

**MINUTES
of the
THIRD MEETING
of the
BEHAVIORAL HEALTH SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

October 8, 2014

**Ballroom A, Student Union, University of New Mexico
Albuquerque**

The third meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Elizabeth "Liz" Thomson, chair, at 9:25 a.m. in Ballroom A of the Student Union at the University of New Mexico (UNM) in Albuquerque.

Present

Rep. Elizabeth "Liz" Thomson, Chair
Sen. Benny Shendo, Jr., Vice Chair
Sen. Craig W. Brandt
Sen. Howie C. Morales
Sen. Bill B. O'Neill
Sen. Gerald Ortiz y Pino
Sen. Mary Kay Papen
Rep. Edward C. Sandoval

Absent

Sen. Sue Wilson Beffort
Rep. Sandra D. Jeff
Rep. Paul A. Pacheco
Sen. Sander Rue

Guest Legislator

Sen. Linda M. Lopez

Staff

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS

Guests

The guest list is in the meeting file.

Handouts

Copies of all handouts, including those from public comment, are in the meeting file.

Wednesday, October 8

Welcome and Introductions

Representative Thomson welcomed those assembled and asked subcommittee members and staff to introduce themselves. The chair then introduced Richard Larson, M.D., Ph.D., executive vice chancellor and vice chancellor for research, UNM Health Sciences Center (UNMHSC).

Dr. Larson welcomed subcommittee members to the UNM campus and provided a handout highlighting challenges to and opportunities in behavioral health in New Mexico. He cited disparities — New Mexico leads the nation in deaths from drug overdose, and its rate of suicide is nearly twice the national average — and a fragmented behavioral health system with a limited work force at all levels. Intermediate-level programs and services need to be expanded, Dr. Larson said, as does coordination with primary care. A severe shortage of psychiatrists statewide is another problem. The Brain and Behavioral Health Institute (BBHI) at UNMHSC is seeking to address many of these challenges, Dr. Larson said, by providing research teams and programs, community education initiatives and support for interdisciplinary efforts. Goals of the BBHI also include expanding crisis services, including mobile crisis teams, and developing a crisis stabilization center in Bernalillo County.

Mental Health Parity

D. Brian Hufford, a partner at the Zuckerman Spaeder law firm in New York and a long-time health care litigator, described several common issues involving mental health parity: limiting numbers of treatment sessions; adding co-pays that apply only to mental health and addiction services; exclusion of residential care; policies that are inconsistent with standards of care in determining what is medically necessary; and repeated denials of coverage. Parity means that a person with mental illness should receive the same level of coverage as for medically necessary services. There are federal laws, including the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which require equal coverage for mental and physical health services, but enforcement is lacking at both federal and state levels, he said. In New Mexico, there is no parity for substance abuse treatment, and the law allows plans to turn down coverage, despite the fact that mental illness and substance abuse are often co-occurring. Urging that state law be amended by requiring compliance with appropriate guidelines for treatment, Mr. Hufford suggested that the parity law enacted by Illinois is a good model.

Lisa Reid, life and health director in the Office of Superintendent of Insurance (OSI), said that as a former mental health provider, she is pleased to see an increased focus on mental health parity in New Mexico. Network adequacy is a very big concern right now, she said, and dovetails into parity. The OSI is working with UNM to develop a tool to track and more closely monitor network adequacy issues.

Janice Torrez, vice president of external affairs for BlueCross BlueShield of New Mexico (BCBSNM), described her company's implementation of mental health parity rules and its

expansion of residential coverage for New Mexico members; policies renewing as of January 1, 2015 will reflect recent changes. The company's efforts also include training of employees to comply with the law; a provider advisory group that receives direct input from providers; and customer satisfaction surveys that are conducted regularly. The company uses the Milliman Care Guidelines for both physical and behavioral health decisions, Ms. Torrez said.

Anita Leal, executive director of CHRISTUS Health Plan, told subcommittee members that CHRISTUS will be in the New Mexico Health Insurance Exchange (NMHIX) as of January 1, 2015. Ms. Leal said her company has been challenged in finding mental health providers for its network. CHRISTUS has provided both mental and physical health services for veterans for more than two decades, she said, adding that it, too, follows the Milliman Care Guidelines for standards of care.

Marcello Maviglia, M.D., medical director of Molina Healthcare, said the main focus of Molina Healthcare is to provide the most effective and least restrictive treatment for mental health and substance abuse issues, with appropriate coordination and integration of care. Molina plans do not impose aggregate lifetime or annual dollar limits, Dr. Maviglia said, and the company is working toward complete compliance with mental health parity laws, including inpatient and outpatient care (see handout). Molina also utilizes member advisory boards and customer satisfaction surveys. Care coordination includes peer support specialists, community health workers and transitional coaches to ensure that recovery plans are being met. Molina services can also include traditional healing modalities for Native American and Hispanic populations.

New Mexico Health Connections (NMHC) is a physician-led, nonprofit cooperative, one of only 23 such cooperatives in the country, that will be offering plans on the NMHIX for individuals and businesses in January. Fifty percent of its board of directors are members. According to Matt McFadden, director of behavioral health management, NMHC, each plan includes mental illness and substance abuse coverage, and most outpatient services do not have limits on dollar amounts or the number of sessions. NMHC wants to encourage the use of these services, he said, because if mental health is addressed, then all health issues are addressed. To increase behavioral health service access, the company has reduced the number of services that require prior authorization, and if a member is denied services, a letter of explanation will include forms and instructions on how to appeal the decision.

Liz Locatur, executive director of behavioral health for Presbyterian Health Plan, Inc., said her company has more than 400,000 members in New Mexico, who comprise nearly one out of three insureds. There is close coordination between health plans and the actual service delivery system, Ms. Locatur said, and many opportunities to work directly with members. Presbyterian maintains a robust structure to comply with mental health parity laws and federal Patient Protection and Affordable Care Act (ACA) requirements, including a regulatory department with subject matter expertise led by a board-certified psychiatrist. Feedback from providers and consumers is sought regularly, and frequent adjustments are made as a result.

Harris Silver, M.D., a retired surgeon who is a health care and drug policy analyst and coordinator of the Bernalillo County Opioid Abuse Accountability Initiative, described the MHPAEA (see handout). In 2013, final rules were promulgated, and insurance plans that must comply with the law include group plans, with 50 or more employees, that offer mental health and/or substance use disorder benefits, all plans in ACA insurance exchanges and all Medicaid managed care organizations (MCOs). Describing three separate cases of individuals who were denied residential treatment in New Mexico (see handout), Dr. Silver revealed the lack of coverage for residential treatment under the following types of health insurance offered in New Mexico:

- few of the larger employers and almost none of smaller employers;
- almost none of the individual and family policies offered on or off the NMHIX; and
- none of the Medicaid MCOs, except for BCBSNM, which offers limited residential treatment when there are certain physical diseases also present, as a "value-added service".

Despite the fact that New Mexico leads the nation in alcohol-related deaths, is second in drug overdose deaths and third in suicides, the state has only 150 beds at three residential treatment centers, with just 60 of those certified for substance abuse treatment, according to Dr. Silver. He described the national Parity Implementation Coalition composed of professional organizations that are pushing for the inclusion of residential treatment in all health plans. There are numerous studies showing the benefits of residential treatment for substance use and certain mental disorders, Dr. Silver said, and it is central to the American Society of Addiction Medicine (ASAM) evidence-based criteria for treatment. He listed a series of actions by New Mexico's Medicaid MCOs that could be considered violations of the MHPAEA, including denial of residential treatment for substance abuse, eating disorders and other mental disorders; refusal of reimbursement for court-ordered treatment; and a "fail first" policy for mental disorders but not for physical disorders, among others. He also cited the Human Services Department (HSD) funding freeze of 15 behavioral health provider agencies, affecting 87 percent of Medicaid constituents receiving mental health/substance abuse services, as a potential MHPAEA violation, since there was no similar scrutiny of medical and surgical providers. Dr. Silver urged legislators to report violations to federal and state agencies and to convene a task force of providers to determine how medical necessity is defined and what mental health/substance use parity should be in New Mexico.

LCS staff noted that UnitedHealthcare declined the subcommittee's invitation to send a representative to participate in today's panel discussion.

On questioning, panel participants and subcommittee members discussed the following topics.

Why are there so few treatment beds in New Mexico? A member noted that the shortage goes beyond beds; there simply are not enough providers. Mr. Hufford responded that if New

Mexico required health insurance policies to cover residential treatment, an increase in beds would follow. Another factor contributing to the shortage of beds is the low rate of reimbursement to providers, he said. Dr. Silver agreed, adding that residential facilities have closed due to low rates of reimbursement and the extended length of time it takes to get paid. Dr. Maviglia said that these are complex issues that have forced crowding of emergency rooms and jails. Another member asked Dr. Silver if all states struggle with this shortage of beds. Not all, Dr. Silver responded: New York created a treatment system, as did North Carolina. Once states require health insurance policies to cover mental health/substance use, health insurers are incentivized not to send patients out of state, Mr. Hufford pointed out, but appropriate reimbursement rates are critical. The ACA says states cannot discriminate among licensed providers, and this may be worth further investigation as a means of enforcing parity, he added. Litigation against an insurer should be a last resort; it is more important for states to establish a system of oversight and enforcement of parity. He urged that ASAM standards be a part of the discussion in crafting legislation to strengthen New Mexico's parity laws.

Other potential violations of existing law. A member inquired about possible violations of the federal Americans with Disabilities Act of 1990 based on discrimination in the denial of treatment services. Mr. Hufford said this definitely could be a civil rights issue, as could be the disruption of services that occurred in New Mexico in 2013. Dr. Silver pointed out the \$12.00 return on investment for every \$1.00 spent on substance abuse treatment, which costs New Mexico \$2 billion to \$3 billion a year. Successful treatment is not all medical, he continued. It includes treating co-occurring and multigenerational issues. Supports are not available in New Mexico, but they are in other states. Another member asserted that until New Mexico gets serious about getting people well, nothing is going to happen; mental health issues go hand-in-hand with substance abuse.

Loophole in the ACA. Dr. Silver described an ACA prohibition on spending Medicaid dollars in facilities with more than 16 beds and the considerable debate surrounding a possible remedy, and he referenced a recent article in *The New York Times* examining the problem (see handout). In California, some facilities have divided up into multiple corporations to get around this prohibition. Parity is not being enforced with New Mexico's Medicaid MCOs, Dr. Silver asserted, but this is not a federal issue; it is a state problem that begins with the HSD. There is nothing in the state's Medicaid waiver about residential treatment.

MCO help with possible New Mexico solutions. One member asked panel participants representing MCOs if their organizations would be willing to work with legislators to craft stronger parity enforcement. Dr. Maviglia emphasized that it would be a mistake to expect residential treatment to solve all of the problems without a better system of care and after-care support, including housing and jobs. Mr. McFadden agreed, saying there is a clear need for residential care, and his organization would not oppose strengthening the law. Ms. Torrez reiterated that BCBSNM does cover residential care and would be glad to work with the subcommittee to help identify other solutions. Ms. Locatur said Presbyterian Health Plan is supportive of a continuum of care, and lack of residential treatment is just one aspect of the

problem. Ms. Leal said CHRISTUS would support exploring better solutions, noting that her company offers many different programs in Texas that are not available through Medicaid in New Mexico.

A member moved that LCS staff begin working on draft legislation to incorporate changes to the state's parity laws suggested by Mr. Hufford and others to give to the LHHS for its consideration. The motion was seconded and passed unanimously.

Minutes Approved

Minutes from the subcommittee's September 17 meeting in Silver City were approved, with instructions to double-check and correct the roster of members listed as attending the meeting. The November 5 meeting of the subcommittee originally scheduled for Gallup made it likely that several members would not be able to attend due to its proximity to the November 4 elections. Members voted and approved moving the meeting to Friday, November 7, in Santa Fe.

Public Comment

Ernesto Baca, legislative coordinator, OSI, said that he needs a sponsor for legislation to update the definition of autism to match the current Diagnostic and Statistical Manual of Mental Disorders.

Evelyn Blanchard, M.S.W., Ph.D., told members she is leading an effort at New Mexico Highlands University's School of Social Work to incorporate a Native American social work institute there, which will be the first in the country. The school of social work's mission upon its 1974 founding pledged to focus on Hispanic and Native American education, Dr. Blanchard told members, and while the effort for Hispanic education has largely been fulfilled, this is not the case for Native Americans. The proposed institute will concentrate on curriculum development, preparation of faculty and participation of New Mexico's Native American populations to ensure that the curriculum is responsive to their needs (see handout). Dr. Blanchard said the school can provide space and material support, and she is seeking endorsement from the Indian Affairs Committee and will be coming to the legislature to seek an appropriation for the program.

Cora Williams said she is a consumer with complicated health issues and does not understand why she cannot deal with all of her concerns in a single visit. She knows her therapist and said she does not want him to be told what kind of medicine she can have or what he can do for her. Ms. Williams said she was told by BCBSNM that she needs to have three different home care providers, which seems like a waste of resources. She is concerned that consumers are not getting what they need.

Ellen Pinnes, attorney and health policy consultant, said she is concerned about data from the HSD since the switch to Arizona mental health providers. In a recent presentation to the Legislative Finance Committee (LFC), the HSD touted increased numbers of consumers receiving behavioral health services. She wanted to call subcommittee members' attention to the

fact that during the last two quarters of 2013, service levels had dropped significantly, and this needs to be taken into account.

Presbyterian Medical Services (PMS) Report on Behavioral Health Services and Capacity

Doug Smith, executive vice president, PMS, described the history of PMS, which is not affiliated with Presbyterian Healthcare Services, Presbyterian Hospitals or Presbyterian Health Plan. PMS is a successor to the United Presbyterian Church's mission work that began in 1901 and was incorporated in 1969 as a New Mexico-based 501(c)(3) organization (see handout). While PMS started out providing only medical services, community needs soon drove it to diversify and to provide clinical integration. Today, PMS provides services to more than 60,000 individuals in 45 health centers in 16 New Mexico counties, Mr. Smith said. PMS is a designated behavioral health core service agency and conducts approximately 140,000 visits annually, in addition to operating a 16-bed adolescent residential treatment center in San Juan County and providing veterans' and family support services. PMS also operates 27 early childhood education facilities, two home care and hospice centers and five senior centers, and it employs 1,150 individuals statewide.

Bill Belzer, director of behavioral health for PMS, described the nonprofit organization's integrated model of behavioral health services delivery, which includes co-located medical and behavioral health programs, the use of fully integrated electronic health records, universal screening for depression and for substance abuse, telephonic psychiatric consultation for primary care providers, outreach to remote communities and populations, housing and employment support, 24/7 crisis services, patient-centered medical homes and comprehensive community support services. Mr. Belzer also outlined PMS' extensive use of evidence-based practices, and he provided a chart of behavioral health users by quarter that showed a drop of 1,400 consumers between the second and fourth quarters of 2013 (see handout). In June 2013, PMS was one of 15 New Mexico behavioral health care providers whose Medicaid payments were suspended following allegations of fraud by the HSD. In October 2013, PMS settled with the state for \$4 million.

On questioning, Mr. Smith, Mr. Belzer and subcommittee members discussed the following topics.

Change in business structure. Asked if PMS was urged to sell its business to an Arizona provider, the executives confirmed that representatives of the HSD, Diana McWilliams and Larry Heyeck, initially told the executives that they could either transition to an Arizona provider or operate under temporary management by an Arizona company. PMS was asked to partner with La Frontera and was urged to terminate all employees, who would then be hired by La Frontera. After resolution of the credible allegations of fraud, PMS was told the employees then could be terminated by La Frontera and rehired by PMS. This plan was dropped when PMS informed the HSD representatives that laying off that many people would require advance notice under federal law and could not be done quickly.

Request for good-cause exception hearing. Within days of being informed of fraud allegations against it, PMS filed a request for a good-cause exception hearing to restore Medicaid funding. PMS did not receive a formal denial of this request for an exception and for a hearing, Mr. Smith said, but was told by HSD representatives that the request would be denied until the attorney general completed his investigation. The state, however, was willing to discuss a settlement. PMS considered laying off 230 employees statewide and the impact of this layoff on services that the organization provides to several thousand consumers, Mr. Smith said, but decided instead to continue operating on its reserves.

D *Dealings with OptumHealth New Mexico (Optum).* In the five years prior to the allegations of fraud against PMS, the company did not receive any notices from Optum of program integrity problems, nor was it ever approached regarding overbilling or other performance issues, Mr. Smith said. PMS staff worked regularly with Optum during this period and was never told of any concerns; regular Optum audits of PMS gave it scores ranging from 88 percent to 97 percent. Mr. Smith confirmed that Elizabeth Martin, chief executive officer of Optum, was involved in settlement discussions.

R *Terms of settlement.* PMS settled with the HSD in order to stay in business, Mr. Smith said. Behavioral health was about 20 percent of its services, and by the date of settlement in late October 2013, discussions had continued for three months, and the nonprofit was within weeks of exhausting its reserves. The \$4 million settlement was based on an extrapolated amount of possible overbilling determined in the Public Consulting Group, Inc. (PCG) audit conducted by the HSD of 15 suspected agencies. PMS disagreed with PCG's findings, Mr. Smith said. PMS' own internal audits had not identified any problems, and once the company was able to see the PCG audit during settlement discussions (the document had to be returned to the HSD as a condition of settlement) and to examine the transactions flagged by PCG, there were zero findings, Mr. Smith said, absolutely not any fraud. PCG told PMS that the HSD would not allow PCG to consider PMS' evidence. The settlement was not a fine or penalty, did not require an admission of guilt and cleared PMS of civil but not criminal liability, Mr. Smith explained. PMS agreed to release the state from future legal action. To date, PMS has not been contacted by the Office of the Attorney General.

Motivation for today's testimony. Mr. Smith and Mr. Belzer said they agreed to speak out at this subcommittee meeting because they are proud of what PMS has accomplished and its commitment to continue services during the extended financial crisis. PMS desires to be a good partner to the state, the executives asserted, and they would like to see remedies put into place so that this cannot happen again.

Results First Cost Benefit Analysis of Behavioral Health Services

Ashleigh Holand is manager of state policy for the Results First Initiative, a collaborative project of The Pew Charitable Trusts and the MacArthur Foundation that is helping state leaders to invest in programs that work (see handout). By identifying current program investments and considering whether the benefits justify the costs, states like New Mexico have been using

rigorous evidence to identify programs that achieve the best results. The first step is to conduct a program inventory, Ms. Holand said, providing statistics from the state's criminal justice programs. Step two is to assess program costs per participant; step three is to predict and monetize outcomes (long-term benefits); and the final step is a cost-benefit ratio for each program. Results First provides a software program and data that incorporate many national studies in its templates.

Jon Courtney, Ph.D., program evaluation manager for the LFC, where the state's Results First Initiative is being implemented, presented a new research report on evidence-based behavioral health programs (see handout). Dr. Courtney noted that the state continues to lead the nation in damaging substance abuse and mental health outcomes despite four transformations of the behavioral health system over the past two decades. The report identifies some programs that are potentially good investments for the state in light of the Medicaid expansion and more than \$537 million budgeted for behavioral health services in fiscal year 2015. The service strategy known as Screening, Brief Intervention and Referral to Treatment (SBIRT) has proven effective, but grant funding ran out. Fortunately, a new grant has been received. Because the HSD claims data are not very detailed, close analysis is hampered, and the state's Interagency Behavioral Health Purchasing Collaborative does not have a comprehensive grasp on what it is spending, Dr. Courtney said.

Charles Sallee, deputy director of the LFC, said that with New Mexico spending over half a billion dollars and a lot more in the future as Medicaid expands, this is a key strategic moment to target and implement what works. Two key categories to look at are supportive housing and assertive community treatment, Mr. Sallee said, urging a focus of resources on high needs. He also urged consideration of multigenerational impacts, including maternal depression, which can cause lasting damage to infants. Mr. Sallee said that the HSD is currently exploring the possibility of including SBIRT as a Medicaid-reimbursable service, and the LFC is examining the possibility of using Medicaid funding for supportive housing.

Project ECHO Proposal to Expand Capacity to Provide Behavioral Health Services in Primary Care

Miriam Komaromy, M.D., associate director of Project ECHO and associate professor of internal medicine at UNMHSC, presented a five-year plan to expand access to treatment for mental health and substance use disorders in a primary care setting (see handout). Known as the ECHO Access Expansion Project, the program would train small teams of primary care providers (a nurse practitioner or physician assistant plus a community health worker and a consulting physician) working in rural and underserved areas to provide high-quality intensive services. Training and support for the primary care team would be provided through the Project ECHO Integrated Addictions and Psychiatry (IAP) Program, Dr. Komaromy said. A pilot version of the proposed project is currently in progress, and in the initial four months of operation, four teams have delivered more than 2,200 visits focused on behavioral health or substance use disorders. The goal of the larger project is to establish clinic teams in 20 community health centers throughout the state that will provide screening, diagnosis and treatment and ongoing case-based

learning and mentorship through the IAP teleECHO program. It is anticipated that, after certain changes to billing codes, team members ultimately will be able to submit sufficient claims to support their salaries. In order to provide a high-quality independent evaluation of program outcomes, an external evaluator, Mathematica Policy Research in Princeton, New Jersey, is prepared to offer an evaluation of the program (see handout). Tina Carlson, manager of behavioral health and addictions at Project ECHO, said that integration into primary care settings is a very cost-effective way to screen and treat these conditions.

Heading Home Proposal

Dennis Plummer, chief executive officer of Albuquerque Heading Home (AHH), described a massive outreach by 250 volunteers from multiple organizations who surveyed people in the Albuquerque area living on the streets or in shelters. According to Jodie Jepson, deputy director of AHH, 1,301 persons were interviewed, 978 of whom were persons experiencing chronic homelessness and who were medically vulnerable. Since then, more than 400 individuals have been permanently housed. It was a multifocused, community-wide assessment, Mr. Plummer said, and it was the result of months of meetings and planning. Those interviewed were prioritized by greatest health risks (see handouts). After 12 months, there has been an 82 percent success rate, according to Mr. Plummer.

Heading Home uses a systematic model that can be replicated, Mr. Plummer said, and includes the provision of housing dollars (vouchers), case management, ongoing facilitation of partner agency work and collaboration on data gathering and research. Mental illness is addressed by assertive community treatment with an interdisciplinary team providing direct care, case management and a link to 24/7 services. Other services provided include social, educational and life skills support. AHH has significantly reduced homelessness in Albuquerque, as well as emergency room visits, Mr. Plummer asserted. A recent study of cost-effectiveness of the AHH program, conducted for the City of Albuquerque by the UNM Institute for Social Research (see handout) found that AHH saved 31.6 percent, or about \$12,831.68 per study group member. A flow chart prepared by the federal Substance Abuse and Mental Health Services Administration captures the AHH model (see handout), according to Mr. Plummer, and a homeless management information system required by the federal Department of Housing and Urban Development provides a coordinated assessment and unified database that can be used for intake statewide.

Last year, a team from the City of Anaheim came to Albuquerque to observe the AHH program for possible use in the California community, and it is now moving forward. Mr. Plummer said he would like to seek funding to teach the AHH model to other communities that would then come up with their own solutions. He has heard of interest by Las Cruces and Gallup, but the AHH has not officially approached other cities since it cannot guarantee any funding, Mr. Plummer said. A subcommittee member noted that even though the mayor of Albuquerque has put his support behind the organization, Mr. Plummer remains "the captain of the team" and is very much responsible for the remarkable success of this collaboration.

Public Comment

Jim Jackson, executive director of Disability Rights New Mexico, said his organization supports great programs like the last two described to subcommittee members, and he urged them to take the lead in expanding access with these programs and to work to convince legislative colleagues to support them.

Cora Williams said she was homeless for 35 years, and she thinks the AHH program is outstanding. If a person has been out on the street, that person has posttraumatic stress disorder (PTSD), she said, and often takes drugs to just to survive. It is terrifying, she said. Medical marijuana works to address symptoms of PTSD, so why is it not covered by insurance?, she asked.

A letter from Daniel Kerlinsky, M.D., an Albuquerque psychiatrist, urged that each city and town in New Mexico conduct a mental health parity day to talk about depression, suicide, anger management, substance abuse, parenting and marital problems in the context of health and the right to health care. Most New Mexicans have no idea that there is a MHPAEA, Dr. Kerlinsky wrote. An education program is needed so that people can break down the barriers to getting help, and the MHPAEA should obligate health insurance companies to develop services wherever a need is identified.

Adjournment

There being no more business before the subcommittee, the meeting adjourned at 4:54 p.m.

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