOptions staffer said she would send each committee member a list of providers in the member's local area, what was paid to each and some information on each local collaborative.

In response to a question from Senator Feldman, Ms. Galbraith said that she would find the amount of the total ValuOptions contract with the state at present and send it to committee members. When asked about billing, Ms. Roebuck said that she needs to do more work on the issue before presenting to behavioral health collaboratives in August and would get back to the committee with requested information about which medicines are charged to the health care provider and which to a health plan.

Senator Ortiz y Pino asked several questions about items included as "enhanced" services and those that are not. Staff explained that children's services are "enhanced" because they have now been amended into the state plan; thus, every Medicaid-eligible child can get services, and there is extra state money available over and above the Medicaid dollars available if there is a gap. Enhanced services are not entitlements, Ms. Roebuck explained. Most other states include substance abuse within a Medicaid plan,

but thus far New Mexico does not. The department is adding mental health into the state plan by amendment. Asked by Representative Heaton about a service plan for family members in crisis, Ms. Roebuck said she would need to come back with an answer.

Other questions dealt with school-based health services versus confidentiality; uncompensated care; the administration of the Los Lunas complex, which ValuOptions will manage; and New Mexico's being fifty-first in the country on mental health spending after Guam. The department still does not know how much per capita is spent on mental health care.

Problems and Suggestions for Native American Mental Health Delivery

Teresa Gomez, deputy secretary of the Indian affairs, introduced the committee to the six principles agreed upon by the Behavioral Health Planning Council for any Indian health delivery system. The deputy secretary is head of the Native American Subcommittee of the Behavioral Health Planning Council, a permanent venue for tribes to have their behavioral health needs addressed. There are six behavioral health regions, with one entirely for Native American behavioral health. A local Native American Behavioral Collaborative Department holds monthly meetings, so there is a permanent forum for addressing such issues.

Deputy Secretary Gomez said that Native Americans are at higher risk for mental disorders than any other group in the country, with a higher percentage of domestic violence, trauma and substance abuse. The Indian Health Service (IHS) has limited emergency help available for behavioral health, but it is not well-funded. Some tribes lack a full-time licensed counselor on site and have no physical infrastructure for providing care, so they seek help off the reservation.

The priorities are to contract with the Native American Health Center at the University of New Mexico; be culturally competent; offer comprehensive services; improve workforce development so that well-trained licensed practitioners are available; and offer a quality management system.

Representative Begaye raised several disputes over Navajo personnel at the Indian affairs Department and suggested that the deputy secretary report to the secretary of Indian affairs that some legislators suspect that the department is biased against Navajo people. He questioned how many residential treatment facilities are available for tribal people and was told there are three and that there are three residential care facilities. He expressed concern about tobacco money for the Ramah Navajo Chapter. Senator Feldman said that the committee will have a full day on managed care as a model, studying the effectiveness of ValuOptions, along with other managed care corporations such as Molina, Lovelace and Presbyterian.

Gaps in the Behavioral Health System

Nancy Koenigsberg, legal director of Protection and Advocacy, a federally funded nonprofit for people with disabilities, appeared before the committee to bring forward some real-life examples of problems that occur when the behavioral health system does not work. She said her organization, whose goal is to protect and promote the rights of people with disabilities in New Mexico, emphasizes the importance of doing no harm as an absolute minimum for a health care provider. She said that Ms. Roebuck neglected to mention what happens during transitions between modes of service for people with disabilities.

She described a client from Senator Kernan's area who had urgent mental health needs but could not be seen for six weeks; the woman moved to another state where she could be helped. Another client with developmental disabilities and mental health issues was caught up in the legal system. When staff tried to review his provider's records to decide which sort of supports or punishments would make sense for him, the records were so poor that they were not usable. When Protection and Advocacy complained to ValuOptions about the provider, it was told that there were few providers in the area, so the company gave the provider "leeway". Another client from the southern part of state would be eligible for SSI if she could get in for an evaluation. However, there was a lengthy wait for such an evaluation. The only way the client was able to get an evaluation was to go to Albuquerque and get a "back alley" service, put her papers together and then get presumptive eligibility.

Ms. Koenigsberg emphasized that these clients are people with the wherewithal to ask for help and therefore represent only the tip of the iceberg of those who need services. The organization deals with such problems all the time — with evaluations, short-term treatment and crisis response — but in large systems, it is difficult to translate service into action. People are struggling. Residential services for children are disappearing, yet there are few options to hospitalization. It is true that hospitalization should be rarely used, but hospital care should not be shut down without alternatives in place.

Last session when the legislature considered Kendra's Law mandating treatment, there were three recommendations from those who have had personal experience with the problems of care for a loved one: (1) continuum of care focused on resiliency where the person is seen as a community member rather than as a person with a psychiatric illness; (2) better crisis intervention from teams of peer specialists rather than from police with guns; and (3) funding for alternatives to hospitalization — ideally, a home-like setting staffed by a peer support specialist with clinical backup. For her last point, Ms. Koenigsberg emphasized the history and context of management and oversight of the Interagency Health Purchasing Collaborative. She said ValuOptions was in New Mexico before and New Mexico did not have a good experience with it. When ValuOptions won the current contract, many people were concerned since they had been burned once. Ms.

Koenigsberg suggested that it is necessary to have a stringent oversight mechanism to see where state dollars are used and whether the state is getting the services for which it asked and paid.

Representative Varela sponsored and the legislature passed an oversight bill for collaboratives last session, but it was vetoed, ostensibly over appointments of legislators to the oversight group, which was seen as a separation of powers issue. Ms. Koenigsberg strongly urged committee members to take up that baton again, since oversight is critical. She said that the group does not want to resort to lawsuits when careful oversight could be effective in solving problems. She noted that Protection and Advocacy filed suit in mid-March to stop a cut in services that have caused recipients not to get what the law requires: notice and an opportunity to be heard.

She expressed concern that residential treatment services were cut drastically in 2006 and that the marked increase in denial of services without hearings or an opportunity to be heard for those who would lose residential services would be a similar violation that may require suit. She said the collaborative urged the committee to take care not to undo the system that has been created — at least not until a new one is fully in place.

Issues Concerning Behavioral Health

Peter Cubra, Mary Dale Wilson and Sarah Couch introduced themselves to the committee as representatives of the Bernalillo County Behavioral Health Collaborative. Mr. Cubra opened, describing the current system as "very disturbing". His primary concern is that ValuOptions has all but eliminated residential treatment for children without putting in place a comprehensive system of community providers, leaving some children who need care with nothing. Mr. Cubra and the others had spoken with ValuOptions about the fact that the system was not adequately funded and talked about reducing residential care for children. However, as of December 23, 2006, Mr. Cubra said, ValuOptions changed the rules, without a hearing or opportunity for comment, and began denying residential care for children. Both the substantive problem of improper care management and the procedural problem of changing rules without notice to the public and an opportunity to be heard are at issue.

Children are in emergency shelters rather than in treatment, according to Mr. Cubra. He said that admissions to residential treatment for children are being denied even though an effective community placement system is not in place. "We are harming children," he said, "and we invite you to do something about it."

He reported that children's court judges in Santa Fe, Albuquerque, Las Cruces and Farmington have told him they cannot get children into residential treatment and, therefore, are no longer even trying to gain the children's admission. He said that the HSD knew months before terminating residential treatment options that children needed alternate plans prior to making a major change, but that the department chose not to develop a proper system.

There is a problem in defining "enhanced services" as including residential treatment for children, since anyone under 21 receives services needed to correct or ameliorate behavioral health problems irrespective of whether the service is listed in the state's Medicaid plan. Congress made it possible in 1989 for states to include care for children in their care plans, even if such services were not expressly listed in a Medicaid plan.

Ms. Couch said that the Bernalillo collaborative has made the creation of a single comprehensive system its top legislative priority. Ms. Wilson and the other two presenters noted that the strength of the collaborative system is that many diverse voices come together to analyze gaps in services and needs for better behavioral health care.

The Bernalillo County collaborative has made plans to create an umbrella plan for an effective behavioral health system. Thus far, Albuquerque Public Schools has agreed to participate, as has the Bernalillo County Health Council and an off-reservation affiliation of Native American persons living in urban areas. The Veterans Administration appears likely to join in the pilot project. Plans for the behavioral health collaborative project would shift the \$80 million currently being spent in the area on behavioral health services made available through ValuOptions to other providers, they said, noting that the state dollars allocated to behavioral health in Bernalillo County are not integrated. Although 167,000 residents of the area are reported to need behavioral health services, only 18,000 received services in 2002.

Ms. Galbraith denied that there is a pattern of deliberate denial of residential care in order to preserve resources for the ValuOptions. She said that the pattern of denials does not indicate that residential care was terminated hastily, as she reviewed statistics showing that in 61 requests, only nine were denied. However, her numbers do not include the months just after the closure that Mr. Cubra mentioned. Discussion followed on denials for care, and Ms. Galbraith promised to provide the committee with information on how many denials were overturned on appeal as a full set of comparative statistics on the use of residential treatment.

Legislators inquired about the \$27 million request and about the structure and purpose of the local collaborative. They were told the sum would be required in addition to what the University of New Mexico and Veterans Administration are already getting, but that the collaborative currently receives no funds. Money could be appropriated to Bernalillo County through the Local Government Division of the Department of Finance and Administration rather than through ValuOptions. The collaborative involves stakeholders, state staffers and individual members of the public in structuring and overseeing a system of care for people with behavioral health needs. The problem with closing access to residential treatment is not only that the system needs high-intensity services but that the department appears to be making a change in rules governing behavioral health care without going into a period of public notice or comment.

Dick Minzner and some of his clients testified that the single decision ValuOptions is supposed to make on residential care is whether or not such treatment is medically

necessary, not whether the system should include residential care at all. He testified that, at one point, virtually 100% of referrals to residential treatment were found medically necessary and then "practically overnight" after December 22, 2006, there seemed to be no medical necessity, even though the source of referrals remained constant. Early terminations of services at facilities resulted from the departmental decisions against approving residential treatment; some eligibility has been terminated even though treatment teams have not recommended termination.

Two of Mr. Minzner's clients testified and described the impact of the denials of eligibility for residential treatment. The patient load reduction in one case resulted in the loss of 47 full-time positions; in another location, only six of 20 residential beds are occupied.

Public Comment on Behavioral Health

Carlos Miera, executive director of the Tricounty Community Services, which provides comprehensive mental health services to Taos, Colfax and Union counties, said that his organization has an eight-bed substance abuse treatment center and social detoxification as well as providing an extensive network of outreach and support. While his agency has worked hard to develop a model program, he said, a lack of funding resulting from the shift of \$900,000 from the northern to the southern part of the state resulted in a cut of \$160,000 to the agency. Services are being cut even though demand is increasing. The agency has exhausted all of its reserves and is on the brink of bankruptcy. If faced with closure, his recommendation is likely to be to close the detoxification center, although the county hospitals would be affected by such a decision. The agency keeps an open caseload of 800 patients, and sees 175 clients per week. Asked by committee members what ValuOptions is doing about the situation, Ms. Galbraith said that ValuOptions is now trying to determine how to save the program, even though the Department of Health determined how much each center would be allotted. Ms. Falls said that the department will submit an expansion request for behavioral health services.

Ben Tafoya, executive director of Hoy Recovery in Espanola, testified that clinics need adequate technical assistance on how to respond to changing standards, as he noted that heroin use is hitting the middle class. There is a problem in small communities such as Espanola where treatment really requires moving the user away from a toxic home environment, where some people will never be successful without getting away from their communities.

Public Comment on Health Care Reform

Dr. Michael Kaufman testified that he has practiced internal medicine in Taos for 30 years. The Taos Community Health Plan and the New Mexico Medical Society have developed a set of principles to apply to health care reform, including these:

- (1) coverage should be universal and continuous;
- (2) any benefit plan should include behavioral health;

- (3) the system should include care that is both equitable and affordable;
- (4) coverage should be overseen by an accountable agency; and
- (5) the plan should be sustainable, emphasizing self-responsibility.

Critical components of a successful plan would be that the care is timely and efficient and that the care be patient-centered.

Mark Chacon from Rodarte, New Mexico, noted that five million persons have joined the ranks of the uninsured since the year 2000 and that a doctor from Taos can make \$100,000 a year more merely by moving to Texas.

Pamela Parker, a survivor of breast cancer who owns her own business, said that her medical bill is now \$1,500 per month since her cancer. Although she has had health care, she cannot go elsewhere without losing coverage.

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Health Care Access in Rural Areas

Ken Spellman, chief executive officer of Holy Cross Hospital, discussed the difficulties of effectively running a hospital in a rural area, even one as desirable as Taos. The hospital nearly closed several times, but was saved through passage of a county-bond issue. Taos was the first city in New Mexico to build a new hospital, and a good facility is essential to attract providers. Retaining providers is difficult at private not-for-profit hospitals, which are leased from the county, since for-profit hospital recruiters are in constant competition. There is a trend for hospitals to hire physicians on staff, but such a decision comes with the problem that liability claims are capped for doctors in private practice, but not for hospitals.

Dan Weaks discussed the need to increase nursing training immediately, as the Higher Education Department has "dropped the ball" on training, despite generous appropriations. He said it is "nonsense" to tolerate a response from the Higher Education Department that it is "making progress" rather than solving the problem. Without the infrastructure for nursing, hospitals cannot support physicians. The problem lies with the educational bureaucracy.

Mr. Weaks raised several other problems: Medicaid and Medicare reimbursement rates are less than costs; automatically closing Medicaid files at the same time as doing outreach to enroll more Medicaid participants is "disingenuous"; using hospitals as clinics increases costs for emergency room visits for all; and mental and behavioral health systems need improvement.

Among the topics addressed in committee member questions and comments were the impact of methamphetamines, ways to eliminate "churning", preventive care, incentives for wellness, retention of doctors in rural areas and medical loan forgiveness.

North Central New Mexico Rural Health Care Access

Larry Lyons, vice president of clinical affairs at Presbyterian Medical Services (PMS), and Larry Martinez, director of the PMS North Central System, summarized the hospital system's services, its guidance center, behavioral health services, outpatient services and 15 primary health care centers. PMS was a pioneer with school-based health and is the only home-care hospice in Rio Arriba County and Questa. Medicaid is the best payer for the clinics, which serve as FQHCs, but the main source of income in the clinics is seeing patients. Mr. Lyons said the shift from 12 to six months in recertification for Medicaid has had a large impact on the clinics. The salary gap between specialists and family practitioners poses a problem, as does retention. The clinics have an incentive plan for both physicians and dentists.

On questions from committee members, Mr. Martinez said that the state is responsible for matching federal dollars for FQHCs, and that the state could improve usage of FQHCs. Discussion extended to incentives and loan-for-service plans, telehealth services and billing and the nurse advice line.

Women's Health

Giovanna Rossi, representing Dr. Justina Trott, talked about women's health care and the need to address barriers to care such as the ability to take time off from work for clinical care, transportation, access in rural areas and a medical emphasis on men rather than on gender-specific care. Women have problems accessing health care. She suggested doing Medicaid outreach to women where they are — at work, at schools and at daycare centers.

Access to Birthing Services

Midwives Beth Enson and Joan Norris talked about their services, which emphasize well care, education and empowerment. The birthing center in Taos constantly struggles to remain open, and financial viability is always a problem since the center collects only 58% of billing. The midwives are not reimbursed for services and spend a good deal on malpractice. The Northern New Mexico Midwifery Center needs legislators to help find some way for midwives to purchase low-cost malpractice insurance and cover home births on medical insurance. Perhaps with universal health care, such changes could be made. The center participates in the First Born Program and in Holy Cross Hospital.

Linda Siegel estimated that there are approximately 200 nurse-midwives in the state, but 25% of babies in New Mexico are birthed by nurse-midwives.

Rural Health Care — University of New Mexico Institute of Public Health

Dr. Wiese, director of the UNM Institute of Public Health, substituted for Art Kaufman to talk about the UNM-NMSU extension project. The two universities are cooperating to use county extension projects for health care in rural areas. The university has made the UNM-NMSU a priority project in addition to the BA-MD program. Project ECHO is also subsumed under the project.

Although the point of the program is to go where public health facilities are scarce, the program gets services delivered at least at the county extension office. The program works with the county health councils, but does not attempt to replace them.

Public Comment

Jim Gilroy thanked the committee for its support of the bachelor of nursing program, which currently has 16 students and runs in 15-month cycles at community colleges and high schools.

Herb Schwartz and Bill Prentiss talked about Veterans for Peace.

Terry Riley reviewed principles for change and asked whether the HSA anticipates cost sharing.

Linda Moscasitive Cirella, a member of League of Women Voters, said she supports the HSA. She belongs to a coalition that supports the HSA, and her study group wants some type of universal health care plan.

George Beorsig advocated adopting the HSA as the best model overall because it is low-cost, guarantees access to coverage regardless of income, health or employment status and because Native Americans can join.

The committee adjourned at 3:08 p.m.