

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

**July 27-28, 2005
Room 322, State Capitol
Santa Fe**

**July 29, 2005
Shiprock Chapter House
Shiprock**

Representative Danice Picraux, chair, called the meeting to order on July 27, 2005 at 10:15 a.m. in Room 322 of the State Capitol. She welcomed everyone and asked the committee members to introduce themselves to the audience.

Present

Rep. Danice Picraux, chair
Sen. Dede Feldman, vice chair
Sen. Rod Adair (7/28)
Rep. William "Ed" Boykin (7/27, 7/28)
Rep. Keith J. Gardner (7/27, 7/28)
Sen. Steve Komadina
Sen. Mary Kay Papen
Rep. Jim R. Trujillo

Absent

Advisory members

Rep. Gail C. Beam (7/27, 7/28)
Sen. Sue Wilson Beffort (7/27)
Rep. Ray Begaye
Rep. Kandy Cordova (7/27, 7/28)
Rep. Miguel P. Garcia
Rep. John A. Heaton
Sen. Gay G. Kernan (7/27, 7/28)
Sen. Linda M. Lopez (7/28)
Rep. Antonio Lujan (7/27, 7/28)
Rep. James Roger Madalena (7/27, 7/28)
Rep. Terry T. Marquardt (7/28)
Sen. Gerald Ortiz y Pino (7/27)
Rep. Edward C. Sandoval
Sen. Leonard Tsosie
Rep. Gloria C. Vaughn

Sen. Clinton D. Harden, Jr.
Sen. Timothy Z. Jennings
Rep. Rick Miera

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

Staff

Phil Lynch
Karen Wells

Guests

The guest list is in the meeting file.

Wednesday, July 27

The chair invited committee members to a dinner Wednesday evening to meet with executive human services directors to discuss priorities for memorials for the session. She reminded the committee of the ground rules of courtesy and timeliness for the hearing. She introduced Secretary Debbie Armstrong of the aging and long-term services department for the first presentation.

Ms. Armstrong reviewed the legislative mandate to present a proposed long-term care policy for the state in November; her plan to educate the committee about the full range of needs and services in a continuum of care; and the system of long-term care presently in place in the state. She reviewed demographics of the population in need of long-term care services, including the elderly and disabled, demonstrating the huge, predicted growth of need for services in the future. In the next 20 years, the older population will grow by 93 percent and the 80 years and older population will double. She pointed out the increased costs to the medicaid program that accompanies this demographic change.

A wheel demonstrating the categories in a progressive continuum of care provided a visual image of the services and needs in a system of long-term care. These categories were described by the secretary, who indicated that in the afternoon, providers and consumers will provide further information about some of these categories. She noted that her charge in developing a long-term care system includes all age groups and all types of disabilities. Overarching themes that affect all levels of care include the critical need for access to information, the principle of self-determination, availability of home- and community-based services, infrastructure needs and disease management and health promotion activities.

Questions from the committee concerned the following:

- access to legal services;
- a request for a visual depiction of all long-term services, where they are now administered and how they are funded;
- efforts to address the long-term care needs of Native Americans and barriers to care;
- ability to work within federal statutory and regulatory restrictions to provide needed care;

- personal responsibility for funding of long-term care services;
- issues of impoverishment as people age and care needs increase;
- determination of appropriate transfers and issues of effectiveness of transfers of programs from other departments of state government to the aging and long-term services department;
- licensure requirements for providers at various levels of care;
- access to services issues and gaps in the system;
- housing and other alternatives to nursing homes;
- problems of homelessness;
- predatory lending;
- the process of third-party assessors for the personal care option;
- tracking of improvements in quality of care over time due to monitoring cameras in nursing homes; and
- hidden costs of home care versus nursing home care.

Jim Jackson offered public comment regarding disability services and said options for home- and community-based services should be the priority for persons in need of long-term care, regardless of their level of disability.

After a lunch break, Secretary Armstrong explained that the afternoon would be devoted to providers and consumers giving their first-hand experiences with the long-term care system in New Mexico.

Jennifer Isaac-Davis from Heritage home health in Albuquerque and Santa Fe described traditional home health care services, which include intermittent skilled professional services, nonprofessional support care and end-of-life care. She identified payers of the provided services, including medicare, medicaid and private insurance, and the services for which payment is available. She described disease management services provided by her agency to address chronic illnesses and prevent use of more expensive levels of care.

She introduced Virginia Gonzales Munch, whose father is a consumer of home health services, who told the committee about her father's life and how he benefits from home health care.

Barbara Zamora thanked the legislators for passing the brain injury waiver. She spoke about services for people with traumatic brain injuries and told her personal story as a person who received a brain injury due to a fall. She received case management and life skills training thanks to a small state fund that covers these services. She acknowledged that if there were more services available, she would benefit from them.

Gina DeGrassi of the program for all-inclusive care for the elderly (PACE) introduced Lisa Herrington, the daughter of consumers of PACE services, who described the importance of the services her father and mother receive. She extolled the benefits of the program and regrets the

presence of a waiting list to receive services.

Gil Gildase, the director of independent living services in Albuquerque, described the services her agency provides, including the personal care option. In addition to describing her program, she spoke as a person with a disability and identified gaps in the array of available services. Medicaid was acknowledged as critical in funding services for the disabled. Equipment, supplies, prescription drugs, transportation, personal assistance services, employment opportunities and accessible housing are essential to make it possible for disabled individuals to live in the community.

Wanda Hansen provides care for her husband who suffered a massive stroke and now suffers from dementia. She had to give up her job in order to meet his needs. She has been providing care for 10 and one-half years. Through involvement with the Alzheimer's association, she is aware of many unmet needs for persons suffering from dementia-related disorders. She stressed the importance of support for care givers. Additional adult day care and respite programs are especially important. Transportation is also crucial when a caregiver is unable to drive. She urged committee members to think about services "somewhere between the Reagans and medicaid".

Mary McCall, also a caregiver for a family member, offered her perspective. Her mother needs help with all aspects of her life. She has Alzheimer's-type dementia. Her mother needs assisted living services, but they are too expensive, and she cannot afford them. Her mother is currently in a boarding home, but she is running out of money and out of options.

Carol Luster with Montebello, a nursing facility in Albuquerque, described its approach to instituting a cultural change in the way long-term care services are provided. It is focusing on preserving dignity, promoting resident choices and creating an environment driven by resident needs and desires.

Harold Melnick, aging and long-term services department, described the services available through the resource center in the department. This center assists individuals to access resources for which they are eligible and to navigate and understand complicated programs such as medicare and prescription drug patient assistance programs.

Secretary Armstrong summarized the points that were made during the day and highlighted some initiatives the department is undertaking. New Mexico was selected to participate in a study being conducted by the University of Minnesota for the federal Department of Health and Human Services to examine promising practices in long-term care reform. New Mexico is considered a leader in rebalancing its long-term care system by emphasizing home- and community-based services versus institutional care. She described the aging and disability resource center that now has a database of more than 6,000 services and is responding to 200 calls per day requesting information. She identified efforts that are underway to develop a self-directed waiver called "Mi Via", which will incorporate all the home- and community-based

waivers and brain-injured services. Efforts to improve coordination of long-term services is a high priority of the department. The intent is to offer home- and community-based services in a managed care environment.

Committee members had comments and questions as follows:

- reductions in funding and services in the personal care option;
- progress in applying for and implementing the self-directed waiver; a copy of the waiver application was requested when it is submitted; details about elements of the self-directed waiver, such as case management services; plans for funding and administration of the self-directed waiver;
- the bidding process for managed, coordinated long-term care;
- funding sources and plans for provision of respite care and other services;
- capitation of managed, coordinated long-term care;
- clarification about what is available through the resource center;
- third party assessors for the personal care option; and
- the need for funding for area agencies on aging, especially in the south valley of Albuquerque.

Miriam DeHar, an acquired brain-injured person, provided public comment, stating that persons in need of services need help in finding out what is available and how to access these services. Anna Otero Hatanaka of the association for developmental disabilities community providers reminded the committee that disabilities groups are exempted from managed care, and urged committee members to continue to support this initiative.

Clifford Rees, general counsel, department of finance and administration, summarized the need for public health law reform and requested committee support for a memorial to study this need. A model public health act exists, and much activity nationally has addressed this pressing need. He noted there are several areas that members of this committee have recognized as needing further study, such as environmental health, health privacy issues and tracking people who have been in contact with a communicable disease. The requested memorial was introduced in 2004 as HJM 30. Mr. Rees would like it to be re-introduced in 2006.

Committee members complimented Mr. Rees on his years of public service to the state of New Mexico. Questions were asked about the probable cost of such a study and the level of interest at the department of health.

Karen Wells provided a brief overview of the medicaid program in New Mexico.

Ellen Pinnes offered public comment. She pointed out that the number of people covered by medicaid is dropping significantly and that most of those who have lost coverage are children. She also clarified that the federal match rate is established in comparison to other states. New Mexico's rate has gone down because some other states are doing worse, not because New

Mexico is doing better economically. Senator Jeff Bingaman has sponsored legislation that would limit the amount that a state could lose. She thanked Senator Kernan and Representative Boykin for sponsoring legislation to permit a person to dedicate tax returns to ALS research.

Charlie Marcus, representing the New Mexico health care association, told the committee that nursing homes rely on medicaid, and yet the reimbursement they receive is insufficient to cover their costs.

The meeting recessed for the day at 5:40 p.m.

Thursday, July 28

The chair called the meeting to order at 9:20 a.m.

Public comment was offered by Dr. Loretta Ortiz y Pino of the Taos clinic for children and youth. She testified that her clinic will be closing on August 31 due to lack of funding and inadequate medicaid reimbursement. It serves over 16,000 children per year. A coalition of parents and other community members has formed and it is working hard with state officials and the New Mexico congressional delegation to try to remain open. She urged the committee to maintain medicaid reimbursement levels to physicians. Ruth Hoffman, Lutheran office of governmental ministries, distributed copies of letters from other providers who also are suffering from low medicaid reimbursement rates. Committee members expressed concern about the problem and support for the clinic.

Pam Hyde and Carolyn Ingram of the human services department (HSD) presented information to the committee about medicaid and other topics as requested by the committee. Ms. Hyde noted that some topics in the handout will be addressed at committee meetings later in the interim. Demographic information about medicaid was provided in writing. Costs of the program have continued to grow even though enrollment is declining. Current fiscal projections indicate the medicaid budget is in a deficit. Reasons for the decline in enrollment were discussed, and outreach efforts, particularly for minority children, were described.

Ms. Ingram provided a financial update addressing the loss of federal match funds (FMAP) and growing program costs. Initiatives to contain costs were described. Details were provided about the new medicare prescription drug program and the medicaid managed care initiative being implemented under an RFP. Ms. Hyde gave a brief review of the status of the behavioral health collaborative. Ms. Ingram described the self-directed waiver that is being developed in collaboration with the aging and long-term services department. Ms. Hyde responded to questions about management of the medicaid waiver for disabled and elderly (D&E). A special appropriation to expand access to the D&E waiver was expended, but it did not go as far as was anticipated due to increased per person costs in the program and expenditures that crossed two fiscal years. Three hundred sixty-two new D&E clients were added to the waiver in FY05. Ms. Ingram addressed the status of mandates that arose from the medicaid reform committee. Ms.

Hyde covered the SCI briefly, as it is part of testimony that will be offered in August. The benefit plan, cost-sharing provisions, financing and plans for marketing of the initiative were briefly described. She highlighted continuing challenges of administering the medicaid program.

Committee members had comments and questions as follows:

- concern regarding staff shortages in the HSD, and the need for increased appropriations for field office staff;
- issues regarding low reimbursement to providers;
- reimbursement for dental hygienists;
- ability of counties to cooperate in financing of the SCI by purchasing health insurance premiums;
- prior authorization and therapeutic interchange of prescription drugs;
- the effect of declining enrollment;
- concerns about the university of New Mexico hospital; the governor's office is working with the hospital to identify solutions; and the HSD sees part of the solution in establishing a special arrangement with the SCI;
- a request for a draft outlining the issues with the university of New Mexico hospital;
- status of medicaid in the schools;
- availability and financing of home- and community-based waiver waiting lists;
- next steps in medicaid cost containment; long-term managed care and the self-directed waiver offer promise;
- preferred drug lists;
- semiannual recertification process and problems with reassignments to managed care organizations;
- availability of data regarding administrative costs of managed care organizations;
- administrative cost and other impacts of semiannual recertifications; the impact on children is of special concern;
- fraud and abuse versus billing problems;
- disincentives to provider participation in medicaid;
- how projected federal cuts would affect New Mexico's program;
- behavioral health issues;
- tracking of the impact of reductions to provider payments and other administrative changes; the medicaid advisory committee is watching these monthly; and
- problems with prescription drug coverage under medicare part D for Native Americans.

Senator Feldman made a motion that the committee write a letter to Senator Bingaman in support of his legislation to prevent any further reductions to the FMAP, which was seconded and passed without objection. She also moved that a letter be written to the congressional delegation to reinforce concerns regarding the negative impact of the "donut hole" in the medicare prescription drug bill, especially on the poor elderly, which was seconded and passed without objection.

Bill Jordan, deputy director of voices for children, and Jim Jackson, director of protection and advocacy, presented an advocacy perspective of medicaid in New Mexico. Mr. Jordan began by discussing the importance of medicaid and the efficiency of the program. Nonetheless, the program has been underfunded by \$52 million in the last two years, and this is resulting in serious drops in coverage for children, despite HSD assurances that enrollment would continue to grow, but at a slower rate. He stated that the SCI is using SCHIP money to fund medicaid, even though children covered under SCHIP must recertify their eligibility for medicaid every six months, while people who enroll in SCI will only have to recertify annually. Goals to insure more children is inconsistent with practices that limit medicaid eligibility for children. Mr. Jackson asserted that the state does not have a medicaid crisis, the state has a health care crisis. Medicaid cuts to control growth in the program have had a real and disastrous effect on disabled people in the state. He provided statistics and information about the impact on the personal care option and the home- and community-based waivers. He challenged the HSD's position on its use of the special appropriation to reduce the waiting list in the D&E waiver, saying fewer people are actually being served. He also expressed disappointment that the money appropriated to serve people with brain injuries will not be available until the self-directed waiver is approved by the federal government. He encouraged the committee to look for ways to extend medicaid coverage to more poor people.

Committee members expressed concern and asked questions regarding the following:

- coverage for Native Americans; and
- adequate coverage for all children.

Senator Tsosie made a motion that the committee formally ask the governor and the HSD to return to 12-month recertification for children until it can be demonstrated that six-month recertification does not adversely affect children. The motion seconded and passed with one opposing vote. Senator Tsosie requested that the committee consider supporting legislation to remove the gross receipts tax exemption from providers who disenroll as providers under the medicaid program. A request was made to engage in a discussion about poverty and the importance of health care coverage for the poor of New Mexico. The welfare reform oversight committee heard a panel presentation on this subject.

Ms. Hatanaka offered public comment about the negative impact of the one and one-half percent decrease in provider payments on developmental disability providers. She testified that these providers need cost-of-living increases in order to continue to deliver quality services. Dr. Carl Friedrichs, a physician practicing in Santa Fe, described a story of a pregnant woman who did not receive adequate care due to being determined ineligible for medicaid. Health care suffers when access to medicaid is overly restrictive. He urged consideration of universal health care coverage. Anna Lucero testified on behalf of full funding for medicaid. Kristin Sharp spoke for the poor families from Taos who could not stay to testify. She read a statement by Joe Fernandez, a father whose children have been receiving service from the Taos clinic. Ms. Pinnes urged the committee to also contact house members in support of HR 2258. Senator Papen

moved this action. It was seconded and supported without opposition.

Jessica Sutin, deputy secretary of the department of health, introduced Dr. Scorsie, Patsy Nelson, RN, and Dorothy Dansfelter. Ms. Sutin acknowledged the value of many of her staff by name. She gave a brief overview of the services provided by the department of health, an update on the governor's school-based health centers initiative and a phased plan for new sites. She also provided progress reports on funding new centers and Native American centers. She spoke about the department's approach to address teen pregnancy; New Mexico has the third-highest teen birth rate in the nation. The department is engaged in a variety of prevention efforts, including abstinence programs, family planning, resilience and risk programs, and parent education. Teen suicide is another important area of focus for the department; New Mexico has the fourth-highest rate of teen suicide in the nation. The governor considers teen suicide a state epidemic. Efforts are targeted toward prevention and crisis response. New Mexico also has a high percentage of obese youth. The department is promoting healthy eating habits and exercise in schools, called the "catch" program. It is also conducting a nutrition task force in collaboration with the public education department, which is working to define standards for healthy food and beverages in schools. A major goal of the department and the first lady is to improve New Mexico's standing in immunizations of children; in the last two years, the state has gone from forty-ninth in the nation to fifteenth, with 84 percent of toddlers now fully immunized. The statewide registry is expected to be up and running this fall. Finally, she presented an update on project ECHO, a project to prevent and treat hepatitis C through the use of telecommunications. Correctional facilities are a prime target to receive these services.

Committee members had questions and asked for clarification about the following:

- costs, privacy, services and hours of service at school-based health centers;
- medicaid coverage for school-based health center services;
- the possibility of using the public health model or the school-based health model to provide affordable access to more New Mexicans; the department of health noted that funding of individual health programs is being done on top of a fragile infrastructure;
- the importance of loan repayment programs for recruitment and retention of physicians;
- the rationale for vetoing money for existing school-based health centers;
- whether mental health services are culturally appropriate for Native American students;
- the extent of school administration support for school-based health centers;
- the importance of public health and the broken health care system in the country; it was noted that the public health system serves all New Mexicans at a very low cost;
- if the department is receiving the percent of gambling revenues that are supposed to be dedicated to addressing gambling addictions;
- a request for updated information on the nutrition task force and the need for nutrition education; and
- the need to look more deeply into additives in foods.

Jane Larsen, chair of the New Mexico family, infant, toddler (FIT) interagency coordinating

council, presented information about the FIT program, services and its needs. Funding is crucial as services provided often exceed the budget or are uncompensated. Access and costs of services are considerable due to the distance and cost involved in providing services in rural areas.

Rachael Porcher, vice chair of the coordinating council and a parent of a child in the program, urged the committee to provide extra funding for the FIT program. She presented concerns and problems from a parent's perspective, including staff shortages and turnover issues, largely related to underfunding.

Committee members asked about the legislation that passed in the last legislative session to require insurance companies to cover FIT services. It is anticipated that insurance companies will be ready to implement this process by October. Kathy Stevenson, department of health, described how the department is collaborating with providers and parents to implement this, as well as how it is using the money that was appropriated to the program. The department is developing a funding methodology that will better serve the program. Michelle Stanley, Loretta Sanchez and others gave personal stories to demonstrate the importance of the FIT program. Ron Garcia, executive director of new vistas, runs a program that provides early intervention and testified to its success. Jay Marsen, who runs a program in Alamogordo, and Ron Seigle, director of Abrazzos, testified to the difficulty of running a program with inadequate funding.

Raul Burciaga informed the committee that the legislative council service is collaborating with New Mexico state university to continue the health care financing study and will report more fully to the committee at a subsequent meeting.

The meeting recessed for the day at 5:40 p.m.

Friday, July 29

The chair called the meeting to order at 9:55 a.m. Representative Begaye made some welcoming remarks, and asked members of the committee and members of the audience to introduce themselves. He introduced Dwayne Chili Yazzi, president of the Shiprock chapter house and mayor of Shiprock, and GloJean Todacheene, vice president of the chapter house, who provided a formal welcome to the committee. Mr. Yazzi also provided historical information about Navajo chapter organization, and the Shiprock chapter. He also described the origin of the name Shiprock, the native name for the town, and the name for the Navajos, Diné, which means "the people".

Leonard Thomas, M.D., Albuquerque area chief medical officer, presented an overview of the Indian health service (IHS), and, specifically, the Albuquerque area IHS. IHS is a federal agency that provides services to any member of any tribe seeking health care in New Mexico, Colorado, Texas and Utah. He noted that funding for IHS is very limited; on a per capita basis, funding is less than for all other populations. He outlined the strategies for quality care, supporting economic viability, providing preventive and public health and for improving communication and

collaboration. He gave statistics regarding health care services provided, primarily primary care. Health trends and disparities in the Native American population were presented; in New Mexico, accidents, heart disease, cancer, diabetes and cirrhosis and chronic liver disease top the list of health problems. Diabetes is particularly prevalent, and is increasing dramatically among children. Deaths from diabetes are continuing to rise, despite new treatment modalities that are available.

Committee members asked questions about the reasons for the prevalence of diabetes, the number of people in need of dialysis and the availability of dialysis centers. Also addressed were the complexities of coordination of benefits and financing to obtain access to health care services for Native Americans.

Senator Tsosie introduced himself and made remarks in Navajo. He questioned why diabetes is not a higher priority in the IHS. Dr. Thomas feels this issue is largely a funding issue. Without adequate funds, health care issues cannot be properly addressed, and access to care will be severely hampered.

Christine Benaly presented a health profile of the Navajo area IHS. She also provided demographic data describing characteristics of Navajos. She described the goals of the Navajo coordinated school health program, including information about risky behaviors, and nutrition status of youth. She described in greater detail the findings of a comprehensive community health status assessment. The number of Navajos has doubled since 1980. The Navajo IHS extends beyond the boundaries of the Navajo Nation. Navajos by county were shown along with a breakdown of Navajos in urban and metro areas. Statistics show that most Navajos use IHS facilities. Socioeconomic status, prevalence of disease, use of traditional medicine and the number of available facilities are some of the demographics in the full report, which is in excess of 130 pages. Representative Begaye asked that a copy of her presentation be provided for the committee. Indicators reflecting quality-of-life issues are largely unavailable; however, 92 percent responded in a survey that they are satisfied with their quality of life. Behavioral risk factors and protective factors are evaluated in the report. Lifestyle issues such as obesity, sedentary habits, screenings for preventable diseases, substance use and abuse were explored. Many questions were considered sensitive in nature, and, therefore, the findings are limited. Only limited monitoring of air quality and water quality is being done and no summary reports are completed. Similarly, statistics for exposure to infectious diseases, workplace hazards, lead exposure and waterborne diseases are very limited to nonexistent. Regarding mental health indicators, only the homicide rate and suicide rate are tracked. Many inconsistencies in collecting data from service unit to service unit contributed to the poor response in some categories. Maternal and child health indicators, mortality rates, leading causes of death and incidence of diseases are included in the report. Information regarding communicable diseases is more reliable due to state and federal reporting requirements. She offered conclusions and recommendations, emphasizing the need for more administrative, resource and funding support, and the importance of partnerships among the Navajo Nation, the federal and state governments and others.

Committee members asked questions and offered comments on the following:

- how youth are being educated about public health, prevention and health promotion;
- issues regarding the incidence of breast and cervical cancer;
- inequities in funding for IHS services;
- diseases and conditions in which Native Americans have better statistics than the general population; Dr. Thomas noted even these are on the rise;
- the low incidence of smoking among Navajos;
- difficulties for Native Americans regarding medicaid and prescription drug coverage under medicare;
- treaty obligations of the federal government;
- the possible connection between housing and problems of obesity;
- the importance of Indian professionals involvement;
- the effect of geography and access to care;
- the balance between traditional and modern medicine; the use of traditional medicine is still very widespread;
- the number of practicing physicians on the Navajo Nation; and
- the "barefoot doctor" model of health care in China.

Dr. Benaly was thanked and complimented for the report, which was her work. She was encouraged to develop it into a booklet for general distribution and to help inform policy. The committee could consider sponsoring legislation to provide funding for the project.

Shelly Frazier, health promotion and disease prevention office, northern Navajo medical center, presented information on prevention and healing programs on the Navajo Nation. She provided background information about the community health program in Shiprock. Its efforts were developed with respect to the Navajo traditional philosophy of four directions: babies and parenting skills, school-based health, women's sexual and health issues and wellness activities. Written materials detailed the many programs in each area. Grant proposals supplement IHS funding. A health promotion and prevention program has been in place in the Navajo Nation since 1980. Despite the statistics that paint a grim picture of Navajo health, this program is seeing positive effects. She showed a video highlighting one program, "just move it", which is a series of fun runs and walks to encourage physical activity and personal responsibility for health. It is in its thirteenth year of operation. The events are held in small communities and are noncompetitive. Last year, more than 35,000 people participated. There is now a national "just move it" campaign that is modeled after this New Mexico program. A basketball tournament for children is happening today to promote awareness of alcoholism.

Committee members applauded Ms. Frazier for her efforts and wonderful programs. Senator Tsosie informed the committee about a film produced by the department of health called "Res Hope", which highlights many other positive efforts of the Navajo Nation.

Henrietta Lewis, director of contract health services for the northern Navajo medical center,

spoke to the committee about contract health services (CHS) and the concept of payor of last resort. She identified the service units within the Navajo service delivery area. The contract health referral process was described both into and out of the IHS system. Eligibility criteria include requirements for the person to be registered as a member of a recognized tribe, medical necessity, residency within the CHS area, identifiable alternate resources and notification. Areas of intervention or referrals were identified. CHS is always the payor of last resort and coordination of benefits with medicaid, private insurance, workers' compensation and others is essential. Barriers to service include medicaid nonparticipating providers, out-of-state authorizations and medicaid eligibility decisions. Blue cross, blue shield is the fiscal intermediary. Data was provided showing the average daily costs of inpatient care, outpatient physician costs, facility costs and transportation costs. Also provided was information about the Shiprock CHS budget.

Committee members had questions regarding the following:

- the number of people in the service area below 200 percent of the federal poverty level;
- the ability to match CHS dollars with medicaid dollars for the purpose of participating in the SCI; Ms. Lewis does not think it is possible;
- the inability of Navajos to receive services outside of the service unit in which they live;
- the economic impact of CHS dollars to the New Mexico economy;
- the high denial rate for contract health services;
- comparisons of access to care for Native Americans versus illegal aliens;
- problems with the payor of last resort, which can lead to untimely delivery of health care services; Ms. Lewis noted that this policy is a federal requirement, but that patient care is not compromised because of this policy;
- the mechanism for out-of-state referrals and non-tribal members residing on the Navajo Nation;
- student eligibility for CHS; and
- any instances of denial of presumptive eligibility by HSD.

Senator Tsosie requested an opportunity to meet with federal IHS representatives in the future. He spoke on behalf of Daisy Brownheart, a non-English speaking Navajo, asking if there is certification of herbalists to allow them to get reimbursed for services. He requested further research into avenues to use traditional remedies especially for behavioral health issues and to have this issue discussed at a subsequent meeting.

Dr. Kim Mohs, internal medicine department, northern Navajo medical center, presented information on diabetes and the relationship between obesity and diabetes and between heart disease and diabetes. The IHS has several diabetes prevention programs that focus on fitness and activity. She presented the lifestyle change program that is particularly targeted to diabetes prevention and that has reduced the incidence of diabetes by 58 percent for those who completed the program. Elements of the program include weight loss and increased physical activity goals. Future plans involve expansion of this program in five other locations. Challenges involve

funding, staffing and training issues. IHS has been proactive in publishing standards of care for diabetes. Statistics show that the Navajo IHS is comparing favorably with managed care organization reports for patients with diabetes. Challenges still remain in the areas of eye care and foot care, and the mortality rate for diabetes among Navajos still far exceeds the United States rate.

Committee members commented on the following:

- the relationship between junk food in schools and diabetes and legislative efforts to change this;
- the need for wellness and health care centers in proximity to where people live; and
- a request for suggestions for legislative action to deal with diabetes. Dr. Mohs suggested banning vending machines from schools and making every effort to encourage physical activity in schools.

Dr. Mohs then gave a presentation on the effects of uranium on health in the four corners area. Vanadium has been prevalent due to the Manhattan project and other initiatives. Purchase of uranium provided an economic boon to the state for many years. Uranium mining occurred in the four corners area from 1947 to 1970, and is now resulting in bad health for many. Negative health effects such as lung cancer have been noted as far back as 1879. In 1948, a recommendation was made to set standards for uranium exposure similar to radiation, but this was not implemented. In 1950, a public health study began on the effect of uranium on miners; however, a condition of the study was that the miners not be informed. In 1960, the results of the study showed an incidence of lung cancer 4.5 times that of the national average. Measurement of occupational exposure to uranium is inconsistent and uncertain to this day. Other irritants besides uranium compound the health risk to miners, resulting in conditions such as silicosis, pulmonary fibrosis, tuberculosis, hearing loss and lung cancer. Native Americans have an undue incidence of these diseases, despite the fact that they smoke cigarettes much less than other populations. Specific health screening is being conducted among former uranium miners. Recent federal legislation strengthens standards and authorizes the public health bureau to provide focused education about the dangers of uranium, and to encourage screening. The northern Navajo medical center applied for a grant and has established a program to respond to this direction.

Dr. Mohs also informed the committee about the effects of above-ground nuclear testing that occurred at the Nevada test site in the 1950s. The New Mexico tumor registry indicates more than 2,000 possible Native American claimants who may have cancer due to this testing.

Questions from the committee included the following:

- the incidence of marijuana smoking among Native Americans;
- the cost of cleanup and health risks secondary to cleanup;
- the possibility of undiscovered mines;

- current interest in opening new uranium mines in the checkerboard area and a recommendation that the governor be encouraged to place a moratorium on the opening of any new uranium mines; and
- the difficulty of radon cleanup.

Dr. Susie John, pediatrician at the New Life center in Shiprock, provided information to the committee about school-based health centers for Native Americans. She identified services provided and challenges in delivering care to adolescents, especially Native American teens. She provided demographics unique to Native American youth, including that 77 percent live in remote areas and that suicides, homicides and accidents far exceed the incidence among white populations. The overall population of Native Americans is much younger than the general population, with 60 percent less than 25 years of age. Some creative initiatives in school-based health have been funded by the Kellogg foundation and promote collaborations with such entities as New Mexico voices for children and others. Medicaid funding is currently problematic, but efforts are underway to expand access to medicaid coverage for these services. Challenges include funding, confidentiality issues, lack of support from school boards, staffing and specialty issues such as transportation and referrals. The governor's initiative to expand school-based health is based on levels of service. Dr. John pointed out that many Native American centers are unable to meet even level one, which is four hours of primary care and four hours of behavioral health services per week, and are therefore ineligible for funding. Sandy Dodge described the Crownpoint program. Shiprock has a designated site of operations, but that is not the case in Crownpoint. There, the program was temporarily shut down, but was reopened at the request of the Gallup schools.

Committee members asked questions as follows:

- the difference between IHS-supported centers and non-IHS-supported centers;
- avenues for billing for services; medicaid and insurance are possibilities, but this is sporadic and hard to track through the IHS system;
- funding losses due to the focus on new centers versus existing centers;
- why the governor's initiative does not fund any centers on Navajo land;
- is medicaid reimbursement 100 percent for services rendered? The medicaid funding is complex and complicated by other IHS funding streams, such as CHS funding;
- any special programs in the centers to address alcoholism or suicide prevention; and
- ways in which the legislature can provide support to federal programs.

Representative Begaye suggested writing a letter to the department of health requesting further testimony and an answer to the question of why Native American sites have not been funded. Dr. John emphasized that funding for IHS services is far less than funding for other populations such as medicaid, prisons or private insurance. A priority for school-based health centers is funding for preventive health. Funding for continued existence of centers is critical. Committee members expressed an interest in identifying how school-based centers are funded, and how to ensure equitable funding to all centers, rather than just to some select centers.

Mr. Yazzi thanked the committee for coming to Shiprock and giving serious consideration to these issues. He also thanked the representatives of the IHS who made presentations. He requested that the record reflect the importance of 12-month versus six-month recertification for medicaid. The meeting was adjourned at 5:40 p.m.