

MINUTES
of the
FIFTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE
October 12, 2009
Pueblo of Pojoaque

October 13-14, 2009
Room 322, State Capitol

The fifth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Danice Picraux, chair, at 8:55 a.m. A subcommittee was present.

Present

Rep. Danice Picraux, Chair
Sen. Dede Feldman, Vice Chair
Sen. Rod Adair
Rep. Nora Espinoza
Sen. Linda M. Lopez (10/13)
Rep. Antonio Lujan
Sen. Gerald Ortiz y Pino

Absent

Rep. Joni Marie Gutierrez

Advisory Members

Rep. Ray Begaye
Sen. Sue Wilson Beffort
Rep. Eleanor Chavez
Rep. Nathan P. Cote (10/12, 10/13)
Rep. Miguel P. Garcia
Rep. Keith J. Gardner (10/13, 10/14)
Sen. Clinton D. Harden, Jr. (10/12, 10/13)
Rep. John A. Heaton
Rep. Dennis J. Kintigh
Rep. James Roger Madalena (10/12, 10/14)
Sen. Cisco McSorley (10/13, 10/14)
Rep. Bill B. O'Neill
Sen. Mary Kay Papen (10/13, 10/14)
Sen. Nancy Rodriguez
Sen. Sander Rue
Rep. Mimi Stewart (10/13, 10/14)
Sen. David Ulibarri (10/13, 10/14)
Rep. Gloria C. Vaughn

Sen. Gay G. Kernan
Rep. Rodolfo "Rudy" S. Martinez
Rep. Jeff Steinborn

Rep. Jose A. Campos

Guest Legislator

Rep. Nick L. Salazar

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

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)

Karen Wells, Researcher, LCS

Jennie Lusk, Staff Attorney, LCS

Mark Harben, Records Officer, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts are in the meeting file.

Monday, October 12**Welcome and Introductions**

Representative Picraux welcomed everyone. The Honorable Linda Diaz, deputy governor, Pueblo of Pojoaque, welcomed the committee to the pueblo.

Impact of Nursing Faculty Shortages (HJM 40)

Pat Boyle, R.N., executive director, Center for Nursing Excellence, introduced Theresa Keller, Ph.D., R.N., associate director for undergraduate studies, New Mexico State University (NMSU), and other members of the task force that participated in the completion of this report. She reviewed the objectives of the memorial and the methods used to gather the information for the report. She provided statistics regarding the current and projected number of nurses in the state. She estimated that in order to meet the projected need for 5,000 nurses, between 48 and 171 faculty members will be needed. Ms. Boyle identified challenges to the recruitment and retention of nursing faculty, including faculty compensation, a weak educational pipeline for developing new faculty, educational models that prohibit collaboration among institutions and a heavy workload environment. Currently, nursing faculty members are paid an average that is less than what a registered nurse in practice is making. Advanced degrees are required to be nursing faculty members. Nurses with advanced degrees are finding many alternative options for careers besides nursing education. The models for the education of nurses lack standardized curricula. Workloads of nursing faculty are demanding, and new faculty are not well-oriented or mentored.

Recommendations from the report address funding, enhanced efficiency, pipeline development and stronger partnerships. The report highly recommends that the Higher Education Department (HED) convene a task force to analyze all state funding for nursing education and develop a system for transparency for all funding directed toward nursing education. The report also highly recommends development of a statewide plan for nursing education. Other

recommendations include steps to identify, support and mentor future nursing faculty members utilizing best practices and promotion of the role of nursing. Some of these measures are already underway through collaborations among the schools of nursing across the state. The importance of online educational opportunities was stressed. A loan forgiveness program exists for nurses seeking graduate level degrees who commit to service as nursing faculty members. Ms. Boyle emphasized that nurses serve at all levels and in all health care settings and that can go a long way toward addressing the goals of health care reform.

Dr. Keller identified particular challenges and barriers experienced by NMSU. As a result of the measures implemented at NMSU, some progress toward building a stronger and more committed faculty is occurring. She highlighted ways in which the legislature can support successful nursing programs. NMSU is highly constrained due to limited space and other resources. She noted that NMSU has partnered with the University of New Mexico (UNM) to develop a statewide comprehensive plan for nursing education and would benefit from letters of support in grant applications. She invited committee members to visit NMSU.

Committee members asked whether private employers are providing any financial assistance to support this need. It was acknowledged that the nursing profession needs to be better at making the case for the value of nursing to begin to increase salaries in the private sector.

The chair interrupted the agenda to allow committee members to introduce themselves.

Committee members expressed their support for the value of nurses and appreciation for the scope of the problem. Clarification was sought regarding long waiting lists to enter nursing school, the shortage of hospice nurses and the qualifications to enter nursing school. Details were sought about the nature of the waiting lists to enter nursing school. A model standardized curriculum using tele-education exists in Oregon that the Center for Nursing Excellence will be reviewed. Committee members expressed willingness to write a letter of support for any efforts that are underway. The potential for the use of simulation experiences versus relying on, and overloading, hospitals and other settings was discussed. Uniform clinical contracts also hold promise for reducing the workload of faculty and enhancing efficiency. A suggestion was made that strong staff support at the HED is essential to accomplish these goals. Len Malry, director of workforce education, HED, identified himself as the point person for nursing education within the department. He referenced a report that the HED has published that reflects how funding is distributed through the funding formula. Ms. Boyle stated that the funding formula is very confusing to nursing schools that do not feel it is working effectively. The HJM 40 task force discussed the possibility of removing schools of nursing from the school funding formula and is working with the HED to explore this. Tracking funding allocations within public educational institutions and from special appropriations is critical information that the committee would like to see developed. Mr. Malry stated his belief that the funding formula is working and that the previously referenced HED report will show that. Discussion ensued about the potential impact of the trend to require all nursing faculty to have Ph.D.s. Currently, school accreditation standards require that nursing faculty have a degree that is higher than the level they are teaching. Concern was expressed about a mandate reportedly being considered by the Board of Nursing to

require that all associate degree nurses obtain a bachelor's-level nursing degree. A question was asked about the extent to which retiring military nurses are being encouraged to move to New Mexico and whether there are any barriers to their obtaining a license in the state. Questions were raised about the ability of licensed nurses in the military to practice across state lines. An objection was stated regarding the nursing position to oppose the ability of non-nurse anesthesiologist assistants to practice in other locations in the state besides at UNM hospital. The ability of nursing schools to obtain national graduate medical education funds was discussed; this is being discussed in health reform proposals, but is not currently available. Clarification was sought about the data provided in the report relative to enrollment and nursing faculty, why salary information was not included in the report for nurse practitioners and the disposition of nurses upon gaining their licenses to various practice settings. It was recognized that the health care sector is one of the only job sectors growing in today's economy. Senator Rue made a motion, and Representative Vaughn seconded the motion, that the committee draft a letter of support to assist the HJM 40 task force to pursue grants. Ms. Boyle said that she would prefer a letter targeted to a particular grant application, but would be grateful for any support the committee wished to give. Clarification was sought regarding to whom such a letter should be addressed. A request was made for the task force to bring back specifics to this committee at its November meeting. The motion was withdrawn. Support was expressed for the recommended memorials to continue the critical work of this task force.

Women's Health Council Report

Giovanna Rossi-Pressley, executive director, Office of the Governor's Council on Women's Health, introduced Michelle Peixinho, a member of the advisory council to the office. She thanked the committee for its support. She discussed reasons why a specific focus on women's health issues is important. She described the administrative structure and mission of the office. She highlighted a public health model around which its work is conducted. Although not a direct service provider, the office works with provider organizations to address important issues affecting women. One example is the work they are pursuing to implement a new statute placing strict limitations on the use of restraints on prisoners who are pregnant or in labor. The office collaborates with UNM on the curriculum for a women's health policy course and supports outreach and education for such initiatives as National Women's Health Week.

Ms. Peixinho, a member of Tewa Women United, spoke about leadership development efforts being promoted through the Women's Health Advisory Council, of which she is a member. Ms. Rossi-Pressley described efforts to promote economic security for women by providing statistics about economic security and women both nationally and in New Mexico. The office has identified a list of policy issues to address economic security issues, including promotion of a living wage, access to health care, medical debt, high-quality and affordable child care, secure retirement and parity for part-time workers. Ms. Rossi-Pressley outlined the fiscal year 2010 and fiscal year 2011 goals for all these areas and identified budget needs and sources of revenue for the office.

Committee members expressed interest in why the office is not located in the Department of Health (DOH). Ms. Rossi-Pressley explained that it was felt that its independent status would

allow for a greater focus on women. A question was asked about possible legislation that could address some of the problems identified. The relationship of the office to the Commission on the Status of Women was explored. The office is administratively attached to the commission and is co-located with it. Clarification was sought about some of the statistics. Ms. Rossi-Pressley noted that the office is required by statute to report annually to the governor and would be happy to share that report with this committee as well.

Integrated Behavioral Health Services Delivery: Pathways Care Coordination Model

Lauren Reichelt, health and human services director, Rio Arriba County, presented a successful model of care for substance abuse that has statewide and national implications. She began with a historical picture of the very high rates of substance abuse in Rio Arriba County and the fragmented delivery system that has always existed there. A survey conducted by the county found many gaps in services at an unacceptably high cost. A pilot program was established to serve very difficult clients and achieve improved outcomes with limited resources. Early experience provided valuable data about the population being served and identified reasons for failure of the assessment and referral system being used. This pilot led Rio Arriba County to partner with an organization utilizing a model of care called Pathways, wherein providers are paid for outcomes of care rather than a fee for services provided. The model has national support, which allows it to compare its project against best practices elsewhere in the country. The initial targeted population was pregnant women at high risk for using illicit substances during pregnancy. The care needs of 20 women were evaluated against pre-determined outcomes. Program evaluation showed great success in cross-agency collaboration, improvement in outcomes and high provider satisfaction. No new funding was needed to implement these changes. Rio Arriba County plans to expand the program to new populations, including the homeless, and to school-based services for at-risk youth. Jack Ortega, Rio Arriba County juvenile justice, described the Rio Arriba Youth Services Providers Partnership, which is using the Pathways model to improve the lives of at-risk youth through coordinated family, education and community services. He reviewed the services the partnership is able to provide due to this collaborative model without expending any additional dollars. Ms. Reichelt closed by asserting that this model, if more broadly applied, could save the state money and improve outcomes.

Committee members asked questions about the number of clients served by the model who were already on Medicaid, the extent of family support and whether the youth program will be able to follow at-risk children through high school. The ability to implement the Pathways model across different funding streams and in different program areas was explored. An explanation was given regarding the difficulty in serving the homeless. Mr. Ortega described the process in which the collaboration between such disparate entities, each with its own funding, was achieved. He credited Judge Robert Vigil with being the initial champion of the effort.

Health Insurance Legislation: Proposed Executive Bills

Katie Falls, deputy secretary, Human Services Department (HSD), and Steven Randazzo, legislative liaison, HSD, described the priority legislative issues for the HSD. These include guaranteed issue of health insurance plans for individuals; exclusion of gender as an insurance premium rating factor; the redefinition of "small group" to allow coverage of self-employed individuals; direct services expenditures at 85%; and small group insurance rating. For each proposal, Mr. Randazzo offered the facts or problems that caused this bill to be proposed and implications if the legislation passes. Copies of draft bills were provided for the committee's consideration. Legislation may be proposed to consolidate administration or selection of different publicly funded coverage options. Additionally, the HSD will propose amendments to the licensed alcohol and drug addiction counselor statute to permit grandfathering of certain qualified, certified counselors. Other bills that will be proposed, but that were not in committee members' packets, were briefly mentioned.

Committee members wondered why some of these measures, particularly guaranteed issue, are being put forward at this time when federal reform may take care of these issues. Concern was expressed that proposed changes would negatively impact the New Mexico Medical Insurance Pool (NMMIP), also called the high-risk pool. The point was made that the high-risk pool offers six or seven insurance options to qualified people, with discounts available for people qualified up to 400% of the federal poverty level. Clarification was requested regarding the number of providers that are licensed to sell health insurance in the state; there are approximately 700 providers. Debbie Armstrong, director, and Michelle Lujan Grisham, deputy director, of the NMMIP offered to provide a list of those providers to the committee. Questions were asked about the interface between the State Coverage Insurance (SCI) program and the NMMIP and how these two programs are different. Clarification was sought about the percentage of insurance plans and individuals in the state that are covered by federally protected insurance plans that would not be affected by this proposed legislation. The current premium tax obligation would not be included in the 85% direct services requirement. Clarification was sought regarding the current percentage attributable to direct services and to whom a requirement of 85% would apply. It would apply to all companies, not only those under contract with the HSD. Comments were offered in support of these measures, none of which is new to the legislature. Questions were asked about the waiting list for SCI and the reasons why a waiting list is being imposed. Questions were asked regarding the waiting list for the developmental disabilities waiver that was appropriated by the legislature. Concern was expressed that these proposed measures have unknown costs and should not be enacted in a time of economic insecurity when the state has waiting lists. Other committee members disagreed, stating that insurance reform measures are unrelated to the ability of the state to fund existing programs. A question was asked about the support or lack of support from insurance companies for these measures, especially in light of the absence of a bill to mandate the purchase of insurance, and whether the HSD intends to consult with insurance companies. Concern was expressed about NMMIP waiting lists for pre-existing conditions.

Sam Howarth, director, Division of Policy and Performance, DOH, described four priorities of the DOH, indicating that individuals with expertise in each area would describe them

in more depth. Harvey Licht, director, Primary Care and Rural Health Office, DOH, spoke about a proposed expansion to the rural health care practitioner tax credit program to include new categories of health care providers. Details were provided projecting the cost to implement this measure. The program has been very successful with physicians and others currently covered. The goal is to incentivize health care providers to remain in practice in rural areas. Dr. Steve Jenison, medical director of the HIV program, DOH, described the department's desire to amend the Human Immunodeficiency Virus Test Act to allow the DOH to notify partners of those individuals newly diagnosed with HIV. The intent is to extend health protection to potentially infected partners. Mr. Howarth spoke about a proposed bill to raise the crime lab fee assessed on individuals convicted of driving while intoxicated. The fees have not been raised since 1997. The final proposal described would create a mid-level dental auxiliary with an expanded scope of practice that would provide dental licensure to dental residents and recognize as licensed any dentist who has been certified regionally.

Committee members asked whether there is any potential for expanding the dental bill to include additional activities for dental hygienists. Clarification was sought about whether this bill includes dental therapists, as previously presented by the Robert Wood Johnson Foundation (RWJF). The DOH is in conversation with the RWJF. The proposal is intended to serve as a career ladder to increase access to dental services with the creation of a mid-level dental practitioner. Charlotte Roybal, consultant with the Con Alma Foundation, provided clarification about the differences between the dental therapist proposal presented to the committee by the RWJF and this proposal. Debbie Maestas-Traynor, a lobbyist for dental hygienists offered further clarification about the current and proposed roles for hygienists if they are added into the DOH proposal. Concern was expressed about the extent of the expanded scope of practice. Committee members asked whether there is support or opposition to the HIV partner notification proposal and what the full impact of the rural health care practitioner tax credit would be.

Public Comment

Ms. Armstrong offered a few comments to follow up the previous testimony. The high-risk pool offers guaranteed issue for individuals who cannot get insurance or who are losing group insurance. She stated that the guaranteed issued proposal as discussed would have the potential to negatively impact the market. One important function of a high-risk pool is that it stabilizes the premiums in the small group and individual markets. She believes the proposal would be confusing and would drive up individual premiums. Finally, she commented that people are not diverted to the NMMIP from SCI due to pre-existing conditions.

The meeting was recessed for the day at 4:50 p.m.

Tuesday, October 13

The meeting was reconvened by the chair at 8:45 a.m.

Provider Credentialing

Debbie Gorenz, president, Hospital Services Corporation (HSC), briefly described the process of credentialing, whereby health care providers are determined to be qualified and capable of providing services to patients that enable these health care providers and institutional entities to get reimbursed for those services. A handout (in the meeting file) identified the requirements of the National Committee for Quality Assurance (NCQA) and the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) for credentialing of providers. She also provided a flow chart reflecting the process. The HSC is a private entity that is a subsidiary of the New Mexico Hospital Association. Ms. Gorenz described efforts that HSC, in collaboration with the New Mexico Medical Society (NMMS) and others, have pursued to streamline the process of credentialing, including the development of a statewide application, an online application process and cooperation with the New Mexico Medical Board to license new physicians. HSC performs primary source verification of the information submitted in a credentialing application. In addition to the medical board, the HSC provides these services for 49 other health care entities in the state. Recently, it partnered with the health plans.

Dr. Kathy Ganz, clinical compliance director, First Choice Community Health, provided a provider perspective of the credentialing process. First Choice has over 50 sites statewide and is a client of the HSC. She reiterated that credentialing is necessary in order to be reimbursed by any health plan or insurance entity. It is the process of verifying and assessing the qualifications of a practitioner to provide care in or for a health care organization. The HSC conducts the primary source verification part of the process. Dr. Ganz provided a historical overview of how credentialing has developed in New Mexico. She highlighted the burdensome, administrative nature of credentialing. In the past, credentialing was only required for reimbursement by Medicare; today, Health South has to repeat this process for 27 different payer sources. She noted that the providers as well as the plans all have credentialing committees and staff dedicated to ensuring the completeness of the applications and that they are progressing through the process on a timely basis. Until recently, the process took up to 120 days to be complete, during which time providers could not get paid for their services. She noted that every month, new requirements are added to the credentialing process by the managed care organizations (MCOs), adding administrative burden and delay. She offered several suggestions to further address these problems. Close monitoring of the new Public Regulation Commission's Insurance Division credentialing regulations will be essential. Establishment of a single credentialing entity for the state to retain a single file for each provider and reasonable fees for the primary source verification part of the process would help. She suggested that Congress should be requested to require alignment of the requirements of the NCQA and the JCAHO and establish shorter time frames for credentialing and re-credentialing.

The chair invited representatives of health plans and others in the audience to comment on this topic. Linda Hubbard, Lovelace Health Plan, noted that the Committee for Accreditation of Quality Healthcare (CAQH) has created a single standardized national application; coupled with a national database of information, it allows a once-in-a-lifetime application process that Lovelace providers utilize. Lovelace conducts primary source verification internally and has its own credentialing committee to approve or deny applications. She provided statistics supporting the

effectiveness of this universal application process. She spoke about the practice of the other health plans, some of which use the HSC. Laura Hopkins, Amerigroup, described her company's process. Dawn Brooks, executive director of the San Juan IPA, stated that it uses the New Mexico standard application and conducts primary source verification and approval or denial in-house. It is certified by the NCQA as a physician credentialing organization. At the request of the chair, Ms. Brooks described her organization.

Victor Lundsford, director of quality at Molina Healthcare, described the process that Molina uses. Primary source verification is performed at a national corporate office. The CAQH national application is used. The time to complete the process has been reduced to approximately 30 to 35 days. Dr. John Sandoval, medical director, Lovelace, affirmed that credentialing is a difficult and frustrating process for providers. He asserted that a more streamlined, centralized process is already in place and working for 800,000 physicians across the nation through the CAQH. Ms. Gorenz clarified that the CAQH application is utilized primarily by national health plans. The HSC will accept that application when it conducts primary source verification. New Mexico has its own standardized application that 95% of the physicians that the HSC credentials use, and it is working well for them. Dr. Ganz agreed that there are opportunities to work together to create more efficiencies to the process. Ms. Gorenz noted that with the new Insurance Division regulations, there will be an opportunity to track the effectiveness and time it takes to credential a provider. Improvement should be seen.

Committee members requested clarification of whether the HSC is state-run and its relationship with the New Mexico Medical Board. A question was asked about who is required to be credentialed in hospitals and other settings. Options were discussed to achieve administrative simplification of the process and the potential for a group of stakeholders to come together to do this. Committee members wondered whether corporate national policies are a barrier to individual state solutions to these problems and whether the Indian Health Service (IHS) mirrors the process for everyone else. The IHS has its own internal process for credentialing; neither the HSC nor the San Juan IPA credentials those providers. It was noted that credentialing seems to duplicate licensure and is very expensive. Some discussion occurred regarding whether an "any willing provider" law would eliminate any of these problems. Support was expressed for a more streamlined credentialing process to retain doctors as providers in New Mexico. Questions were asked about the total cost of credentialing: individual physicians are not usually charged and the hospital or the health plan absorbs the cost. It was noted, however, that it can take between 20 to 40 hours for a practitioner to fill out one application. Considering all the associated documentation that must be accumulated, the cost in lost productivity can be enormous.

Clarification was sought regarding whether the Insurance Division regulations apply to all providers who need to be credentialed; these new regulations apply to the health plans and require more timely processing of applications. The committee recognized that during the 120 days that a physician is awaiting credentialing, the physician is seeing patients but not getting paid. Questions were raised regarding which insurance companies are taking the longest and shortest times to process applications. A request was made that the committee see the data accumulated by HealthSouth on this topic.

It was acknowledged that delays occur during post-credentialing, when a health plan enters the information into its systems. These delays contribute to providers not getting paid; this additional time can take from 30 to 45 additional days. A committee member commented that credentialing through the health plans has a stranglehold on health care providers and that this is a major contributor to the cost of health care in New Mexico. A question was asked regarding whether providers who are not members of the San Juan IPA can get credentialed through it. Ms. Brooks is working with the insurance companies and plans to accomplish this. Clarification was sought regarding how and why practitioners are referred to the national practitioner database and whether or not this step can be abused. The committee acknowledged that this issue is very complex and difficult to address.

Opportunities for Improved Credentialing Coordination Pursuant to Section 27-2-1.2 NMSA 1978

Larry Heyeck, deputy director, Medical Assistance Division (MAD), HSD, stated that he has personal experience with the credentialing process that predates his current role in the HSD. He asserted that the process does need to be simplified and that the HSD is obligated to work on this. HSD contract provisions and regulations require that the process must be completed within 45 days. The MAD reviews applications of all questionable providers; this is a federal requirement and one for which it is audited. Great care must be taken to ensure that providers caring for Medicaid clients meet high standards. The contracted health plans have all met these high standards. Mr. Heyeck spoke in support of the accreditation processes required by the NCQA and the JCAHO, including the credentialing requirements. This does not mean the process should not be simplified, and the HSD is working with the Insurance Division to do this. He suggested that a memorial calling for all stakeholders to come together to address this would be very valuable.

Committee members asked whether the Insurance Division new 45-day time line applies to Medicaid. Mr. Heyeck stated that the time line does apply, but that the requirement for use of a standardized form does not. More consultation with the Insurance Division is needed, but the goal of a uniform process and form is reasonable. He offered to respond to this committee with a letter before the end of the calendar year responding to these requests. The chair noted that the committee's last meeting is the first week in November and requested that something be presented at that time. Mr. Heyeck agreed.

Morris J. (Mo) Chavez, superintendent of insurance, was invited to make comments. He stated that the Insurance Division is ready and willing to work together with interested parties to achieve simplicity and uniformity and will be diligent in implementing the new regulations.

Medicaid Breast and Cervical Cancer Treatment Program

Gena Love, cancer prevention and control section head, DOH, Julie Weinberg, deputy director, MAD, and Kathryn Karnowsky, management analyst, MAD, provided information about the breast and cervical cancer treatment program in New Mexico. Ms. Love described the DOH program, which is funded by the federal Centers for Disease Control and Prevention (CDC) and which screens low-income women for breast cancer. Currently, the funding allows the department to screen an estimated 18% of eligible women, according to the eligibility standards set by the CDC. The goal is to screen early enough to allow for the most effective treatment. In 2002, treatment for these women became a benefit of Medicaid. The DOH and the HSD have worked together to ensure that all screened women have access to treatment. Funding comes from various sources, including a CDC grant, the tobacco settlement funds (TSF) and revenues from license plates. Approximately 90 women per year are referred to Medicaid as a result of this early screening. Ms. Weinberg provided background information about this program in Medicaid. The program is an optional eligibility category, which includes a requirement that the woman has been screened through the DOH's screening program. She provided data regarding the number of women served since its inception, how much the program has cost in actual paid claims and statistics regarding screenings and diagnoses of women in New Mexico. In 2008, 11,822 women were screened by the DOH; 95 were diagnosed with breast cancer and eight with cervical cancer. She noted that the federal medical assistance percentages (FMAP) for this program is 80%, which is higher than the traditional Medicaid program.

Committee members asked questions regarding the growth in the number of women served and the overall cost of the program; why the costs have increased substantially more than the number of women served; whether any woman is ever rejected for care once referred; and how quickly women are served once they are referred. Presumptive eligibility allows women to be served on the same day that cancer is diagnosed. The DOH case manager works with the diagnosed women to ensure that treatment is provided immediately in the most appropriate setting. Clarification was sought regarding the numbers of women who are covered for these services and how many new women are served each year. Approximately 90 women come into the program each year. A question was asked about the source of the TSF that is allocated to Medicaid; the Tobacco Settlement Permanent Fund is not tapped for Medicaid. A question was asked about the outcome and survival rate for women served by this program. Overall, women who are screened early have vastly better survival rates, which is why the DOH works diligently to screen women early. Women who are Medicaid-eligible tend to be screened at a much more advanced stage of the disease. Women remain on the program as long as the physician certifies that they are receiving treatment. Traci Cadigan, American Cancer Society, affirmed that one-half of the TSF goes into the permanent fund as part of the settlement and the other one-half remains available to be used for purposes such as this program. Clarification was sought regarding the eligibility process, presumptive eligibility and whether illegal immigrants are eligible to receive these services. Medicaid cannot cover women who are not legal.

Cambiar New Mexico

Bob Tafoya, chief of staff, and Debra Pritchard, director, Juvenile Justice Division, Children, Youth and Families Department (CYFD), presented updated information regarding the Cambiar New Mexico program. The program, based on the Missouri model, holds youth accountable for their actions through the use of youth care specialists who serve as counselors, mentors and coaches to the youth. Services are provided in settings that resemble a home or college campus setting. This program was implemented in New Mexico over a 12-month period beginning in July 2007. Demographic information about the clients served was presented; 96% of the clients are being served in 10 southern counties. The CYFD has a training institute to assist supervisors and managers to understand the goals and expectations of this model. The CYFD has collaborated with the Missouri Youth Services Institute (MYSI) to accomplish this training as well as to manage the units through appropriate evaluation and policies. Emphasis on team units allows for improved relationships with clients, as well as positive staff-to-staff and client-to-client relationships. The CYFD has established a supervised release panel to evaluate the progress and treatment plans of the clients. The CYFD continually monitors facility population trends to ensure appropriate use of secure and non-secure facilities. The CYFD has redesigned the focus of community corrections programs to also emphasize a team approach and to ensure that juvenile probation officers are supporting youth in the community through case planning and case management. Ms. Pritchard identified numerous ongoing challenges. Transitioning from a correctional to a rehabilitative model and addressing behavioral health issues of clients on an ongoing basis are ambitious tasks. Issues of employee recruitment, retention and overtime are demanding and some staff continue to resist the model. Secretary of Children, Youth and Families Dorian Dodson has established a juvenile justice commission, consisting of experts in the field, to provide external recommendations to the department regarding the juvenile justice system. Recommendations have been made regarding Cambiar New Mexico, as well as other areas. Performance measures that the CYFD reports quarterly to the legislature were provided.

Committee members had questions about whether youth are followed for a period of time after discharge into the community; community parole officers are much more engaged in helping youth be successful in the community and reducing recidivism rates. Questions were asked about the characteristics of the client population, where they are housed and whether members of the legislature are welcome to visit these facilities unannounced. A question was asked about how many youth are in a facility due to violence and the comprehensiveness of risk assessments that are performed on admission. Ms. Pritchard asserted that all clients in the CYFD facilities receive the same attention to safety. Questions were asked about the disposition of youth who are older than age 18 who re-offend; the CYFD is tracking the long-term disposition of these youth. Concern was expressed that the legislature does not have a clear picture of the problems with youth offenders based on the information presented. Thanks and appreciation were offered regarding the service provided by this program. Questions were asked about how youth are helped to continue their education while in a CYFD facility; the nature and extent of psychiatric services provided to the youth; and how youth with continuing behavioral health needs are served after discharge. Assurances were sought that facilities and behavioral health providers are receiving their funding on a timely basis.

Committee members had questions and made comments about Cambiar New Mexico. Recognition was offered that the Missouri model is a valuable model that has a very low recidivism rate and serves to rehabilitate youth and keep them out of the adult system. A committee member urged other committee members to visit Missouri and witness the model first-hand. Ms. Pritchard suggested that visiting a New Mexico facility would be equally valuable. A suggestion was made that during the next interim, the committee consider visiting the J. Paul Taylor Institute in Las Cruces. A question was asked about how the model serves youth with severely unstable mental health conditions; Ms. Pritchard assured the committee that the excellent staff is very well qualified to meet these needs and does so on a daily basis.

Behavioral Health Survey Results

Senator Gerald Ortiz y Pino presented the findings of a survey he requested the LCS to conduct on his behalf regarding community providers' perception of the transition to OptumHealth New Mexico (OHNM) as the statewide entity (SE) to manage behavioral health services. He noted that the survey consisted of 10 questions that were sent to 62 behavioral health providers, 49 of which responded. He stated that this survey does not purport to be a statistically valid survey; nonetheless, it reflects some serious concerns among the provider community. He reviewed the questions and responses as reflected in the handout (see the meeting file).

Linda Roebuck, director, Interagency Behavioral Health Purchasing Collaborative, (IBHPC) and Dr. Sandra Forquer, president, OHNM, were invited to comment if they wished. Ms. Roebuck stated that she is well aware of the problems and has become increasingly dissatisfied. She has called in national consultants to conduct a diagnostic assessment; they found that the problems are not attributable to providers, but that serious system issues exist. Dr. Forquer acknowledged that there are serious issues and that she is working very hard to fix them. They have prepared a letter to the provider community to get their input on the proposed changes. She described "service registration", which is an area of serious problems. Ms. Roebuck noted that service registration is closely tied to payment of claims, so a problem with one affects the other. Although the system established to provide expedited payments will ultimately require a reconciliation to an actual claim, Ms. Roebuck stated that no recoupment of inaccurate payments will occur until the registration and claims system is working well. OHNM is in the process of customizing payment processes for the future until the system is working smoothly. Four administrative relief pieces are being put in place to ameliorate the problems: first, providers will only need to register consumers at the beginning and end of care; second, providers will not need to enter service requirements prospectively; third, enrollment of clients will only have to occur once, regardless of how many sites the client utilizes within a single organization; and fourth, enrollment and registration will be brought in-house for institutional providers.

Committee members had many questions and concerns as follows:

- the amount of administrative cost incurred by OHNM; approximately 12.6% of a total of approximately \$46 million;
- a concern that New Mexico is outsourcing money to an out-of-state, for-profit organization;

- a contention that the concept of the IBHPC should be revisited;
- an assertion that one provider is owed close to \$1 million and has hired an attorney; attorney costs will only add to the cost to the state;
- frustration about not understanding the entire behavioral health system, including the roles of the IBHPC and the SE;
- frustration about whether IBHPC money is being well-spent, whether there is enough being spent and a feeling that there is inadequate accountability over the system;
- frustration that inadequate system testing was conducted in advance of taking over the contract;
- concern that the lack of ability to play claims will drive providers out of the state;
- a request that a similar survey be conducted for the coordination of long-term services (CoLTS) program;
- an observation that the collaborative concept has not solved the problem of fragmentation;
- an acknowledgment by Ms. Roebuck that a deeper look needs to be taken at all levels of behavioral health (BH) administration;
- concern that providers are feeling a sense of retaliation when they raise questions or concerns; Dr. Forquer strongly asserted that any individual instance of retaliation that she becomes aware of would result in that staff person being terminated;
- thanks to Senator Ortiz y Pino for conducting this survey;
- appreciation to the provider community for shielding clients from the effects of these problems;
- a fear that clients are not receiving needed services;
- a question of why this occurred because OHNM has experience in other states; New Mexico has some unique issues, including more funding streams than other states and more complexity;
- a hope that the IBHPC will conduct surveys on an ongoing basis;
- frustration regarding assurances (August) from the IBHPC that providers would be paid and problems would be fixed;
- consideration of what would work better;
- whether any corrective action is called for or required at this time; Ms. Roebuck has asked for a legal opinion on exactly what corrective actions and sanctions are available to the IBHPC;
- a request that by the next day, the IBHPC lawyers identify what the sanctions will be, what interest will be paid to providers for late or improperly denied claims and how the state will be made whole;
- a comment that the vendor should pay the bill for the independent assessment that is being performed;
- a fear that some clients will end up in the correctional system;
- a desire that the issue be handled like a business, with OHNM held accountable, not the clients;
- clarification regarding when interest is paid on unpaid claims; interest can only be assessed on claims that have been entered into the system;

- a request was made that information about claims paid be made available to the committee in some form other than in the aggregate to allow the committee to fully comprehend the financial landscape of the problem; and
- a request was made of Deputy Secretary Falls to provide the same information regarding the CoLTS program.

A committee member read a statement calling for the HSD to immediately discontinue the CoLTS program and return to the previous long-term care system. It was noted that the statement is unrelated to the debate about the IBHPC. A committee member expressed concern that the motion would lead to contractual problems. Following a brief discussion, the chair suggested revisiting the topic at a later time.

Public Comment

Dr. David Ley, director, New Mexico Solutions, one of the organizations that responded to the survey, and Shannon Freedle, C.E.O., Team Builders, Inc., thanked the committee and Senator Ortiz y Pino for conducting the survey. They stated that providers are frustrated that the IBHPC has not made more progress in three years. The system is complex with many conflicting rules. Having a single contractor limits the effectiveness of the state system. Providers have been asking the same questions for a long time, and they feel they have not been invited to be part of solving the problem. In other parts of the country, providers or provider cooperatives are part of the decision-making during the planning process and not only as problem solvers. Dr. Ley commended OHNM and Ms. Roebuck for working very hard to fix things, but the system is still not fixed. Providers are requesting an invoice billing system until the OHNM billing system is fixed. Providers have absorbed the impact of the problem, using all reserves and leaving no reserves to deal with projected Medicaid shortfalls. Mr. Freedle testified that his agency has a presence in 14 counties around the state. It submits well over \$4 million in claims, about 40% of which have not shown up in the OHNM claims system. This appears to be a systemic problem for which no one receives notification. In August, his agency was paid for only about \$.60 on the dollar; in July, around \$.30 on the dollar; and no reimbursement has yet been received for September. He contends that no amount of training would have helped because the system does not work. He implored the committee not to do away with the whole SE contract, as providers could not survive another major change. Dr. Ley stated the desire of the provider community to work with OHNM and the IBHPC to address and fix the problems.

Committee members expressed a belief that small providers should be paid interest on late payments. Clarification was sought about whether providers are or are not currently involved in the problem-solving process. Dr. Ley and Mr. Freedle stated that they have ability to make public comment but are not partners to the IBHPC process. A question was asked regarding whether the state could automatically pay a percentage of unpaid claims. The expedited payment system was set up to address just that. The IBHPC and the SE are working on solutions, and Mr. Freedle hopes that the problem will not be ongoing. Committee members expressed concern that OHNM gets the state's money with no repercussions for its failures. One committee member believes this problem is very widespread in other departments, other contracts and other programs where payments are not being made for contracted services. A clarification was sought regarding

whether providers fear retaliation or being labeled as troublemakers; the fear is for lost referrals or having concerns discounted. A question was asked regarding the rejection rate of claims; this was recognized as a new problem, the extent of which is unknown. When claims are rejected, the provider is not receiving notification of the rejection and neither is OHNM. Previously, providers have seen one-third of claims paid, one-third denied and one-third pending. So far, providers are continuing to provide services, but soon they may no longer be able to. Expedited payment has helped, but it promotes a false sense of viability.

Deputy Secretary Falls corrected information given yesterday regarding the SCI. There are no pre-existing conditions for SCI; however, some applicants are encouraged to apply to the NMMIP instead, as it is a better program.

The committee recessed for the day at 5:20 p.m.

Wednesday, October 14

The meeting was reconvened by the chair at 8:50 a.m.

Healthy New Mexico Task Force: Goals and Progress: Program to Integrate Early Intervention and Case Management in Underserved Communities

Alfredo Vigil, M.D., secretary of health, offered preliminary comments regarding prevention and wellness efforts in the DOH and the nation. He described the goals and mandates in SB 129, legislation that required the development of a Healthy New Mexico Task Force in the DOH. He updated the committee on statistics regarding chronic disease and what the DOH is doing to address chronic disease and its impact in New Mexico. He described the process the DOH followed to address the requirements of the legislation, which included working with New Mexico First to convene two town hall meetings to gather input from a broad audience. Over 170 people participated in one of two town hall sessions and generated nearly 100 recommendations. Secretary Vigil briefly summarized recommendations that were made in the areas of healthy eating, physical activity, tobacco control and clinical preventive services. Legislative recommendations were highlighted. Ongoing efforts to address these focus areas were described. The department will continue to monitor these efforts, as well as continue to lead the Interagency Council for the Prevention of Obesity and to partner with the Healthy Weight Council statewide. The DOH supports the integration of medical, dental, behavioral and public health services to meet the needs of the community such as those provided at the South Valley Health Commons and the Hidalgo Medical Services. Health commons delivery systems are emerging in other locations and are supported by the department as well.

Committee members asked whether early results are available comparing these initiatives to determine whether any model is more successful than any other. The DOH tracks and monitors all the DOH programs; a racial and ethnic health disparities report card was provided to committee members that reflects this information. Members wondered which approaches motivate people to change; the best results are seen when an entire community becomes involved. A request was made for the DOH to provide data on the characteristics of the obese, especially

very young children. The critical importance of collecting and monitoring data in all areas was stressed, and committee members expressed a need for guidance from the DOH regarding establishing priorities for data collection. Dr. Vigil noted that data collection is an expensive and underfunded venture. Questions were asked regarding why the town hall recommendations contain no recommendations on alcohol use and abuse and whether the DOH is still actively involved in this area. Clarification was sought about a Las Cruces health and wellness initiative and the changes in school schedules that promote healthier behaviors without adding to the cost of education. These measures are now being replicated in schools in other locations. A suggestion was made to add diet drinks to the recommendation to impose a tax on sweetened beverages and junk food. Patty Morris, director of obesity programs, DOH, provided details about the numerous initiatives being promoted around the state, including collaborations with the Women, Infants and Children (WIC) program, outreach to schools, cooking classes and others. Clarification was sought regarding the source of the recommendations. The recommendations came from the 170 participants of the town hall meetings. Concerns were expressed regarding the unique health issues affecting Native Americans and how they are being addressed within the DOH. Committee members asked how parents are educated about the health needs and behaviors of their children. Appreciation and support was expressed for family gardens and other initiatives that can be implemented in schools and that work to change behaviors at little or no cost. Committee members were interested in how outreach to rural areas is accomplished. The importance of personal and parental responsibility was raised. A committee member volunteered to work with the department to obtain funding from the Millbank Foundation to develop a research project on obesity. Obesity was compared to a public health problem, as the impact of obesity is so great and affects so many areas of health care delivery, coverage and reform.

Dr. Vigil provided an update on the H1N1 vaccine. This vaccine has been developed on an expedited basis, and new shipments will be distributed to states and providers on a rolling, weekly basis as they become available. The DOH has an effective distribution system that is working. It is being administered to all high-risk populations under the direction of the DOH. He acknowledged that the virus is in full swing and is ahead of the availability of the vaccine. Just yesterday, instructions were sent to all state employees urging them to stay home if they are sick and included instructions about how to use their sick leave.

Disease Management and Healthy Lifestyle Promotion in Employee Health Plans

Nancy Bearce, bureau chief, Employee Benefits Bureau, Risk Management Division, General Services Department, presented information on efforts undertaken by the state to promote healthy behaviors among state employees. State employee health insurance statistics were provided. She described the advantages of medical, pharmacy, dental, vision and wellness benefits. Disease management programs are available for an additional per member, per month fee, with employees most interested in disease management for asthma, diabetes, low back pain and heart/pulmonary disease. A wellness initiative, called *Get Well New Mexico*, began in 2005. It includes activities such as health fairs, risk assessments and education in healthy eating, exercise and tobacco and alcohol cessation activities. In 2008 and 2009, the state began mobile mammography and expanded the activities of health fairs to include blood pressure, naprapathy and raffles for memberships to gyms, bicycles and other prizes that promote health and wellness.

Physicians are encouraged to prescribe walking for diabetics in a program known as the prescription trails program. Currently, the bureau is working to re-energize wellness efforts; performance measures have been added to track effectiveness in this area. All the health plans offering state employee health insurance have wellness, disease management and case management staff, including 24-hour nurse hotlines. The Risk Management Division was able to retain many prevention and wellness benefits in the state health insurance plan despite budget cuts. The return on investment reported by carriers is \$2.00 saved for every \$1.00 spent on wellness activities. The Risk Management Division is eager to continue to participate in and partner with the Health New Mexico Task Force.

Given the positive ratio of savings for prevention and wellness, questions were asked about barriers to keeping these benefits in the face of rising health insurance premiums. It was acknowledged that individual savings do not necessarily translate into aggregate savings for the state. Clarification was requested regarding the disease management vendors; these are within the health plans at an average cost of \$2.60 per member, per month. The results of the use of disease management are measured and reported quarterly to the state. A question was asked as to whether employees receive a discount on premiums for participation in disease management; no, employees are eligible for discounts for such things as gym memberships directly from the plan in which they are enrolled. Ms. Hubbard stated that there is new interest in offering discounts that are directly connected to outcomes; an important element of such a program is to have educational support to help enrollees quit smoking, lose weight or other activities. These incentives, however, are not available to state employees at this time. Joanie Pompeo, Presbyterian Health Plan, stated that employee wellness initiatives have been successful and resulted in no increases in premiums, but they do not offer discounts. Ms. Pompeo emphasized that these are not available to state employees. Jennifer Sedillo of United Healthcare stated that United Healthcare offers no discounts to state employees compliant with wellness behaviors, but it does offer some discounts to other customers. Clarification was requested regarding whether state laws relative to premium allocation would need to be changed to allow state employees to have access to the discounts that are available to other insurance beneficiaries. The responses stated that the law is silent with regard to healthy behaviors; permissive language in the law would be beneficial to giving access to discounts to state employees. An observation was made that collection of data about prevention, wellness and disease management activities among state employees could lead to an ability to project and measure productivity, absenteeism and lifestyle changes as well as reduced health care costs. Ms. Bearce agreed that collection of this data would be beneficial; currently, this would require close collaboration with other state agencies and divisions, such as the State Personnel Office. A consolidated database would be helpful. A question was asked about why state employees choose an indemnity plan rather than a managed care plan. A question was asked about the coverage, if any, of behavioral health services; yes, all four plans provide this coverage, including coverage for diagnosis and assessment of autism.

Primary Care Case Management

Mr. Heyeck testified that Medicaid fee-for-service clients, who are the only ones who could benefit from a primary care case management program, represent a very small portion of the total population enrolled in Medicaid. The department has tried to develop primary care case

management for Native Americans, but has been unable to find a vendor to implement it. He stated, however, that the development of patient-centered medical homes is being started and closely mirrors the concept of primary care case management.

Mr. Heyeck was asked if the HSD is, in fact, not implementing this pilot program as required by law. He stated that the HSD has been unable to find a provider to implement it and was not funded to do it. Approximately 80,000 people remain in fee-for-service programs, but that number is shrinking. The promise of patient-centered medical homes within managed care will serve more people going forward. With the implementation of the CoLTS program, many expensive Medicaid recipients previously in the fee-for-service population, such as the developmentally disabled, are now in a managed care environment. A question was asked about which HSD Native American liaison efforts are underway. A committee member referenced the primary care network model that predated managed care in Medicaid. A study performed by UNM indicated a savings to the program of \$53 million in that project. Mr. Heyeck responded that the implementation of managed care was a result of the success of that project and has resulted in major savings to the state every year. Additionally, as more Medicaid recipients are covered by managed care, the savings will increase. A request was made for the studies that show savings under managed care. A committee member contended that reimbursement for primary care physicians is so low that they are simply referring patients to specialists. If primary care physicians were adequately reimbursed for care management, the overall cost of health care would decrease. This is the concept of the patient-centered medical home.

Chronic Disease Management Initiatives in Private Insurance

Mr. Howarth, director, New Mexico Health Policy Commission (HPC), described a survey conducted by the HPC of seven managed care plans, four of which responded to the survey. Results of the survey indicate that three of the four respondents do offer incentive programs that reward health care providers for controlling chronic diseases. The chronic diseases for which these incentives are awarded are asthma, behavioral health issues, cardiovascular conditions, diabetes and hypertension. Other incentive program components include breast and cervical cancer screenings, early prenatal care, immunizations and postpartum depression and well child visits. Participating managed care plans use health care effectiveness data and information set (HEDIS) measures to track the effectiveness of these initiatives. No studies have been conducted to determine the actual benefit of these incentives; however, managed care companies perceive benefits in the areas of improved health of beneficiaries, clinical effectiveness of care provided and decreased hospitalizations. Disadvantages noted were increased administrative costs, a presumption that providers should be providing this kind of care anyway without incentives and that the current system of reimbursement is based on fees for services rendered, not outcomes, and therefore does not easily accommodate incentive pay. The HPC offered three recommendations: continue to monitor national health reform, focusing especially on wellness initiatives; perform a literature review analysis to determine what existing wellness and prevention programs have demonstrated success; and perform a literature review on outcome-based models of reimbursement.

Committee members asked whether the UNM Cares model has improved health outcomes and reduced emergency room use. An observation was made that managed care companies have very little incentive to provide wellness programs when many members have the opportunity to change plans on a yearly basis, thereby robbing the plans of the benefits of a healthier membership. Alternately, these benefits can be considered to be enticements to members choosing a particular managed care organization. Ms. Hubbard offered the comment that health plans believe that over time, they will realize cost benefits of wellness programs. The survey did not address this issue. It was noted that there is a big difference between chronic care management and screening. The cost-to-benefit ratio is more easily demonstrated in chronic care management. Committee members were interested in the variation of premiums for the health plans to state employees. Mr. Howarth will see that the information is provided. Ms. Hubbard was asked whether Lovelace has conducted any definitive studies regarding the effectiveness of disease management. She replied that HEDIS measures, which are nationally measured, do demonstrate effectiveness of disease management; however, wellness and prevention studies have not yet demonstrated their effectiveness.

Cost of Chronic Illness and Wellness (HJM 24)

Heather Balas, president, New Mexico First, described the process by which this report on HJM 24 was prepared. The working group included a cross-section of participants representing business, state government and wellness providers. She described the known impact of chronic illness on employers and the return on investment that can be realized through implementation of workplace wellness programs. Many large employers are already implementing wellness programs, but most small employers cannot afford to do so. Recommendations include things that employers can do, that insurance companies can do and that the legislature, as an employer of state employees, could do. Recommended legislative solutions include a requirement for nutritious food to be available in vending machines in the workplace, tax credits for employers who implement worksite wellness programs, investment in comprehensive wellness programs for state employees and requiring state employee health insurance to conduct risk assessments on at least 5% of enrollees. Finally, the report recommends that this committee host an expert presentation by a national worksite wellness economist during the 2010 interim. The HJM 24 working group is looking into sponsorship for this expert's travel and expenses.

Committee members asked how the projected savings were estimated. The information was derived from a study that was conducted by the Wisconsin Public Health and Health Policy Institute, which is included in the report. Questions were also asked about the voluntary steps being recommended for health plans to take and whether the contract with health plans for state employees insurance coverage requires availability of health risk assessment. Health risk assessments are available, but are not a requirement. Setting a benchmark would incentivize the plans to educate members about this benefit. Jim Campbell, Wellness Improvement Experts, noted that the cost of chronic disease to an employer is three times the cost of the absenteeism rate for that employer. Susan Jacobi, Johnson & Johnson, who is a member of the HJM 24 task force, stressed that a cooperative effort is necessary among employers, employees and insurers to ensure the effectiveness of wellness programs.

Eating Disorder Programs

Sandra Lynn Whisler, M.D., professor of pediatrics, UNM, shared a personal story of her daughter's struggle with anorexia, the lack of providers to treat this condition and the exorbitant cost of obtaining treatment. She provided background information about eating disorders and the lack of availability of providers in New Mexico. Eating disorders have increased since the 1950s and now cross all ethnic groups, affecting younger and younger children. It can progress to a chronic, lifelong disease. Eating disorders have the highest mortality rate of all the psychiatric disorders. To effectively treat this condition, UNM contemplates an integrated approach managing physical, psychiatric and nutritional needs of patients. Outpatient programs should have both intensive and supportive levels of treatment, and an inpatient program is needed as well to treat children in New Mexico. Preventive programs are also critical. Dr. David Graeber, M.D., noted that treating this disease is very challenging. Early and intense evaluation would help determine the level of care and support needed for each child.

Committee members asked whether the current physician capacity at UNM could accommodate such a program. Dr. Whisler and Dr. Graeber are trying to generate interest in this concept, which is in the conceptual stage of development. The disease is unrecognized and underdiagnosed. By the time an anorectic child is seen, the disease is generally very advanced. A question was asked about how a concerned parent or health care provider could find a provider with expertise in eating disorders. It was emphasized that treatment requires a well-coordinated team approach to be successful. Questions were asked about the scope of this problem statewide. Those providers who do treat eating disorders report incidents all over the state; however, the belief is that many cases are going undiagnosed.

Research Report: Threats to the Behavioral Health Safety Net Providers Since the Implementation of the IBHPC

Marnie Watson, research associate and senior ethnographer, along with Miria Kano, program manager and senior ethnographer, Behavioral Health Research Center of the Southwest, began by defining ethnography, which is a qualitative approach to conducting research. Ms. Watson apologized for the absence of the principal investigator on this project, Cathleen E. Willging. The purpose of the study is to provide an overview of major themes in behavioral health safety net institutions (SNIs) within the context of New Mexico behavioral health reform. She identified the sample and characteristics of the SNIs that participated in the study and the methods of gathering the information, which included both qualitative and quantitative approaches. Themes that emerged were that the new behavioral health structure in New Mexico has resulted in administrative demands, financial issues, issues surrounding the comprehensive community support services (CCSS) program transition, fee-for-service transition issues and statewide entity transition issues. Administrative burdens resulted in increased costs to 60% of providers and decreased accessibility of services to clients. In general, financial problems increased throughout the four years of the study and were particularly profound in rural and economically depressed regions of the state. Specific issues included such problems as insufficient funding, fewer resources and transition stress. The lack of reimbursement for transportation was especially difficult in the CCSS program because it requires that services be provided *in vivo* as opposed to clients visiting a centralized location or office. Providers who

formerly relied on reimbursement made in one-twelfth draw-downs find the transition to fee-for-services billing very difficult due to the variability of this reimbursement.

Some good findings were also found, such as an ability to bring up new services, increased access to continuing education and training and a reorientation to the possibility of recovery for the most seriously ill clients. Clients and families are generally happy with the services they are receiving. Recommendations include the following: augment support for rural SNIs, or those that lack reserves; ensure providers that the new SE will not experience the same problems experienced by the previous SE; continue improved communication channels; reduce paperwork requirements; further evaluate of the effectiveness of CCSS; and continue to work with SNIs to improve their availability to track authorization and utilization of services.

Appreciation was expressed for the work of the researchers. Questions were asked regarding the people interviewed, the ultimate length of the study and a request for a copy of the final report when it is completed. A statement was made in support of hearing testimony such as this from someone other than state officials.

Public Comment

Roque Garcia commented that the BH system under the IBHPC has consistently discounted provider input and is a dismal failure. It is an inefficient system and is getting worse. Many providers used to have six months of reserves but are now down to 30 days or less. Administrative costs increased from 12% to more than 30%.

Behavioral Health Issues Revisited

Testimony the committee heard the previous day about the failures of the behavioral health system, particularly the failure of the new SE, were brought before the committee for additional debate and consideration.

Dr. Forquer, Ms. Roebuck, Deputy Secretary Falls, Bill Belzner, deputy director, IBHPC, and Mark Reynolds, general counsel, HSD, each made comments addressing the problems previously raised and indicated their willingness to respond to questions and concerns of the committee. Dr. Forquer noted that OHNM had experienced unanticipated logic problems with its computer system, but fixes are already in place. In response to a question regarding whether timeliness of payments is defined in the contract, Mr. Reynolds replied that time frames are set within which claims must be paid and this is supported by regulations. He is analyzing the current situation and preliminarily disputes whether OHNM is timely. Clarification was sought about the allegation that some submitted claims had been lost in the system.

Dr. Forquer admitted that there is clear evidence that providers have submitted more claims than OHNM can identify. Through diagnostic assessment, OHNM knows that there are approximately 30 large providers that use a particular software product called "connectivity directors". OHNM cannot identify claims the providers know they have submitted. Some of these claims are rejected without OHNM's knowledge; therefore, OHNM did not know the claims were submitted. OHNM has now committed to work through these rejected claims. Dr. Forquer

reiterated proposed changes to the billing process (described on Tuesday), indicating that these changes are outlined in a memo to providers. Provider input is necessary as the proposed changes are very significant. A copy of the memo was given to committee members.

Committee members asked if the IBHPC has determined if the SE is in compliance with the contract relating to payment of claims. Mr. Belzner reported that it is in substantial compliance with that one element of the contract. OHNM is currently under a plan of correction for one (unidentified) area of the contract, and diagnostic assessment may reveal other areas that are out of compliance. Ms. Roebuck clarified that the timely payment requirement concerns "clean claims"; OHNM is in compliance with that. OHNM is *not* paying the number and amount of claims submitted by providers. In fact, many claims are lost, and OHNM is unable to provide an explanation for what has happened to the lost claims. The IBHPC is assessing overall compliance with the contract.

Committee members had questions regarding penalties for lost claims and late payment of claims. Dr. Forquer advised the committee that she has received approval to use a provider's original date of claims submission to determine interest payments. A committee member asked to receive that in writing. Ms. Roebuck indicated that when the IBHPC and OHNM agree in writing on terms of compliance, they will share that written document with the committee. She noted that a formal agreement will have to be developed; she is reluctant to specify the details of that agreement until all findings are examined. Deputy Secretary Falls said that when it comes back before the committee in November, the IBHPC will be in a much better position to answer all of the committee's questions. She asserted that it has the same questions that the committee has.

Committee members wanted to know if the contract with the SE is tight enough or whether changes in the contract are anticipated. Additionally, the committee wanted to know whether sanctions are specified in the contract. Mr. Reynolds responded that sanctions are included in the contract. Analysis of compliance with the contract is ongoing; the early belief is that there is non-compliance with the contract. Article VIII addresses enforcement and the process for an array of sanctions and options. Once a determination is made that there is non-performance, Ms. Roebuck will take the finding to the IBHPC to determine the level of sanction. In response to a question, Mr. Belzner noted that the previous SE, ValueOptions New Mexico, was sanctioned 12 times; civil monetary penalties totaling \$12 million were assessed, some of which are still outstanding.

Committee members expressed dissatisfaction with the claims processing process, asserting that the process to validate OHNM's claims processing process was inadequate. A question was raised of whether a requirement for validation of the claims processing process was in the contract. Mr. Reynolds stated that it is not in the contract, but that it would be nice if it were. Committee members expressed general discontent with the lack of connection among the committee, the IBHPC and contract development and oversight. With a contract of this magnitude, the committee members expressed the opinion that they should be involved in the process of creating it at the beginning. Committee members also were surprised to hear that the previous SE had been sanctioned and felt that they should have heard about that at the time. Ms.

Roebuck stated that this information was reported to the Legislative Finance Committee (LFC) and that committee members sought assurance that providers know before signing a contract with the SE what services are covered in the contract. Mr. Belzner responded that OHNM was required to contract with all providers who wished to participate with no changes in covered services. There were changes to fee schedules and classifications.

Grave concern was expressed that providers will be put out of business due to the lack of reimbursement during the first three months of the transition to OHNM. In an emergency such as this, claims should be paid and providers protected. Regardless of the reasons, providers are not currently being paid, and they should be paid with no questions asked. In response to a question, providers in the audience indicated that the previous SE is paying claims. Concern was expressed that these and other issues should have been worked out during the transition.

Clarification was sought about the relationship between providers and the IBHPC if the system is not performing and what obligation the IBHPC has to make providers whole. Mr. Reynolds stated that the contract is between OHNM and the state; there is no contractual relationship between the state and providers. Ms. Roebuck added that the primary obligation of the IBHPC is to keep the services provided and paid. A committee member expressed a strong feeling that OHNM should be put on a 180-day notice and its contract terminated. It was noted that page 70 of the contract states that "the SE shall make every effort to reduce administrative burden on providers", and OHNM is not doing that.

Discussion followed regarding whether the IBHPC considered all the options, including a state monitor. Mr. Reynolds noted that the review of contract compliance is not yet complete. Appointment of a state monitor is one option. Should a state monitor be called for, it would be necessary first to determine what a state monitor should do. Committee members desired to know the cost of the diagnostic assessment and expressed the opinion that the assessment should be paid for by OHNM, not the IBHPC. Strong sentiment was expressed that payment for the diagnostic assessment should not come out of funds dedicated to development of new and innovative services and projects.

Public Comment

Mr. Garcia, director, Rio Grande Behavioral Health Services, testified that up to July 1, 2009, his company was being paid for 99% of claims on a timely basis. After July 1, payments went to zero.

Mr. Freedle stated that claims issues for providers are more than a technical issue and that finding OHNM to be in substantial compliance with payment requirements does not help providers get through the day. Of 78 claims his business submitted in July, OHNM only received 46. He implored the IBHPC to stop saying OHNM is in substantial compliance; the statement does not recognize rejections or denials of claims for reasons that are not understood. Providers feel things are not substantially OK.

Patsy Romero, consultant for northern providers and a former employee of ValueOptions New Mexico, said she was testifying as a taxpayer. She feels that the state was sold a bill of goods in this contract. The state was assured that things would go smoothly; however, providers cannot get answers and things are not working. A provider in Espanola had to postpone hiring a Spanish-speaking clinician because it has submitted \$1 million in claims but has only been paid a little over \$100,000. She feels that a state monitor is needed to monitor both the IBHPC and OHNM.

Jim Jackson, Disability Rights NM (DRNM) (on behalf of Nancy Koenigsberg), stated that the DRNM has heard many of the same issues, but has not been flooded with consumer complaints, which he feels is a testimony to the providers. If these issues are not dealt with quickly, there will be consumer complaints.

Carol Reinhardt, a provider, stated that her company's reserves are exhausted and a line of credit has been denied. She has already laid off some employees and cannot last much longer.

Violanda Nunez, executive director, Ayudantes, echoed previous comments and stated the situation is very urgent. She requested restoration of the one-twelfth draw-down method of reimbursement. Ayudantes is closing on October 30.

Following all the public comment, committee members sought assurance that payment would be sent to providers within one week. Ms. Roebuck stated that she could not guarantee that and that the issue of denials needs to be resolved first. A committee member asked Dr. Forquer if she has been paid by the state for September. Dr. Forquer replied that from July 1, 2009 through September 30, 2009, OHNM has received \$69,548,000. Of that, \$54 million is remaining. She declined to commit to paying providers within one week, but said OHNM is carefully looking at an invoice method of payment requested by providers. The committee member reiterated the request that payments to providers would be out within seven days. At least two providers have already made a decision to close. Deputy Secretary Falls and Secretary Vigil were urged to exert strong management and get this done. Deputy Secretary Falls replied that she will be working on that and that she does understand the emergency nature of the situation. Dr. Forquer asserted that nothing new is needed; an expedited payment process already allows for presumptive payments, but she cannot promise to pay all claims within seven days.

Committee members felt strongly that no providers should have to close their doors this month. A committee member stated that recoupment is a necessary part of this process; however, another committee member stated that the providers should not have to be held accountable for this round of payments because the SE has not been held accountable. This committee member will pursue further action if she hears that these claims are not being paid.

Senator Feldman made a motion urging the IBHPC to ensure that the SE make payments in full within seven days and with no recoupment. The motion was seconded by Representative Lujan. Brief discussion acknowledged the separation of powers and that the legislature does not have the authority to direct action in such a motion, but the motion expressed the strong feeling of

the committee calling for action by the executive. The chair called the question, and the motion was passed unanimously.

A committee member asked whether the interest rate of 1.5% on unpaid claims goes to the provider. The contract language seems unclear on this point. Mr. Reynolds thinks it is not clear, but that in the past, the interest has gone to the state. Committee members stated their belief that the provider should get the interest and that the contract should be changed to make that clear. A committee member, in a strongly worded statement, claimed that this whole set of problems should be seen as a failure of the executive and that if checks do not go out within seven days, resignations should be submitted. He stressed that the executive branch of government is ultimately accountable.

There being no further business, the committee adjourned at 5:20 p.m.