#96

October 8, 2017

Bernalillo County Commission
c/o Clay Campbell, Chief of Staff to County Manager
1 Civic Plaza NW
Albuquerque, NM 87102

Re: Comments on Draft Agreement between Bernalillo County and UNM Hospital

Dear Bernalillo County Commission,

Thank you for negotiating a draft Memorandum of Understanding (MOU) with UNM Hospital and the opportunity to provide public comment on it. The MOU will have a far-reaching impact on Bernalillo County's healthcare system and provide greater accountability over the $90 million of taxpayer mill levy funding that is sent to the Hospital each year.

We write, however, to express our serious concerns with the MOU provisions on financial assistance (Draft MOU Exhibit A, Section D). As drafted, the MOU allows for UNM Hospital to continue to deny financial assistance to the most vulnerable and low-income county residents, and to charge these patients exorbitant 50% upfront fees for surgeries, preventing them from getting medically needed care. The County should not concede to an erosion of the safety net that damages the health of our communities.

The lease agreement with UNM Hospital gives it the important role of serving as the safety net provider for low-income patients in the County. The lease states that as long as UNM Hospital continues to receive mill levy funds, it will provide the same medically necessary care to indigent residents that is provided to all other patients of the Hospital.[1] This is vital to ensure that county residents can access primary care, behavioral health and hospital care, to protect our families against financial debt, and to keep uncompensated care costs down for all hospitals and providers in the area.

We urge you to require UNM Hospital to fulfill this important obligation by ending discriminatory practices and ensuring all low-income patients can access financial assistance programs, as follows:

1. **UNMH financial assistance programs must be available to low-income patients who cannot buy insurance or get other healthcare coverage.**

We agree that patients should be encouraged to seek healthcare coverage that is available to them under the Affordable Care Act (ACA). But the draft MOU allows for UNMH to continue its extreme step of denying these patients financial assistance when they cannot get that coverage. As a result, UNMH's financial assistance program has become a supplemental program that mostly covers people who already have insurance, rather than those who are uninsured. Meanwhile, low-income uninsured patients are enrolled into a "discount" program, but this is not really a discount because it just reduces gross charges into a bill that reflects the actual cost of care. UNMH acknowledges this is not "financial assistance".

Patients most in need of a hospital safety net are being denied it – including low-income families that cannot afford to purchase insurance on the Exchange, seniors who cannot enroll in Medicare

[1] *See* Board of County Commissioners of the County of Bernalillo and Regents of the University of New Mexico, 1999 Lease Agreement for Operation and Lease of County Healthcare Facilities, Section VII(E) (1999).

#96

because they are outside the enrollment window, and individuals facing personal and financial hardships that make it impossible to sign up for coverage. These patients are often exempt from the ACA mandate to get insurance because they are very low-income, Native Americans, immigrants, or have financial or other hardships.[2] Nevertheless, UNMH believes they should have obtained coverage anyway and denies them financial assistance.

While the Hospital assures that it will offer financial assistance to patients if insurance is "unaffordable", this is a hollow commitment because almost every ACA coverage option meets UNMH's affordability standard on paper, even though it is not affordable in reality. Many working families cannot afford insurance through the Exchange, even with the help of federal ACA subsidies.[3] Families living under 225% of the federal poverty level do not have the income to meet basic living expenses.[4] For example, a single mother with one child who earns $2,030 a month (150% FPL) must pay for necessities like rent, food, gas, and childcare that totals up to $3,360 per month. She already faces a major budget deficit and cannot afford the $100 in monthly premiums that a Silver plan would cost on the Exchange after federal subsidies.[5] Yet UNMH assumes her family has an "affordable" coverage option and would deny her financial help for medical care.

Recommendation: Draft MOU Exhibit A, Section D(3) requires significant revision. It reads: "The County recognizes that... UNMH's financial assistance program is a payer of last resort. Therefore, the County understands that UNMH may require patients to seek other health insurance through employers, the Exchange, the State's High Risk Pool, Medicare Parts B and D, or any other coverage source, including Medicaid, EMSA, etc. prior to eligibility for financial assistance."

We recommend: "The County recognizes that UNMH's financial assistance program is a payer of last resort for patients that have public or private insurance or related third-party coverage. UNMH should educate patients on their eligibility for coverage options, but cannot require patients to enroll in insurance or coverage to receive UNMH's financial assistance programs."

This revision is based on language used by federal HRSA guidance for FQHCs,[6] and would accomplish the goal of encouraging patients to seek coverage, while allowing them to access hospital financial assistance programs when they cannot get the other coverage. The revision also more accurately describes what it means to be a "payer of last resort", which applies to scenarios when a person actually has other insurance (not when they could theoretically get it).

Although the Hospital has concerns that patients may remain uninsured and use hospital financial assistance as a substitute for coverage, we are seeing a worse outcome now -- patients are remaining uninsured because of financial circumstances and left without any help at all. This MOU revision would actually incentivize the Hospital to provide better assistance to patients with enrollment by effectively educating them on their options and the value of having healthcare coverage – including the health benefits and financial help they would receive from the Hospital as a supplemental program, and potential ACA tax penalties for not having coverage.

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[2] There are nine different exemptions to the ACA mandate to buy insurance. *See* I.R.C. § 5000A.

[3] Surveys cite affordability as the top reason why people remain uninsured. *See* NM Health Insurance Exchange 2016 survey; Commonwealth Fund, *Who are the Remaining Uninsured and Why Haven't They Signed Up for Coverage?* (Aug. 18, 2016).

[4] Economic Policy Institute, Basic Family Budget Calculator, August 2015 (using 2014 dollar estimates), at: http://www.epi.org/resources/budget/. Methodologies are described in technical documentation available on the website.

[5] Healthcare.gov, 2017 health insurance plans and prices (Nov 2016) (quoted for 30 year old mother in Albuquerque).

[6] See HRSA Policy Information Notice 2014-02, at 14 (Sept. 22, 2014) stating that federally qualified health centers must maximize revenue from public, private or third party coverage sources and should educate patients on the coverage options available to them, but that "health centers cannot require patients to enroll" in public, private or third party coverage.

#96

2. UNMH may not discriminate against immigrants in its financial assistance programs.

The County must take a stance against the Hospital's discriminatory policies for immigrants – policies that are out of line with medical norms and the common practice of hospitals across the county. UNMH does not allow immigrants to access financial assistance programs if they are lawfully residing with visas that the Hospital considers to be "temporary" visas (despite clear federal guidance that these individuals can still meet state residency requirements),[7] undocumented, or have deferred action status (DACA). These patients are eligible for local indigent care programs under state law, but UNM Hospital still insists that a federal law requires that they be excluded from the Hospital's financial assistance programs.

The New Mexico Center on Law and Poverty provided an extensive legal analysis to the county attorney's office in April 2016 describing why the federal law does not apply to UNM Hospital's programs. The federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) excludes certain immigrants from federal benefit programs like Medicaid, but it does not apply to state or local benefits in the same manner. The prohibitions do not apply when states have affirmatively allowed for their programs to cover all immigrants, such as in New Mexico where state laws authorizing county and hospital indigent care programs apply to all persons, including undocumented immigrants.[8] Programs that discriminate against immigrants are also unlikely to survive a legal challenge under the state constitution's Equal Protection Clause. In addition, UNM Hospital is not a "state agency" that is subject to the federal law because it has no executive or rulemaking power and lacks authority to verify the immigration status of patients. Instead, the Hospital is classified under the federal law with tax exempt educational and charitable institutions that are not required to verify immigration status.

Recommendation: Draft MOU, Exhibit A, Section D(2) states that "These patient payment policies and financial assistance program policies shall comply with and be applied to the extent permitted by federal law, rules, and regulations, and to the extent not preempted by applicable federal law, shall comply with state laws, rules and regulations, applicable to governmental entities such as the University and UNMH".

This entire clause is unnecessary and should be removed. It is already self-evident that the Hospital must comply with state and federal laws, with or without the MOU. The application of federal preemption is a legal issue that UNM Hospital has misinterpreted, and adds no value to the MOU for the County.

In place of this language, we recommend the following: "Financial assistance programs shall be available to all Bernalillo County residents meeting income and residency requirements. Immigration status may not be used to determine county residency or eligibility for financial assistance."

3. UNMH must stop charging exorbitant 50% down payments for surgeries and ensure all low-income patients are charged reasonable copayments and fees that are set according to income.

UNM Hospital's policy to charge 50% of the costs of surgery upfront for low-income, uninsured patients is in violation of its lease with the County and must be ended. These patients, who are living in or near poverty, are having medically needed surgeries get canceled because they were unable to come up with $15,000 or more all at once. Not only are they being restricted from enrolling in UNMH financial assistance programs (as described above), now they are being charged exorbitant down payments that shut them out of getting hospital care. The policy is a major reversal of a long-standing commitment

[7] Immigration status may not be used to determine state residency under federal Medicaid rules. 42 CFR 435.956(c).

[8] *See* Hospital Funding Act, NMSA 1978 Sec. 4-48B-8 (authorizing counties to enter into agreements with other agencies for the care of sick and indigent persons); *Perez v. Health and Social Services*, 1977-NMCA-140, at 6 and 18, 91 (establishing that the term "person" or "resident" in statutes for state-funded medical assistance include undocumented immigrants).

#96

made by UNM Hospital in 2005 to charge low-income patients the same co-payments for surgeries as patients who are enrolled in the UNM Care financial assistance program (which now mostly covers people with insurance) – co-pays that range from $25 to $300 depending on the person's income level.[9]

The 50% down payment policy was adopted again in 2015. UNMH's Patient Payment Policy has a chart that shows "self-pay" patients must pay 50% the estimated charges of surgeries for down payments, while patients on the UNM Care financial assistance program are charged lower co-payments according to their income.[10] The policy did not clearly show what down payments are expected from low-income, uninsured patients who are in the "discount" program. Up until then, they had been charged the same way as UNM Care patients. In May 2017, UNMH issued clarifying guidance stating that low-income patients in the discount program would be charged 50% down payments for all surgeries, but may be appealed through the Chief Medical Officer if they are "urgent".[11] The policy has no such requirement for other patients, and simply says: "Patients who qualify for Medicaid, Medicare, Commercial Insurance, UNM Care, or other third party coverage will be cleared to proceed for scheduling".

The policy is plainly discriminatory and in violation of the lease because it does not allow low-income, uninsured patients to get medically necessary surgeries that every other patient is able to get. The only way to get surgeries without paying exorbitant down payments is if the care is specially approved as "urgent", not just medically necessary. Although UNM Hospital has publicly said this care is "purely elective", insinuating that it is not really needed, these same surgeries would be scheduled for other patients. "Elective" care in fact refers to all non-urgent or emergent care in the medical context, and would include medically necessary care that is not considered "urgent" but nonetheless should be done to correct a major medical condition and prevent it from worsening into a life-threatening emergency.

Recommendation: Draft MOU, Exhibit A, Sections D(4) and D(5) do not clearly prohibit UNM Hospital from charging exorbitant 50% down payments, and create major concerns because they are inconsistent with the lease or weaken the lease in several ways. First, having two separate clauses with two different standards for low-income patients, including those who are eligible for financial assistance programs and those who are not, tacitly allows them to be treated differently with how much they are charged in down payments or copayments, even though their income levels are the same. This conflicts with the lease's language that requires indigent patients to have equal access to medically necessary care.

Second, the language that the policy should "not create a material barrier to such patients' access to medically necessary health care" is entirely insufficient. This would allow UNMH to continue to insist that nobody is denied medically necessary care from its 50% down payment policy because patients can at least get special approval from the Hospital to waive the fee if the care is urgent. "A material barrier" is also a vague standard in this context and allows the Hospital to create bureaucracies that supposedly work on paper, but that are in practice difficult to administer and that effectively deny patients care.

Third, the language throughout these sections state that UNMH will "endeavor" to provide reasonable fees, co-pays, or down payments to patients, not that it "shall" provide them. This soft language is

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[9] See Governor Richardson's Health Care Summit on the UNM Health Sciences Center, Held December 5, 2005 in Albuquerque, New Mexico, on file with the New Mexico Center on Law and Poverty. The report states that Dr. Paul Roth announced several policy changes including "Replacing the old UNMH self-pay policy requiring a 50-percent down payment with one that has the same down payments as the co-payments for UNM Care patients, thereby helping needy New Mexicans who have no reasonable alternative for their care.

[10] *See* UNM Health Sciences Center, Patient Payment Policy, Doc #2619 (Oct. 30, 2015).

[11] *See* UNM Hospitals, Finance Guidelines for Surgical Cases for Providers (Non-Emergency Cases), Revised May 2, 2017, ("For patients qualifying for the indigent status and discount, to be cleared for scheduling must, subject to the medical urgency exception below, make a down payment of 50% of their expected remaining balance.")

#96

inappropriate given the Hospital's role as the county's safety net provider. The basic premise of financial assistance programs is to charge people what they can afford so that they can access medical care. The Hospital needs to have a clear and transparent standard for how it makes this determination.

We strongly recommend removing both sections D(4) and D(5) and replacing them with one that states: "UNMH will provide low-income patients with access to medically necessary care by establishing a fee schedule of co-pays, down payments, and payment plans that are set reasonably according to income."

4. **UNMH must ensure that no low-income patient will be sent to collections for medical bills.**

In 2015, the Hospital announced that it would no longer send low-income patients to an outside collections agency if they had set up a payment plan with the Hospital, even if they defaulted on payment. Prior to that time, UNM Hospital had been sending more than $80 million of patient bills into collections, leaving low-income families in massive debt and damaging their credit ratings.[12]

Despite this significant improvement, the policy against collections is not clearly stated anywhere in the Hospital's financial assistance and patient payment policies. Instead, there is only one sentence in the Patient Payment Policy that merely states that patients will not be sent to an outside collections agency for "co-pays". It does not mention what happens to the rest of the bill.

Recommendation: MOU Exhibit A, D(8) does not fully capture the new collections policy and allows for it to be easily changed by the Hospital at any time in the future, leaving low-income patients at risk of losing this important protection. The language "(as defined in one or more policies)" should be removed because it allows the Hospital too much flexibility to change who the collections policy covers. The terms "who is on a payment plan" should also be redrafted because it could be interpreted to mean that a person must be making payments in order not to be sent to a collections agency, even though the intent of the clause is to ensure they are not sent to collections even if they default on payments. We recommend changing this section to state "UNM Hospital will maintain and/or modify its billing services to provide that no low-income patient is sent to a collection service for payment."

We are overall concerned that UNM Hospital's policies on financial assistance are discriminatory and unduly complex. There is no reason to have two different tracks of financial services for low-income county residents that keep one group from accessing the medically necessary services and financial assistance programs that are available to other patients. We urge the County not to be complicit in this discrimination and to ensure the MOU treats all low-income patients the same, as required by the lease. We are happy to provide our assistance as you follow up on these provisions with the Hospital.

Sincerely,

/s/ Sireesha Manne
New Mexico Center on Law and Poverty

Signed on behalf of:

Casa de Salud
Centro Savila
District 1199 National Union of Hospital and Health Care Employees

[12] University of Health Sciences Center, Healthcare Summit Reports, Report 11, Bad Debt and Write-Off Analysis, Fiscal Years 2013 through 2015 (Dec. 7, 2015).

#96

Encuentro
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Cc: W. Ken Martinez, County Attorney

Clay Campbell

From: mailservices2@sks.com
Sent: Sunday, October 08, 2017 3:04 PM
To: info; Tiffany E. Chamblee; Clay Campbell
Subject: A public comment was submitted online

#103

Name
Julia Stephens

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Subject - Choose One:
UNMH Lease Agreement

Comment
07OCT2017
Julie Stephens comments re: UNM Hospital DRAFT MOU (September 5, 2017) Requesting public input on the UNM Hospital DRAFT (September 5, 2017) MEMORANDUM OF UNDERSTANDING is a positive step forward. The MOU is an opportunity for Bernalillo County to express the desire of the community to improve and strengthen prevention and a health safety net for all indigent and underserved residents. Requiring measurable goals with targeted outcomes are essential in evaluating the effectiveness of expending nearly 100 million tax dollars, annually, over the coming eight years.
My comments follow within each identified section(s) of the Draft 2017 MOU.
II. Mutual Covenants
B.2. It is the discretion of Bernalillo County to determine what Navigational services are funded and at what level to assure that a community health safety net continues to be developed and is coordinated among the Mil Levy and tax supported behavioral health funds that does not mix funds, conflict with or duplicate services.
The UNM/HSC administrated Pathways to a Healthy Bernalillo County have established an eight year record of supporting a network of community based navigators who demonstrated positive community health outcomes and established a foundation for building a stronger safety net for all underserved County residents. The MOU must designate a minimum of $1.2 million annually for Pathways. As well as additional funds to be distributed and administrated by UNM/HSC Office for Community Health in order to assure the best outcomes with indigent and underserved populations including coordination and accountability of navigational services by all programs.
The posted draft MOU language is transactional in nature and disconnected from a description of the hospital's community and public obligations, nor it does not mention Pathways anywhere in the document or the exhibits. For example, Exhibit B does not include any accountability measures for the navigational programs described in II.B.2.

EXHIBIT A TO MOU
A. REPORTING AND INTERACTION

#103

A.2 Public input mechanism by UNMH that is proposed is grossly insufficient. The description is simply that of current practice, as required of the Board of Trustees which does not reflect community input and Health Care Task Force recommendations for community involvement in planning and monitoring progress in achieving community health measures through the Mil Levy public funding.
New wording must replace this section to describe UNMH agreement and facilitation in the formation of a Community Health Resources Oversight Board (similar to Police Oversight Board) including appropriate accountability measures in Exhibit B.
A.3. and A.4. What are the intentions, specifically, in these sections? They seem to be redundant and lack meaning. How would these be acted on and monitor progress?
B. ACCOUNTABILITY AND TRANSPARENCY
B.8. What is the description of a "grievance" (which has been manipulated by health insurance companies). What is the difference between complaint, appeal, grievance, and what are the actions required in response to these? How will these be collected? How does the public know when they can file a grievance?
C. PRIMARY CARE/LOW INCOME
C.3 To stop the current practice, add language including: NO low-income resident will be excluded from UNMCare, or successor financial assistance programs, for their medically necessary care, and/or uninsured or low-income residents will not be required to pay medically-necessary surgery costs upfront or have their bills sent to collection.
C.4. Add language including: build an integrated system of primary care and navigation support to reduce ER utilization through a) triage programs, b) setting up expanded evening and weekend hours in safety net primary care centers, and c) navigation support to access these services instead of ER visits.
D. FINANCIAL ASSISTANCE
D.2. Add wording that requires UNMH to clarify what constitutes a policy versus changes to practices or procedures that have an impact on affordability and access to services by indigent populations, and how the County and public will be advised of these kinds of changes. 50% up front for surgeries is an example, as well as many, of a change in practice that UNMH must put in a policy, reviewed by appropriate oversight bodies.
4. & 5. Change the word "endeavor" to "shall".
10. Remove, "including those in incarceration," as this population is addressed in detail in #11. Include language related to, "UNMH will coordinate with and support community-based nonprofit organizations to conduct outreach to County residents that are experiencing barriers to accessing medical services and financial assistance through Medicaid or insurance."
Add an Exhibit that describes the Pathways program, the allotment of funding, with accompanying accountability measures.
11. Should have accompanying accountability measures for case management and coordination services that are provided to persons leaving incarceration under this agreement. Add an Exhibit to describe this program, the allotment of funding for it, and accompanying accountability measures.
EXHIBIT B: Accountability
The Exhibit does not provide descriptions of the populations Navigation services are to serve and where they are to be placed, e.g. in the community. Exhibits describing the program details and allotments of funding are needed, similar to the 2008 MOU.
It is important to use adjustments for case complexity and local wages to develop metrics that can be readily compared to peer hospitals, state averages, and national averages.
None of the accountability metrics (that pertain to UNMH) address specific community-benefit activities or provide evidence of their effectiveness.

- The first set of metrics (margins, return on equity etc) are basic hospital financial metrics that are published online. They are meaningful measures of hospital financial stability, but they don't speak to community benefit and they are widely available.
- The second set of metrics are related to the return on investment in fixed assets. These are slightly more meaningful per reflecting the degree to which UNMH is reinvesting revenue in physical assets. However, they also illustrate the degree to which the hospital is investing in projects with high financial ROI versus community benefit.
- The third set of metrics - CEO compensation relative to the compensation of other staff and other CEOs of comparable hospitals — are helpful in understanding UNMH staffing.

#103

- The 4th set of metrics - hospital costs - are very specific to Medicare "exposure" and meant to better reflect the growing share of hospital revenue attributable to out-patient services. They appear to be not relevant enough to community benefit to justify trying to understand them.
- The 5th set of metrics — Community Benefit — fall short of describing target goals and how UNMH is impacting related specific outcomes and the overall health of the community and its various populations of indigent and underserved residents.

Clay Campbell

From: mailservices2@sks.com
Sent: Sunday, October 08, 2017 5:04 PM
To: info; Tiffany E. Chamblee; Clay Campbell
Subject: A public comment was submitted online

#106

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EleValle: South Valley Healthy Communities Collaborative

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Subject - Choose One:
UNMH Lease Agreement

Comment
EleValle has analyzed the draft agreement and is recommending the following improvements to ensure that UNM Hospital is held accountable as our Public Hospital for providing medically necessary care to all Bernalillo County residents who cannot afford to pay.

Overall, EleValle is calling for 1.) Affordable access to medically-necessary care for all people living in Bernalillo County; 2) A community health oversight board, and 3.) Expansion of the Pathways to a Healthy Bernalillo County Program, a community-based navigation program.

Recommendations:
Bernalillo County should adopt a resolution that outlines what it expects from UNMH as a public safety net hospital in terms of county health improvement goals and indicators and to require UNMH to report progress on its attainment of the county's goals and on the evidence-based strategies that it is implementing to achieve those goals and objectives.

When it comes to providing financial assistance and payment policies, the agreement uses the word "endeavor," which means to "make an effort." This is UNACCEPTABLE. In many other places, the agreement says that UNMH "shall" and "will" do certain things. Throughout the agreement, replace the word "endeavor" with the word "shall."

In Exhibit A, Section D. FINANCIAL ASSISTANCE, Replace Items 3. 4. 5. 6. 7. 8. with the following:

3. As a Public Hospital and a Safety Net Institution, UNMH is responsible for providing medically-necessary care to Bernalillo County patients who are unable to pay. This is the definition of a safety net hospital. While UNMH will make every effort to assist patients with obtaining medical coverage, it will not require low-income residents to purchase health insurance prior to being screened for and enrolled in UNMH financial assistance programs. Forcing people to seek coverage delays care, and forces people deeper into poverty.

#106

4. As a Public Hospital and Safety Net Institution, UNMH is responsible for providing medically-necessary care to all people residing in Bernalillo County, regardless of their insurance status or their ability to pay. UNMH shall establish patient payment policies and co-pay, down payment and sliding fee schedules that are reasonable and affordable to people based on income and family size.
5. UNMH, as a Public Hospital and Safety Net Institution, shall establish patient payment policies for low-income patients who are not eligible for financial assistance that do not create a barrier to such patients' access to medically-necessary health care.
6. The payment plans shall be based on income and family size and be reasonable and affordable, as determined by a percentage of monthly income not to exceed 5%.
7. UNMH shall proactively work with non-emergency patients before they incur bills to determine their financial status and eligibility and to inform them of their rights to seek financial assistance and to make payment plans, rather than waiting until demand for payment has been made.
8. The hospital shall not send financial assistance and self-pay discount patients to collections. The hospital by its own admission only collects 25 cents on the dollar from collections efforts against extremely poor, vulnerable patients, and harms the economic stability of families and the community as a whole through unnecessary collections tactics. If patients default on payment plans, they should receive credit/debt counseling and have the opportunity to restructure their payment plans to make them affordable.

In the agreement, Section II. MUTUAL COVENANTS, Replace ITEM B.2. with:

UNMH shall use $1.2 million in proceeds from the UNM Hospital Mill Levy (property tax revenue) to fully fund expansion of the Pathways to a Healthy Bernalillo County Program. Funding shall be increased each year to scale the program commensurate with the verified need in Bernalillo County for community-based resource navigation and advocacy assistance.

As it reads now, the final draft of the MOU fails to specify Pathways as the navigation program. This failure to specify Pathways makes it possible for the hospital to take funds from Pathways and reallocate those funds to other programs. Pathways is a nationally-recognized, proven model that is community-based and accountable for results. In 2008, Pathways was specifically designated in the MOU as the program to be funded for the purpose of expanding "community-based outreach and navigation support in the health system through community-based programs." Pathways shall be designated by the 2017 MOU as the navigation program.

Comments Regarding Exhibit A,
SECTION A. REPORTING AND INTERACTION
1. The draft accountability measures are wholly inadequate, as they are described as simple numbers at a point in time, without any context or tracking of trends. The denominators for many of the measures are known and should be included, such as number of patients on UNM Care as a percentage of the number of Bernalillo County patients whose incomes meet financial eligibility guidelines. Likewise, the Number of UNM Care enrollees tells us nothing about their utilization rates or patterns, and whether UNM Care is the payor of last resort second to a primary payor source, and the cost of the care covered by UNM Care financial assistance.

2. The mechanisms currently in place at UNMH for providing public input on planning, development and operations are wholly inadequate. The negotiation of the MOU, behind closed doors, for more than a year, is indicative of UNM Hospital's lack of capacity to engage stakeholders in planning. Another recent example of UNMH's propensity to dismiss public input is its refusal to incorporate all of the County's Health Care Task Force's recommendations. Further, the hospital administration recently reinstated a draconian 50% upfront policy, without informing or involving its own board of trustees, and while the administration was negotiating this MOU with Bernalillo County. At its July 2017 meeting, the UNM Hospital Board of Trustees scolded former CEO Steve McKernan for failing to involve the board in development and consideration of this new 50% upfront policy before it was implemented. The board has continued to

wrestle with the consequences of this poorly thought out and rationalized policy for the past four months, in meetings that have been closed to the public without citing an exception to the Open Meetings Act.

3. The mechanism for collaboration on community health initiatives between UNMHSC and BernCo envisioned in this section is vague and neglects to involve the community whose health is at stake. As a national leader in community-based participatory practice, UNMHSC should be cognizant of the need to involve the community in planning community health initiatives.

4. Item 4 gives the county and IHS the opportunity to provide input and comments on semi-annual goals, yet there is no mention or mechanism for involving the community impacted by the attainment or lack of attainment of these goals. Community members who have concerns about accountability or transparency or actions of UNMH have nowhere to go. County representation on board is not enough, as county appointees, for example, didn't have information about the 50% up front payment policy.

SECTION B ACCOUNTABILITY AND TRANSPARENCY

4. The pie chart that UNMH is accustomed to using in its existing quarterly financial reporting to the County is meaningless and wholly invented. UNMH has long asserted that all its revenue goes in to one account to cover operations and maintenance of the hospital, and that any allocation by UNMH Department of how mill levy money is spent is artificial and made for illustrative purposes only.

8. UNMH's Grievance process is wholly inadequate given that so many people experience barriers before they are considered patients and/or are unaware of the grievance process, afraid to register complaints and don't seek help.

Bernalillo County should require the Public Hospital to develop a comprehensive, proactive public education campaign, like it has done in the past, to educate potential patients about the financial assistance programs available at UNMH and to implement those policies consistently and fairly, to reduce the burden on people to come forward with complaints when the system has failed them. A Bernalillo County-appointed oversight board would be the best place to receive and take action on system-level complaints.

Clay Campbell

From: mailservices2@sks.com
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Subject: A public comment was submitted online

#116

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Subject - Choose One:
UNMH Lease Agreement

Comment
I serve on the Board of Directors of the Immigrant & Refugee Resource Village of Albuquerque, one of the five nonprofit agencies identified collectively as the International District Resource Circle, an applicant for funding that derives from that portion of the Bernalillo County (BernCo) Hospital Mill Levy dedicated to the Pathways program. Pathways provides navigational services and transition planning and case management services to the indigent population of BernCo. I have reviewed the Memorandum of Understanding (MOU) including Exhibit A and B and offer these comments.

First, no mention is made of Pathways in the body of the MOU, especially in Article II., Section 2. where it would make most sense, because it is the mechanism by which navigational services programs and a transition planning and case management services program are delivered to the client population.

Next, in Exhibit A to the MOU, that deals with the obligations of UNMH, I have explicitly identified areas where greater commitment is needed on UNMH's part regarding services to be provided. These are:
1. On the "positive" side, in section B.8. I am pleased to note that "UNMH will collect all grievances regarding patient payment policies and financial assistance program ..." That is a huge plus.

2. From the "needs improvement" perspective, I would like to see UNMH make a greater commitment by making the following changes to the MOU:
a. In Section C. Primary Care/ Low Income Care, make the follow changes:

In subsection C.2. rephrase the first sentence to read that "UNMH will maintain and enhance its coordinated care delivery programs ..."

In subsection C.3., rephrase the first sentence to read that "UNMH will assist Bernalillo County residents ..."

#116

In subsection C.4., rephrase the first sentence to read that "In an effort to decrease emergency waiting times, UNMH will identify alternative case venues ..."

b. In Section D. Financial Assistance, make the follow changes:

In subsection D.4., delete "endeavor to" and rephrase the first sentence to read that "UNMH will continue its financial assistance policies ..."

In subsection D.5., delete "endeavor to" and rephrase the first sentence to read that "UNMH will establish patient payment policies ..."

In subsection D.7., delete "make reasonable efforts" and rephrase the first sentence to read that "UNMH shall determine the financial status of all patients with outstanding bills, and inform these patients of their rights ..."

In subsection D.8., delete "maintain and/or" and rephrase the first sentence to read that "UNMH will modify its billing services to provide that no financial assistance-eligible or financially indigent low-income patient ..."

c. In Section F. Behavioral Mental Health and Substance Abuse Care, make the follow changes:

In subsection F.2., delete "evaluate the opportunity to" and rephrase the first sentence to read that "UNMH will expand behavioral and mental health care ..."

In subsection F.4., delete "plans to continue to" and rephrase the first sentence to read that "UNMH will provide primary care clinics with behavioral and mental health care services ..."

In subsection F.5., delete "evaluate the ability to" and rephrase the first sentence to read that "UNMH will provide individually identifiable patient health information ..."

In subsection F.6., delete "evaluate the viability of expanding the school based clinics to" and rephrase the first sentence to read that "UNMH will work with the UNM Medical Group, Inc. and the UNM School of Medicine to include behavioral health services."

In subsection F.7., delete "evaluate the possible provision ..." and rephrase the first sentence to read that "UNMH will provide the following: ..."

In subsection F.8., delete "evaluate" and rephrase the first sentence to read that "UNMH will institute a data sharing program ..."

In subsection F.9., delete "evaluate development of" and rephrase the first sentence to read that "UNMH will develop a system to track ..."

And finally Exhibit B needs to be modified to incorporate the appropriate measures for these changes.

Thank you for the opportunity of commenting on the draft MOU.

Frank Jerabek
505-263-7187
fjerabek@pobox.com

Clay Campbell

From: mailservices2@sks.com
Sent: Monday, October 09, 2017 2:23 AM
To: info; Tiffany E. Chamblee; Clay Campbell
Subject: A public comment was submitted online

#118

Name
William Wagner

Address
1317 Isleta Blvd. SW

Phone Number
505-312-7296

Email
bill@centrosavila.com

Subject - Choose One:
UNMH Lease Agreement

Comment
October 8, 2016

Comments of Bill Wagner, PhD, LCSW
Executive Director of Centro Sávila

RE: Draft Hospital MOU dated Sept. 5, 2017

Comments on the Draft MOU

I. RECITALS
No comment.

II. MUTUAL COVENENTS;

A. UNMH is Bernalillo County's public hospital and was founded with a mission to serve the poor and county residents that could not afford to access health care in the private healthcare system. Given existing health disparities in Bernalillo County, it is incumbent upon the County to ensure that UNMH stays true to that mission. Language in this section needs to be more specific about how any new investments in the hospital under "operations and maintenance" will ensure that such expenditures are true to UNMH's original mission to provide healthcare to residents that can not access the private hospitals.

B.2. This section addresses efforts by the University to address social determinants that impact and are predictive of many health outcomes. Upstream, preventative case management services are critical to improved health outcomes and cost containment. How did the County come to decide that roughly 2% of the total Mill Levy ($2,060,000) was the cap on such services? It appears that many of these resources will be used when residents will be transitioning out of

institutionalized living (such as incarceration at MDC). While such case management and navigation services are critical when people are transitioning, they are equally important to prevent the types of crises that often result in residents being hospitalized or incarcerated. Why not expand these services to 5% or 10% of the budget and make them available to all county residents that need them. Prevention of health crises is the best and lowest cost intervention.

One program that is currently funded by the county, The Pathways to a Healthy Bernalillo County Program, is not mentioned by name in the MOU. The county should look at the performance based pay structure of the Pathways program, the fact that such programs are embedded in non-profit programs in the community that refer to UNMH and the capacity of the program to identify systems barriers that contribute to poor health outcomes. The Pathways program is an excellent resource for understanding Bernalillo County's public health safety net gaps and the MOU should ensure that it remains the standard for navigational services.

III MISCELLANEOUS

Exhibit A TO MOU

A. REPORTING AND INTERACTION.

A.2 (Community input)
This is a critical aspect of the MOU that needs to be specific. This is an opportunity for UNMH to truly engage the community it serves and to hear from consumers whose input has not been solicited. The County needs to be explicit about the expectations of how community input will be solicited and what the response of UNMH shall be.

A.3 (Mechanism for collaboration)
No specific timeline was given.

A.4 (Setting goals)
Goals must have a public health component that use epidemiological data and health outcomes to ensure community health is improving. It is not enough to state what services were provided.

A.5 (Evaluation of behavioral health initiatives) The county and UNMH should work together to set up a HIPAA compliant universal patient identification number that can be used to track patients across systems (public and private) and institutions. A timeline is necessary.

A.6 (Budget)
Budgets should be tied to specific targets and open to adjustments if goals are not being met.

B. ACCOUNTABILITY AND TRANSPARENCY

B.1 (Relating to reports (i.e., Exhibit B) meeting County's approval) The reporting activities listed in the attached Exhibit B do little to explain how public health is being improved by UNMH use of Mill Levy funds. Bernalillo County should have minimum expectations of public health outcomes critical to the mission of UNMH, including low income access to care, integration of behavioral health into primary care, access to drug and alcohol recovery services and the outcomes.

B. 2 (Relating to patient safety)
No comment

B.3 (Relating financial reporting and audits) The county should have access to both where the funds were spent and the outcomes that those expenditures produced in relation to UNMH's mission as Bernalillo County's Public Hospital.

#118

B.4 See above.
B.5 See above.

B.6 (Relating to adapting data to meet County and IHS needs) The county should be explicit about what changes to data requests are acceptable and a minimum threshold of required data should be established that ties expenditures to public health outcomes.

B.7 (Relating to public access to information in reports) No comment

B.8 (Relating to quarterly reporting on patient grievances regarding payments) UNMH has a history of addressing individual complaints with its financial assistance program while disregarding systems/policy barriers. The county could set up explicit expectations of how such data will be reported and measures that UNMH will be required to take when systemic access barriers are identified.

C. PRIMARY CARE/LOW INCOME CARE

C.1 (Relating to adding primary care clinics@ one per year) It sounds like this is about real estate rather than providers. The county could do a population based assessment of needed service providers that could be based in existing locations i.e. existing unstaffed school based health centers.

C.2 (Relating to planning with community partners and co-locating with Department of Health and others.) The county could explore the co-location of UNMH staff at trusted community-based non-profits and orgs.

C.3 (Relating to encouraging people to get coverage (presumably payment source for services).
Expanding health insurance coverage saves the county money and improves health outcomes. Given that Hispanic New Mexicans have the highest disparities in health insurance coverage, attention should be paid to culturally and linguistically appropriate outreach, especially in areas of the county that have lower rates of insured.

C.4 (Relating to working on reducing emergency room waiting times) Linking access to trauma informed drug and alcohol recovery and behavioral health services is critical in this area, given the high incidence of co-occurring disorders that lead to emergency room visits.

C.5 (Relating to secured entry and services areas for patients from MDC) No comment.

C.6 (Relating to telemedicine between UNMH and MDC) No comment.

C.7 (Relating to increasing specialty services for Native Americans) No comment.

C.8 (Relating to a promise to think about addressing children's health, including the role of school based health clinics as well as other services) The county should be explicit that access to healthcare is a human right and that every child in the county has access to upstream/preventable primary care services. Anything less unnecessarily creates human suffering and wastes taxpayer dollars.

D. FINANCIAL ASSISTANCE

Reviewer's general comments:
Many of the subsections gloss over pivotal issues, kicking the can down the road.

D.1 (Financial assistance policies for Native Americans) No comment.

#118

D.2 UNMH is a public hospital and should not be a gatekeeper that decides which residents receive public health care and which ones don't. Such policies put our entire population at risk of public health outbreaks and higher costs when people go without treatment until they need to use the ER. By denying care to some immigrants and refugees, UNMH is not only denying some taxpayers the right to service, but also runs the risk of being perceived by county residents as a place where they might be racially profiled. The county can expect better from UNMH on this regard.

D.3 (Relating to financial assistance as "payer of last resort" and the need to apply for insurance)

"Medical Necessity" is a placeholder that was created by managed care organizations and utilization is often determined by staff that have not worked directly with the patients. The county can prioritize access to healthcare is a human right. No county resident should be held to a different standard of eligibility based upon their ability to pay, national origin or other racial/ethnic identity.

D.4 (Relating to regarding fees, co-pays, and down payments to income) See above.

D.5 (Relating to regarding fees, co-pays, and down payments for indigent persons who are ineligible for financial assistance.) See above.

D.6 (Relating to re-payment plans for non-indigent persons who are unable to pay)
The county needs to look at whether or not the eligibility thresholds are meaningful. Healthcare costs are the leading cause of bankruptcy. Many Bernalillo county residents have lost their life savings due to costs associated to healthcare. Bernalillo County and UNMH must take every measure to avoid catastrophic medical debt. Poverty is a leading cause of health disparities.

D.7 (Relating to determining financial status of persons unable to pay bills) This could be more specific on how culturally and linguistically appropriate education will be provided.

D.8 (Relating to not sending persons on a payment plan to collections.
In addition for not sending to collections, there should be a path for waiver or suspension of payment for persons who are unlikely to ever cover their debt. The county could ask UNMH to hire a local collection agency that could improve local economy and provide more culturally/geographically relevant resources and support.

D.9 (Relating to consolidation of separate bills for component entities at UNM) No comment

D.10 (Relating to outreach to persons needing financial assistance or needing insurance) No comment.

D.11 (Relating to services for persons being released from incarceration) Reporting should be linked to outcomes. The Pathways program does just that and demonstrates cost effectiveness. The County should be explicit about the Pathways to a Healthy Bernalillo County program here.
F. Behavioral Mental Health and Substance Abuse Care
F.1

#122

Clay Campbell

From: Tiffany E. Chamblee
Sent: Monday, October 09, 2017 8:41 AM
To: Clay Campbell; Julie Anne Baca
Cc: Tracy Dingmann; Stephanie Guzman
Subject: FW: Public Comment re: draft MOU Agreement with UNMH
Attachments: Public Comment -- Bernalillo County draft of Agreement with UNMH.docx

Tiffany Chamblee
Communication Services Coordinator
Bernalillo County
505-468-7438

From: Karen Navarro [mailto:knavarro411@yahoo.com]
Sent: Sunday, October 08, 2017 5:18 PM
To: info <info@bernco.gov>
Subject: Public Comment re: draft MOU Agreement with UNMH

Below and attached is my public comment (attached for ease of printing and sharing it).

Public Comment submitted by:
Karen Navarro
12413 Cloudview NE
Albuquerque, NM 87123
(505) 463-0872

I am writing to express my grave concerns about the draft MOU Agreement between the University of New Mexico Hospitals (UNMH) and the Indian Health Service. I was employed at St. Martin's Hospitality Center (SMHC) for 21 years (1993-2014), 18 of those years as Client Advocate in the Day Shelter assisting homeless and other low-income individuals and families with resources and I&R. I have a very good idea which programs in this county are effective and which ones are not. Currently I serve on the MHRAC Resources Subcommittee.

I have many concerns with this draft Agreement which I know are being addressed by the NM Center on Law & Poverty and other expert advocates, but I will focus my remarks on the apparent intention of the draft Agreement to eliminate funding for the Pathways Navigators program. This program is win-win.
By any measure it is successfully fulfilling its stated purpose year after year to "expand community-based outreach and navigation support in the health system through community-based programs," and is one of the most effective programs in our county. It undeniably has had proven results, and in fact *prevents exorbitant costs* by skillfully case managing individuals who would cost our county far more if they did not have this support. ie., You could actually be *increasing* costs to UNMH over and above

what you think you would save by axing – or even decreasing funding for this program. And both the County and UNMH should recognize that with the agreement in its current form you would be ending a program that dramatically enhances the health and well-being of UNMH patients.

In my years as Client Advocate at SMHC I collaborated with numerous Pathways Navigators, including Dannis Marquez at AHCH, Martha Montes at Encuentro, Dawn Begay at First Nations (FNCH), and Alma Olivas at Centro Savila Clinic, as well as advocates at Enlace Comunitario, UNM SE Heights Clinic, and others. In each case I was absolutely confident in the professionalism and the dedication of the Pathway Navigator to work tirelessly for the health and stability of our mutual client. I was frankly shocked to learn that via this MOU Agreement, both the County and UNMH have undervalued the essential services of Pathways Navigators. I am profoundly disappointed and I urge you to reconsider.

Specifically, I urge you to amend the Agreement to clearly state that "the Pathways to a Healthy Bernalillo County Program shall be fully funded at $1.2 million per year, and shall be expanded each year to more adequately meet the needs of low-income, uninsured residents of Bernalillo County."

My other criticisms of the draft Agreement which will be addressed in detail by others, include:

1) Failure to assure that all immigrants, documented or undocumented, receive the same level of care as do legal residents and citizens.
2) No one should have to pay 50% up front before being *allowed* to have medically necessary surgery. Not in this county. Not in this state. Not in this country. Co-pays should be reasonably determined by income, $25 to $300.
3) Uninsured low-income individuals who do not qualify for Medicaid or Medicare, and who cannot afford to purchase insurance on the Exchange, should not be denied medical care at UNMH, thereby being dropped through the social net that is UNMH's role to provide. All the years I worked at SMHC before Medicaid was expanded in this state, I could count on UNM Care as the "go to" indigent care for my clients' care at UNMH, along with the care provided by AHCH, IHS, First Nations (FNCH) and other clinics. That should be the case now for the individuals described above.
4) Eligibility for UNMH services should be strictly according to eligibility by income and residency (See ## 1-3 above).
5) UNMH should act to prevent a low-income person's bill being sent to collections. Collection agencies are the "black hole" for individual and family debt, as they make it impossible to pay their grossly inflated charges. While at SMHC, I had a couple of clients who experienced this.

As an active member of the homeless services community, I absolutely support new projects such as the county's Resource Reentry Center for people released from MDC and adding more school-based clinics. What I cannot and will not accept, however, is for these new endeavors to be used as the rationale for cutting services to low-income residents of Bernalillo County, and for cutting a program as awesome and effective as Pathways Navigators. This is, in my view, a "Sophie's choice," ie., choosing to help some vulnerable county residents while turning your back on many others, denying

#122

them needed care. You should not choose. You should provide the funding to adequately take care of folks, and fund the programs that have a proven track record of doing so.

Sincerely,

Karen Navarro

#97
5124

October 7, 2016

Comments of Bill Wiese, MD, MPH
Member of Bernalillo County Healthcare Task Force (2014)

RE: Draft Hospital MOU dated Sept. 5, 2017

General comments:

1. Having Exhibit A as a lengthy and detailed blueprint is a huge step for moving forward. Commendations are due for the people who labored to prepare this. Many items intersect with the recommendations in the 2014 County Healthcare Task Force Recommendations. It is essential that Exhibit A be pursued actively and in good faith and that progress be monitored with the understanding that it is in everyone's interest to work jointly to pursue opportunities and address barriers.

2. Of particular importance, the MOU calls for using the first two years to set goals and plan for evaluation. The MOU absolutely needs to be supported by specific goals that project health-related outcomes for all of the hospital's programs and initiatives. Without reference to goals and specific targets, currently favored tallies activities, while of use for hospital administration are otherwise just numbers.

3. In addition to tracking measures of health and access for UNMH patients, the County needs data on the County's broader population looking at health needs and resources and gaps in services with the focus being on high-risk demographic groups. Such analyses enable planning and development of priorities and set framework for documentation of progress, identification of barriers, mid-course adjustments, and evaluation of policies. The responsibility of creating goals and targets and measure should be a priority for the County. It will require assistance from the Hospital, the HSC, and DOH. It needs to be completed in two years. It will be a major undertaking.

Specific comments on the Draft MOU (These are sequenced according to sections of the Draft.)

I. RECITALS
No comment.

II. MUTUAL COVENENTS;

A. The Mill Levy vote was for funding "operations and maintenance." The wording used in this section expands the language to state, "operations and maintenance, and improvement and conduct" (of the Hospital and Mental Health Center)." This unfamiliar phrasing needs to be explained. A concern would be, for example, that "improvement"

#97 & #124

might be used to justify use of the Mill Levy for capital expenses (such as toward the construction of a new, "improved" hospital).

B.2. This section deals with the University "continuing to fund from its operational funds one or more navigational services programs and a transition planning and case management services program. The expenditure for the services will be no more than $2,060,000 annually, adjusted by consumer price index rate, for each year."

Why is the County agreeing to limit the stated amount ($2,060,000) as a ceiling ("no more than")? It should be phrased as a minimum amount ("at least...."). The navigational services are innovative and proven programs that are just getting underway. Evaluation confirms their critical importance. In addition to directly addressing social determinants of health, they serve to greatly amplify the effectiveness and impacts of clinical care and prevention. These programs should be encouraged to expand and flourish.

The Draft MOU is silent with respect to Pathways, a specific program within the category of "navigational programs." Embedded within community-based social service agencies, Pathways is the only navigational service that reaches into the community for persons with critical needs who are not effectively engaging the health care system. This is an important high risk demographic in the County. In the past, Pathways has been a target for elimination by UNMH administration, presumably to redirect its funding into other hospital operations. With all the fuss and controversy about Pathways, this community outreach should be recognized and explicitly protected with a specified minimum share of this budget item ($1.2 million/yr).

III MISCELLANEOUS

Exhibit A TO MOU

A. REPORTING AND INTERACTION.

A.1 (Reports)
The singular strength of this section is that it recognizes the need for developing goals and evaluation. It is suggested that this will be addressed in the first two years. The importance of this cannot be overstated. The current reality is that the operations of UNMH are devoid of goals that tie to the health of the county's residents and particularly of its indigent populations.

Exhibit B shows the proposed reporting template to be used during the first and second years. With development of goals and evaluations, the County's need for information goes way beyond these. Please refer to additional comments attached to section relating to Exhibit B, below.

A.2 (Community input)
This is important and was a priority for the Healthcare Task Force. Sadly, this seems more or less a recitation of existing inadequate structures for representation from the

#97 & #124

County, its underserved communities, and Native Americans—structures that have been described by some as either being disregarded by or being rubber stamps for hospital-driven planning. The Hospital has been selective in embracing community comment. Criticism should create opportunities for constructive engagement and dialogue. The model for working across public entities needs be one of partnerships in moving toward agreed upon goals. Having community-oriented measurable goals is a requisite.

A.3 (Mechanism for collaboration)
Needs a timeline.

A.4 (Setting goals)
Goals must go beyond hospital tallies of activity and effort and include health status, outcomes, and impact that reference high-risk populations.

A.5 (Evaluation of behavioral health initiatives)
Needs to include timelines.

A.6 (Budget)
Budgets should be tied to specific targets and open to adjustments if goals are not being met.

B. ACCOUNTABILITY AND TRANSPARENCY

B.1 (Relating to reports (i.e., Exhibit B) meeting County's approval)
The report template in Exhibit B is primarily helpful to UNMH for purposes of administration and management. It is insufficient for creating accountability for spending the Mill Levy. Future quarterly reports should address toward goals relating the County's population, improved access to heath care, improved health status and reduced health risk for those at high risk. Reporting should identify barriers and setbacks as well as prospects and plans for remediation. Reports should apply not just persons using UNMH address the needs of people across the County, particularly those who are indigent and without insurance and those in groups at high-risk.*

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* A few of the County's "high-risk groups:"
  a. The mentally ill. Are there measurable outcomes goals regarding current County/UNMH initiatives?
  b. The incarcerated. (ditto)
  c. Newborns. Proactive steps targeting newborns in high-risk families or other high-risk demographics can generate enormous potential for public savings. What are the policy objectives and measures for steps now being taken?
  d. Adolescents. Adolescence is a stage that establishes the adult behavioral risk-profiles and that predict premature morbidity and mortality. Adolescents don't seek out UNMH for care or guidance.
  e. Persons with chronic illness who are not engaged in treatment or effective follow-up. (This footnote is continued on next page.)

#97 & #124

The County may have a list of specific activities for UNMH to undertake. It is not apparent that the County has targets or measurable goals or measures of impact for addressing unmet access to health care, health status, outcomes, or impact for the Hospital's use of $92 million a year. These will hopefully emerge during the planning still to be done over the next year.

B. 2 (Relating to patient safety)
This is the one area in Exhibit B for which reference standards for performance are available.

B.3 (Relating financial reporting and audits)
Verification of accounting management is a core element of fiscal accountability. Just viewing the cash flows, however, is seldom sufficient in the absence of reference whether outcome goals and priorities are being met. Meaningful stewardship requires understanding whether the cash flows are relating to human needs being met and whether the original planning assumptions are stable.

Aligning use of the Mill Levy for operations and maintenance should be a given. It's a legal requirement. The alignment should embrace the specifics of this MOU.

B.5 (Relating to tracking amounts of funding going to specific hospital departments)
UNMH has apparent increased willingness to show how much of the Mill Levy is going to any given department—a good thing. Again, the real issue is how resources are impacting priority outcomes and goals.

B.6 (Relating to adapting data to meet County and IHS needs)
The County (with UNMH) should add and track outcome goals and impact. This isn't currently being done in any significant manner. It isn't necessarily easy and the hospital and HSC should help out. The white paper on mental health could stand as an example of the initial steps needed to move in this direction.

B.7 (Relating to public access to information in reports)
Hospital has history of willingness to respond to public inquiries (with limitations). As it is with most others, the public has few if any reference points for interpreting the data.

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f. Persons with alcohol and drug dependency disorders.
g. Immigrant populations.
h. Undocumented persons.
i. Persons and families that are homeless.
j. The elderly – many lack primary care; many need supportive services.
k. Persons needing post-acute care and follow-up.
l. Persons needing medical care but having competing priorities that keep them apart from established medical services.
m. Persons living in neighborhoods in the bottom quintile for life expectancy.

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& #124

B.8 (Relating to quarterly reporting on patient grievances regarding payments)
No comment.

C. PRIMARY CARE/LOW INCOME CARE

C.1 (Relating to adding primary care clinics@ one per year)
Ultimately we should be striving toward all having opportunity for access to primary care Adding clinics may seem right, but should be assessed in the context of the County's broad goals and collective capacity for expanding access to primary care and balanced with the need to serve sub-population and demographics that have the greatest needs. For example, we could build more clinics and still not reach the at-risk newborns, adolescents, the elderly, people with mental illness or experiencing social decompensation. Most of these populations require off-site services. Such balanced planning is needed obvious.

C.2 (Relating to planning with community partners and co-locating with Department of Health and others.)
Reflects a positive change toward integrated planning and services.

C.3 (Relating to encouraging people to get coverage (presumably payment source for services).
Having insurance is associated with better health and lower charity costs.

C.4 (Relating to working on reducing emergency room waiting times)
This issue likely reflects a need to address underlying systemic issues that extend beyond a need for "alternative care venues."

C.5 (Relating to secured entry and services areas for patients from MDC)
Appropriate.

C.6 (Relating to telemedicine between UNMH and MDC)
Appropriate.

C.7 (Relating to increasing specialty services for Native Americans)
No comment.

C.8 (Relating to a promise to think about addressing children's health, including the role of school based health clinics as well as other services)
The County needs to declare outright the goal that every child and adolescent resident in the county should have the opportunity for access to age-appropriate preventive and healthcare services and define what these should address. This should lead to a gap analysis such as has been done for mental health. It's hard to imagine that SBHC's would not be a major component in addressing unmet issues in child and adolescent health care.

D. FINANCIAL ASSISTANCE

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Reviewer's general comments:
Many of the subsections gloss over pivotal issues, kicking the can down the road.

Issue #1. The MOU should clearly state overarching (eventual) goal that every county resident have the opportunity for access to medical care regardless of income. The Mill Levy enables UNMH to serve the medical needs of uninsured indigent residents.

The scope of "medical care" should be defined with reference to an existing comprehensive medical insurance plan available in the community. It should not be defined has "medically necessary care," which inserts ambiguity and can be wielded to withhold care that would otherwise be medically important and would be offered unchallenged for persons with insurance.

D.1 (Financial assistance policies for Native Americans)
No comment.

D.2 (Relating to patient payment and financial assistance program policies)
The wording provides a defense of the status quo and has been used to shut off discussion dealing with how the current policies create barriers to health care for some indigent County residents.
In the past, proof of being legally in the U.S. has been a requirement for benefits under UNM Care (with co-pays scaled according to income). This is not dealt with in the MOU. Does UNMH plan to maintain a policy that would place uninsured undocumented patients into the Self-Pay category with its "benefits" of a 50% discount and requirements for prepayment for "non-urgent" services? Such relegation to Self-Pay, any legal justifications notwithstanding, carries the stains of discrimination and institutional racism. Lawyers should be asked to describe what it would take to serve these patients on par with other uninsured indigents. It's not possible reconcile such recent (and current?) policy with the County Commission's resolution regarding the County as friendly to immigrants. Silence on this issue implies complicity.

D.3 (Relating to financial assistance as "payer of last resort" and the need to apply for insurance)
Looking for insurance coverage makes sense. Using "medically necessary services" to describe medical services is problematic for reasons stated above.

D.4 (Relating to regarding fees, co-pays, and down payments to income)
Using "medically necessary services" to describe medical services is problematic for reasons stated above.

D.5 (Relating to regarding fees, co-pays, and down payments for indigent persons who are ineligible for financial assistance.)
To the extent this applies to uninsured, indigent, persons with established residence in the County, finding a way to grant all of them financial assistance on a par with others should be the priority. (See D.2, above.)

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& #124

D.6 (Relating to re-payment plans for non-indigent persons who are unable to pay)
There are income levels above official lines poverty that generate insufficient revenue to ever cover major hospital bills. Repayment plans should never push County residents into poverty—poverty itself being a major risk factor for increased morbidity and mortality.

D.7 (Relating to determining financial status of persons unable to pay bills)
Appropriate.

D.8 (Relating to not sending persons on a payment plan to collections.
In addition for not sending to collections, there should be a path for waiver or suspension of payment for persons who are unlikely to ever cover their debt.

D.9 (Relating to consolidation of separate bills for component entities at UNM)
Appropriate.

D.10 (Relating to outreach to persons needing financial assistance or needing insurance)
Appropriate.

D.11 (Relating to services for persons being released from incarceration
This is needed and appropriate. Broad goals should be set so that reporting incorporate outcomes and impact on the totality of need in addition to numbers of persons served.

E. NATIVE AMERICAN CARE
No comments. Comments deferred persons who can speak for the Native American communities being served.

Exhibit B

Exhibit B presents a data-reporting template based on what has previously been used for quarterly reports. It emphasizes information of performance such as tallies of activity (e.g., numbers of patient encounters) and information related to costs that are of importance primarily for the administration of hospital operations. In addition, there are some red-flag items (e.g., wait-times for appointments and numbers leaving the ER without being seen and some measures of quality that tie to national standards) that are of general interest. The template does not significantly address health-related outcomes for the Hospital's programs or impact in the community.

Conversely, County managers have done little to quantify the County's health-related needs, generate health-related goals, or set outcome-based targets against which to measure progress. Without such framework, tallies of activities alone convey little that can be usefully interpreted for persons responsible for policies or interested in impact.

The County should work with the Hospital and the levels of both administration and

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clinical departments and with the HSC and probably with public health to characterize and address the needs of its several high-risk population subgroups and to set measurable goals and measures in order to track progress and report back to the community.

Both the County and the Hospital need to accept this challenge as part of creating an accountable system of health care.

Such an undertaking will require funding. It is an essential requirement for stewardship.

#125

Clay Campbell

From:	Tiffany E. Chamblee
Sent:	Monday, October 09, 2017 8:49 AM
To:	Clay Campbell; Julie Anne Baca
Cc:	Tracy Dingmann; Stephanie Guzman
Subject:	FW: Public comments on Draft MOU with UNMH -- Anjali Taneja MD MPH
Attachments:	Anjali Taneja public comment Draft MOU Oct 8 2017.docx

Tiffany Chamblee
Communication Services Coordinator
Bernalillo County
505-468-7438

From: Anjali Taneja [mailto:anjali@casadesaludnm.org]
Sent: Monday, October 09, 2017 12:05 AM
To: info <info@bernco.gov>
Subject: Public comments on Draft MOU with UNMH -- Anjali Taneja MD MPH

Please find attached my public comment about the Draft MOU among UNM Hospital, Bernalillo County, and the IHS.

I have cut and pasted it below as text, and am also attaching it as a Word document.

I look forward to next steps, and would be happy to be in conversation about this MOU.

Thanks,

Anjali

October 8, 2017

Public comments of Anjali Taneja MD MPH. anjali@casadesaludnm.org. Cell: 310-503-2544.

Re: Draft Hospital MOU dated Sept 5, 2017

#125

Many of my comments on UNMH's 50% up front payment policy essentially denying essential care to uninsured low-income patients who do not have or qualify for health insurance, are in this Guest Column that was published in the ABQ Journal this summer:

https://www.abqjournal.com/1049692/new-unmh-policy-targets-poorest-patients.html

The MOU between the county and UNMH has no teeth at all, if UNMH can silently introduce a policy like this, WHILE the MOU is being negotiated. This brash act by a University Hospital that is a safety net for our residents, shows exactly why the MOU will not mean anything unless it has more details and expectations in it. Community members have been present at 3 meetings of the UNMH Board of Trustees this summer and nothing has come out of our concerns. There are two county appointed members of the board and they do not have enough power to pressure the board to act differently. This issue (the new May 2017 draconian 50% up front payment policy that has blocked our patients from receiving essential surgery such as for patellar fracture or for ACL & MCL ligament tears in a knee, and may block many other patients) has been tasked to the Quality subcommittee of the board, who most recently reported out to us (the community) and the board of directors at their meeting on Sept 29th. This subcommittee kicked the can down the road, saying they would not change anything about this policy and would instead look to the MOU public comment and changes by county, to decide any changes in the future. This is horrible and stunning. And it only means that the county has an even greater responsibility to its residents, as UNMH has washed its hands of any responsibility unless given pressure.

Other comments on the MOU are as follows:

FINANCIAL ASSISTANCE AND PATIENT PAYMENT POLICIES

• NO low-income county resident shall be excluded from UNMCare for their medically necessary care.

• Low-income residents shall not be required to purchase health insurance prior to being screened for and enrolled in UNMH financial assistance. Such a requirement causes delays which can be harmful to people's health and cause financial hardships.

• UNMH financial assistance programs shall have simple qualification rules based on county residence and financial need. The programs should be proactively promoted before people receive hospital bills and they should be affordable.

• No uninsured, low-income residents shall be required to pay medically necessary surgery costs upfront. The Hospital shall reinstate affordable down payment policies and allow patients to pay the balance after they receive medically-necessary care.

• No uninsured, low-income residents shall have hospital or medical bills sent to collection. Payment plans should be reasonable based on a person's income, family size and ability to pay over time. Reasonable payments shall be defined as a percentage of a person's income not to exceed 5%.

• All policies will be in writing and readily available to the public both in electronic and printed formats. Policies will be clearly identified and all written material will be in language understandable to the general public.

PATHWAYS NAVIGATION PROGRAM

• The Pathways to a Healthy Bernalillo County Program shall be fully funded at $1.2 million per year, and shall be expanded each year to more adequately meet the needs of low-income, uninsured residents of Bernalillo County.

• Pathways should be specifically described in the agreement through a separate exhibit, like it was in previous agreements. The exhibit on Pathways should clearly state the purpose of the program, which is to "expand community-based outreach and navigation support in the health system through community-based programs."

OVERSIGHT AND ACCOUNTABILITY

• The County Commission's 2015 Health Care Task Force recommended the establishment of an entity for the County to: 1) Administer and monitor mill levy funds; 2) Engage in safety net planning and evaluation; 3) contract with other providers to fill gaps and test innovative models; (4) Create a defined system of health planning and accountability for mill levy funds that measures health outcomes; and (5) Establish a public participation process, including the creation of a community health board.

• The County should include these community-led recommendations in the final agreement with UNMH.

• Bernalillo County should establish and appoint a community health oversight body, comprised of community leaders and public health professionals who understand health indicators and operational metrics. Such a body would be able to ascertain the efficacy of UNMH in meeting community-identified health improvement goals/objectives.

• Bernalillo County should adopt a resolution that outlines what it expects from UNMH as a public hospital in terms of county health improvement goals and indicators and to require UNMH to report progress on its attainment of the county's goals on an annual basis and to report on the evidence-based strategies that it is implementing to achieve those goals and objectives.

• Bernalillo County and UNMH should strengthen the accountability measures contained in Exhibit B ACCOUNTABILITY MEASURES

• Measures shall be broken down by race, ethnicity, primary payor source, income quintile, zip code, and other factors that provide meaningful context in terms of health equity. Data shall be reported over time to show trends.

Thank you for taking time and consideration to involve the residents of Bernalillo County in this MOU process. I hope you will take all our public comments into serious consideration for a stronger negotiation with UNM Hospital.

#125

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