Governor Richardson's Health Care Summit on the

University of New Mexico Health Sciences Center

Held December 5, 2005 in Albuquerque, New Mexico

I. Introduction

The Honorable Bill Richardson, Governor of the State of New Mexico called upon the Regents of the University of New Mexico to conduct a special statewide summit to address the way in which UNM Hospital (UNMH) is fulfilling its public health mission and the funding crisis that is threatening the UNM Health Sciences Center (HSC). Two hundred thirty people participated (and 170 observed) on December 5, 2005 to share perspectives and seek consensus on the first draft of a collaborative plan that will have broad support.

The health care challenges in New Mexico are well known. There are an estimated 150,000 medically uninsured residents in the four counties comprising central New Mexico, including Bernalillo, Valencia, Sandoval and Torrance counties. In Bernalillo County, approximately 100,000 people have no health insurance coverage. That rate is growing by about two percent per year. Health care coverage options are limited for low-income individuals and whose employers do not offer insurance plans (34%). The unemployment rate in Bernalillo County is 4.8%. Risk factors and chronic disease rates rise as income and education levels fall. The highest income disparities and dropout rates are in the Southeast Heights and South Valley of Bernalillo County. Those two quadrants have the highest adult and infant death rates and highest rates of asthma, hepatitis, and HIV/AIDS. They also have the highest number of visits to UNMH, primarily to the emergency room.

The UNM HSC's financial report presented at the Summit showed that the cost of uncompensated care in fiscal year 2005 was $131,267,834 which is $44,876,287 in excess of funds directly allocated for uncompensated care. The uncompensated care is provided by UNMH and the School of Medicine (SOM) faculty, who are the doctors for UNMH. Additional public funds are needed to adequately address the current public mission. Funding to cover the current uncompensated care gap must be addressed, as well as support to build capacity for future needs.

II. Pathways to Progress

The Academic Health Center at UNM is called the UNM Health Sciences Center. The clinical enterprise of the UNM HSC is made up of the UNMH and the SOM. The mission of the UNM HSC is to improve the health of our communities and significantly contribute to the public welfare of the larger society in which the UNM HSC resides. The UNM HSC does this in a way that sets it apart from all other entities and individuals committed to the same goal through a distinctive social mission and delivery of unique public goods:

1. Caring for vulnerable populations--due to the nature of their medical condition or their socio-geo-economic circumstances--with a special commitment for Bernalillo County indigents and Native Americans.

2. Producing the next generation of health professionals.

3. Conducting research intended to advance the health of the public through discoveries in the laboratory and translating these to cutting-edge clinical practices as well as designing and

managing new and innovative approaches to the delivery of healthcare services through health systems, outcomes and preventive medicine research.

4. Assuming a leadership role in improving health by providing guidance to policy makers in the public health and medical arenas, e.g., health disparities, responses to public health threats and ethical issues arising in health care, research and education.

At the Summit, the UNM HSC demonstrated its commitment to addressing concerns raised by Bernalillo County, the Community Coalition for Health Care Access and other advocacy groups and individuals. Executive Vice President for Health Sciences, Dr. Paul Roth, announced several policy changes and new initiatives, including:

1. Replacing the old UNMH self-pay policy requiring a 50-percent down payments with one that has the same down payments as the co-payments for UNMCare patients, thereby helping needy New Mexicans who have no reasonable alternative for their care;

2. Changing the payment/collection policy so that payment plans for self-pay patients will be appropriate to each person's financial situation;

3. Improving the availability of interpreter services 24/7 through various means, including hiring a consultant to study UNMH's interpreter services, and agreeing to consider the recommendations of the consultant;

4. Improving HSC UNMH/SOM relations with the community by creating an Office of Community Affairs that will report directly to the HSC Executive Vice President, by initiating the search for a director of the office, and by establishing a Community Affairs Advisory Council to advise the HSC Executive Vice President;

5. Providing transparent and regular financial information and engaging in ongoing discussions with stakeholders about financial trends and issues affecting the HSC UNMH/SOM and the constituencies they serve.

During the Governor's address at the Summit he made a commitment to insure every child under the age of five, and to restore the 12-month Medicaid Certification.

III. Principles that Guide Recommendations

While participants represented a diversity of interests, all agreed that the UNM HSC, through the UNMH and SOM, plays a critical role in bringing health to all New Mexicans and that action is required to avert a looming crisis. The current fragmented nature of the U.S. system of health care provision and funding has created a set of conditions in which a single solution to health care issues we are facing locally is not viable. Creating and implementing a system of solutions will require broad input, participation, and commitment. The recommendations that follow acknowledge the following principles that emerged during the Summit:

1. Healthcare is a basic human right. Participants agreed that all New Mexico residents deserve good health care, regardless of their ability to pay for it, or immigration status.

2. The UNM HSC has a special obligation to Native Americans. Along with its obligation to Bernalillo County, the UNM HSC has a special obligation to provide healthcare to Native Americans.

3. The UNM HSC can only serve the public good when it does so in partnership with the public. The challenges currently faced by UNM HSC cannot be understood and resolved by UNM HSC alone. The social, cultural, and economic situations of the people in our state who are not receiving adequate healthcare due to lack of resources differ greatly.

4. The UNM HSC receives public funds and must be accountable to the public.

5. Statewide solutions are integral to resolving the issues. The communities served by the UNM HSC extend well beyond the four-county central New Mexico area and include some of the state's most fragile populations. UNMH is the only public hospital in the four counties comprising central New Mexico and 45% of the state's population. The unique mission of the UNM HSC has left this institution scrambling to provide care and pay for the cost of care. The challenge of uncompensated care is real. The growing funding gap is not sustainable. New Mexico is a state that can invest in a way that is fiscally responsible and that secures sustainable revenue sources for the UNM HSC.

IV. Summit Recommendations

The recommendations are compiled from the reports of each of the 23 tables, with approximately 10 people at each table. Any recommendation that was made by at least 20% of the tables has been included in this report. Recommendations are arranged by the questions considered during the Summit.

Question One Recommendations

How can coverage be provided to more patients?

1 A. **Expand the Medicaid rolls in our state by increasing eligibility and outreach.**

Almost all of the tables discussed ways in which Medicaid directly impacts UNMH and how UNMH will benefit if the number of New Mexicans who have Medicaid health care coverage is maintained or increased. Because Medicaid involves a three-to-one match in federal dollars, there was an overall group consensus that increasing the number of New Mexican families with Medicaid will have a positive impact on UNMH's budget. Some tables made specific recommendations, shown here as 1B, 1C, 1D.

1 B. **Eliminate Medicaid Auto Closure.**

The current auto-closure system in Medicaid has resulted in tens of thousands of New Mexicans experiencing a lapse in their Medicaid health care coverage. Thirteen tables recommended eliminating the current auto-closure system.

1 C. **Require 12-Month Medicaid Re-certification.**

Change the six-month re-certification requirement to a 12-month recertification requirement in order to be less burdensome for poor families. Eleven tables recommended this change.

1 D. **Include Parents of Children up to 100% FPL for Medicaid Eligibility.**

Change the Medicaid eligibility criteria to include parents of children up to 100% of the federal poverty level. Seven tables recommended this change.

1 E. **Expand UNMCare outreach.**

Fourteen tables recommended expanding the UNMCare Program by increasing outreach. Many participants acknowledged that this good program could be expanded to include more Bernalillo County residents so they have health care coverage in a cost efficient way. Several tables recommended that UNMCare be expanded to all residents of Bernalillo County regardless of immigration status.

1 F. **Remove the current cap imposed on UNMH for State Coverage Insurance and expand SCI.**

Ten tables recommended removing the current cap imposed on UNMH for State Coverage Insurance and expanding SCI.

1 G. **Provide State-sponsored Universal Health Care.**

Nine tables recommended providing universal health care coverage through a state-wide program and recognized that this would solve UNM HSC's financial problems.

1 H. **Expand Emergency Medical Services for Aliens. (EMSA)**

Five tables recommended that the Human Services Department policies be revised so that all emergent and routine labor and delivery services for undocumented women are covered.

Question Two Recommendations

What new and/or improved opportunities exist for the UNM HSC to meet the medical needs of indigents, self-paying patients, and Urban Indians?

In addition to Recommendations 1A through 1H above, which the participants recognized would provided new and improved opportunities for UNM HSC to serve Bernalillo County's and the surrounding counties' indigents, self-paying patients and Urban Indians, the participants made the following recommendations:

2 A. **Fulfill the intent of the 1952 contract regarding priority service at UNMH for Native Americans.**

Summit participants recognized that the UNM HSC has a special obligation to Native Americans, especially those who live in urban areas in the four-county region. Summit participants recommended that the UNM HSC provide leadership in working with Native Americans, including urban Indians, to assure that the intent of the contract is fulfilled.

2 B. **Improve Interpretation and Translation Services at UNMH.**

Six tables recommended that interpretation and translation services be improved to ensure that all non-English speaking patients have qualified interpreters available at every stage of their visit to UNMH. This includes interpretation and translation for financial assistance, billing and in the business office.

Question Three Recommendations

What is the HSC's responsibility to the four-county region and the state? How can the HSC fulfill this responsibility? (or, Where will the funding come from?)

There was broad recognition at the summit that UNM HSC, through the UNMH and SOM, is a statewide public safety-net facility. Consequently, increased public funding is needed to cover the growing gap in uncompensated care, which totaled $45 million in fiscal year 2005. Because of its unique social mission and delivery of services available only at UNM HSC, participants responded to the question of: Where will the funding come from?

3 A. **Create a state-wide gross receipts tax.**

Thirteen tables recommended creating a statewide gross receipts tax.

3 B. **Increase the number of people on Medicaid.**

Eleven tables recommended increasing the number of people on Medicaid in order to pull in more federal Medicaid dollars at a three to one match.

3 C. **Earmark a Portion of State Gaming Compact Funds for Urban Indian Health Care.**

Seven tables recommended earmarking a portion of state revenues from gaming compact funds for Urban Indian health care.

3 D. **County Mill Levy**

Six tables recommended that each county create a mill levy to leverage funds for indigent care at the UNM HSC.

Question Four Recommendations

How can the UNM HSC enhance its financial reporting and accountability to the public regarding the patient care mission?

4 A. **Develop an Accountability Report to be provided by the UNM HSC.**

Sixteen tables recommended that UNM HSC provide to the public a report (on an annual, semi-annual or quarterly basis) detailing information which would include funding for indigent care, how money is spent on indigent care, and performance in specific programs.

4 B. **Establish an Office of Community Affairs.**

Fourteen tables recommended that an Office of Community Affairs be established to advocate for patient access to care and accountability at UNMH. This office would be a vehicle for community input into significant UNMH decision making.

V. Health Care Summit Background

The Governor's Request

In a letter dated July 19, 2005, to the University of New Mexico Board of Regents, Governor Bill Richardson expressed his desire to address issues and concerns raised by Bernalillo County, the Community Coalition for Healthcare Access, UNM Health Sciences faculty and staff, and other advocacy groups and individuals that UNMH is not fulfilling its public health mission and is putting financial concerns ahead of the needs of the people it serves.

The Governor recognized the delicate financial balancing act that UNMH/SOM and other public hospitals are forced to perform to attempt to meet the healthcare needs of the population while remaining fiscally viable. He acknowledged the UNM HSC's challenge of providing uncompensated care in the face of 400,000 uninsured New Mexicans. "However, the bottom line remains that these financial challenges must not improperly limit the public's access to needed healthcare, regardless of the ability to pay," the Governor further stated in his July 19, 2005 letter.

The Governor called upon UNMH and the HSC to open its books and be completely transparent regarding its fiscal performance and strategic plans. He asked that the Summit study the issue of uncompensated care and bring forth recommendations to address the gap between the costs and the public revenue allocated for this purpose, provide a clear explanation of the financial performance, and provide for public input into the hospital's management.

The Regent's Sub-committees

To that end, the Regents appointed two subcommittees to review the financial reports and to set the agenda for the Summit. The subcommittees met in September, October and November of 2005. The summit was held on December 5, 2005 in Albuquerque, New Mexico. The subcommittees represented a diversity of interests.

The Finance Subcommittee met on numerous occasions and sifted through numerous financial reports, spreadsheets and cost-to-charge ratios. This subcommittee affirmed its commitment to the core mission of the UNM HSC and urged that UNMH/SOM be an accessible, affordable, accountable and quality health care provider for the residents of the State of New Mexico, regardless of their financial status. Furthermore, the subcommittee passed a resolution preliminarily concurring with the UNM HSC's financial report for the purposes of the summit showing that the cost of uncompensated care in fiscal year 2005 was $131,267,834 which is $44,876,287 in excess of funds directly allocated for uncompensated care.

This gap threatens the financial viability of the UNM HSC. The subcommittee's resolution also recommended that the Regents adopt a resolution agreeing to provide to the public, including the NM Center of Law and Poverty and the Community Coalition for Health Care Access, the type of information described in the Governor's July 19, 2005 letter, including an annual report card analysis of uncompensated care. (This was passed by the Regents in 2005.)

The UNM HSC's Obligation to Bernalillo County Residents and Native Americans

All agreed that the UNM HSC has a de facto mission as a statewide safety net hospital, because of its status as the state's only Level 1 Trauma center and because it offers specialty care not available elsewhere. In addition, UNMH is the only public hospital in the four counties region comprising central New Mexico and 45% of the state's population.

UNMH has an even greater role to the residents of Bernalillo County, including those who are Native American, under a three-party lease agreement with Bernalillo County and the Department of the Interior in federal trust obligation for Native Americans. This lease requires the county to levy taxes for the hospital, subject to voter approval, and obligates the hospital to care for indigent residents at the same level that it provides care to patients with third-party payment sources.

Approaches to Health Care Coverage

There are several approaches to providing health care coverage that can be built upon. In 2003, some 65,000 children were enrolled in Medicaid, which is approximately 65% of those eligible. In addition, about 14,000 financially eligible adults were enrolled in UNMCare, a program designed to provide managed care for low-income and indigent county residents. This represents 14% of the 100,000 adults who may be financially eligible for UNMCare. The UNM State Coverage Insurance is a new opportunity to provide health care coverage to 3,500 low-income adults. All three of these programs should be expanded to help provide uninsured New Mexicans with health care and to address the problems of uncompensated care at UNM HSC, as well as other health care institutions.

Summit Methodology

The summit was divided into three segments. The first segment, in the morning, framed the issues from the perspective of state legislative leaders, Bernalillo County, UNM leadership, the Community Coalition for Healthcare Access, the Urban Indian community and patient advocacy organizations.

The second segment, in the afternoon, was small group dialogue among participants. Twenty-three tables of 10 participants each, discussed the same four questions. Each table had a facilitator and a scribe. The questions addressed were as follows:

> How can coverage be provided to more patients? How can we pay for the approaches and solutions we propose? How can we as a community work together to make it happen?
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> What new and/or improved opportunities exist for the HSC to meet the medical needs of indigents, self-paying patients and urban Indians? How can we pay for the approaches and solutions we propose? How can we as a community work together to make it happen?
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> What is the HSC's responsibility to the four-county region and the state and how can the HSC fulfill this responsibility? How can we pay for the approaches and solutions we propose? How can we as a community work together to make it happen?

How can the HSC enhance its financial reporting and accountability to the public regarding the patient-care mission. How can we pay for the approaches and solutions we propose? How can we as a community work together to make it happen?

The third segment, at the end of the day, was a reporting of consensus findings and suggestions from individual tables to the plenary session. These findings were typed into a computer and projected on a large screen so that participants could read what was being said. This text can be found in the appendix of this document.

Appendix

Plenary Session Notes

(The comments below represent suggestions, ideas and consensus findings made at the individual tables and reported out to the group. These findings were typed into a computer and projected onto a screen. These are the notes from that reporting session).

- Expand SCI throughout the State. How much would it cost to expand SCI?
- Expand Medicaid.
- Define who is responsible to develop integrated health care for New Mexico.
- Form teams from the Summit group to identify initiatives.
- UNM needs to develop formalized partnerships with hospitals throughout New Mexico. How can we enhance care in local communities and unburden some at UNM?
- Within Bernalillo, work with partners with community organizations to develop comprehensive models, not just tertiary, but go deep and vertical.
- Expand what we have at UNMCare, statewide coverage, look at healthcare plans in other states and see what we can garner. Cost them out.
- Expand trauma services statewide.
- Statewide indigent GRT to provide to UNMH. Establish healthcare trust fund to support services throughout New Mexico. Establish partnership between Tribes and UNM. .5cent statewide GRT = $200M.
- State needs to accept the fact the UNMH is the statewide hospital, and provide resources. Provide money to expand tele-health, coordination and reach to communities with health disparities, cultural and linguistic services, and satellite offices.
- Create four-county consortium to address funding issues.
- More transparency in financial reporting, demographic information, sources of money. Reporting more often (quarterly). Use Office of Community Affairs to be leader in true partnership (translators, hours of operation), share and support resources throughout the state.
- Hospital is a confusing place. Seating isn't available.
- Need to support HSC to educate and produce more doctors, nurses and pharmacists.
- In bringing more resources, need more health care practitioners. Provide tuition reimbursement to get kids into health professions.
- Eliminate auto-closing of Medicaid.
- Reverse criteria for UNMCare to expand eligibility regardless of immigration status.
- Ensure that the Office of Community Affairs is independent and Community Advisory Board is community centered.
- Optimize medical interpretation and translation services.
- Earmark some gaming funds for urban Indian healthcare.
- Train intake processing workers to look for all forms of healthcare coverage to.
- Forestall further income tax to help pay for this.
- Expand resources, more doctors.
- Expand Medicaid eligibility, increase population, aggressive outreach, increase reimbursement.
- SCI should only go to new folks, do not shift from other programs. Encourage more people to enroll.
- Stop auto-closure, rescind it.
- Create better partnership with IHS and share staff. Keep the program running there.
- Increase tele-health funds, and help line. Get MCO's to put in more money. Pull money from bioterrorism for health.
- Train medical interpreters. Fund training here at UNM, create program here.
- Establish universal healthcare.

- UNM provides specialty care in partnership with other counties through expanding SCI and UNMCare.
- There should be a bi-annual indigent report card for health indicators to provide feedback.
- Educate patients how to use the system. This would reduce the use of ER and specialty care.
- Leverage some lottery or gaming money for Native American primary care.
- Leverage Medicaid to the maximum.
- Survey SOM and hospital to identify all employees who have firs or second language that is not English. Have them available to provide interpretation when other translators are not available.
- Expand the Roswell facility for long term care.
- End auto-closure.
- 12 month re-certification.
- Medicaid eligible parents at 100% Federal Poverty Level.
- Expand EMSA eligibility so all births by undocumented women are covered.
- Expand State Insurance Coverage to maximum coverage.
- Increase Medicaid reimbursement for services only UNM HSC provides (for example NICU, trauma, and burn unit).
- Increase county reimbursement to cover their residents by creating new revenue through regional or statewide GRT and/or increase out of county indigent care appropriation.
- Ask Legislature to create a new fund for out of county trauma care at UNM HSC.
- Expand UNMCare if new revenue opportunities are approved.
- Reaffirm the relationships and obligations with urban Native American populations to provide access to services, per the 1954 contract, and also explore opportunities for Medicaid eligibility.
- Optimize and expand participation in all existing programs and train staff to ensure all those eligible are enrolled.
- Designate a portion of Indian gaming revenue to General Fund to General Fund and earmark it for healthcare for Native Americans.
- Bottom line, we need to start considering a general strategic plan for the well-being and health of the citizens of New Mexico rather than trying to fix short-term problems.
- Reinstate the urgent care next to the ER to reduce bottleneck in the ER.
- When you look at TQM, look at the source of the problem. Hold Summit at local level (counties); a summit similar to today for urban and other Native American organizations; if there are gaming recommendations, include Native Americans at the table.
- Cut out the Medicaid middle-man.
- Integrate billing, establish global billing.
- Use promoters for the healthcare work in the local communities, establish health commons.
- Encourage collaborative competition with other healthcare providers.
- Redefine who we are--we are a healthcare provider, an academic medical center. Are we both? To what degree are we one or both?
- Marketing, we don't communicate. Allocate funds for marketing. Better educate people to use our system better.
- To provide healthcare for business workers, two-tier minimum wage.
- This group formally endorses the Governor's proposal for 12-month re-certification.
- We involve the community to define what the UNM report card should be.
- *How are we going to pay for it?*
- Have a yearly external audit of uncompensated care and have State pay for the shortfall.
- Tobacco fund money gets diverted to other funds. Why doesn't all the tobacco fund money go to today's healthcare needs?
- Today's dollars but we are really talking about tomorrow's healthcare outcomes. We need to talk about long term health issues.

- Recognize the need for paying patients and being able to increase the number of insured parties. It shouldn't be a two-tiered system.
- Give mill levy back to the state for Medicaid matching.
- We haven't changed the system that is broken - violence, disability, chronic disease. There has to be an inherent commitment to improve health outcomes of the community, i.e. prevention.
- We can reduce the need for services if we have a good prevention program. Also, how do you design an integrated healthcare system to treat the population? Integrate health services into this.
- We also have an alcohol fund. More money is collected than is needed for alcohol services. Extra money is diverted into the general fund.
- Better communication about the new building going up. Where is this money coming from?