A Report to Governor Bill Richardson Addressing Health Care Coverage and Access in New Mexico

Governor's Task Force on
Health Care Coverage and Access
Steering Committee Final Report
October 15, 2003

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Governor Bill Richardson's
Health Care Coverage and Access Task Force
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A. Overall Recommendations

1. Within the ultimate goal of universal coverage and access, incremental steps need to be taken. Each step taken must be developed and implemented not as a final solution in itself, but with consideration of its contribution to the ultimate goal.
2. Coverage and access to care are interdependent. Initiatives are needed to address both access to care and coverage.
3. Assuring coverage and access for all people living in New Mexico as defined by this Task Force should be a shared responsibility of individuals and families; New Mexico businesses; state, local, tribal, and federal governments; and organizations established to assist the public/community in that endeavor.
4. New Mexico should use common, objective measures to track changes over time on access and coverage issues.
5. Current potential Medicaid reductions being discussed for FY05 are likely to increase the number of uninsured or underinsured New Mexicans. Any such cuts should be avoided if possible. If cuts occur, they should be done to reduce benefits before reducing eligibility as much as possible.
6. New Mexico state level leadership should advocate at the federal level for health care reform on a range of issues that affect health care coverage and access in the state.
7. All of these recommendations will require additional development and analysis to determine feasibility and cost, conducted collaboratively by the Executive and Legislative branches with input from public and private stakeholders.

B. Recommendations About Coverage

Strategy One: Maximize Medicaid as resources for match are available.

Strategy Two: Explore the development of an insurance purchasing pool (IPP) to provide cooperative and voluntary purchasing options for businesses, non-profit employers, governments, tribes and tribal enterprises, individuals (including those with low incomes), and families to purchase basic, comprehensive, catastrophic, and long-term care coverage at rates they can afford.

Strategy Three: Implement financial policies - including tax code changes, reimbursement rates, and data collection and use - that will: a) encourage individuals, families, and employers to purchase coverage; b) encourage health care professionals to come to, stay in, and practice in New Mexico, especially in rural areas and for Medicaid and Medicare clients; and c) assist policymakers to track and address health care access and coverage issues.

C. Recommendations About Access

Strategy Four: Develop and implement a comprehensive statewide health care plan, including strategies to increase access, educate the public, utilize existing resources, and develop the workforce.

Strategy Five: Reform behavioral health (mental health and substance abuse) system.

Strategy Six: Establish state oversight of nursing home and hospital facilities related to financial stability and impact on access to services

D. Recommendations About Next Steps

The best timing for initial legislative action on these recommendations is in the January 2004 regular session, with any subsequently needed legislation addressed in special or regular sessions later. Therefore, the Governor should provide an appropriate message for bills relating to health care during the 2004 regular session.

Strategy Seven: Define clear accountabilities within the Executive Branch for implementation of the recommended action steps in this report, as approved by the Governor.

Strategy Eight: Establish clear scopes of work for advisory and oversight committees in relation to these action steps; communicate information and opportunities for input to stakeholders.

Governor Bill Richardson's
Health Care Coverage and Access Task Force
Steering Committee Report

I. BACKGROUND

A. Charge

The Governor's Health Care Coverage and Access Task Force (HCCA Task Force) was charged by Governor Bill Richardson to make recommendations regarding a range of ideas outlined in the Governor's Proposed Health Care Agenda for New Mexico to assure health insurance coverage and health care access. The Steering Committee of the Task Force prepared this report, utilizing input from the Task Force members.

Eight Guiding Principles from the Governor were utilized in the Task Force and Committee deliberations (Attachment A). The Committee also defined key terms for this report (Attachment B). These definitions are utilized throughout this document.

Membership in the Task Force and Steering Committee represented a broad cross section of legislative, business, provider, advocate, government, and community leadership. The Task Force was co-chaired by Jim Hinton, CEO of Presbyterian Healthcare Services, and Ellen Leitzer, J.D., Co-Director, Senior Citizens Law Office. The Committee was staffed by Secretaries Patricia Montoya, Department of Health and Pamela Hyde, Human Services Department. Members of the Steering Committee and the larger Task Force are listed in Attachment C.

The full Task Force met three times and the Steering Committee held three additional meetings between July and October 2003. In addition, subgroups (Strategy Teams) of the Task Force met one additional time in September 2003.

B. Status of Coverage and Access in New Mexico

Much could be written about the lack of any or adequate insurance for people living in New Mexico. However, a few key facts from available information set the context for this report. These include:

- Medicaid is the single largest payer of health care for New Mexicans, covering 21.3 percent of total state population;
- 20.7 percent of New Mexicans are uninsured, with no coverage at any time during the previous calendar year;

- Of the 79.3 percent of New Mexicans with some insurance during part the previous calendar year, some have insurance only part of the year and some have inadequate insurance;
- A significant portion (approximately one-third) of children and adults below 100 percent and 200 percent Federal Poverty Level are uninsured;
- As many as 62 percent of uninsured New Mexican adults and 29 percent of insured adults report having unmet health needs;[1]
- Regardless of coverage, 36 percent of adult New Mexicans have unmet health care needs, according to the U.S. Census Bureau;
- $300 million in uncompensated care, or 15% of total health care premium costs, in New Mexico are due to care of uninsured;
- The public supports 75-85 percent of uncompensated care through federal, state and local government programs;[2]
- Impacts of lack of coverage include much greater likelihood of emergency room use at a higher than necessary cost, and diagnosis of disease at later and more costly stage of illness;
- Uninsured people with chronic illnesses receive fewer services and have increased morbidity and worse outcomes; nationally, 18,000 uninsured Americans die prematurely.[3]
- 251,854 individuals were served by primary care community clinics; 83,090 Native Americans were served by IHS; there are 187,000 veterans in the state. The degree of overlap among these figures is not well defined.

II. RECOMMENDATIONS

A. Overall Recommendations

1. **Within the ultimate goal of universal coverage and access, incremental steps need to be taken.** The Task Force supports an ultimate goal of universal coverage and access for all New Mexicans. We realize that this goal will take time. Incremental opportunities must be utilized to reach that goal, as resources are available. Each step taken must be developed and implemented not as a final solution in itself, but with consideration of its contribution to the ultimate goal. These steps must be chosen in light of long-term economic impacts, and should represent a consistent, coherent whole, recognizing flexibility in approaches. Consistent with Governor Richardson's comments, the goal is universal access utilizing a variety of public and private mechanisms. Since the Governor expressed his opinion that a

[1] U.S. Census Bureau, Current Population Survey; NM Health Policy Commission, Household Survey: "Unmet health care needs" is measured in this manner: when asked about their ability to access health care, individuals could respond that they were able to receive care "sometimes," "never," or "whenever" they sought it. Individuals responding "sometimes" or "never" were considered to have unmet needs.
[2] National Academy of Sciences, Institute of Medicine (2003). *Hidden Costs, Value Lost: Uninsurance in America.*
[3] Ibid, p. 2.

combination of public and private approaches was preferable to a single payer system at this time, the Task Force did not discuss a single payer system as an alternative for recommendation to the Governor.

2. **Coverage and access to care are interdependent.** The Task Force has defined access to care as the ability of everyone in New Mexico to obtain appropriate, timely, cost effective care. This definition does not include use of an Emergency Room for non-emergency needs, and recognizes the need for access to services beyond primary care. Coverage alone does not assure access to care, as documented in recent national and New Mexico data. In addition, reimbursement from persons with coverage is a critical foundation for the financial viability of care providers. Cost-shifting by providers to cover the costs of those without coverage leads to increased costs and higher premiums for those with coverage. While persons without coverage do have some access to primary care and some report having no unmet needs, the majority do have unmet health care needs. Society pays in increased costs and reduced productivity due to these unmet health care needs of the uninsured. Therefore, initiatives are needed to address both issues, to improve and sustain the health of New Mexicans in a cost-effective manner for everyone.

3. **Assuring coverage and access for all people living in New Mexico as defined by this Task Force should be a shared responsibility of individuals and families; New Mexico businesses; state, local, tribal and federal governments; and organizations established to assist the public/community in that endeavor.** We should not assume at this point in time that government will fund all health care coverage or access for people living in New Mexico. Rather, the individual should share in the cost to the extent they are able. Businesses and non-profit employers should participate in the cost of health care coverage for their employees, and that coverage should be portable, to the extent possible. Government should help individuals, businesses and non-profit employers to afford the cost of coverage and health care, but should only pay for such coverage for those who are otherwise unable to pay for it. Public and private sectors should play a shared leadership role in making sure such coverage is available and affordable through the private market or through publicly funded subsidy for those who unable to pay. Individuals also need to exercise personal responsibility in prevention of illness and in appropriate use of health care resources.

4. **New Mexico should use common, objective measures to track changes over time on access and coverage issues.** Shared and consistent use of such measures across various stakeholders will enhance collaboration, reinforce progress, guide improvements, and insure accountability. Planning to address coverage and access issues and tracking these measures will require collection and reporting of consistent high quality data. In addition to measures of access and coverage, six key themes highlighted in the Governor's Agenda merit continued monitoring as initiatives are designed and implemented. When these common measures are finalized, consideration should be given to the establishment of clear

target levels and timeframes for each measure, utilizing input of stakeholders with responsibility for reaching the targets.

The indicators listed below for these themes are a starting point for defining shared measures for access, coverage, and these themes:

Theme	Indicator
Reduce cost of coverage	Reduce the rate of controllable growth of total health care expenditures (including costs to families, payers, uncompensated care), with these specific components: - costs for individuals and families -costs for payers -cost effective use of existing services -burden on providers of uncompensated care
Expand adequacy of coverage	Uninsured: -Reduce uninsured by a defined percentage per year each year over a specified number of years, pursuant to the comprehensive statewide strategic health plan -Maintain same percentage who have coverage Underinsured: -Increase number of people who have coverage that includes behavioral health, primary care, specialty care, and preventive care, at an affordable cost
Improve consistency of coverage	-Reduce number of persons with interrupted coverage for 12 consecutive months -Increase the months/year of coverage per person living in NM
Increase availability of care	-Ratio of appropriate health care professionals and services, in relation to benchmarks
Enhance quality of care	-Reduce severity of illness at time of diagnosis
Improve appropriate utilization	-Increase positive perception of appropriate utilization, based on survey of people and providers AND/ OR -Utilize an objective, quantifiable measure of utilization, similar to those usually used in health care, but including alternative providers

5. **Current potential Medicaid reductions being discussed for FY05 are likely to increase the number of uninsured or underinsured New Mexicans.** Any such cuts should be avoided if possible. If they occur, they should be done in such a way as to reduce benefits before reducing eligibility as much as possible. Revenue enhancements such as increasing the premium tax or implementing a nursing home, residential treatment center (RTC), and Intermediate Care Facility/Mental Retardation bed fee that would be included in the Medicaid rate for these services should be considered in lieu of budget cuts where possible.

6. **Provide state level leadership in advocating at the federal level for health care reform.** Advocacy should address increasing the priority of health care issues on the federal agenda, federal responsibility for the costs of health care for persons dually eligible for both Medicaid and Medicare; Medicaid reform allowing more flexibility while protecting the state/federal partnership and without block grants or allotments; increased disproportionate share hospital (DSH) funds; more flexibility in the use of SCHIP funds and in retaining unspent allocations; federal tax reform that encourages and supports the purchase of coverage; national tort reform; and bipartisan health care reform that would provide health care coverage and access for more people living in America.

7. **All of these recommendations about reducing the uninsured and increasing access will require additional development and analysis.** The Task Force Steering Committee recognizes that all of the recommendations in this report will require additional analysis to determine feasibility and costs. The costs reflected in the report at this point are general estimates rather than specific projections for budget planning. Each recommendation could be put into operation in a number of ways and on different timeframes, thus affecting the cost. The source of funds to implement these recommendations could also vary. In keeping with the Governor's principle of fiscal viability, the Task Force Steering Committee assumes that further work will be done by stakeholders, Governor's office, state departments, consultants, and/or the Legislature before final proposals are presented to the Legislature for action.

B. Recommendations About Coverage

The goals of the Task Force Steering Committee's recommendations about coverage are as follows, in priority order:

1. Decrease the number of Medicaid eligible children who are not enrolled;
2. Decrease the number of children whose families have access to employer-based or other commercial coverage but who are not enrolled;
3. Decrease the number of parents and guardians of Medicaid children who do not have some form of health coverage;
4. Decrease the number of low-income working adults who are uninsured;
5. Decrease the number of people living in New Mexico who are underinsured;
6. Increase the number of employers who offer at least a basic coverage plan for their employees;
7. Provide affordable options for the purchase of coverage to some children and their families and to certain low-income working adults, as well as to New Mexico businesses and non-profit employers; and
8. Decrease the number of different publicly purchased health coverage infrastructures to increase efficiencies and cost to taxpayers.

Strategy One: Maximize Medicaid as Resources for Match Are Available

Justification:

1. Medicaid brings into the state either $3 or $4 for every $1 in General Fund expended through federal matching funds, resulting in approximately $5.68 in economic activity. This economic activity results in revenue back to the General Fund (GF), thereby reducing the investment to less than 69¢ in General Fund. New Mexico has failed to utilize $85 million in available SCHIP money for children's health care and will soon lose another $70 million if these funds are not utilized by September 2004. This means a loss of almost $1 billion in economic activity for the state's economy.
2. There is no cheaper way to provide coverage for children and low-income adults, freeing other public dollars (e.g., public health clinics) to cover other uninsured adults.
3. The resulting savings to businesses and to health care systems in reduced uncompensated care will offset many of these costs; a portion of these savings may be able to be used to fund the GF portion of this strategy through an assessment on those businesses who do not offer employer-based coverage (either on their own or through the insurance pool described below) and through an assessment on facilities/health care systems whose uncompensated care costs are reduced.

Action Step 1: Conduct aggressive outreach to reduce the number of Medicaid- and SCHIP eligible but unenrolled children from 54,000 to 25,000. Encourage parents and guardians to insure their minor children through Medicaid, if they are eligible.

- Cost @ ~$2000 per child per year = $58 million (total); $10.5 – 14.5 million (GF)
- Cost of Outreach = $1.5 million(total); $750,000 (GF)

Action Step 2: Implement the State Coverage Initiative (SCI) for low-income working adults with children, up to 200% Federal Poverty Level (FPL), with a limited benefit approximately comparable to a Basic Plan, and with premiums and co-pays.

- Current cost estimates for 10,000 adults = first year estimates are $16.2 million (total public funds); $1 million (GF); $2 million in other match funds from public hospital or county indigent funds; and the rest in employer and employee cost-sharing; subsequent years will require additional matching dollars to allow up to 40,000 adults to participate.[4]

Action Step 3: Increase Medicaid eligibility for adults to 100% FPL, with at least a Basic Plan benefit package and co-payments as allowed by the federal government.

[4] These figures are subject to additional actuarial analysis and may change.

- Cost = @ ~$3720 per person ($950 State General Fund) per year x an estimated 71,250 adults (assuming 75% enrollment rate) = $265 million total; $67.7 million State General Fund.

Action Step 4: Remove automatic pharmacy dispensing payments and allow for negotiated fees.

- Cost = Would reduce the costs of pharmacy dispensing for Medicaid.

Action Step 5: Enroll all waiting list children in the Disabled and Elderly waiver.

- Cost = ~$16,667 per child x 355 children = $59.2 million total; $14.8 State General Fund.

Action Step 6: Establish a waiver for services for individuals with traumatic brain injury.

- Costs for TBI are to be determined (would likely be higher than providing PCO services for such individuals).

Action Step 7: Encourage Medicaid and Medicare dually eligible individuals to participate in *Salud!* MCOs or a PCCM alternative.

- Cost = Should decrease costs.

Action Step 8: Add licensed chiropractors, acupuncturists, native healers, certified peer counselors, certified nutritionists, and certified midwives to the Medicaid program where the use of such practitioners can be shown to reduce an eligible individual's health care costs with the same or better outcomes.

- Cost = Should decrease cost of care for the individuals receiving the care.

Strategy Two: Explore the development of an insurance purchasing pool (IPP) to provide cooperative and voluntary purchasing options for businesses, non-profit employers, governments, tribes and tribal enterprises, individuals (including those with low-incomes), and families to purchase basic, comprehensive, catastrophic, and long-term care coverage at rates they can afford.

Justification:

1. Currently, several different entities funded by taxpayer monies purchase coverage or health care administrative services on behalf of various populations (state employees, school employees, state retirees, small employers, high risk individuals who are otherwise uninsurable, Medicaid enrollees, city and county employees,

state university employees and retirees, etc.). Each of these entities has its own administrative and information system infrastructure. Combining these efforts and entities may possibly achieve two cost saving results: a) reduce administrative costs and b) provide purchasing power for some types of benefits (e.g., pharmaceuticals).

2. Because the IBAC is still evolving, the economic benefit and impact of the existing public purchasing consortium (IBAC) has not been systematically analyzed or documented. Data regarding possible effects of such a coordinated purchasing approach should be developed and analyzed.
3. A possible benefit to a pooled purchasing arrangement is the provision of a vehicle for commercial purchasers and individuals to use voluntarily if coverage is not available through other means. Small employers who want to provide coverage benefits for their employees sometimes cannot afford these benefits, especially if one or more of the small group is deemed to be a high utilization risk. Persons who are self-employed or not working often cannot find coverage offered at affordable rates for individuals or families without being part of a group.
4. The use of IBAC or an IPP as this vehicle for voluntary employer and private individual participation would need analysis to determine impacts on existing pools' costs.
5. It may be cost-effective to the state and the economy as a whole to subsidize the cost of coverage for some individuals (e.g., through the Medicaid system or the New Mexico high risk pool) in order to keep the cost of coverage and/or the cost of health care down for those who can afford all or part of the cost of their care.
6. A pooled purchasing approach may result in increased numbers of individuals and families with health coverage while using the private coverage market for underwriting and plan administration.
7. Currently, several jurisdictions around the country are in various stages of developing and implementing purchasing pools. These efforts may provide useful guidance to New Mexico as it considers the development of an IPP.
8. The impact on the private insurance market and on New Mexico's healthcare infrastructure, economy and access issues are not currently known. While there may be merit in pooling arrangements, the potential economic effect on the existing healthcare infrastructure and market should be considered.

Action Step 1: Review and analyze pooling projects in other jurisdictions and the concept of private participation in IBAC. Develop a small work group of stakeholders to work with Executive and Legislative branch leaders to evaluate the information and determine the best approach to public and comprehensive pooling in New Mexico.

Action Step 2: Explore benefits and costs of consolidating existing publicly funded health insurance pools and authorities into one administrative entity and insurance purchasing pool (IPP) that will purchase and/or administer health care coverage on behalf of all publicly funded populations. At a minimum, state employees, state retirees, public school employees, state colleges and university employees and students, counties, cities, Medicaid, and possibly the state high risk pool, and the health coverage alliance should be considered for analysis of some or all purchasing and administrative processes (e.g., pharmacy, information systems, procurement processes,

marketing, plan administration, etc.). Charge the Legislative Health and Human Services Committee, as part of the comprehensive health care cost study, to explore the benefits and costs in partnership with and using the expertise of the Executive Branch, public and private entities, and include its findings in the report due November 2004.

- Cost = To be determined; savings in administrative costs and savings in cost of coverage may accrue.

Action Step 3: Allow small employers to reduce the cost of their employees' coverage by placing high risk individuals in the portion of the IPP that covers individuals with high risks or the current New Mexico high risk pool, to the extent allowable by law.

- Cost = To be determined, depending on numbers referred and federal funds available to subsidize the coverage for those with special conditions; attention would have to be paid to comparability of coverage.

Action Step 4: Allow employers who have not provided or contributed to the cost of health coverage for their employees in the last 12 months to buy into the pooled purchasing entity with the costs borne by the employer and its employees.

- Cost = To be determined.

Action Step 5: Assess need for mandatory approach to coverage through all public and private employers by 2008, based on evaluation of impact of voluntary strategies that have been implemented.

- Cost = To be determined, depending on numbers of lives covered and type of plans offered, paid for by employees and employers who voluntarily participate in the IPP.

Action Step 6: Develop and offer through the IPP at least one of each of the following: a) a Basic Plan; b) additional benefits to create Comprehensive Plans for employers or individuals who want to "buy up"; c) a long-term care product; d) a catastrophic policy or reinsurance program. Develop and offer a state-sponsored reinsurance product.

- Cost = To be determined, depending on types of products offered and numbers and types of populations covered, paid for by employers and employees and other individuals who voluntarily participate in the IPP.

Action Step 7: Develop and offer through the IPP or other pooled purchasing arrangement a voluntary professional liability product(s) for health care professionals, within state laws regarding malpractice.

- Cost = To be determined, depending on types of products offered and numbers and types of populations covered, paid for by employers and

employees and other individuals who voluntarily participate in the pooled purchasing arrangement.

Action Step 8: Evaluate the operation and evolution of IBAC as a potential model for an IPP in the future.

Strategy Three: Implement financial policies – including tax code changes, reimbursement rates, and data collection and use – that will: a) encourage Individuals, families and employers to purchase coverage; b) encourage health care professionals to come to, stay in and practice in New Mexico, especially in rural areas and for Medicaid and Medicare clients; and c) assist policymakers to track and address health care access and coverage issues.

Justification:

1. New Mexico's tax structure is currently being reviewed for change, modernization and equity of applicability. Taxes should not be changed in such a way that will reduce the available General Fund for Medicaid match, or will reduce the amount of federal funds received by the state for health care.
2. Tax revenue received by the state from the economic impact of the health care industry should be considered when decisions about health care expenditures are made.
3. Some kinds of tax credits or deductions may be able to help reduce the costs of coverage or the costs of doing business as a health care professional in New Mexico.
4. The active use of accurate cost and population data can help policy makers and employers/insurers make better financial and public policy decisions about health coverage, access and expenditures.
9. New Mexico's current Medical Malpractice Act is one of the better in the country and should be supported as it is. However, many medical and other health care practitioners find the cost of liability insurance increasingly difficult to afford. These costs can have an impact on practitioners' ability to continue practicing in rural areas or for low-income populations.

Action Step 1: Provide refundable tax credits and/or deductions for health care professionals who practice in rural or underserved areas.

- Cost = To be determined, depending on type and size of credits/deductions.

Action Step 2: Provide refundable tax credits and/or deductions to partially defray the costs of professional liability insurance for scarce health care professionals.

- Cost = To be determined, depending on type and size of credits/deductions.

Action Step 3: Provide refundable tax credits and/or deductions for employers who provide basic, comprehensive or long-term care insurance coverage or buy into the IPP, and for employees if they purchase commercially available or buy into employer-based or IPP insurance options.

- Cost = To be determined, depending on type and size of credits/deductions; preliminary analysis for the Interim Legislative Health and Human Services Committee from the New Mexico Tax and Revenue Department indicates that the cost of a refundable tax credit covering total premium could be as high as $165.5 million in lost revenue or additional expenditures. However, this figure includes a credit for all eligible individuals/families. If Medicaid eligible individuals/families were excluded, this number would be significantly less. Costs could also be reduced in other ways.

Action Step 4: Provide refundable tax credits and/or deductions for caregivers not otherwise reimbursed by public funds where the care recipient would otherwise be utilizing Medicaid funded services.

- Cost = To be determined, depending on type and size of credits/deductions.

Action Step 5: Change laws to prevent disposal of assets in order to become Medicaid eligible.

- Cost = To be determined; may reduce costs for Medicaid long-term care.

Action Step 6: Change laws to provide protection of assets guarantee upon purchase of long-term care policy that precludes or limits the need for Medicaid funded services.

- Cost = To be determined; may reduce costs for Medicaid long-term care.

Action Step 7: Assure the data collected or available through the Health Policy Commission, the IPP, the New Mexico Insurance Division (NMID), health care encounter data, and national uninsured and health care expenditure data are analyzed and utilized in policy making and quality monitoring, including profiling of providers and managed care entities.

- Cost = To be determined, depending on data available, collected and reported, and viability of existing data collection and reporting systems and mechanisms.

Action Step 8: Use New Mexico tax returns and educate tax preparation companies to identify and outreach to individuals who may be eligible for Medicaid.

- Cost = Minimal; part of Medicaid outreach plan.

Action Step 9: Revise nursing home and hospital rate structures to encourage

community-based alternatives.

- Cost = To be determined; could save money to publicly funded systems such as Medicaid and County indigent funds.

Action Step 10: Develop and implement financial incentives for families and individuals to utilize appropriate community-based alternatives to nursing home care.

- Cost = To be determined.

C. Recommendations About Access

The goals of the Task Force's Steering Committee in the area of health care access are as follows:

1. Improve New Mexico's ranking on key indicators of health status.
2. Prioritize New Mexico's health care efforts to maximize scarce public and private resources.
3. Increase the number and quality of the health, behavioral health and oral health care workforce in New Mexico.
4. Decrease the number of individuals reporting unmet health care needs.
5. Improve the behavioral health care system so that more evidence-based and recovery/resiliency-oriented services are available for available state government dollars and that service access is easier for behavioral health consumers, their families and providers.
6. Decrease the impacts of untreated mental illness and substance abuse on New Mexico's communities, taxpayers and businesses.
7. Decrease the impact on state government, taxpayers and health care recipients of hospitals and nursing homes that are not financially or programmatically viable, that offer low quality care, or that impact the availability of other health care due to inadequate planning and oversight.

Strategy Four: Comprehensive Statewide Planning

Justification:

1. Health care must be viewed as a system, in focusing on access, workforce and financing issues. We need a shared framework to describe our desired system of health care delivery. Key indicators and targets for improvement must be defined, to set foundation for policy direction and focus public and private efforts on agreed upon results.
2. The system should utilize a continuum of care model, emphasizing wellness and prevention stressing personal responsibility, primary care, secondary care, tertiary care and long term care.

3. Attention must be paid to New Mexico's unique health risk factors as well as health disparities. We must also address barriers to access to care for all populations. Collaboration and potential integration of health and social services will be considered, as opportunities to align services to those in need and reduce unnecessary costs.
4. Coordination across IHS, VA and public access providers is critical, to optimize continuity of care and appropriate resource utilization.

Action Step 1: Convene an interdepartmental group with a community advisory group to draft a template for the statewide health plan. Develop the content, including key health status indicators focusing on New Mexico prevalent diseases and issues. Create mechanisms for refinement of content over time.

- Cost = Human resource time state departments and involved stakeholders.

Action Step 2: In the plan, identify strategies to move toward universal access, which may include mobile health care clinics; use of telehealth; increased workforce recruitment and retention efforts; use of promotoras and peer counselors; a caregivers 24-hour hotline; and redirecting financing to different levels of care, transportation consortiums, and care management.

- Cost = Human resource time of state departments and involved Stakeholders.

Action Step 3: Develop and implement a communication plan to educate the public about the strategic plan and their role in assuming responsibility for their own health and building a healthy New Mexico; paying attention to culture and health literacy levels.

- Cost = To be determined. Allocation of existing state staff time. May involve additional costs of a project manager, for less than $50,000, and for public advertising/marketing (amount to be determined based on plan).

Action Step 4: Inventory all public sector providers regarding capacity and annual utilization, as basis for enhancing coordination among providers and assuring optimal utilization of current resources; assure DOH's public health clinics are providing care for those with unmet needs and are maximizing reimbursement opportunities

- Cost = Some focused assessment and evaluation time.

Action Step 5: Establish a Health Care Workforce Development Center, with responsibilities including but not limited to a 24-hour telephone triage practice support line for rural or isolated practitioners and authority to direct licensing boards to develop annual plans to increase reciprocity, reduce barriers to licensure, and take steps to increase the number of health care professionals practicing in underserved areas of New Mexico. Assess the health care workforce to identify availability and need for

healthcare personnel. Address specific recruitment and retention issues as needed.

- Cost = To be determined

Action Step 6: Increase amount of financial assistance available for workforce needs through additional loan forgiveness and reduced tuition, tied to service obligations in New Mexico.

- Cost = To be determined

Action Step 7: Consider the designation of a portion of state lottery scholarship funds for health professional education needs (masters and above), tied to service obligations in New Mexico.

- Cost = To be determined

Strategy Five: Behavioral Health (Mental Health and Substance Abuse) Reform

Justification:

1. The Medicaid system does not have a well-developed set of mental health or substance abuse benefits, leaving other public resources to pay for these services for adults with serious mental illnesses, children with severe emotional disturbances, and individuals with serious or chronic addictions.
2. Untreated mental health and substance abuse disorders are estimated to cost New Mexico's businesses, taxpayers, and families more than $3 billion annually. For every dollar spent on substance abuse and mental health treatment and services, $7.14 and $10 respectively are saved in other social, governmental and economic costs. For every dollar spent on substance abuse prevention, treatment and research, $41.43 is spent by the state of New Mexico on the consequences of substance abuse in other state funded systems such as corrections, child welfare, MR/DD, etc.[5]
3. The Governor has recently announced decisions to consolidate state behavioral medicine oversight and to "carve out" behavioral health services from Medicaid *Salud!.* The Task Force Steering Committee did not have the time to discuss or comment on that decision. However, the Committee is taking this opportunity to make specific recommendations regarding the implementation of these decisions.

Action Step 1: Develop a comprehensive plan to create a single system of care in the state for behavioral health services purchased with state and/or federal funds, for adults and children with mental health and/or substance abuse service needs, including correctional populations (services, funding, and oversight).

[5] Behavioral Health Needs and Gaps in New Mexico, July 15, 2002.

- Cost = Some cost savings redirected into services, through consolidation of administrative infrastructures, but amount is yet to be determined.

Action Step 2: Establish common service definitions and consistent standards across state agencies that emphasize evidence-based practice and support community-based care (such as mobile crisis teams, assertive community treatment, intensive family intervention, wrap around services, multi-systemic therapy and intensive outpatient services for substance abuse).

- Cost = To be determined. Some startup costs; funds could be redirected from the existing system, and additional resources may be needed to match federal Medicaid dollars.

Action Step 3: Develop and implement a system that requires first time DWI offenders to attend treatment programs and expands treatment options for these offenders.

- Cost = To be determined. DWI fines could be applied to the costs of these services.

Action Step 4: Consolidate DFA's DWI program and DOH's substance abuse services in DOH.

- Cost = Should not require additional funds

Action Step 5: Establish and utilize specific criteria for the selection of behavioral health services contractors in the future, including coordination of behavioral and medical services, particularly in pharmaceutical treatment.

Action Step 6: Establish and utilize specific criteria for the selection of behavioral health services contractors in the future, including impact on availability of behavioral health managers if a single source contractor is utilized.

Action Step 7: Establish and utilize specific criteria for the selection of behavioral health services contractors in the future, including these requirements for entities bidding on contracts:

- Based in New Mexico;
- Nonprofit entity or agreement to profit caps;
- Limit on percentage of state funds used for administration and/or profit;
- Demonstrated quality outcomes at least as high as current MCO's/providers;
- Minimum fee schedule for providers, to ensure sustainable services and infrastructure.

Action Step 8: Delay the implementation of the behavioral health services carve out until 2006, to allow time for adequate planning.

Strategy Six: Establish state oversight of nursing home and hospital facilities related to financial stability and impact on access to services.

Justification:

1. Currently, the level of state oversight of the sale and purchase of health facilities is inadequate. If a facility is not sustainable after a transaction, access can be severely hampered. The state is at risk in its safety net provider and consumer protection roles. Costs to government/taxpayers for other services often increase when hospitals and/or nursing homes are not financially or programmatically viable or offer low quality care.
2. Licensure authority of the Department of Health as currently practiced is limited to staffing, functioning and facility safety issues.
3. DOH currently has receivership authority for nursing homes, but no authority to intervene when hospitals close all or portions of their services.
4. This strategy is not a re-enactment of Certificate of Need.
5. Management of facility utilization will support improving access, by utilizing the most appropriate level of care.

Action Step 1: Require that plans for new health facilities be reviewed by the state for financial solvency and sustainability, and for impact on existing health care access and costs in the affected communities and statewide.

- Cost = Could save costs in the long run; costs of staff and contractors for analysis of plans and/or receivership to be determined.

Action Step 2: Develop a process to prevent closed nursing home beds from being reopened and redirect funds toward community-based services.

- Cost = To be determined; could save funds, depending on how community-services are funded and for whom.

Action Step 3: Provide DOH discretionary authority to assume receivership of hospitals in emergency situations, for a transitional period.

- Cost = To be determined.

D. Recommendations About Next Steps

The goals of actions to be taken after the end of this Task Force are:

1. Enhance shared knowledge among key stakeholders regarding access and coverage, including status on key indicators, impact of initiatives, opportunities for improvement;

2. Build ongoing partnership across the public and private sector, including advocates, legislators, and other key stakeholders on health care coverage and access initiatives;
3. Optimize timeliness and utility of stakeholder input in designing and implementing initiatives;
4. Insure appropriate accountability by Executive and Legislative Branch, providers, insurers, advocates, and others in moving forward.

After much discussion, the Steering Committee recommends (see Strategy Seven, Action Step 4 below) that the best timing for initial legislative action on the recommendations in this report is in the regular January 2004 regular session, with any subsequently needed legislation addressed in a special or regular sessions later. The Governor and his appointees are urged to work with the Legislative HHS Interim Committee and other legislative leaders to determine what legislation is needed to implement the recommendations in this report. The HCCA Steering Committee recommends that the Governor include health care on the call for the January 2004 regular session.

Strategy Seven: Define clear accountabilities within the Executive Branch for implementation of the recommended action steps in this report, as approved by the Governor.

Justification:
1. Clear accountability is needed to insure timely movement in conducting necessary analyses, engaging needed resources, designing and implementing appropriate initiatives, and insuring ongoing accountability for effective action.
2. On-going stakeholder input will enhance the outcome of the analysis and final decision-making process.

Action Step 1: From the Governor's Office, designate lead accountability within Executive Branch for each approved action step**.**

Action Step 2: Establish expectation that lead accountability will engage advisory/oversight groups as needed in decision-making, implementation, and monitoring of action steps.

Action Step 3: Establish a partnership between Legislative and Executive leadership and staffs to develop common approaches to any required legislative action to implement these recommendations.

Action Step 4: Refer actions that will require legislative action and that are ready for action to the Legislature's Health and Human Services Committee for the upcoming session, and place health care on the Governor's call for the January 2004 session.

Strategy Eight: Establish clear scopes of work for advisory and oversight committees in relation to these action steps; communicate information and opportunities for input to stakeholders.

Justification:

1. Many of these recommendations involve multiple stakeholders, and the coordination of that involvement is an essential responsibility of the accountable entity.
2. Coordination across Executive and Legislative branches and public and private stakeholders in engaging others can optimize the cost-effectiveness for all participants.
3. Timely opportunities for learning and participation in policy deliberations across the diverse stakeholders in coverage and access issues will enrich the solutions developed and strengthen the support for their implementation.

Action Step 1: Review current advisory and oversight committees involved in these initiatives, including appointing authority, charge, membership, connection to other groups, and flow of information. Review Task Force recommendations regarding groups/individuals needing to be involved in these initiatives.

Action Step 2: Clarify charges for each group, in scope and authority. Articulate usual sequence of gathering input and decision-making. Assess need for and potential role of any Governor's Task Force and Steering Committee in future.

Action Step 3: Identify and communicate to stakeholders the roles of these groups, including mechanism to provide input.

Action Step 4: Establish communication workgroup including public sector, provider, insurer, advocate, and legislative representation, to coordinate communication mechanisms for optimal two-way information sharing

Attachment A

Guiding Principles from Governor's Proposed Health Care Agenda for New Mexico

1. The ultimate goal is to address the multiple health care needs of all New Mexicans by addressing insurance coverage and access issues as resources allow.

2. Bold action is needed now that is doable *and* will set a clear direction toward serving more individuals and families with better services to meet their unique needs.

3. Multiple approaches, over time, will be required to develop and finance the different needs of different ages and types of populations within New Mexico.

4. A combination of public and private approaches will be necessary, with the state and federal government providing strong leadership and oversight roles.

5. Policies and actions must be financially viable, taking into account both costs and impact on New Mexico's economy; where possible, finances should be oriented toward reducing other state expenditures or increasing state revenues in exchange for required state expenditures on coverage and access.

6. Build on and/or eliminate existing structures to create a single point of coordination and accountability for moving toward coverage and access for all New Mexicans.

7. Priority populations for general health and behavioral health benefits include: a) children who are eligible for and have access to but are not enrolled in public or private insurance; b) parents and guardians of children eligible for/enrolled in Medicaid; and c) low-income working adults whether with or without children.

8. Actions must take into account that health and economic development are intrinsically linked with improved health of people living in New Mexico having a positive impact on economic development and strong economic development playing a role in improving the health status of people living in New Mexico.

Attachment B

Working Definitions Used for the Report

A. General terms:

1. *People living in New Mexico*: People who are physically present, or domiciled, or a legal resident of New Mexico, who have been in New Mexico for at least six consecutive months, regardless of immigration status.
2. *Universal*: Realistic opportunity exists for all people living in New Mexico to purchase or be provided health care coverage and access.
3. *Coverage*: Different types of benefit options offered under a public or private plan or insurance contract.
4. *Uninsured*: No coverage of any kind over previous calendar year (US Census definition).
5. *Underinsured*: Coverage that is: a) interrupted during year, or b) does not cover all the basic insurance plan services.
6. *Continuity of coverage*: Continuity = consistency: Not interrupted over time. Not only available for part of the year.
7. *Access to care*: Ability of people living in New Mexico to obtain appropriate, timely, cost effective, affordable health care. This definition does not include use of an emergency room for non-emergency needs.

B. Levels of coverage:

1. *Basic Insurance Plan or Policy*: Includes following services or benefits:

    - Inpatient Hospital
    - Durable Medical Equipment (DME)
    - Physicians' Services, Inpatient And Outpatient
    - Primary/Preventive/Early Detection, Including Family Planning and Oral Health
    - Emergency Room Services
    - Diagnostic And Assessment Services
    - Therapeutic And Diagnostic Radiological Services
    - Laboratory Services
    - Pharmaceuticals
    - Behavioral Health (Mental Health and Substance Abuse) Inpatient and Outpatient
    - Organic Eye and Natural Tooth Injury Treatments

    The amount of services available (i.e., limitations on the benefits and co-pays) can vary.

2. *Comprehensive Insurance Plan or Policy*: A Basic Policy/Plan to which any of the following services are added:

    - Chiropractic/Massage/Acupuncture
    - Other Practitioners' Services, Including But Not Limited to Traditional Medicine Men/Healers
    - Dental/Vision/Hearing
    - Home Health
    - Hospice
    - PT/OT/ST
    - Rehabilitation Services
    - Nutritional Services
    - Crystal Therapy, Aromatherapy, Herbal Therapy
    - Non-Medically Necessary Elective Services
    - Any of the Long-Term Care Policy Services

3. *Long-Term Care Insurance Policy or Plan*: One that includes any of the following services:

    - Habilitation services
    - Home Health
    - Assisted Living
    - Skilled Nursing Facility
    - Intermediate Care Facility for Mental Retardation
    - Individual Living/Personal Care/Attendant Care

4. *Catastrophic Insurance Policy or Plan*: One in which the amount of deductible or premium and co-pays paid by the insured before the coverage pays for services is significantly higher than most basic or comprehensive coverage policies/plans.

5. *Minimum Insurance Policy or Plan*: One in which:

    - Benefits are less than in a basic plan/policy; and
    - All services are capped annually and/or over insured's lifetime; or
    - There are limitations to or no legally mandated services and legal rights protections for the insured.

    In such a policy or plan, there may or may not be co-payments and/or deductibles.

Attachment C

Membership of Steering Committee and Task Force

Work Group Members (Names in bold-faced type = Steering Committee Members):

First Name	Last Name	Organization
Gayle	Adams	Lovelace Health Systems
Dale	Anderson	Aztec Media
Manny	**Aragon**	State Legislator (D-Bernalillo & Valencia, 14)
Polly	Arango	Family Voices
Loretta	**Armenta**	Albuquerque Hispano Chamber of Commerce
Pat	Bartels	New Mexico Physical Therapy Association
Sue Wilson	**Beffort**	State Legislator (R–Bernalillo, Santa Fe, & Torrance, 19)
Kathleen	**Blake**	President-elect, NM Medical Society
Walt	**Bolic**	Economic Forum – Chair of the Economic Forum's Health Care Committee CEO Delta Dental
Dale	Bolson	Children, Youth & Families Department
Maureen	**Boshier**	NM Hospital & Health Systems Association
Harriett	Brandstetter	La Clinica de Familia
George	Bunch	NM Pediatric Society
Raul	Burciaga	Legislative Council Service
David	Canzone	David Canzone, L.L.C., Oriental Medicine Association of New Mexico (OMANM)
John	Carey	Association of Commerce & Industry (President)
Gerald	Carson	Long term care insurance specialist

Teri	**Cole**	Greater Albuquerque Chamber of Commerce
Bob	DeFelice	First Choice Community Health Center
Diane	Denish	Lieutenant Governor's Office
William	Doggett	American Chiropractic Association
Michael	Donnelly	AARP
Christy	Edwards	NM Public School Insurance Authority
Mary	Feldblum	Health Security for New Mexicans Campaign
Dede	**Feldman**	State Legislator (D–Bernalillo, 13)
Deborah	Fickling	Mental Health Association in New Mexico
Roque	Garcia	Rio Grande Behavioral Health Services
Joie	Glenn	New Mexico Assoc. for Home & Hospice Care
Ramsay	**Gorham**	State Legislator (R–Bernalillo, 1)
Martha	**Gorospe-Charlie**	EPICS (Educating Parents of Indian Children with Special Needs)
Frank	**Hesse**	NM Health Policy Commission
James	**Hinton**	Presbyterian Healthcare Services
Ruth	**Hoffman**	Lutheran Office of Governmental Ministry
Eduardo	**Holguin**	National Education Association - NM
Pam	**Hyde**	NM Human Services Department
Patty	Jennings	NM Medical Insurance Pool
Sharon	Jones	Cimarron Health Plan
Norton	Kalishman	McCune Charitable Foundation
Steve	**Komadina**	State Legislator (R–Bernalillo & Sandoval, 9)

Chris	Krahling	Blue Cross & Blue Shield of NM
Pat	Larragoite	New Mexico Health Policy Commission
Todd	LeCesne	UNM Medical School – Physician Assistant Program
Ellen	**Leitzer**	Senior Citizens Law Office
James	**Lewis**	City of Albuquerque
Andy	**Lopez**	Ex. Dir. Las Clinicas del Norte
Linda	**Lopez**	State Senator (D-Albuquerque, 11)
Susan	Loubet	New Mexico Women's Agenda
Michelle	Lujan Grisham	Aging and Long Term Care
James	**Madalena**	State Legislator (D-Bern, McKinley, Rio Arriba & Sandoval, 65)
Randy	Marshall	NM Medical Society
Ken	**Martinez**	State Legislator (D-Cibola, McKinley, San Juan, 69)
Dan	**Matthews**	UNM Dept of Psychology Clinic Health Action New Mexico (HANM)*
Steve	McKernan	University Hospital Administration
Wayne	Miller	National Association for the Mentally Ill - Chair
Kay	Monaco	New Mexico Voices for Children
Juan	Montoya	New Mexico Catholic Conference
Pat	**Montoya**	NM Department of Health
Samuel O.	**Montoya**	NM Association of Counties/NM County Insurance Authority
Brian	**Moore**	State Legislator (R–Curry, Harding, Quay, Roosevelt, S.M. & Union, 67)
Joe	Moquino	Tribal Health Care Alliance
Sigrid	Olson	Albuquerque Health Care for the Homeless

Mary Kay	**Papen**	State Legislator (D–Dona Ana, 38)
Danice	**Picraux**	State Legislator (D-Bernalilo, 25)
Lauren	Reichelt	Rio Arriba Family Care Network
Cynthia	Reinhart	Chair, Health Policy Committee, Alb. COC
Anslem	Roanhorse	Navajo Nation – Division of Health
Carolyn	Roberts	New Mexico Nurses Association
David	Roddy	New Mexico Primary Care Association
Joan	Rutherford	New Mexico Health Insurance Alliance
Milton	Sanchez	NM Retiree Health
Ed	**Sandoval**	State Legislator (D-Bernalillo, 17)
Linda	Sechovec	NM Health Care Association
Eric	**Serna**	NM Public Regulation Commission, Insurance Division
Donna	Smith	Risk Management Division
Anne	**Sperling**	President of NM State Association of Health Underwriters
Kathleen	Stoll	Families USA
Jessica	Sutin	Health Policy Coordinator for the Governor
Tom	**Taylor**	State Legislator (R-San Juan, 1)
Bernie	Teba	Office of Indian Affairs
Floyd	Thompson	Gallup Indian Medical Center
Jim	**Toya**	Albuquerque Area HIS
Jim	**Trujillo**	State Representative (D-Santa Fe, 45)
Andrea	Trybus	Albuquerque Public Schools

Sally	Tyler	Am. Fed. of State, County and Municipal Employees (AFSCME)
William	Ulwelling	Legis. Rep., Psychiatric Medical Association
Rick	**Wadley**	President Bank of America. Rep. For the Association of Commerce and Industry
Jeannette	**Wallace**	State Legislator (R-Los Alamos, Sandoval, Santa Fe, 43)
Ed	Zendel	New Mexico Municipal League

ATTACHMENT D

Steering Committee Voting Record

OVERALL RECOMMENDATIONS							
DESCRIPTIONS	Incremental Steps	C & A Inter-dependent	Shared Responsibility	Common Objective Measures	Medicaid Reductions = increased uninsured	Advocacy at Federal Level	Additional Develop-ment & Analysis
S/C Member	Rec. 1	Rec. 2	Rec. 3	Rec. 4	Rec. 5	Rec. 6	Rec. 7
Aragon	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Armenta	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Wilson-Beffort	AG	AG	AG	AG	AG	F	F
Blake	F	F	F	F	F	F	F
Bolic	F	F	F	F	F	F	F
Boshier	F	F	F	F	F	F	F
Cole	F	F	F	F	F	F	F
Feldman	F	F	F	F	F	F	F
Gorham	AB	AB	AB	AB	AB	AB	AB
Gorospe-Charlie	Absent	Absent	Absent	F	Absent	Absent	Absent
Hesse	F	F	F	F	F	F	F
Hinton	F	F	F	F	F	F	F
Hoffman	F	F	F	F	F	F	F
Holguin	F	F	F	F	F	F	F
Hyde	F	F	F	F	F	F	F
Komadina	AG	F	AG	F	F	F	F
Leitzer	F	F	F	F	F	F	F
Lewis	F	F	F	F	F	F	F
Lopez, Andy	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Lopez, Linda	F	F	F	F	F	F	F
Madalena	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Martinez	F	F	F	F	F	F	F
Matthews	F	F	F	F	F	F	F
Montoya, Pat	F	F	F	F	F	F	F
Montoya, Sam	F	F	F	F	F	F	F
Moore	F	AG	AG	F	AG	F	F
Papen	F	F	AB	F	AB	F	F
Picraux	F	F	F	F	F	F	F
Sandoval	F	F	F	F	F	F	F
Serna	F	F	F	F	F	F	F
Sperling	F	F	AG	F	F	F	F
Taylor	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Toya	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Trujillo	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Wadley	F	F	F	F	F	F	F
Wallace	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Total For	24	24	21	26	23	26	26
Total Against	2	2	4	1	2	0	0
Total ABstain	1	1	2	1	2	1	1
F = For							
AG = Against							
AB = Abstain							

STRATEGY ONE; MAXIMIZE MEDICAID AS RESOURCES FOR MATCH ARE AVAILABLE								
DESCRIPTIONS	**Aggressive Outreach**	**SCI**	**Adults at 100% of FPL**	**Pharmacy Dispensing Fee**	**Wait List Children in D&E Waiver**	**TBI Waiver**	**Dually Eligible in PCCM and MCOs**	**Add Practitioners**
S/C Member	**S1, A1**	**S1, A2**	**S1, A3**	**S1, A4**	**S1, A5**	**S1, A6**	**S1, A7**	**S1, A8**
Aragon	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Armenta	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Wilson-Beffort	AG	AB	AB	AB	AB	AB	AB	AB
Blake	F	F	F	F	F	F	F	AG
Bolic	AG	AG	AG	AG	AG	AG	AG	AG
Boshier	F	F	AB	F	AG	AG	F	F
Cole	F	F	AG	F	AG	AG	F	F
Feldman	F	F	F	F	F	F	F	F
Gorham	AB	AB	AB	AB	AB	AB	AB	AB
Gorospe-Charlie	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Hesse	F	F	AG	F	AB	AB	F	AG
Hinton	F	F	AG	F	AB	AG	F	AG
Hoffman	F	AG	F	F	F	F	F	F
Holguin	F	AB	F	F	AB	F	F	F
Hyde	F	F	F	F	AB	AG	F	F
Komadina	F	F	AG	F	F	F	F	F
Leitzer	F	AG	F	AG	AG	F	AG	F
Lewis	F	F	F	F	F	F	F	F
Lopez, Andy	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Lopez, Linda	F	F	F	F	AB	F	F	AB
Madalena	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Martinez	F	F	F	F	F	F	F	F
Matthews	F	AG	F	F	F	F	F	F
Montoya, Pat	F	F	AG	F	AB	AB	F	F
Montoya, Sam	F	F	F	F	F	F	F	F
Moore	AG	F	F	AG	F	F	F	AG
Papen	F	F	F	F	F	AB	AB	F
Picraux	F	F	F	F	F	F	F	F
Sandoval	F	F	F	AG	F	F	F	F
Serna	F	F	F	F	F	F	F	F
Sperling	F	F	AG	F	AB	AB	F	AG
Taylor	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Toya	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Trujillo	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Wadley	F	F	F	F	AG	F	F	AG
Wallace	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Total For	**23**	**20**	**17**	**21**	**13**	**16**	**22**	**17**
Total Against	**3**	**4**	**7**	**4**	**5**	**5**	**2**	**7**
Total Abstain	**1**	**3**	**3**	**2**	**9**	**6**	**3**	**3**
F = For								
AG = Against								
AB = ABstain								

STRATEGY TWO: EXPLORE DEVELOPMENT OF AN INSURANCE PURCHASING POOL...	
Please note that the language in the report for Strategy Two was voted on as a whole rather than individual votes on each action step.	
S/C Member	**VOTE**
Aragon	Absent
Armenta	Absent
Wilson-Beffort	AG
Blake	F
Bolic	F
Boshier	F
Cole	F
Feldman	F
Gorham	Absent
Gorospe-Charlie	F
Hesse	F
Hinton	F
Hoffman	F
Holguin	Absent
Hyde	F
Komadina	AG
Leitzer	F
Lewis	F
Lopez, Andy	Absent
Lopez, Linda	F
Madalena	F
Martinez	F
Matthews	F
Montoya, Pat	F
Montoya, Sam	F
Moore	F
Papen	F
Picraux	F
Sandoval	F
Serna	F
Sperling	F
Taylor	Absent
Toya	F
Trujillo	F
Wadley	F
Wallace	F
Total For	**28**
Total Against	**2**
Total Abstain	**0**
F = For	
AG = Against	
Ab = Abstain	

STRATEGY THREE: IMPLEMENT FINANCIAL POLICIES ...										
DESCRIPTIONS	Tax Credit/ Deductions for Health Care Professionals	Tax Credit/ Deductions for Professional Liability Insurance	Tax Credit/ Deductions for LTC Insurance	Tax Credit/ Deductions for Caregivers	Prevent Disposal of Assets	Protection of Assets if LTC Insurance	Utilize Existing Data	Tax Returns for Outreach	Revise NH/Hospital Rate Structure	Financial Incentives for Comm-Based Care
S/C Member	S3, A1	S3, A2	S3, A3	S3, A4	S3, A5	S3, A6	S3, A7	S3, A8	S3, A9	S3, A10
Aragon	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	AGreed to in final discussion of whole document. Not voted on as an individual strategy.
Armenta	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	
Wilson-Beffort	AB	AB	AB	AB	AB	AB	AB	AB	AB	
Blake	F	F	F	Ab	F	F	F	F	AG	
Bolic	F	AB	F	AB	AB	AB	AB	AB	AB	
Boshier	F	F	F	AB	F	F	F	F	AG	
Cole	F	F	F	AB	F	F	F	F	AG	
Feldman	F	F	F	F	F	F	F	F	F	
Gorham	AB	AB	AB	AB	AB	AB	AB	AB	AB	
Gorospe-Charlie	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	
Hesse	F	F	F	F	F	F	AB	AB	F	
Hinton	F	F	F	AB	F	F	F	F	AG	
Hoffman	F	F	F	F	F	F	F	F	F	
Holguin	F	F	F	F	F	F	F	F	F	
Hyde	F	F	F	F	F	F	F	F	F	
Komadina	F	F	F	F	F	F	F	F	AG	
Leitzer	F	F	F	AB	AB	F	F	F	F	
Lewis	F	F	F	F	F	F	F	F	F	
Lopez, Andy	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	
Lopez, Linda	F	F	F	F	F	F	F	F	F	
Madalena	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	
Martinez	F	F	F	F	AG	F	F	F	F	
Matthews	F	F	F	AG	F	AB	F	F	F	
Montoya, Pat	F	F	F	AB	F	F	F	F	F	
Montoya, Sam	F	F	F	F	F	F	F	F	F	
Moore	F	F	F	AG	AG	F	F	AG	AG	
Papen	F	F	F	AB	F	F	F	F	AG	
Picraux	F	F	F	AB	AB	AB	F	F	F	
Sandoval	F	F	AG	F	F	F	F	F	AG	
Serna	F	F	F	F	F	F	F	F	F	
Sperling	F	F	F	AB	AG	AB	F	F	AB	
Taylor	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	
Toya	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	
Trujillo	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	
Wadley	F	F	AB	AG	F	F	F	F	AG	
Wallace	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	
Total For	25	24	23	12	19	21	23	22	14	0
Total AGainst	0	0	1	3	3	0	0	1	9	0
Total Abstain	2	1	3	12	5	6	4	4	2	0
F = For										
AG = Against										
AB = Abstain										

STRATEGY FOUR: COMPREHENSIVE STATEWIDE PLANNING							
DESCRIPTIONS	Convene Group for Template	Strategies Toward Universal Access	Communi-cation Plan	Inventory Providers	Health Care Workforce Dev Center	Additional Loan Forgiveness and Loan Reduc.	State Lottery Funds for Health Prof. Educ.
S/C Member	S4, A1	S4, A2	S4, A3	S4, A4	S4, A5	S4, A6	S4, A7
Aragon	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Armenta	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Wilson-Beffort	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Blake	F	F	F	F	F	F	F
Bolic	F	F	F	F	F	F	F
Boshier	F	AB	F	F	AB	F	F
Cole	F	AB	F	F	F	F	AB
Feldman	F	F	F	F	F	F	F
Gorham	AB	AB	AB	AB	AB	AB	AB
Gorospe-Charlie	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Hesse	F	F	F	F	F	F	F
Hinton	F	AB	F	F	F	F	AB
Hoffman	F	F	F	F	F	F	F
Holguin	F	F	F	F	F	F	AG
Hyde	F	F	F	F	F	F	F
Komadina	F	F	F	F	F	F	F
Leitzer	F	F	F	F	F	F	F
Lewis	F	F	F	F	F	F	F
Lopez, Andy	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Lopez, Linda	F	F	F	F	F	F	F
Madalena	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Martinez	F	F	F	F	F	F	AG
Matthews	F	F	F	F	F	F	F
Montoya, Pat	F	F	F	F	F	F	F
Montoya, Sam	F	F	F	F	F	F	F
Moore	F	F	F	F	F	F	F
Papen	F	F	F	F	F	F	AG
Picraux	F	F	F	F	F	F	F
Sandoval	F	F	F	F	F	F	F
Serna	F	F	F	F	F	F	F
Sperling	AB	F	F	F	AB	AB	AB
Taylor	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Toya	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Trujillo	Absent	Absent	Absent	Absent	F	F	F
Wadley	F	F	F	F	F	F	AG
Wallace	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Total For	24	22	25	25	24	25	19
Total AGainst	0	0	0	0	0	0	4
Total Abstain	2	4	1	1	3	2	4
F = For							
AG = Against							
AB = Abstain							

STRATEGY FIVE: BEHAVIORAL HEALTH REFORM								
DESCRIPTIONS	Comprehensive Plan for Single SOC	Common Service Definitions	Treatment for First Time DWI	Consolidate DFA and DOH SAS Prog.	Coordination of BH and Medical	Impact on BH Managers	Requirements for BH Entities	Delay Carve-Out until 2006
S/C Member	S5, A1	S5, A2	S5, A3	S5, A4	S5, A5	S5, A6	S5, A7	S5, A8
Aragon	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Armenta	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Wilson-Beffort	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Blake	F	F	F	F	F	F	F	AG
Bolic	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Boshier	F	F	AB	F	F	F	F	F
Cole	AG	F	F	F	AB	F	F	AB
Feldman	F	F	F	F	F	F	F	AB
Gorham	AB	AB	AB	AB	AB	AB	AB	AB
Gorospe-Charlie	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Hesse	F	F	F	F	F	F	F	F
Hinton	AG	F	F	AB	AB	F	F	F
Hoffman	F	F	AB	F	F	F	F	AB
Holguin	F	F	AB	F	F	F	F	AB
Hyde	F	F	F	F	F	F	F	AG
Komadina	AG	F	AG	F	AG	F	AG	F
Leitzer	F	F	F	F	F	AB	F	F
Lewis	F	F	F	F	F	F	F	F
Lopez, Andy	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Lopez, Linda	F	F	F	F	F	F	F	AB
Madalena	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Martinez	F	F	AG	AB	AB	AB	AB	AB
Matthews	F	F	F	F	F	F	F	AB
Montoya, Pat	F	F	F	F	F	F	F	AB
Montoya, Sam	F	F	F	F	F	F	F	F
Moore	F	F	AG	F	F	F	F	F
Papen	F	F	F	F	F	F	F	F
Picraux	F	F	F	F	F	F	F	F
Sandoval	F	F	F	F	Absent	Absent	Absent	Absent
Serna	F	F	F	F	Absent	Absent	Absent	Absent
Sperling	AG	F	F	F	AB	F	AB	F
Taylor	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Toya	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Trujillo	F	F	F	AG	F	F	F	F
Wadley	AG	F	F	F	AB	AB	F	F
Wallace	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Total For	20	25	19	22	17	20	20	13
Total Against	5	0	3	1	1	0	1	2
Total Abstain	1	1	4	3	6	4	3	9
F = For								
AG = Against								
AB = Abstain								

STRATEGY SIX: ESTABLISH STATE OVERSIGHT OF FINANCIAL STABILITY OF NH AND HOSPITAL FACILITIES			
DESCRIPTIONS	**Review Plans for Solvency and Stability**	**Redirect Closed NH Funds to Comm-Based Srvs.**	**Receivership of Hospital**
S/C Member	**S6, A1**	**S6, A2**	**S6, A3**
Aragon	Absent	Absent	Absent
Armenta	Absent	Absent	Absent
Wilson-Beffort	Absent	Absent	Absent
Blake	AG	F	F
Bolic	Absent	Absent	Absent
Boshier	AG	AG	F
Cole	AG	AG	F
Feldman	F	F	F
Gorham	AB	AB	AB
Gorospe-Charlie	Absent	Absent	Absent
Hesse	F	F	F
Hinton	AG	AG	F
Hoffman	F	F	F
Holguin	F	F	F
Hyde	F	F	F
Komadina	AG	AG	F
Leitzer	F	F	Absent
Lewis	F	F	F
Lopez, Andy	Absent	Absent	Absent
Lopez, Linda	F	AG	F
Madalena	Absent	Absent	Absent
Martinez	Absent	Absent	Absent
Matthews	F	F	F
Montoya, Pat	F	F	F
Montoya, Sam	F	F	F
Moore	AG	F	F
Papen	F	AG	F
Picraux	F	F	F
Sandoval	F	AG	F
Serna	F	AG	F
Sperling	AG	AG	F
Taylor	Absent	Absent	Absent
Toya	Absent	Absent	Absent
Trujillo	F	F	F
Wadley	AG	AG	F
Wallace	Absent	Absent	Absent
Total For	**16**	**14**	**23**
Total Against	**8**	**10**	**0**
Total Abstain	**1**	**1**	**1**
F = For			
AG = Against			
AB = Abstain			

STRATEGY SEVEN: DEFINE CLEAR ACCOUNTABILITIES ...				
DESCRIPTIONS	**Designate Leads**	**Engage with Advisory Groups**	**Legis/Exec Partnership**	**Health care on Jan.2004 call**
S/C Member	**S7, A1**	**S7, A2**	**S7, A3**	**S7, A4**
Aragon	Absent	Absent	Absent	Absent
Armenta	Absent	Absent	Absent	Absent
Wilson-Beffort	Absent	Absent	Absent	Absent
Blake	F	F	F	F
Bolic	Absent	Absent	Absent	Absent
Boshier	F	F	F	F
Cole	F	F	F	F
Feldman	F	F	F	F
Gorham	AB	AB	AB	F
Gorospe-Charlie	Absent	Absent	Absent	Absent
Hesse	F	F	F	F
Hinton	F	F	F	F
Hoffman	F	F	F	F
Holguin	F	F	F	F
Hyde	F	F	F	F
Komadina	F	F	F	F
Leitzer	F	F	F	F
Lewis	F	F	F	F
Lopez, Andy	Absent	Absent	Absent	Absent
Lopez, Linda	F	F	F	F
Madalena	Absent	Absent	Absent	Absent
Martinez	Absent	Absent	Absent	Absent
Matthews	F	F	F	F
Montoya, Pat	F	F	F	F
Montoya, Sam	F	F	F	F
Moore	F	F	F	F
Papen	F	F	F	F
Picraux	F	F	F	F
Sandoval	F	F	F	F
Serna	F	F	F	F
Sperling	F	F	F	F
Taylor	Absent	Absent	Absent	Absent
Toya	Absent	Absent	Absent	Absent
Trujillo	F	F	F	F
Wadley	F	F	F	F
Wallace	Absent	Absent	Absent	Absent
Total For	**24**	**24**	**24**	**25**
Total Against	**0**	**0**	**0**	**0**
Total Abstain	**1**	**1**	**1**	**0**
F = For				
AG = Against				
AB = Abstain				

STRATEGY EIGHT: ESTABLISH CLEAR WORK FOR STAKEHOLDER GROUPS				
DESCRIPTIONS	Review Current Groups	Clarify Charges	Communicate to Stakeholders	Communication Workgroup
S/C Member	S8, A1	S8, A2	S8, A3	S8, A4
Aragon	Absent	Absent	Absent	Absent
Armenta	Absent	Absent	Absent	Absent
Wilson-Beffort	Absent	Absent	Absent	Absent
Blake	F	F	F	F
Bolic	Absent	Absent	Absent	Absent
Boshier	F	F	F	F
Cole	F	F	F	F
Feldman	F	F	F	F
Gorham	F	F	F	F
Gorospe-Charlie	Absent	Absent	Absent	Absent
Hesse	F	F	F	F
Hinton	F	F	F	F
Hoffman	F	F	F	F
Holguin	F	F	F	F
Hyde	F	F	F	F
Komadina	F	F	F	F
Leitzer	F	F	F	F
Lewis	F	F	F	F
Lopez, Andy	Absent	Absent	Absent	Absent
Lopez, Linda	F	F	F	F
Madalena	Absent	Absent	Absent	Absent
Martinez	Absent	Absent	Absent	Absent
Matthews	F	F	F	F
Montoya, Pat	F	F	F	F
Montoya, Sam	F	F	F	F
Moore	F	F	F	F
Papen	F	F	F	F
Picraux	F	F	F	F
Sandoval	F	F	F	F
Serna	F	F	F	F
Sperling	F	F	F	F
Taylor	Absent	Absent	Absent	Absent
Toya	Absent	Absent	Absent	Absent
Trujillo	F	F	F	F
Wadley	F	F	F	F
Wallace	Absent	Absent	Absent	Absent
Total For	25	25	25	25
Total Against	0	0	0	0
Total Abstain	0	0	0	0
F = For				
AG = Against				
AB = Abstain				

DESCRIPTIONS	People living in NM	Universal	Coverage	Uninsured	Underinsured	Continuity of Coverage	Access to Care	Basic Ins. Plan or Policy	Comprehensive Ins. Plan or Policy	LTC Ins. Policy or Plan	Catastrophic Ins. Policy or Plan	Minimum Ins. Policy or Plan
S/C Member	**Def. A-1**	**Def. A-2**	**Def. A-3**	**Def. A-4**	**Def. A-5**	**Def. A-6**	**Def. A-7**	**Def. B-1**	**Def. B-2**	**Def. B-3**	**Def. B-4**	**Def. B-5**
Aragon	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Armenta	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Wilson-Beffort	AG	F	F	F	F	F	F	AB	AG	F	F	F
Blake	AG	F	F	F	F	F	F	F	F	F	F	F
Bolic	F	F	F	F	F	F	F	F	F	F	F	F
Boshier	F	F	F	F	F	F	F	F	F	F	F	F
Cole	F	F	F	F	F	F	F	F	F	F	F	F
Feldman	F	F	F	F	AG	F	F	F	F	F	F	F
Gorham	AB	AB	AB	AB	AB	AB	AB	AB	AB	AB	AB	AB
Gorospe-Charlie	AB	F	F	F	AG	F	F	F	F	F	F	Absent
Hesse	A	F	F	F	F	F	F	F	F	F	F	F
Hinton	F	F	F	F	F	F	F	F	F	F	F	F
Hoffman	F	F	F	F	A	F	F	F	F	F	F	F
Holguin	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Hyde	F	F	F	F	F	F	F	F	F	F	F	F
Komadina	AG	F	F	F	F	F	F	F	F	F	F	F
Leitzer	F	F	F	F	AG	F	F	F	F	F	F	F
Lewis	F	F	F	F	F	F	F	F	F	F	F	F
Lopez, Andy	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Lopez, Linda	AG	F	F	F	AG	F	F	F	F	F	F	F
Madalena	F	F	F	F	F	F	F	F	F	F	F	F
Martinez	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Matthews	F	F	F	F	AG	F	F	F	F	F	F	F
Montoya, Pat	F	F	F	F	F	F	F	F	F	F	F	F
Montoya, Sam	F	F	F	F	F	F	F	F	F	F	F	F
Moore	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Papen	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Picraux	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Sandoval	F	F	F	F	AG	F	F	F	F	F	F	F
Serna	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Sperling	F	F	F	F	F	F	F	F	F	F	F	F
Taylor	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Toya	F	F	F	F	F	F	F	F	F	F	F	F
Trujillo	F	F	F	F	F	F	F	F	F	F	F	F
Wadley	F	F	F	F	F	F	F	F	F	F	F	F
Wallace	F	F	F	F	F	F	F	F	AG	F	F	F
Total For	19	25	25	25	18	25	25	24	23	25	25	24
Total Against	4	0	0	0	6	0	0	0	2	0	0	0
Total Abstain	2	1	1	1	1	1	1	2	1	1	1	1
F = For												
AG = Against												
AB = Abstain												

Attachment F

Governor's Task Force on Health Care Coverage and Access
October 7, 2003, Meeting
Feedback on 10/1 Draft Report
NOTE: Feedback refers to 10/1/03 draft; thus page numbers referred to will not track with this version of the report.

Group One

Summary Report:

Strengths:

- Maximization of Medicaid; emphasis on uninsured children/adults
- Incremental steps toward universal coverage

Concerns:

- IPP pool purchasing: Cost shifting among various consistencies unclear as to shared risks/funding; insurance costs not driven primarily by administrative costs, but by other costs
- No plan for recruitment/retention of providers and to address medical malpractices
- Not enough information about cost analysis
- Incremental toward single payer system

Individual comments:

Text clarification requests:

- "Encouraging" parents: be more specific about what this means an how to do it
- Acronyms (pp 6,8,9): use word or name once before going to acronyms
- Clean up math (p.9, Step 1): is $750 million incorrect? sentences rough definition
- Define "*promotora*" (need glossary of definitions)
- Page 8: (First strategy, number 8) change decrease to increase, to use positive language
- P. 8: $3 for every $1: clarify sentence
- P. 5: #3: end sentence at "shared responsibility"
- P. 16 #4: and #5, 6, 7: similar. Use #7 first. Separate under 1, then 3 and 4 to end
- P. 22: do separate bullet for herbal therapy, as it is evidence-based and others are not
- P 10, Action Step 9: Clarify intent because I understand Medicaid provider participation is determined not on a patient by patient basis
- P. 12, Action Step 4: Is this use of caregiver inclusive of family members or professional caregivers?

Strengths:

- Incremental steps toward universal coverage and other aspects (6 votes)
- Shared responsibility: business, communities, government (2)
- Emphasis on statewide health plan (3)
- Maximization of Medicaid and emphasis on uninsured children and low income working adults (7)
- Clear note of cost shifting factor (1)
- Waiting until January session to act on legislative issues (1)
- Coverage and access are interdependent and are important for all New Mexicans(2)
- Exclusion of single payer makes other parts of report more palatable (1)
- Some financial policies (1)
- Inclusion of complementary providers (1)

Concerns:

- Cost shifting among various constituencies within IPP
- Report doesn't articulate recruitment/retention of providers; support the medical malpractice act as well as developing pooling professional liability products (8 votes)
- IPP: unclear as to shared risks and funding
- In the limited cost analysis, still lots of specifics to be determined (5 votes)
- IPP: look at the overall cost of medical care, not just the administrative costs of healthcare
- Strategy Six does not contain a certificate of need (1)
- Is this an incremental plan to steer us toward a single payer system? (3)
- Cost to the insured
- Levels of coverage under basic plan (p. 21) (2 votes)
- Doesn't address workers' compensation (1 vote)
- Strategy 2, step 1: alliance is categorized with public funded entities and it's privately funded
- Behavioral health carve out: mixed protocol issues
- Medicaid reductions for '05 in conflict with overall document

Group Two:

Summary Report:

Strengths:

- Pooled purchasing arrangement
- Pulling data together for decision-making
- Tax credits for employers, etc.

Concerns:

- Pooled purchasing arrangement

- Financial analysis needed
- Needs to move to integrated health and social services system
- Personal responsibility needs to be emphasized
- Process for input; didn't reach consensus

Individual comments:

Text clarification requests:

- P. 6: improve appropriate utilization: change "or" to "and"
- P 6: "controllable growth:" control it rather than reduce rate
- P 7: feasibility and costs: micro "costs and macro costs need to be included
- Overall recommendation #1: second line from bottom, "t this time:" is this really a qualifying term?
- P. 5: #3: business "should," etc: does that equal a mandate?
- #1: "residents" changed
- p. 12: "mandatory" clarify in Step 4
- P. 11: action step 2: in "portion of purchasing pool:" Is there a pool? How does this relate?
- P. 4, #2: Coverage and access are interdependent. Does supporting language include that statement?
- P. 9z; #6: enroll all waiting list children from D and E waiver: should not be bias for children only
- P 8: Who are "low income working uninsured?" Concern about terms
- P 15: Behavioral health carve out: includes more than Salud!

Strengths:

- Pooled purchasing arrangement (10 votes)
- Inclusion of *promotoras* for Medicaid reimbursement (5 votes)
- Comprehensive statewide planning (2 votes)
- Coverage and access a shared responsibility, with public and private collaboration (4 votes)
- Strategy one: maximize Medicaid reimbursement (5 votes)
- Access accepted as a specific term, so not everyone needs insurance to solve problems (1 vote)
- Goal is universal healthcare coverage
- Elimination of mandates (2 votes)
- Pulling data together for decision-making (6 votes)
- Addressing growing population of mentally ill: pooling resources: delay until 2006 (2 votes)
- Taxation: no changes to tax code that encroach on Medicaid (2 votes)
- Cost/benefit analysis for all recommendations (4 votes)
- P. 6, #6, advocating federal assistance on rates
- Tax credits for employers (6 votes)
- Catastrophic insurance augment other infrastructure in place (2 votes)

- Interesting proposals raised: a range
- Document useful: focused and specific; user friendly
- Recognition of inability of moving funds to home/community based services (1 vote)
- Eliminate redundancy of administration (1 vote)
- Community advisory board in statewide planning
- Emergency Room use does not constitute access to care (1 vote)
- Strategy 6: need to look at nursing homes/facilities from financial perspective

Concerns:

- P5 #4: No mention of data collection for reimbursement rates for hospitals, and health plans and private providers
- Strategy #2: No discussion of rising cost of commercial insurance and how to stem tide (2 votes)
    - Absence of analysis of current insurance market
    - Strategy #2: Nothing to promote vibrant insurance community; not allowed to investigate why commercial insurance has gone up; encourage parents to get private insurance
- P 11, #4: Assess need for mandatory approach: No mandates included (1 vote)
- No strategic plan for how to achieve access and coverage
- Pooled purchasing arrangement (7 votes)
- P12, strategy 3: Eliminate: this group shouldn't recommend about taxes
- P. 12 re taxes: need strengthening
- Add non-profits to insurance pool, through new non-profit association
- P 8: Contradiction: decrease number of children and adults without coverage: mandates versus choice/options: allow employers to buy in (4 votes)
- Nothing in report that moves toward integrated health and social services model for reducing costs (6 votes)
- Need to emphasize personal responsibility for healthcare: missing in report as an emphasis early on (6)
- Concerned: where to draw the line if someone can afford healthcare…and who determines?
- Counties are concerned with putting DWI into DOH: might lose prevention: keep no fault insurance (3 votes)
- Inconsistent statements by segregating certain behavioral health programs
- P 16 #5: criteria must include CARF accreditation (1 vote)
- P 16: Behavioral health carve out: amend to "based in communities to be served"
- P 15 #5: increase number of professionals practicing: no discussion of how; need to increase number in urban areas (1 vote)
- Financial studies should have been done: recommendations might have been changed with cost information (6 votes)
- P. 8: coverage priorities inconsistent: first priority should be coverage for those who are working
- Some language purposely misleading (p5, #3): not assume "at this time" Government won't fund all of this; consider unintended consequences (3 votes)

- Concern re process for input
- Need to look at overall impact of proposal
- P. 8: concern re maximize Medicaid: feds are concerned with “schemes” states come up with
- Bias toward kids: need to consider long term effect of expanding senior programs
- Before covering poor and disabled, concern that non-residents are brought in with unintended consequences: cost issues a problem with report (2 votes)
- Prescription drug issues not addressed: need transparency re costs (4 votes)
- Regarding aggressive outreach for kids: those not covered now are not typically ill, thus added to managed care pool: if kids get sick, put in fee for service? Needs analysis
- Was 300% of poverty level for children taken out for kids to get report accepted: need to take care of poorest first (1 vote)

Group Three

Summary Report:

Strengths:

- Common definitions
- Reasonable performance indicators to measure
- Identifies specific approaches and options

Concerns:

- Lack of information related to cost specificity/fiscal implications/financial viability
- Failure to zero in on “immediate wins”/”low hanging fruit” vs. global perspective/goals
- Decisions made on quick schedule thus inadequate opportunity to obtain/consider data and technical expertise

Individual comments:

Text clarification requests:

- Page 3, Item 1.b. needs data source(s)
- Page 3, Item 1.b. last bullet unclear
- In general, outline is unclear in terms of moving from general to specific and showing relationship of recommendations to strategies to action steps
- Page 4, Item 2.A.1, is reiteration of guiding principal
- Page 9, action steps hidden/lost in too much verbiage
- In general, clear statements related to goals and strategies are needed; executive summary needed
- In general, clarification needed between steps and objectives
- Page 6, Theme 3, clarify "uninterrupted"

Strengths:

- Brevity

- Relationship between access and coverage
- Excellent description of status of health care in NM

- *Common definitions*

- *Reasonable performance indicators to measure progress*
- Provides consensus of stakeholders, thus marketable package

- *Identifies specific approaches and options*
- Provides good and useful data otherwise not available
- Good linkage to guiding principles
- Pulls together disparate activities, e.g., long term care, behavioral health, physical health
- Recognizes behavioral health as integral part of health care
- Reflects a basic philosophy of "Children First," which is as it should be

Concerns:

- Lack of information related to cost specificity/fiscal implications/financial viability
- Failure to zero in on "immediate wins"/"low hanging fruit" vs. global perspective/goals
- Failure to obtain task force feedback relative to report specifics, i.e., substance of report (Oct 7 meeting lost opportunity)
- Premature termination of task force
- Decisions made on quick schedule thus inadequate opportunity to obtain/consider data and technical expertise
- Strategies are not bold enough
- Unclear if will accomplish cheaper premiums
- Needs to include consumer-driven indicator regarding quality of care
- Doesn't define taxpayer funded level of care
- Doesn't clarify health care as right vs. privilege
- Underlying flaw – LTC, i.e., frail populations not integrated
- There is not a clear Native American component
- There is no clear direction to strategies/action steps

Group Four

Summary report:

Strengths:

- Identification of need for statewide strategic planning
- Consensus on the importance of Medicaid and its impact on the state economy and need to leverage federal funds

- Recognition of importance and interdependence of rural and underserved issues and cultural issues and needs

Concerns:

- Report recommendations are not internally consistent; lack of compatibility between strategies and actions
- Report not bold enough and too little may be accomplished by 2008 or other clearly identified date
- Removal from the beginning discussions of topics like SCI and single payer

Individual comments:

Text clarification requests:

- P. 6: misstatement: should read:" Reduce number of persons with interrupted coverage"
- P9: Not $715 M but $715,000
- P 21: Not abortion: was not discussed: did not want to get in to discussion of abortion
- P. 16: clarification needed for "behavioral health managers"
- Clarify "takeover" clause by feds for dually-qualified individuals
- P 8: double check multiplier effect of Medicaid: $5.75
- P. 6: Add e.g., liquor excise tax and tobacco products and preventive effect on youth
- P 8: clarification and more justification for #2
- P. 9: SCI with children at 200%???

Strengths

- Complex process; recognizing this is beginning, not end (5 votes)
- Need for statewide health planning (8 votes)
- Task Force/Steering Committee took work seriously
- Summary of consensus on issue to increase coverage/access (3 votes)
- Consensus on importance of leveraging Medicaid federal funds on state (3 votes)
- Recognition of rural, underserved, cultural issues (6 votes)
- Identifying that coverage and access are interdependent (2 votes)
- Pooled purchasing (5 votes)
- Inclusion of indicators to measure meeting goals (2 votes)
- Heightens awareness that there are many good programs in place, but need tweaking (1 vote)
- Pooling underserved populations and prioritizing within this population (2 votes)
- Balances needs of uninsured/underinsured, employers (1 vote)
- Emphasized leadership as a common requirement (2 votes)
- Adhere to fiscal responsibility when creating any of these programs (2 votes)
- Committee size allowed all stakeholders representation in process (1 vote)
- Long term process undertaken in regular legislative session or afterwards (2 votes)

- Communication /coordination among entire system /continuum (e.g., providers, workforce, public/private, tribes) (3 votes)
- Public education/self responsibility involved (4 votes)
- Maximizing matching Medicaid funds (4 votes)
- Specific, not too general: measurable items
- Formulated 8 strategies are important

Concerns:

- Need for a minority report, or a public way/process to disagree with components of the report (2 votes)
- Overwhelming support for public involvement, rather than identifying private insurance options and enhancements to those options (1 vote)
- Concerned with language: increase Medicaid enrollment, decrease benefits
- Requires further behavior health strategies (e.g., not using SCHIP except for SCI): (3 votes)
- Be more inclusive to all New Mexicans, not just based on socio-economic status (1 vote)
- Removal from beginning of certain items (i.e., single payer, SCI) (4 votes)
- Information gaps affecting setting priorities on how to move forward
- Need Executive Summary and short-term and long-term steps (3 votes)
- Report recommendations are not internally consistent; lack of compatibility between strategies and action steps (5 votes)
- Report not bold enough: too little may be accomplished by 2008 or some other clearly defined date (5 votes)
- Definitions need further refinement (e.g., people residing in NM) (2 votes)

Group Five

Summary Report:

Strengths:

- Comprehensive, statewide plan with coordination among departments and accountability
- Coordinating and integrating behavioral health across departments, including connections, if done carefully

Concerns:

- Not costed out: needs to be analyzed
- Unrealistic: plan is ambitious with too few resources and mechanisms to be accomplished in a short time frame
- Define basic coverage to include effective methods of providing good care

Other comments:

- Review the definitions: what ought to go into basic: midwife; intermittent home health
- Text: change first indicator to “Manage the rate of growth”; second indicator: note goal of 100% coverage; third indicator: “increase” the number of persons

Individual comments:

Text clarification requests:

- Very disappointed that the clear measurement for adequacy was removed from the document. We feel that we need to have it clearly written into the plan. Would like to see the goal be that in five years New Mexico will attain 100% coverage
- The "improve consistency of coverage" indicator should read, “Manage the rate of growth with uninterrupted coverage for twelve consecutive months.

Strengths:

- Centralized planning process
- Universal coverage and access included
- Opportunity to provide a good deal of input
- Coverage is for everyone in New Mexico
- Shared responsibility for coverage and access
- Definitions provided for levels of coverage
- Mental health inclusion
- Focus on measurements and inclusion of benchmarks
- The first strategy is good, it includes clear action steps
- The plan recognizes that Medicaid provides an opportunity for New Mexico
- Savings from pooling
- Like that the plan maximizes Medicaid with a decrease of benefits vs. eligibility
- Strategy Six includes financial stability of Nursing Homes
- “Carve out” a good idea, if it is done slowly and thoughtfully
- Mental health coverage for all people, including corrections populations
- Strategy Four, comprehensive planning, good work Steering Committee
- Includes complementary services as part of the solution
- Strategy Three provides language to retain healthcare providers
- Strategy Seven is excellent, have seen the collaboration in action, good work
- Strategy 8 involves stakeholders in the process
- Strategy 7 involves accountability at the executive level

Concerns:

- Strategy Three: the actions plans could take lots of time
- Accountability is not written deeply into the plan
- Trying to do too much all at once
- Lacks the mechanisms to reduce uninsured population
- Lacks mandates to bring the plan into fruition
- Levels of coverage (pages 21 and 22) needs to include midwifery and abortion in basic plan, also the home health care services need thought, think about intermittent and chronic care
- There are no incentives for providers and carriers to participate in the plan

- Strategy Two is inflated; we are hanging too much here. It has not always worked in other states
- Definitions are limiting basic coverage (attachment B); we need to realize that the definitions are leading the plan in some ways, look at basic coverage more closely
- The plan is not "costed" out! We do not know the real fiscal impact, slow down and do the analysis
- Coverage for college students is not addressed. They need to be looked at with respect to the fact that some will move here and cannot wait the six months for coverage
- Single payer system not discussed

Group Six

Summary Report:

Strengths:

- Healthcare is a system. To achieve the system we envision and espouse—the planning, collection of data, developing indicators and targets, cost effectiveness, communication between all levels , accountability—all are necessary for a system
- Report has woven a tapestry that has a variety of approaches—private and public; inclusive as a whole; sense of shared responsibility

Concerns:

- We did not have enough time to fully discuss the IPP (not against it, but clarity of its definition): need more time; breadth of discussion too short (who's covered, who's not, etc.) to look at breadth and impacts
- Financing: not enough attention or information regarding costs and choices; Native Americans are a resource; hard decisions need to be made

Other comments:

- Need to continue the conversation we have started: much more to do: can't stop midstream; not a one-time solution

Individual comments:

Text clarification requests:

- P6, step 6: clarify
- P10, step 2: define what's included in "business;" clarify "employer;" can non-profits participate? does "government" include tribes or tribal enterprises?
- P 10, strategy 2: "A" vs. "the" purchasing pool
- P 8, strategy 1: Would maximizing Medicaid leave out some populations (due to income)?
- P. 8, Strategy 1: Streamline Medicaid application process
- P 10, Strategy 2: Can tribes opt in?
- P. 21: Not abortion: clarify what this means (non surgical)
- P 9, Step 3: Add outreach or combine 1 and 3 (delete enforcement)

- P 5, Step 3: Need clarification on portability

Strengths:

- Strong focus on ensuring financial viability; good data needed for policy decisions
- Establish universal coverage as ultimate goal
- Emphasis on community based alternatives for care
- Emphasis on maximizing Medicaid
- Insurance purchasing pool: Action Step 2: allow selection of high risk participants
- Strategy 7: clear responsibility and legislative/executive cooperation
- Emphasis on planning and measurable outcomes
- Process of collective effort to address health care
- Continuum of public/private solutions: individual and shared
- Suggestions of new revenue (bed premium, etc.)
- Comparative cost data among alternatives permits policy decisions
- Priority populations are highlighted I Medicaid/IPP
- Inclusiveness of "people living in NM"
- Strategy 8: committee scope and clarity
- Strategy 5: behavioral health reform: need for consideration: allocation of greater $ to care, not administration (step 7)
- Comparative statewide plan and factors included and tie to Strategy 7, commitment to involve others
- Pragmatic and realistic, compared to other states
- P. 5, recommendation 3: strong statement on shared responsibility for costs
- Emphasis in Strategy 6 on financial stability of health care institutions
- P 14, Str 4, action step 2: suggestions of alternatives as a whole rather than as individual initiatives
- State-wide planning

Concerns:

- Report lacks specific recognition that health care policy is about perpetual reform
- Language re IPP doesn't satisfy concern regarding effect on private insurance market; IPP idea has notoriety: concern that it's not a cure-all nor evil
- Item 6 in Principles: not much weight; not enough attention to how it's addressed
- IPP: needs more work on definition and implications : to be public entities first and then expand as feasible (issues re eligibility and inclusion without definition)
- Cost of Medicaid solution not defined: need better info about how this translates to economic benefit
- Efforts continue regardless of funds available, especially at stakeholder level
- Concept of "reinsurance" not addressed; possible state buying of insurance
- Native American healthcare delivery system not recognized as resource, like Medicaid, Veterans System
- Lack of time to become comfortable with OPP
- Tapestry approach leaves impression one doesn't have to make choices
- Need further cost detail

- Tax section is weak

Individual comments submitted (may be repetition of comments listed in groups)

Text clarification requests:

- Page 4 and 5: 2A2: what is the recommendation?
- Page 5, 2A2: Third sentence needs clarification: are we talking about "reimbursement" or out of pocket payment or payment by/for services to persons with coverage
- Page 6: Enhance quality of care indicator: Reduce severity of illness at time of diagnosis: what about interventions to follow? I can't believe this is the only measure of quality of care
- Page 8: Strategy One, Action Step 2: "No cheaper way"? Is that for eligible uninsured children or all children? Seems to me there are "cheaper" ways if we are talking about all children and if we are talking about "cheaper" to government
- Page 8: Item #3: I don't understand why health care facilities that lost funding for uncompensated care would be assessed if that lost cost were eliminated.

Strengths:

- Strategy #1 contains concrete action steps that can be addressed within the next 12 months.
- Addresses the use of complementary healthcare providers in the way the state addresses the problem of access and availability.
- Clearly identifies cost shifting for uncompensated care as a factor in healthcare crisis
- Allows for incremental steps (i.e., pooling of some or all administrative processes of publicly funded programs
- Levels of coverage under basic
- It's a start
- Incremental implementation is an easier sell and will generate buy in from public
- Exclusion of a discussion of a single payer option makes other recommendations more palatable
- Positive statement of public concern with health care coverage/access
- Coverage/ access independent for all New Mexicans
- Solution in incremental steps
- Addresses issues in a comprehensive manner but some not as well thought out, i.e., behavioral/mental health
- Shared responsibility
- Waiting until January 04 session with possible special session after January 04
- Proposal for multilevel involvement from private insurance companies and government: public and private combination versus single payer
- The use of integrative medicine therapies such as acupuncture, chiropractic, native healers, etc.

- Goals of “coverage” are positive in that they are measurable
- Maximization of Medicaid resource through match
- Clarity on working definitions
- Financial policies that focus on the General Fund matching, incentives for practitioners in rural and underserved.
- Use of NM tax returns to outreach to those eligible for Medicaid
- Format fairly clear and easy to read
- Report is comprehensive with well defined justifications, strategies, and supporting action steps
- The report addresses and fully covers most of the guiding principles
- Attempts to quantify costs are included
- Addresses uninsured children and low income working adults
- Advocacy and priority of health care issues on the federal agenda
- Emphasis on a state-wide health plan
- Incremental steps to address universal coverage
- Share responsibility of individuals, families, business, state, local, federal government
- Seeks to reduce or eliminate administrative redundancy
- Used consensus method: everyone spoke
- Goals clear: universal coverage and access; we can do it incrementally; shared responsibility; tracking of results through measurement
- Pooled purchasing arrangement: separate high risk clients from “average” people; to use market forces to maximize coverage and negotiate costs (p10)?

Concerns:

- Strategy 3 contains action plans that would require detailed legislative definition
- Strategy 3, action step 7: need to assure that data collection includes complementary provider statistics and utilization
- Draft doesn’t address the use of complementary physicians to participate in roles of physician extenders to increase access and availability to non emergency services
- IPP concept not clear—subsidized—one combined risk pool or simply a purchasing agent. Funding mechanism unclear
- No certificate of need
- Does not address continued fee increases by providers
- Recommendation to add healthcare to Governor’s call list during a 30 day session
- Limited cost analysis
- Potential for cost shifting among various constituencies within insurance purchasing pool
- Incremental plan to steer toward “single payer” system
- Access recommendations do not address need for increase in number of providers in the future
- Can the state adequately address and solve this problem/issue without nationwide solution?

- Does not address integration of workers' compensation with health care
- Medicaid: clarify what are we doing currently to enroll children? What would it look like if we did it better? For example, "encourage" parents to enroll children: replace with an action: medical enrollment opportunities at low-income schools
- Cost: impact on insured; cost analysis needed
- Recruitment/retention of providers: cost analysis needed
- Report fails to articulate the need to reduce paperwork for providers in proposed "new system". Rationale: IF we have a limited amount of money to spend and we are losing healthcare professionals due to low reimbursement, then we must cut cost at the office operation level of providers. If the new proposal increases office costs, it will fail. There also must be adequate penalties against HMOs and insurance companies for excessive management costs.
- Basic coverage needs to include: PT/OT/Speech; acupuncture; chiropractic. Rationale: these will save costs by avoiding high cost procedures and dependence on drugs.
- How much will it cost?
- Behavioral health carve out for Medicaid? For all others? Mixed protocol issues with drugs/care: Who will arbitrate between medical and behavioral health?
- Behavioral health economic productivity to taxpayers: need specific $ amounts
- Medicaid reductions discussed for '05: conflict with overall goal of document
- #1 issue: pooled purchasing imitative. Administrative cost savings may be a one time only savings. The majority of costs in the healthcare dollar is for medical/behavioral cost of care.
- Pharmacy carve outs: where are rebates?
- AAHD 1997 survey: "Private employers who participate in pooled purchasing do not have lower insurance costs. 1997 monthly single premiums for small employer participants were $180 compared to $172 for non-participants.
- AAHD 2000 case study: state sponsored purchasing have "neither saved money nor expanded coverage" i.e., Health Insurance Plan of California, Cleveland's Council of Smaller Enterprises, Florida Community Health Purchasing Alliance indicate: no impact on number of uninsured; no significant administrative savings compared to general market. California has experienced large increases in health insurance premiums.
- Certificate of Need
- Cost aspects would need to be more defined. Cost and funding extremely critical to implementation. Concrete examples of cost savings could be included…for example, has the government's pooled purchasing resulted in significant cost savings on health care and would this be increased?
- New Mexico Health Insurance Alliance is defined as publicly funded…it is privately funded (Strategy Two, Action Step 1)
- Consolidation of DFA's DWI program and DOH Substance Abuse services
- Strategy 6 does not include Certificate of Need
- Page 11, Action Step 6 should read, "New Mexico must continue its efforts in supporting the NM medical malpractice act, which as assisted in providing affordable and available liability insurance for private practice physicians

throughout the state. Development and offer through a purchasing pool a voluntary professional liability product(s) for those health care providers who do not choose or do not qualify to participate under the provisions of the Medical Malpractice Act

- Page 10, Action 9: Adding additional providers under the program: The report needs to adequately reimburse participating providers at minimum 125% Medicare with annual increases to reimbursement before adding providers.
- D and E waiver for all children: what about other children
- State high risk pool: how incorporate
- Employers who have not covered employees for last 12 months: allow them to buy in: why not say they must, and give them tax credits or deduction?
- Include non-profits in pooled purchasing
- Would like to see data source for statistics quoted on pages 3 and 4
- Sequence/logic of A, B, and C don't seem to follow general to specific in this format
- Page 16, Action Step 7: I have great concern over shaping criteria around these requirements. What does based in NM mean? By the way, this has been a topic of great concern at the NM State Investment Council's deliberations to manage private investments and place conditions on managers to be "locally-based." I also have concern about limiting non-profit entities to a profit cap. Many "non-profit" entities operate "for a profit" and this provides an unfair playing field. After all, for profit entities pay income taxes! How will the determination of state funds used to cover administrative expenses be determined? Again, I see this as unnecessary regulation that limits business.
- Plan should be prioritized. Strategies and steps seem to have "equal standing" in the document.
- Page 9 – This may be more of a question, but on Action Step 8, I don't understand why Medicare clients wouldn't be better off with a Senior Plus plan rather than Salud MCOs or Medicaid case management program. Questions of quality and choice aside.
- Page 10 – I'm not clear on how the program would add more covered services, but evaluate utilization and outcomes prior to use of new practitioner services to compare value and quality as is suggested in Action Step 9.
- Page 12 - Action Step 4 - is this intended to cover family members care for an individual? This is not clear as to what is meant by "caregivers not otherwise reimbursed …" Could mean denied billed services, could mean alternative health care providers, family members, etc.
- Page 13 – Action Step 8 – Because Medicaid rates in nursing facilities are, on average, well below the cost of services according to Medicaid cost reports, this seems to presume a lot for the report to imply that lower rates would encourage cheaper community-based alternatives. If the report is addressing case-mix reimbursement, rate adequacy should be a starting premise before rate cuts are suggested. Sounds good intuitively and, of course, no one wants to go to a nursing home, but I don't know if this is based on data that evaluates the total costs (Medicare, Medicaid, etc.) of community-based alternatives.

- Page 17 – Strategy Six – Justification seems weak, i.e., in #1 – in my experience, facilities in difficulty were more stable after acquisitions so why would the state want to inhibit sale/purchase of facilities? Also, if the state Medicaid program pays rates which only support low quality care, I'm not sure much is gained with oversight, especially given the high costs of state operated facilities and high cost for Department receivership in a recent case. This does sound like a re-enactment of Certificate of Need provisions, but I'm not sure I understand the scope of the perceived problem.