S. HRG. 101-1272

IMPROVING ACCESS TO PRIMARY HEALTH CARE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ALBUQUERQUE, NM

AUGUST 28, 1990

Serial No. 101-28

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

35-735 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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APPENDIX

IMPROVING ACCESS TO PRIMARY HEALTH CARE

TUESDAY, AUGUST 28, 1990

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Albuquerque, NM.

The committee met, pursuant to notice, at 1 p.m. at the Seventh Street Senior Citizen Multi-Service Center, Albuquerque, NM, Senator Pete V. Domenici presiding.

Present: Senator Domenici.

OPENING STATEMENT OF SENATOR PETE V. DOMENICI

Senator DOMENICI. Hello, everybody. Nice to be with you. Let me first tell you we are going to have a little bit of a problem, because we only have one microphone so we are going to try, as best we can, to share it here between the witnesses and me. Can you-all hear? All right.

Let me just say to the witnesses who will be testifying in the next 3 hours, thank you for coming to this hearing here in Albuquerque. And to you who are here as guests, thank you for coming. I am going to give a brief statement about where we are and what this hearing is about and then call our first witness.

So let me again welcome everyone here today to this field hearing of the U.S. Senate Special Committee on Aging. Today's hearing will examine the importance of primary health care, and the particular problems that older Americans face in getting access to needed primary care services. We will also examine ways we can improve this situation.

I want to begin by thanking the Chairman of this Committee, Senator David Pryor of Arkansas, and the Committee's ranking Republican, Senator John Heinz of Pennsylvania, for letting us hold this hearing here in Albuquerque. I know they, along with other members of the Aging Committee, are tremendously interested in this important issue and in ways that we can improve health care access for the elderly.

I am very pleased, and think you will be, too, that we have with us today Dr. Joyce Berry. She is the Commissioner of the Federal Administration on Aging and an appointee of President Bush.

I have known Dr. Berry for a long time and I want to commend her for her work in behalf of America's senior citizens. Dr. Berry, as you might suspect from her title, is the Nation's chief official and advocate for the needs of America's elderly. I greatly appreciate the fact that she could be with us here today and that she

would come here from Washington to hear, firsthand, of some of the things that we are doing in New Mexico and of some of the needs that we have here. I am especially pleased she is here to share her perspective with you and with us.

I am very happy to welcome her to the Land of Enchantment and I am sure some of you, who are activists in senior citizen matters already know her. For you that don't, I am sure you will appreciate her.

I am also pleased that Jeff Sanders could be with us. While some of you don't know him, I know him quite well. He used to work for us on the Budget Committee staff, but they stole him from us and took him over to the Administration, and he is now the Director of the Health Care Financing Administration's Office of Legislation and Policy, and he can help us understand the health financing aspects of this issue, and what HCFA is doing and what their thoughts are to improve access to primary health care.

We have a number of distinguished people testifying today who came from across New Mexico. I requested that the Committee hold this hearing since I believe those testifying can give the Committee an important appreciation of the challenges of providing primary health care in a State that is culturally diverse and which must serve many in medically underserved, often rural areas.

I also believe that this Committee can learn much from the innovative network of clinics, senior citizen centers, and other services that many in our State have developed to serve older New Mexicans. While the challenges are great, in a State with very limited financial resources, I am pleased to be able to showcase today much of what we are doing and hopefully we can improve upon that.

United States of America's health care system is in tremendous need of reform. Health care costs are now the fastest growing major portion of the Federal budget of the United States. And, believe it or not, all by itself health care is 12 percent of the gross national product of the United States. Even with that—and for you who might do a bit of arithmetic, 12 percent of our gross national product means we are spending more than $600 billion a year on health care, private and public—even with that, as many as 32 million Americans lack health coverage, and Medicaid, the principal program serving the health care needs of the poor, covers only about 40 percent of the poor.

So there could be no doubt that all of us serving at the national level and the local level have to find new ways to curb the ever-increasing cost growth if we are going to improve access to health care. Over the next few years, Congress will consider many reform options and I believe we could do much by concentrating on two kinds of reform. Obviously, there are many more. But I believe the expansion of access to basic primary health care coverage is a badly needed reform.

And from what I can tell, if we were to handle it properly, we might be able to build substantial new primary health care coverage at reasonable rates, if we used some of the innovative approaches to delivering that service.

Second, I believe the time has come to reform in a dramatic way the medical malpractice system. That is not the subject of today's

hearings, but rather my statement to you that I believe a significant portion of the health care cost is driven by the current system of malpractice tort liability which I think we should change dramatically and yet cover those who are victims of negligence.

Primary health care, which we are examining today, involves basic health care services such as what you get when you go to a doctor for a check-up or because you don't feel good and you go there to see what's wrong, and some of the preventive services that are delivered in that manner.

Primary care services tend to be relatively inexpensive, and that's in comparison with other kinds of care, like hospital care and the like. These are often very cost effective services. They can prevent the onset of more serious health conditions, and if available more frequently, people will not get as sick as they get before they go visit the doctors.

We have seen a very important example of that. I would say to the Commissioner in the Veterans delivery system, I think New Mexico will prove that with rural health clinics for the VA that ultimately veterans will not be nearly as sick, nor will they frequent the hospital nearly as frequently because they will be taken care of close to home in rural clinics.

Yet, we have to admit that many do not get primary health care services. They do not, either because they can't afford it or because of cultural or language differences that cause them not to be aware of what kind of care is available or important. And many others can't get access simply because health care services are not available in their areas.

In the United States our elderly population presents a very unique challenge for assuring access. Many older Americans live in rural areas where there are few health care professionals, and they have great difficulty in finding care. While most older Americans are covered—and let me repeat this. While most older Americans are covered by Medicare, some preventive services are not covered under Medicare and some people are not aware of what they need and what they need to do to be covered. Still others have difficulty traveling and so face access problems, even if traditional health services would be available or are affordable.

So we will hear today from those who are trying to meet the health and other service needs of seniors through community health centers, through senior centers located throughout the State. I have had the chance recently to visit several of our community health centers, and just last week visited La Casa de Buena Salud in Portales where primary care services are integrated with other senior services at one location. They have a terrific program. And I am pleased we have a representative from La Casa here today.

Everything isn't rosy, but it sure is better than it was 8 or 10 years ago, before we had La Casa and the coordinated services. I was pleased to support them and I am pleased with the great efforts that are being accomplished there.

These clinics play a crucial role in providing access to those in medically underserved areas, both in rural and urban areas, and I believe that we should devote more resources to these kind of services that are provided in this manner. And, frankly, I say to those

of you who are in government, it is interesting to note that these kind of delivery systems are far less controversial than 5, 10 years ago.

Whenever we would try them, doctors would oppose or pharmacists would oppose. It seems we have matured, and clinics and centers where we have professionals, and the community is united, that people are beginning to understand that it may be one of the unsung heroes of the last few years, and we may want to look at those for expansion for primary care.

I might mention that the Federal Government spends about $500 million on community and migrant health centers. I am currently working on a proposal to expand coverage of primary care services for the poor that could be rendered, not mandated, but could be rendered by community health centers and elsewhere.

While none of us as yet are engaged nationally in dramatically increasing these services, as I indicated, we are looking for reform. And I am just suggesting to you that my proposal for reform is, as I have just described it, to expand coverage of primary care services for the poor. And it could be rendered by community health centers.

My proposal also would improve reimbursement under Medicare and would take steps to improve the ability of the medically underserved areas to obtain services of health care professionals.

I hope we can explore some of these ideals today and find other constructive ways to improve access to care. So I look forward to your testimony. And with this we are going to proceed and try to stay on schedule. But we do want to hear from the witnesses. So let us now move to our first witness. Our first witness today will be Dr. Joyce Berry, Commissioner of the Administration on Aging. Dr. Berry, would you join us, please?

STATEMENT OF DR. JOYCE BERRY, COMMISSIONER, U.S. ADMINISTRATION ON AGING, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, WASHINGTON, DC

Dr. BERRY. Thank you, Mr. Chairman, and I will certainly call you Mr. Chairman of this hearing. Let me commend you, Senator Domenici, for your distinguished track record in improving services to older persons. There are many newcomers to the field of aging. Aging tends to be a very popular topic these days, but you are certainly no newcomer to the field of aging.

It's a privilege for me to represent the Department of Health and Human Services and the Administration on Aging at this field hearing in the great State of New Mexico, where you have one of the finest State Directors on Aging in Dr. Stephanie Fallcreek.

And, one important issue is the one you have taken a leadership role in, as evidenced by this hearing today, and that is health care for older Americans. When you and I celebrated the 25th anniversary of the Older Americans Act with a number of your colleagues on Capitol Hill last month, we acknowledged the statute that set the stage and objectives for quality lifestyles for older Americans.

And, that standard is that all older Americans are entitled to the best possible physical and mental health which society can make available without regard to economic status. Your interest in assur-

ing early access to preventive care is consistent with this objective of the Older Americans Act, and prevention is a major priority of Secretary Sullivan. The Department has undertaken a number of initiatives in this area. Early access to preventive health care and proper health screening could prevent many unnecessary illnesses which harm our seniors and prove costly to society.

I wish to comment on your focus on the rural elderly. You may remember that in 1978 there was a hearing in which you sponsored or introduced an amendment to the Older Americans Act to provide expanded services to the rural elderly.

The focus at today's hearing acknowledges what we knew then, and that is that special provisions must be made to ensure access to health care services to the rural elderly, many of whom in this State and across the country are low-income, minority and poor.

You also speak in your proposal of the impact of physical mobility of older Americans on access to services. I commend your focus here, due to the fact that many of our seniors not only are poor, minority, and in rural areas, but many more are increasingly frail. In fact, the number of old-old is growing rapidly. Many of the old-old have limitations of some sort which limit mobility.

Mr. Chairman, I believe there are a number of efforts underway that are designed to assist in this critical area of adequate access to primary care for the poor and rural elderly, and I speak not as an expert in the area of health care; I leave that area to my capable colleagues Dr. Gail Wilensky, Administrator of the Health Care Financing Administration, and Jeff Sanders. I want to, however, comment on the Department's initiative and several efforts that AOA has underway under the Older Americans Act.

With regard to the departmental initiative, as you know, Secretary Sullivan is deeply committed to improving the health status of minority and low-income persons and reducing disparities in the incidents of premature death, chronic disease, and a number of other illnesses.

In keeping with a departmental program direction of the Secretary HHS, a major HHS strategy will be focused on improving access to services for minority and low-income populations. Departmental activities which are presently being planned include: (1) increasing the number of minority health professionals, (2) ensuring that both minority and nonminority health professionals with special training in minority health problems are available and accessible to minority communities, (3) improving access to health care for minorities and low-income persons by locating, as you mentioned, health care services in or near communities and other areas where poor and low-income persons reside, and thereby increasing access to HHS health care programs for Hispanics and other minorities, and (4) ensuring that minority group members eligible to be served by health care providers are provided such service without regard to race, color, or national origin.

Just a point of reference. As part of the Department's minority health initiative, Secretary Sullivan had requested an additional $55 million in the proposed fiscal year 1991 budget to fund the National Health Service Corps. Under the National Health Service Corps, students are given loans to apply toward medical school on

the condition that after graduation the individual will work 2 or more years in areas which lack medical services.

Now, in terms of what the Administration on Aging is doing, I will touch on a few areas—I realize that time is of the essence here—a few areas which relate to improving access to services by our rural and low-income seniors. I will begin by mentioning the first area which is related rural elderly. Much of what we are doing is being done through the National Resource Center on the rural elderly. This center is at the University of Missouri, Kansas City, and it serves as a focal point for providing information, training and technical assistance on rural programs and services for older persons.

You spoke earlier in terms of getting the services to the people most in need. Our resource center is developing profiles on mobile health training and other effective ways to get the services to the community level. They have developed resource files and monographs and other such information which I can provide for the record.

Second, in terms of minorities, we have the National Resource Center on Minority Aging Populations at San Diego State University which is working to provide technical assistance to the network related to health care and the rural minority elderly. The center has developed a number of papers which I hope will guide us as we move forward in terms of developing policy.

In addition to specific emphasis on the rural and minority elderly, we have developed, with the Public Health Service—and you mentioned this—linkages between the Network on Aging and the community health centers.

What we are trying to do, in fact, is increase the participation of older persons at our community health centers. We were finding, in fact, that older people were not using the community health centers for a variety of reasons. So we have stepped up our efforts there.

We have a memorandum of understanding with the Public Health Service where we are trying to increase linkages at all administrative and programatic levels, and I think this is critically important, in view of the hearing here today.

Third, I will just mention that in rural areas many of us know that it's important to establish linkages between community social service agencies and community health centers and hospitals. Hospitals play a critical role in the rural areas. And, what we have been told is that more and more hospitals are serving as a primary point of entry for older people. We also think they can provide a resource for coordination of care for the rural elderly. So we are supporting a number of demonstration projects in terms of the effectiveness of hospitals in taking on this multi-dimensional role in terms of coordinating care for older people.

And, I will just mention one last area, and that is transportation. You and I talked 10 years ago about the major and critical role that we need to play in terms of ensuring adequate transportation services to the rural elderly. It is still one of the major problems that we face in terms of accessibility of services. I am pleased to report that I recently signed an agreement with Brian Clymer, Administrator of the Urban Mass Transportation Administration,

where we are trying to link our two networks to assist older persons. And we have a particular focus on the low-income and minority elderly residing in rural areas. I am delighted that the Department of Transportation has agreed to work with us in this area.

I have mentioned just a few examples of what the Department and the Administration on Aging have underway. Let me just say that here in the State of New Mexico I am keenly aware of the special needs of the Hispanic and Native American elderly.

I mentioned Dr. Fallcreek's work. She certainly is a leading advocate on behalf of improved services for the rural, low-income and minority populations. Dr. Fallcreek is also recognized in the area of prevention and health promotion which is of concern to us.

Also, within your State, Mr. Curtis Cook is, as you know, Executive Director of the National Indian Council on Aging, and he has successfully advocated for a number of changes to the Older Americans Act which impacted on Native Americans.

Now, what will we do in the future? One of the things I intend to do immediately is to issue a program instruction, a policy document to our network of State and area agencies on aging, directing them to focus attention on the critical needs of the rural and low-income older persons, in terms of access to primary health care services.

I will issue those program instructions shortly, asking the network to step up its efforts to ensure accessibility of care for rural and lower income older persons. Secondly, I intend to focus on innovative ways to improve access. This is why we are here today. It's a problem that's been with us for quite a while.

One big area of focus is information and referral. I still get letters from seniors and their families from across the country who don't know where to turn for help. Third, I intend to set up a number of advisory councils to the Commissioner, and one of them will be related to rural aging. And, I hope that I can address this important area through these advisory councils.

Just a couple of more points. In terms of discretionary grants funding, I think we can do much more in terms of focusing attention on rural aging and access to health care.

And, the last of the goals we've set for fiscal year 1990 was that of prevention and alternatives to institutional care. Nothing has changed, Mr. Senator. Older people still want to remain in their homes and in the community for as long as possible with the appropriate supportive services.

So, in conclusion I want to assure you that as Commissioner on Aging, I will work closely with the network of State and area agencies on aging and service providers. The issues involved in targeting resources to the low-income and rural elderly will be foremost on my agenda.

And, last, Mr. Chairman, I appreciate your invitation to appear at this field hearing today. I want to commend you again for your leadership here in the State of New Mexico, and most importantly to me, in the District of Columbia, in the Nation's capital. On behalf of the elderly, I assure you of my commitment to work with you within the Department in this area. Once again, thank you.

Senator DOMENICI. Thank you very much, Dr. Berry. Just keep the mike there. Let me ask a couple of questions. We are fully

aware, and you-all should know, that the Commissioner, who is essentially in charge of administering the Older Americans Act, is not in charge of the delivery of health care. Health care is delivered and financed by others.

We fund the community health services, or we pay through Medicare for services that seniors get from a variety of places: Private doctors, hospitals, private clinics. But it does seem to me, Dr. Berry, that it is important that, even though your mission is not the actual delivery of health care, that you take a lead in trying to find out what's going on with reference to seniors, in terms of access to health care.

Might I ask, even though we are in Albuquerque, this is a rural State, and it is true, is it not, that for seniors—one of the most difficult aspects of health care is in rural areas, the rural elderly have a difficult time both with facilities and in getting to and from facilities that take care of them; is that not true?

Dr. BERRY. This is true. Accessibility of services to the rural elderly is one of the most critical issues that we face. On the positive side, I think we can try to improve visibility of the services that do exist. I mentioned the letters that I get from across the country. I think we can do more in terms of information and referral and visibility. I would also suggest that the aging community be more engaging with many of the traditional rural America-type organizations whose business has not been related to older persons in the past, but certainly we should get some of the rural America type organizations involved in the challenges we face, in view of the demographics. And, lastly, I might mention that the time is ripe for addressing this area under the reorganization process of the Older Americans Act.

Senator DOMENICI. And, in that regard, under reauthorization, you would be speaking of providing better access, is that what you are referring to?

Dr. BERRY. Exactly.

Senator DOMENICI. Transportation has been a problem under the Act because of the liability of those who furnish buses. That isn't getting any easier.

Dr. BERRY. It isn't. I think we need to look closely, as well, to where our Title V workers are employed. We know Title V continues to be one of the most important programs under the Older Americans Act and I think with increasing numbers of older people who are at home and at risk in the community, we can no longer afford to have Title V workers unemployed.

Senator DOMENICI. One last question. And then if Jeff Sanders would answer a couple of questions, I would appreciate it. Commissioner, let me ask you this: You know, we tend, in the United States, to fragment our entire delivery system. So I just described to you in our opening remarks how the Veterans Administration was doing a very exciting thing in New Mexico.

In fact we are the pilot State. They are going to try differently in the other States, but in our State they built four clinics. Instead of just saying, "Come on to the hospital," they chose regions and they built small clinics—and it's totally run like the hospital, in terms of casework and in terms of qualifications. You've got to be a veteran and all, and a doctor runs it with helpers.

They tell us that they are going to experiment in one other State with something that I want to ask you about. They are going to experiment with mobile delivery of health care for veterans. So they've got New Mexico, and they have created the four centers. They already know two that have been opened for a while and are enormous successes. People are going there instead of coming a hundred miles.

But they say they are going to have mobile delivery systems to experiment in another State. Could I ask, how would you go about finding out whether these programs succeed? Because it seems to me we can no longer afford to leave these little niches. We've got to know about it. A mobile has some real credibility or potential. It can't be left alone just because the veterans are running it. It's marvelous, but don't you think that Health and Human Services ought to know about it and the aging community?

Dr. BERRY. I certainly do. And I think, Mr. Chairman, that there are some models for us, in terms of social services delivery in the rural areas and in terms of mobile-type services. Clearly, older people would prefer to have services provided to them in their communities and in the neighborhood. That's where they live. That is where they have raised their children, for the most part. That is where they go to church. And, as we age, as older people we have physical limitations.

So, clearly, the notion of having mobile services in the community is important. I can just say that I do represent the aging community on the Undersecretary's Task Force on Health Care. While the Older Americans Act has not called for me to play an active role in terms of health care, I asked Secretary Sullivan to appoint me to membership on the steering committee that Mrs. Horner chaired, and I sit with Gail Wilensky and a number of others deliberating on matters relating to health care.

I mention that because the steering committee is a forum where I can make suggestions, and I am sure Jeff may want to comment on this area as well. I can draw another analogy related to the Social Security Administration and the Administration on Aging. Older people get very frustrated when they have got to go from one office to another looking for services. They have got to go to one office looking for food stamp services and another office in terms of finding out about transportation and information and referral.

I am pleased to just report that Secretary Sullivan has charged Gwen King and myself with trying to coordinate services in terms of a focal point. We have a number of sites going—demonstration efforts in Boston, New York, and across the country. I mention the coordination factor only to support your notion of having a coordinated cluster of services in the community. I suppose the issue is always how do we do it.

Senator DOMENICI. Right.

Dr. BERRY. And in this fiscal climate of what will it cost.

Senator DOMENICI. Let me suggest, however, and I give you this, and maybe we can work together on it, but it seems to me that if you look in our rural communities, one of the most expensive and most difficult areas is the transportation of seniors to various places, including health care service.

Dr. BERRY. Yes.

Senator DOMENICI. I was wondering if we might consider in reauthorization, permitting part of the transportation money at the option of the rural area, to go toward the transportation of health care in a mobile manner to the small community. I mean, I am only guessing, but we spend a lot of money with the insurance and the buses and everything else. It might be that if there was an option to take a part of a State, and, say, take the transportation money and put it into a mobile delivery system and then marry up the health care part from somebody else, you could take the health care to the senior instead of having to move them.

Dr. BERRY. Let me just say that the time is ripe for discussing this, the feasibility of it. I am willing to explore this concept with State directors like Dr. Fallcreek. I am currently developing a legislative proposal to present to Secretary Sullivan, and I would like to explore this and report back to you, if I might.

Senator DOMENICI. Fine. The other thing that I want the people to understand, because the Commissioner went through it very quickly, and we did not go over it in my opening remarks, but the President this year, for the first time in many years, has requested a substantial increase in a program called National Health Service Corps. I think he has asked for $55 million in new money, and I believe Congress is going to give that to the President. And I want you all to know what that is.

We have historically trained a number of doctors and medical professional people under this National Health Service Corps idea, where we essentially assure young people who are going to medical school that we will pay their way, essentially, if they then serve in a public manner at one of the facilities that needs them, such as one of the community health centers or the like.

I am absolutely convinced, and I would like your thoughts on it, that we need to reinject some significant vigor into this program. We have to have more, rather than less, of our young people coming out of medical school and related professional schools for health care—even if we have to pay for their education—if they would be committed to serving the poor of our country in some of our public or quasi-public facilities. I find that most of the clinics could not exist and do a good job without National Health Service Corps doctors.

Dr. BERRY. It's an incredible program.

Senator DOMENICI. I think it's critical. Do you agree?

Dr. BERRY. I agree wholeheartedly. I asked Dr. Mason, the Assistant Secretary for Health, who feels likewise, as well as Dr. Robinson with the Minority Health.

Senator DOMENICI. So you all are pushing it very vigorously.

Dr. BERRY. We have been very supportive of that program and continue to be so.

Senator DOMENICI. I wonder, Jeff, if you could help us with an overview picture on financing. Could you answer a few questions. Maybe you ought to use this mike.

Mr. SANDERS. I have got a big mouth.

Senator DOMENICI. Talk loud. Jeff, if you look at our overall health programs, we do not invest, particularly government resources, heavily or highly in primary and preventive health care

services, relative to our investment in care for more acute and chronic health problems.

STATEMENT OF JEFF SANDERS, DIRECTOR, OFFICE OF LEGISLATION AND POLICY, HCFA, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. SANDERS. Well, our public programs provide pretty much full coverage of acute care. Once someone is sick, we provide pretty much full coverage for the classes of people that we cover. The two things that we don't cover are certain chronic care, and we are selective in our coverage of preventive care. So if you take that, we invest relatively more through our health care systems in helping people once they are already sick than we do in helping them prevent becoming sick.

Senator DOMENICI. I don't know if you-all heard that, but the point I was trying to get an expert to tell us about, and should probably be rather logical to everyone, most of the U.S. Government's health care programs had their origin in taking care of people who were already sick or providing hospital coverage for people who needed to go to a hospital. So over the last 25 years, wherever we have expanded, if I understand you correctly, we have continued to expand from where we began and we did not begin with a real emphasis on primary health care or on preventive type medicine.

And what he has just told us is if you look at all this money I indicated we are spending, in particular the part that is Federal, which is a very substantial portion of that $600 billion we spend every year, you are saying that we continue to focus on chronic and acute and not on the others?

Mr. SANDERS. We are just starting to focus in on the others. The first steps are being taken.

Senator DOMENICI. Let me ask you one other question. If as we reform America's health care system we place much greater emphasis on the improving access to primary health care services, could we expect to improve the health of our citizens and to reduce costs, based upon information you have.

Mr. SANDERS. The fact of the matter is we don't have information. I think it's hard to answer that. It's intuitively true, in some sense, but we don't have anything that right now would allow us to say, for sure, one way or the other. We do have some major demonstration projects underway that will help us answer these questions.

The Health Care Financing Administration is funding five major demonstration projects that attempt to test, among other things, Medicare covering more preventive services, counseling, early intervention. And we are testing whether that serves money or not.

I would like to take this opportunity to make a quick pitch. It may help answer your question, too. The Administration and Dr. Gail Wilensky, are very committed to managed care. For the people here, managed care includes health maintenance organizations. That's an option in the Medicare Program. Senior citizens, wherever there is an HMO available, have an option of participating in it. The reason we think managed care is such a good thing is

because of some of the criticisms that I think you have rightly leveled at the health care systems. It's fragmented. We pay for things differently. No one looks out for the overall health of the beneficiary.

We think HMO's address most of those concerns. You put one person in charge of the health of the entire person, you give them a fixed amount of money, and they determine the best way to keep these people healthy.

The reason this helps answer your questions, is from the experts there we found that, of the HMO's, 88 percent cover preventive care, full preventive care. In the Medicare Program they get paid 95 percent of the same amount that we estimate the health care for the elderly get paid overall. They add preventive care and they still make a go at it. Many, many HMO's that are out there doing business on a day-to-day basis believe that if you do a better job of covering certain preventive care that overall costs will go down.

Senator DOMENICI. Could I just ask? When you speak of managed care, let me switch for a minute and ask you. With reference to such institutions as community health centers that started many years ago, some have some problems. We are having some right here with one of ours, nonetheless, I have found, Mr. Sanders, that the delivery is at a pretty reasonable rate for those who go to that kind of facility. Do you have any observations about that?

Mr. SANDERS. We have nothing specific, other than to say those are clearly low-cost providers. By all measures, services provided at community health centers cost less than they do in most other settings. There are a lot of reasons for that. Part of the reason is the providers are paid less—many of them are National Health Service Corps physicians.

Health care used to be a community service. It's become big business, to some extent. At the community health center you have the old system of community and it is cheaper as a result.

Senator DOMENICI. I thank you very much. Commissioner, thank you for being here. Now we have two witnesses and after they testify we will take a 10-minute break and move right along. We have two from the State of New Mexico: Alex Valdez, the Secretary of New Mexico's Human Services Department. Mr. Valdez, would you please take the witness table? And while we are at it, let's have Stephanie Fallcreek, the Director of New Mexico State Agency on Aging. You can join together and shift the mike around as you finish. Mr. Valdez, would you please open? If you have prepared remarks, they will be made a part of the record as if you read them, and the same for the Director. Please proceed.

STATEMENT OF ALEX VALDEZ, SECRETARY, NEW MEXICO HUMAN SERVICES DEPARTMENT, SANTA FE, NM

Mr. VALDEZ. Mr. Chairman, on behalf of the Human Services Department for the State of New Mexico, and Governor Garry Carruthers, I would like to thank you for the opportunity to be able to present information pertaining to the issue of access to primary health care services for the elderly.

As you are aware, the Human Services Department administers the Medicaid Program. This program, funded at a level of approxi-

mately $341 million for the current fiscal year, serves approximately 142,000 low-income persons through payment of health services provided by physicians, hospitals, pharmacies, and nursing homes in New Mexico.

I am happy to report the program as configured by Congress and funded by both the Federal and State government contributes significantly to the availability of health care services for the elderly. In addition to providing basic health care services, the Medicaid Program has become increasingly important in the provision of long-term care services, specifically nursing home services for the elderly.

Fortunately, in New Mexico the Medicaid Program provides a generous array of services, once a person has become an eligible recipient. Eligibility standards are, however, relatively restrictive in New Mexico, as entry into the program is generally attained through Aid to Families with Dependent Children or the Supplemental Security Income eligibility.

Currently, to become eligible for Medicaid coverage through the AFDC Program, recipients must have incomes at or below 35 percent of the Federal poverty standard. Recent expansions in Medicaid eligibility have resulted in the provision of health care services to specific population groups such as pregnant women and infants with incomes at or below 133 percent of the Federal poverty level. The majority of persons served are the poorest of the poor.

Because of income eligibility standards, there are a large number of low-income New Mexicans who do not have access to health care coverage or primary health care services. One population group which encounters significant financial difficulties due to illness or injury are the elderly who are just above SSI eligibility standards. While these persons may be eligible for Medicare, they are required to pay the premiums, deductibles, and copayments for services.

Persons who are SSI eligible have these many costs paid through the Medicaid Program. There are services which are not paid through the Medicare Program. One such service is the purchase of prescription drugs. The greatest number of requests for assistance received by the Human Services Department is that for help in the payment of prescription drugs. Often elderly persons are unable to pay for large prescription drug expenses. The irony confronting many of these individuals is that they are not poor enough to qualify for Medicaid services, yet they do not have adequate resources to afford prescriptions which can require as much as $500 per month, if not more.

The Human Services Department applauds your efforts and the efforts of Congress in wanting to look at ways in which we can enhance our service to the poor through the purchase of prescription drugs as a start. The Medicare Catastrophic Coverage, before repeal, had provisions that applied for that. We suggest that those provisions be revisited by Congress to see if there is a way in which we can alleviate the responsibility and the huge expense to the elderly that are falling through the cracks in the purchase of their prescription drugs.

In addition to this program, I would also like to discuss another which we have experienced in the administration of the Medicaid

Program. In 1988, we initiated a number of efforts designed to contain costs in the program. These efforts were undertaken in response to unparalleled expenditure growth. Over a period of 12 years, the Medicaid Program budget has increased from an annual level of $61 million to $341 million. We are projecting a $1 billion annual budget within the next 10 years, and in our budget requests for this next fiscal year we are projecting an increase in budget of $50 million.

Among our cost containment efforts was a proposal to limit Medicaid reimbursements for services to persons who are Medicaid-Medicare eligible. Immediately after issuing this proposal, the Department was besieged with protests from physicians. Of greatest concern was the impact of the proposal on physicians with an unusually high ratio of Medicaid-Medicare eligibles in their practices.

To test the validity of this claim, the Department conducted a survey of physician caseloads and determined that those in northern rural areas of the State do, in fact, have a significant percentage of their caseload comprised of persons who are Medicaid-Medicare eligible. This situations is the cause or great concern to the Department and one which should be addressed by other parties involved in the delivery of health care services.

If Medicare-Medicaid eligible persons rely upon a limited number of physicians for services, there should be grave concern regarding the availability of doctors to take the places of those who will retire or terminate their practices in the future.

In light of our research, we chose not to limit reimbursements for services to recipients in this category, and instead have sought to upgrade physician reimbursement levels. Toward this end, the Departments secured a $1.8 million physician fee update appropriation, and in this next fiscal year are proposing a $2.5 million increase for purposes of physician reimbursement.

Traditionally, the Medicaid physician reimbursement levels have been significantly lower than those paid by Medicare and private insurers. It is important that as we address the issue of access that we recognize in Federal and State supported health care programs the issue of reimbursement for physicians of primary care.

Of particular interest to the Department is your proposal to extend primary health care to all persons with incomes at or below 100 percent of the Federal poverty level through the Medicaid Program. This proposal, though costly, is a strong step forward in solving the problem of health care coverage to the uninsured. New Mexico has a very large uninsured population. Recent figures indicate that 28 percent of the population is uninsured.

Through expansion of preventive and primary care, many more costly medical services may be avoided. It is important, however, that preventive and primary care services be defined so that States know, in advance, what coverage is to be provided so that they may provide for that within their own budget process.

Your proposal also addresses issues such as revitalization of the National Health Service Corporation. The Human Services Department strongly supports this move. Historically, the National Health Service Corporation has been one of the primary health providers in rural areas throughout America and in rural areas throughout New Mexico.

One of the issues which these providers are continually confronted with is that of the ability to retain and hold physicians that come to them. Because of that issue, your proposal addressing physician assistants and nurses is also commendable in terms of being able to provide to many rural communities a steady supply of those who can provide primary care.

If the problem of access to primary health care is to be addressed effectively, the problem of the uninsured must be resolved. We must work to eliminate the absence of access due to lack of resources, because this is the most critical factor impacting access to health care services.

Once again, Senator, on behalf of the Department, we thank you for your interest and all of the support that you have given to the Department during this administration. Thank you, sir.

[The prepared statement of Alex Valdez follows:]

PRESENTATION TO
THE SENATE SPECIAL COMMITTEE ON AGING
HUMAN SERVICES SECRETARY ALEX VALDEZ
August 28, 1990
7th Street Senior Citizen Multi Service Center
714 7th Street, S.W.
Albuquerque, New Mexico

Mr. Chairman, members of the Committee, and guests, I wish to thank you for the opportunity to provide the perspective of the Human Services Department regarding the issue of access to primary health care services for the elderly.

As you are aware, the Human Services Department administers the Medicaid Program. This program, funded at a level of approximately $341 million for the current fiscal year, serves approximately 142,000 low income persons through payment of health services provided by physicians, hospitals, pharmacies and nursing homes. I am happy to report the program as configured by Congress and funded by both the federal and state government contributes significantly to the availability of health care services for the elderly. In addition to providing basic health care services, the Medicaid Program has become increasingly important in the provision of long term care services, specifically nursing home services for the elderly.

Fortunately in New Mexico the Medicaid Program provides a generous array of services once a person has become an eligible recipient. Eligibility standards are however, relatively restrictive in New Mexico, as entry into the program is generally attained through Aid to Families with Dependent Children (AFDC) eligibility, or the Supplemental Security Income (SSI) eligibility. Currently, to become eligible for Medicaid coverage through the AFDC Program, recipients must have incomes at or below 35% of the federal poverty standard. Recent expansions in Medicaid eligibility have resulted in the provision of health care services to specific population groups such as pregnant women and infants with incomes at or below 133% of the federal poverty level. The majority of persons served are the poorest of the poor.

Because of income eligibility standards, there are a large number of low income New Mexicans who do not have access to health care coverage or primary health care services. One population group which encounters significant financial difficulties due to illness or injury are the elderly who are just above SSI eligibility standards. While these persons may be eligible for Medicare, they are required to pay the premiums, deductibles, and copayments for services. Persons who are SSI eligible have these costs paid through the Medicaid Program. There are services which are not paid through the Medicare Program. One such service is the purchase of prescription drugs.

The greatest number of requests for assistance received by the Human Services Department is that for help in the payment of prescription drugs. Often elderly persons are unable to pay for large prescription drug expenses. The irony confronting many of these individuals is that they are not poor enough to qualify for Medicaid services, yet they do not have adequate resources to afford prescriptions which can require as much as $500 per month.

Because portions of the Medicare Catastrophic Coverage Act were repealed, prescription drug purchases will not be a covered service through Medicare. Had this portion of the bill not been repealed, many of the elderly would have avoided the situation of being devastated by the high cost of needed prescriptions. This gap remains one of the most serious problems confronting the low income elderly population. As you are aware, payment for prescriptions is an optional service in the Medicaid Program. In other words, we are not required to cover this service as a condition for receiving federal dollars necessary to operate the program. We have decided however, that continued payment for this service is necessary and in the best interests of the overall financial status of the program. Access to prescription drugs often results in avoidance of more costly health care such as hospitalization. If persons with medical conditions requiring medication have access to needed prescriptions, they do not require other more costly forms of treatment. Consideration should be given to a means of eliminating this gap in health care services for a considerable portion of the population, many of whom are elderly.

In addition to this problem, I would also like to discuss another which we have experienced in the administration of the Medicaid Program. In 1988, we initiated a number of efforts designed to contain costs in the program. These efforts were undertaken in response to unparalleled expenditure growth. Over a period of twelve years, the Medicaid Program budget has increased from an annual level of $61.2 million to $341 million. We are projecting a $1 billion annual budget within the next ten years, and there is a serious possibility that the state will have inadequate resources to support a program of this size.

Among our cost containment efforts was a proposal to limit Medicaid reimbursements for services to persons who are Medicaid-Medicare eligible. Immediately after issuing this proposal, the Department was besieged with protests from physicians. Of greatest concern was the impact of the proposal on physicians with an unusually high ratio of Medicaid-Medicare eligibles in their practices. To test the validity of this claim, the Department conducted a survey of physician caseloads and determined that those in northern rural areas of the state do, in fact, have a significant percentage of their caseload comprised of persons who are Medicaid-Medicare eligible. This situation is the cause of great concern to the Department and one which should be addressed by all parties involved in the delivery of health care services. If Medicaid-Medicare eligible persons rely upon a limited number of physicians for services, there should be grave concerns regarding the availability of doctors to take the places of those who will retire or terminate their practices in the future.

In light of our research, we chose not to limit reimbursements for services to recipients in this category, and instead have sought to upgrade physician reimbursement levels. Toward this end, the Department secured a $1.8 million physician fee update appropriation from the Legislature to be implemented during the current fiscal year. The Department is also proposing a $2.5 million increase in physician reimbursements during the next fiscal year, and in the third year of this initiative, we hope to bring reimbursement to levels to those paid by Medicare. Traditionally, the Medicaid physician reimbursement levels have been significantly lower than those paid by Medicare and private insurers. Through this approach, the Department will be seeking to provide incentives for physicians to participate in the program thereby serving persons in areas which have encountered persistent shortages of Medicaid providers. One problem which cannot be addressed entirely through this approach is the problem of attracting physicians to serve rural areas. Reimbursement is only one of the factors which impact the decision of a physician to practice in a rural area. Efforts to improve access in these areas should include consideration the problem of practices without sufficient backup, the problem of malpractice lawsuits and the absence of adequate transportation systems.

Of interest to the Department is the proposal introduced by Sen. Domenici to extend primary health care to all persons with incomes at or below 100% of the federal poverty level through the Medicaid Program. This proposal, though costly, is a strong step forward in solving the a problem of health care coverage to the uninsured. New Mexico has a very large uninsured population. Recent figures indicate that 28% of the population is uninsured. Through expansion of preventive and primary care, many more costly medical services may be avoided. It is important, however, that preventive and primary care services be defined so states know the extent of coverage in doing their own planning. Senator Domenici's proposal also addresses issues such as revitalization of the National Health Service Corporation. The Human Services Department strongly supports this move. This effort will have a major impact on expanding health care in rural America and in particular rural New Mexico.

If the problem of access to primary health care is to be addressed effectively, the problem of the uninsured must be resolved. We must work to eliminate the absence of access due to lack of resources, because this is the most critical factor impacting access to health care services. Thank you.

Senator DOMENICI. Thank you very much, Secretary Valdez. I have a few questions but let's get on with Stephanie and then come back.

STATEMENT OF STEPHANIE J. FALLCREEK, D.S.W., DIRECTOR, NEW MEXICO STATE AGENCY ON AGING, SANTA FE, NM

Dr. FALLCREEK. Thank you, Mr. Chairman, for inviting me to join you for this hearing. Serving with such a distinguished group of witnesses is indeed a privilege. I am specially pleased that the Department of Health and Human Services has sent representatives from both the Administration on Aging and the Health Care Financing Administration.

The crucial interdependence of our efforts in the aging network and the health care network at all levels, Federal, State, and local has not been adequately recognized in the past.

Nationwide, access to primary health care for elders is limited by many barriers, such as financial, an inadequate supply of appropriately trained health care personnel, and a complex and fragmented human services delivery system, transportation and a scarcity of effective information and referral resources.

In some areas of the country, however, depending upon population density, elder and community economic resources, public transportation, access may not be as great a problem as in others.

Elderly access to primary care is one of the most important issues facing New Mexico's aging network. As one of the fastest growing retirement States, sixth fastest growing in the Nation between 1980 and 1989, our need for primary care services for elders is mushrooming.

Interestingly, New Mexico also has one of the fastest growing populations in terms of its younger persons in need of primary care. It is important to note that population projections indicate that a high level of growth in the older population can be expected to continue well into the next century. Census projections suggest that New Mexico will remain in the top 15 States in terms of percent increase in the over-60 population. Heavy immigration of elders from other States is a significant contributor to this trend.

As a State, where more than 20 percent of elders live below poverty, and one where a significant portion of the population is uninsured or underinsured, financing primary care for persons of all ages poses a major challenge.

New Mexico is also distinguished by its rurality. Nationwide, population density is about 64 per square mile, while in New Mexico it is about 12.2 person per square mile. A large proportion of older New Mexicans live in very rural areas, which might be better described as remote, with few options for transportation to primary care, long-term care, or other social and supportive services.

The multicultural composition of New Mexico also presents special challenges to access to primary care. Hispanic and American Indian elders lag behind the majority population in terms of health status as well as access to primary care services.

Rurality, limited income, language, and other cultural barriers, and lack of coordination in State and Federal health care programs

compound the challenges for these and other minority elders in New Mexico.

Considering these factors, it is clear that older New Mexicans face most or all of the same challenges to health care access which exist nationwide, but perhaps they face them on a different order of magnitude.

They are, in fact, in multiple jeopardy due to the combination of rapid increase in New Mexico's older population, extreme rurality and disproportionate poverty and cultural barriers to access. Each of these barriers poses a distinct challenge. Separately, and together they call for solutions which can be tailored to different State level, regional level, and local needs and resources.

Although access to primary care is a statewide problem for elders, barriers to access for rural elders in general, and rural minority elders in particular, are the most severe. There are three problems of overriding concern: Financing, shortage of primary care providers, and transportation.

An old Chinese proverb says: "It's not enough to aim, you must hit."

New Mexico's targeted response to elder access problems has been well-intentioned and appropriated "aim" but also it has been fragmented and inadequate, much like the available, federally supported programs and resources designed to address these problems.

There is no significant initiative which focuses on elderly access to primary care. We have perhaps taken aim but we have not yet hit the target. Numerous community health care clinics dot both the urban and rural landscape. Many of these clinics are underfunded and understaffed, but nonetheless serve large numbers of patients, though not as many as need the service they offer.

Others appear to serve fewer patients than their budgets would indicate they should be serving. Some clinics do an excellent job of reaching younger adults and children, but an abysmal job of reaching and serving elders. In many cases there appears to be little communication or coordination between the aging network programs and the health care network programs with responsibility for this situation shared among the providers.

In part, at least, exorbitant prescription drug costs, which must be borne by those clinics for the elderly, appear to discourage clinics from reaching out to elderly. Also, the scarcity of community-based, long-term care services in rural New Mexico means that many community heath centers when they do reach out to elders, may be inappropriately expected to provide a range of services for which they are ill-equipped.

Clinic staff are often untrained in serving geriatric primary care needs, but in other cases staff have taken advantage of the federally supported geriatric education and training offered through New Mexico's community colleges and universities, such as those of the Geriatric Education Program, (GEC) at UNM which needs to be continued and expanded.

However minimal, the primary care services offered by the publicly subsidized community health care clinics, in some communities these far exceed the opportunities for access available through private providers. Many private providers do not accept assignment of Medicaid patients. Some specialists are now informing their pa-

tients that they will no longer accept Medicare patients due to the required filing of the reimbursement forms. In many rural communities there are so few insured or privately paying patients that health care providers cannot be recruited or retained, and there are an inadequate number of publicly supported health care positions to fill in the gaps.

New Mexico's elders historically have been blessed with a responsive State legislature. Where Federal support for many elder programs, such as the supportive services component in the Older Americans Act, has eroded significantly over the last decade, perhaps by more than 30 percent in inflation-adjusted dollars, the State has attempted to fill in the gaps with general fund resources. In several programs, State support exceeds Federal support significantly.

A network of more the 160 senior citizen centers, most of them offering multiple services, including transportation, serves the estimated 220,000 New Mexicans over 60 years of age. With an agency budget of approximately 13 million operating dollars, the Administration on Aging, through its Area Agencies on Aging, provides service to more than 90,000 New Mexicans in these centers.

Minorities and low-income elders—and it's a fact we are very proud of in New Mexico—are served in proportion to or in excess of their proportionate representation in the population in many aging network programs.

These centers and their diverse services often provide the primary source of transportation assistance to rural elders. Despite this relatively stable network of dedicated providers, the rising demand for and the increasing cost of health care related transportation has resulted, in some communities, in declining access to transportation.

The State legislature has been generous in providing funds for the purchase of vehicles, but increased operating costs, particularly insurance costs, are taking a heavy toll on operating budgets.

Senator DOMENICI. Particularly what?

Dr. FALLCREEK. Insurance. Similarly, access to the information and referral services which facilitate appropriate and cost-effective use of primary care services is available mainly through the senior center network. Yet, many rural centers operate with a skeleton staff, pay minimum wages and few or no fringe benefits. The staff has little or no training in the information and referral skills that are needed to facilitate access.

New Mexico, incidentally, has one of the lowest costs in the region of providing many of the services of senior centers. And, in fact, that's because I feel like we sometimes exploit the staff who are working in those centers. It may take all their paid time to operate the nutrition and transportation programs, yet you expect them also to manage an effective information and referral program.

Senator DOMENICI. Plus you have great volunteers.

Dr. FALLCREEK. Plus we have fantastic volunteers.

There are other formal and informal aging network programs in New Mexico which play key roles in facilitating elder access to primary care as well as other services. Among the most important are New Mexico's senior employment and senior volunteer programs.

Our numerically small elderly population has limited access to the Federal funds available to support both senior employment and volunteer activities. But State general funds have been made available to supplement the need in this area.

Older workers in both the Title V and State-funded older worker programs provide critical manpower at the local level, driving buses, delivering homemaker services, cooking and delivering meals, etc. Rural transportation systems depend heavily upon older workers, whether they are participating in subsidized training and employment positions, acting as senior center volunteers, or serving as permanent employees of the program.

Senior companion volunteers are key individuals in facilitating access to primary care for many homebound elders and adults. In addition to the companionship and emotional support for which they are well-known, these low-income stipended volunteers assist with making medical appointments, providing information and referral support to their clients, coordinating or providing transportation to medical care, and assisting clients to comply with the recommendations of their primary care providers.

Particularly in rural areas the assistance provided by the senior companions and other volunteers is crucial. Yet, it is in rural areas where there are the fewest funded senior companion slots. New Mexico has only 65 federally funded senior companion slots, all allocated to American Indian elders. State funds support 152 slots which currently serve only 22 of New Mexico's 33 counties.

These companions, working half time, serve between 600 and 1,000 homebound adults annually, helping to preserve and to promote both dignity and independence in frail homebound New Mexicans. With additional slots and additional funding, senior companions could contribute even more, and very cost effectively, to improve primary health care access.

Simultaneously, both older workers and senior companions themselves benefit from program participation. Their improved self-esteem, their enhanced knowledge of the human services system, and the support they receive from local program sponsors to care for their own health and well-being contribute to their appropriate use of health care services.

Two other volunteer programs merit attention as well and contribute directly to improved access to primary health care. The health insurance and benefits, a volunteer program providing insurance counseling and information about the variety of services and benefits of the program, has over 100 volunteers in 18 counties. These volunteers have served more than 1,700 persons in the last year and a half, providing crucial assistance with access issues. The growing old with health and wisdom, a health promotion project generously funded by the Administration on Aging as a demonstration project, has volunteers currently delivering basic health education and health promotion activities in more than 15 of New Mexico's counties.

Mr. Chairman, I have a few recommendations which I would like to add for the record.

In the Public Health Service and Health Care Financing Administration:

1. Support the concepts of your primary care proposal.

2. Provide more funds for clinics, rural staff, geriatric training programs for primary care services.
3. Expand coverage by Medicaid of primary and preventive care to those at 133% of poverty level and below.
4. Increase the number of community health centers and the budget of existing effective community health centers to better support outreach and services to elders.
5. Allow reimbursement of nurse practitioners and physician's assistants in rural areas where physicians are not accessible, including services provided on site in senior centers and meal sites.
6. Provide funding for cooperative health education and other preventive services between health departments and aging network programs, including senior citizen centers.

FOR THE ADMINISTRATION ON AGING

1. Provide increased funding for supportive services, especially transportation and information and referral.
2. Use a funding formula which recognizes the special problems of rural states, those with a high percentage of minorities and low income elders, those where the small numbers of elders increases the costs per capita of providing services.
3. Provide funding for state and/or area agency on aging staff positions to develop and coordinate disease prevention and health promotion programs for elders and fund the health promotion component of the Older Americans Act. There have been many effective demonstration projects which must be discontinued due to lack of operating funds.
4. Allow the designation of single state planning and service areas to facilitate statewide systems of service deliver in rural states or those with very small populations.
5. Fund a Senior Service Corps under the OAA to encorage and enhance participation of senior volunteers in a variety of activities to (1) as Senior Health Advocates improve access to primary care through escort services, transportation assistance and information and referral support; (2) as Senior Health Advocates provide peer education and support in the area of health promotion and other preventive health activities.

ACTION

1. Increase funding for Senior Companion slots targeted to rural areas.
2. Allow reimbursement of volunteers expenses associated with transportating clients to health care appointments where resources permit.
3. Consider the transfer of funds and management of Older American Volunteer Programs from ACTION to the Administration on Aging to enhance coordination of services and minimize administrative fragmentation at local, state, and federal level.

Senator DOMENICI. You have the specific recommendations you are going to make for the record? We will make this a part of the record rather than deal with them now. I want to make sure that all witnesses get a chance.

Let me ask just a couple of questions. Mr. Secretary, let me ask, why do we have the health care shortages—particularly of doctors in rural areas?

Mr. VALDEZ. Mr. Chairman, I believe there are several reasons for that. First, we can go to the issue of compensation for doctors. In rural areas of New Mexico, and I am sure rural areas throughout the country, the ability for a physician to make an adequate or reasonable standard of living is not as opportune as it would be in the more urban located centers where there is private insurance to be able to draw on, as well as a higher standard of living to be able to draw on. I think it's a common premise that in rural America it is a poorer America than what we find in many of our urban centers.

Another factor is that physicians who settle in rural America may be the only provider in that community and they oftentimes find themselves on call 7 days a week, 24 hours a day. And it will result in burnout and exhaustion of our physicians providing services in our rural communities.

In order to assist with that situation that we find in many communities, it's important that we consider and look at better utilization of physician assistants, for instance, to be able to alleviate some of the responsibilities that that primary physician would find himself or herself, in a rural community.

We also have the issue of access to hospitals, access to medical libraries——

Senator DOMENICI. For the doctors?

Mr. VALDEZ. For the doctor. Access for the doctor to other members of the profession. All of which can result in a member of the profession wanting to settle in a more urban area where they have access to a multitude of different types of services for their education and training and their decisionmaking and treating. That is a very complex question, one which calls for a multitude of different issues confronting that rural physician. I believe that addressing reimbursement first, addressing the supply of physicians, quality of the work environment would all lead to improving our physician base in rural New Mexico.

Senator DOMENICI. Everyone should know that that question I asked is a very complex one. It's not necessarily New Mexico. It's generic to the United States. Our medical schools deserve a great deal of credit because many years ago they did try a basic program from the very beginning. They were getting doctors in the medical school who would work on a program of being rural doctors, where the entire atmosphere, environment, everything around it, Mr. Secretary, gave them the kind of moral and psychological buildup that you just described is lacking. They got used to that early. It was a model in the Nation.

I must say, however, that we are still noticing a great, great disparity of doctors in the cities, versus doctors in rural areas. It's getting worse, not better, and we have got to work on it. That's why I asked the question.

Let me ask you, Alex. This is not really part of this hearing, other than as I continue to speak about different ways of delivering health care, including so-called community health centers which are funded by the Federal Government. I think I told you the amount of money that we spend. I think the right number is, for community health centers per se, without migrant health, it's only about $500 million, nationally, for the entire network. That would include the Family Health Center here, and you are aware of three or four in the north. You are aware of the one that's going to testify here, in Portales.

I just wanted to ask, in your capacity as the State's leading officer, do you, in any informal way, evaluate centers such as that? How they fit into the delivery system? They are free, understanding the government is essentially their funder. So I would not be critical if you are not involved. But I just wonder, do you know whether they are effective? And do you do anything to find out if they are? Or is that somebody else's job?

Mr. VALDEZ. No. We do not undertake such an evaluation, perhaps minimally at best. But that evaluation comes about in terms of the Medicaid Program itself. And the issue of access, for instance, to prenatal care, and the type of service delivery that we find in rural areas for purposes of providing prenatal care. It's a more specific type analysis, in terms of a specific type of service delivery that the State is looking at, which should be a more broader and universal type analysis of how the health care center fits in the overall scheme of things for health care delivery.

Senator DOMENICI. In other words, you are saying if they are delivering a kind of care for which you are responsible, you look at them to see that they are doing that right?

Mr. VALDEZ. Correct. The Health and Environment Department for the State plays a much more significant role in the service delivery of such entities.

Senator DOMENICI. So that what's going on currently in the news here with reference to this very large center that serves 40,000 people here in our valley, that's not under your jurisdiction at this point?

Mr. VALDEZ. No. That is correct, sir, the review would more than likely take place through the Health and Environment Department, unless it involved an issue of Medicaid and money for medication.

Senator DOMENICI. I have no further questions. We will take a 10-minute recess and then we will go over.

[A recess was taken from 2 to 2:30 p.m.]

Senator DOMENICI. So everyone will know now, we have three witnesses here at the table, and then immediately following these three witnesses we have five people who are involved in various clinics and consumer activities for seniors, and they will be our last five. So let's proceed. And for the three that are here, if you will, make your testimony as brief as possible. We will take the testimony and make it part of the record. Let's start with Peggy Folk, executive director of New Mexico Primary Care Association. She is representing the community health centers and the primary care providers. Peggy will give you a prospective of providers in medically underserved areas. So would you please proceed.

STATEMENT OF PEGGY FOLK, EXECUTIVE DIRECTOR, NEW MEXICO PRIMARY CARE ASSOCIATION, ALBUQUERQUE, NM

Ms. FOLK. Thank you, Senator. Our association represents 21 community, migrant, and homeless health care delivery systems who provide primary health care services at over 46 health center sites throughout New Mexico; 10 of the 21 health service delivery systems provide Federal funding through Public Act 330 and 340. But with New Mexico being a very rural, poor State, with 28 percent of its population uninsured, and an additional 25 percent underinsured, our members are the principal providers of primary care services to the medically indigent population.

Although New Mexico ranks fifth in the Nation in size, it ranks 45 in per capita income. Of New Mexico's 33 counties, 19 are considered frontier areas; "frontier" being defined as less than 7 people per square mile. These areas, for the most part, are quite

remote and have very limited resources to attract health care professionals. That makes access to primary health care both an economic and geographic issue, as outpatient demographics point out.

In 1989, our members provided primary care services to over 113,400 New Mexicans, of which 56 percent, or 63,560 were provided services on a sliding fee scale because of no insurance or inadequate insurance coverage.

Of the 113,400 patients our health centers saw in 1989, only 9 percent had their services paid for by Medicare. This low is directly related to the lack of Medicare coverage for preventive or "routine" health services such as annual checkups, hearing or vision testing, mammography, lab work, dental care, and medications. Health prevention services clearly are not covered.

The New Mexico Medicaid Program provided coverage to only 15 percent of our patients in 1989. The low percentage of coverage by Medicaid is attributable to several facts. For the elderly who qualify for the SSI program, Medicaid provides coverage if their income does not exceed 77 percent of the Federal poverty guidelines. This means an elderly couple who earn over $6,400 per year are ineligible for Medicaid. New Mexico Medicaid does cover under the Qualified Medicaid beneficiaries whose annual income does not exceed 90 percent of the Federal poverty guidelines but only for coverage of Medicare copayment deductibles.

You have heard about the AFDC population and the fact that the Medicaid programs cover only those people who fall below 37 percent of the Federal poverty guidelines. This means a family of four who earns more than $4,699 a year is ineligible. As you can see, there is a large gap in coverage of primary health care services by both Medicare and Medicaid.

Our members throughout the State participate in a wide array of health services for the elderly, from routine screenings, such as hypertension, diabetes, and cholesterol, annual flu vaccines and tetanus booster shots.

In Portales, NM, La Casa de Buena Salud Health Center houses the Los Abuelitos Senior Center and shares in many of their activities. At La Familia Medical Center in Santa Fe, during this past year, through a grant from the State Agency on Aging, they received a grant to provide dental services and dentures to elderly indigent. In addition, many of the centers discount for senior companion programs and retired senior volunteer programs.

During the past year several of our members participated in the senior health promotion program entitled growing old with health and wisdom. Programs such as this do demonstrate there is coordination between primary health care centers and seniors throughout New Mexico. They do not, however, meet all of the needs, which brings me to my comments on your proposal to access primary and preventive care.

To say that we are excited by your proposal is truly an understatement. It is a proposal whose time has come. I would like to direct my comments to specific components of the proposal.

Expansion of Medicaid eligibility for primary and preventive services will go a long way to provide health care services for the 28 percent of New Mexicans who fall into the category of unin-

sured, with the buy-in concept, and allowing actual purchase of service and copayments was not only innovative but equitable.

We would suggest that consideration be given to include perhaps prenatal care and delivery services and that a mechanism would be developed to address people who are found by the health care providers to need additional services.

Revitalizing the National Health Service Corps is of great interest to us and a true necessity in expansion of primary health care services. From the mid-1970's through the mid-1990's the National Health Service Corps assisted in providing health professionals to rural underserved areas in New Mexico. In 1985, New Mexico had over 50 National Health Service Corps assignees. However, since 1985 a severe reduction in funding has resulted in that number dwindling to less than a dozen.

The immediate need for providers is very great. Therefore, when we look at putting dollars to the scholarship program, we would really encourage, initially, that more money be put into loan repayment. It will bring providers on line much more quickly. As you know, the scholarship programs take between 7 and 8 years until we get someone through school and practicing. After a few years, those dollars could shift somewhat to put a little bit more money back into the scholarship program, after the loan repayment has brought enough people.

Another issue you did not address in your proposal that we would like to have addressed is to make sure that the dollars are there to keep salaries competitive so that we can encourage providers into the National Health Service Corps and allow those community health centers to keep the provider salaries competitive with the private market.

The priority for primary care specialists and special attention to frontier areas is truly appreciated. We would suggest that you prioritize further within the primary care field, giving top priority to family practice, general practice, and mid-level generalists.

Partial scholarship awards would be quite helpful in attracting providers. Also, we would like to see that applied to loan repayment. This year in New Mexico we have had a husband and wife, both physicians, who wanted to job share in a rural health clinic and were quite interested when they saw the loan repayment program. However, because they were not both full time they were ineligible for participation.

Although your proposal does not specifically address the National Health Service Corps Medication Education State Based Loan Repayment Program, it has truly been a vital component to both recruitment and retention efforts in primary health care centers in medically underserved areas in New Mexico.

New Mexico is one of the original seven States funded. They have continued to receive funding. They are now going into their third year. Last year New Mexico received $140,000 under that program, and it directly is responsible for getting 10 primary care providers in underserved areas in the State.

This year the program has been expanded to include mid-level providers and most recently had made arrangements for both nurse practitioners and nursing assistance.

The community health center authorization, of course, is very important to us. The proposed increases are quite necessary to assure those health centers can continue to meet the expanding needs of providing primary care, particularly basic health care to the medically underserved.

We were also pleased to see a separate authorization for new community health centers. The last community health center, new start, in New Mexico was a National Health Service Corps conversion in Santa Fe in 1987. We would strongly encourage that some priority be given to existing National Health Service Corps sites which receive no Federal funding other than provider, and that those facilities that will qualify as local health centers under the Federally Qualified Health Center Act also be looked at.

We would also ask that as these new starts be brought on the line, the base budget for the community primary health program be increased so that we are assured the support that those can continue.

We strongly support the inclusion of Medicare under the federally qualified health center legislation. This will definitely have a positive impact on access for senior citizens. Currently, in New Mexico, the federally qualified health center legislation for the federally funded health centers will start up in probably sometime in October.

Providing Medicare reimbursement to nurse practitioners and physician assistants in rural areas, regardless of the site of services, will also increase the number of available providers for those areas. Without the mid-level providers in New Mexico, many areas of the State, particularly those frontier areas, will be without any health care services, whatsoever.

The tax incentive for health professionals to serve in rural areas will make rural practice more attractive. We would also suggest that the criteria for rural areas include health manpower shortage areas and medically underserved areas. The primary care association has been working with a variety of groups in encouraging the University of New Mexico family practices residency program to rotate their residents out into community health centers during the second and third year of their residency. It is my understanding that the issue has been addressed in the budget in the upcoming year.

As you stated, the medical school does an excellent job of getting them out. We should like to see them continue to get the residents out and see what the rural practice was like in the last few years of their residency. It would be an excellent goal to recruit those.

Increased funding for area health education centers has an excellent potential for enhancing primary care services. We would strongly recommend language which ensures coordination with State primary care associations and State cooperative agreement. Thank you, Mr. Chairman, for inviting me to testify.

Senator DOMENICI. Thank you. Let me just take this opportunity, and I am sure that, Peggy, this is good news to you and those you represent. As you know, Congress has mandated reform in physician payments. We have been engaged as a nation in a very strange way of paying doctors and specialists and high tech kind of professionals at a very healthy schedule for reimbursement. But we

didn't treat the primary care doctor very well; the one who just saw a person, who needed the typical doctor's evaluation rather than going in for a specialist and for something that involved significantly high technology.

I am pleased to tell you that effective January 1, 1992 that Medicare physician payment is going to change substantially. It will increase payment to primary physicians and reduce payments for the so-called high tech's services, and specialists. This increase is estimated at about 27 percent, phased in over 3 years for the primary health care physicians. I am sure that, aside and apart from any of the facilities that are the public kind that you represent, that you would agree with me that reimbursement for primary health care was one of the very, very difficult parts of the Medicare system.

Ms. FOLK. It certainly has been. We are very excited to hear that.

[The prepared statement of Peggy Folk follows:]

NEW MEXICO
Primary Care Association
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STATEMENT OF

PEGGY A. FOLK

EXECUTIVE DIRECTOR

NEW MEXICO PRIMARY CARE ASSOCIATION

Mr. Chairman and Members of the Committee:

My name is Peggy Folk and I am the Executive Director of the New Mexico Primary Care Association in Albuquerque, New Mexico.

The New Mexico Primary Care Association is one of 43 state based organizations who coordinate federal and state primary care resources, assist members in the recruitment and retention of health care professionals, promote the use of state resources such as Medicaid, Maternal and Child Health, Special Populations funding for primary care purposes, provide technical assistance, shared services, and promote partnerships and affiliations with State and Local Health Departments, State Agencies, Area Health Education Centers, Medical Residency Programs, and other health care providers.

Our Association represents 21 community, migrant and homeless healthcare delivery systems who provide primary health care services at over 46 health center sites in 20 of New Mexico's 33 counties.

With New Mexico being a very rural, poor state with 28% of its population uninsured and an additional 25% underinsured, our members are the principal providers of primary care services to the medically indigent population.

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Although New Mexico ranks 5th in the nation in size, it ranks 37th in population and 45th in per capita income. Of New Mexico's 33 counties, 19 are considered Frontier Areas. Frontier being defined as less that 7 people per square mile. These areas, for the most part, are quite remote and have very limited resources to attract health care professionals. This makes access to primary health care both an economic and geographic issue, as our patient demographics point out.

In 1989, our members provided primary care services to over 113,400 patients of which 56%, or 63,560, were provided those services on a sliding fee scale because of no insurance or inadequate insurance coverage.

Of the 113,400 patients our health centers saw in 1989, only 9% had their services paid for by Medicare. This low percentage is directly related to the lack of Medicare coverage for preventive or "routine" health services such as an annual check-ups, hearing or vision testing, mammography, lab work, dental care, or medications. Health prevention services are not covered.

The New Mexico Medicaid Program provided coverage to only 15% of the 113,400 patients our members saw in 1989. The low percentage of coverage by Medicaid is attributable to several facts. For the elderly who qualify for the SSI Program, Medicaid provides coverage if their income does not exceed 77% of the Federal Poverty Guidelines. This means an elderly couple who earn over $6,483 per year are ineligible for Medicaid. New Mexico Medicaid does cover Qualified Medicare Beneficiaries whose annual income does not exceed 90% of the Federal Poverty Guidelines but only for coverage of Medicare co-payments and deductibles.

For the AFDC population, the Medicaid Program covers <u>only</u> those people who fall below 37% of the Federal Poverty Guidelines. This means a family of four who earns more than $4,699 per year is ineligible. This group consists of many working poor who are uninsured.

As you can see, there is a large gap in coverage of primary health care services by both Medicare and Medicaid.

Our members participate in wide array of health services for the elderly from routine screenings such as hypertension, diabetes, and cholestrol, to annual flu vaccines and tetanus booster shots.

In Portales, New Mexico, La Casa de Buena Salud Health Center houses the Los Abuelitos Senior Center and shares in many of their activities.

La Familia Medical Center in Santa Fe, through a grant from the State Agency on Aging, provides indigent elderly with dentures through the health center's dental program. In addition, they provide discounted physical exams for the Senior Companion and Retired Senior Volunteer Program.

At Centro Rural de Salud Health Center in Carlsbad, the health center, in coordination with the Senior Center, is setting up an exercise and nutrition program for seniors entitled Por La Vida.

During the past year the G.T.G. Health Care System in Gallup, Grants, and Thoreau, the Farmington Community Health Center in Farmington, and La Casa de Buena Salud in Portales, have been participating in the Senior Health Promotion Program entitled Growing Old With Health And Wisdom. This program provides an overview of the participants health and health habits including a nursing health assessment and a personal health assessment, a variety of health screens and counseling services such as nutrition and smoking cessation programs.

Programs such as these demonstrate the good coordination between primary health care centers and seniors throughout New Mexico.

They do not, however, meet all of the needs, which brings me to my comments on Senator Domenici's Proposal on Access To Primary and Preventive Care.

To say we were excited about the proposal is an understatement. It is truly a proposal whose time has come. I would like to now direct my comments to the specific components of the proposal.

1. Expansion of Medicaid Eligibility for Primary and Preventive Care will go a long way to provide health care services for many of the 38 million Americans who are uninsured. In New Mexico 28% of our citizens fall into that category. The buy in concept is innovative and equitable. We would suggest that consideration be given to include prenatal care and delivery services and that a mechanism be developed to address those people who are found, by the health care provider, to need additional services.

2. Revitalizing the National Health Service Corps will greatly improve both geographic and economic access to health care.

   From the mid 1970's through the mid 1980's, the National Health Service Corps assisted in providing health professionals to many underserved areas. In 1985 New Mexico had over 50 National Health Service Corps assignees. However, since 1985 a severe reduction in funding of the National Health Service Corps has resulted in that number dwindling to less than 12.

   The immediate need for providers is very great. Therefore, we suggest that in the next few years more dollars be put into the Loan Repayment Program as it produces immediate providers with less dollars into the Scholarship Program which takes seven to eight years to see results. Then as the number of National Health Service Corps providers increases, more dollars could be shifted into the Scholarship Program. In addition, dollars to retain National Health Service Corps providers salaries needs to be addressed. As we all know it is more cost effective to retain providers than to recruit new ones.

   The priority for primary care specialities and frontier areas is appreciated. We would suggest that within the primary care fields you further prioritize giving top priority to Family Practitioners, General Practitioners, and Mid-Level Generalists.

The awarding of partial scholarships will be quite helpful in attracting providers. This year we had a husband and wife, both physicians, who job share one position at a health center. They were both interested in Loan Repayment but because they were not both full-time, could not apply.

Although your proposal does not specifically address the National Health Service Corps Medical Education State Based Loan Repayment Program, it has been a vital component to both recruitment and retention efforts in primary health care centers in medically underserved areas of New Mexico. Last year New Mexico received $140,000 under this program which directly assisted in retaining 10 physicians in these areas. This year it has been expanded to also include mid-level providers. We strongly encourage the continuation of this program as it has been truly successful here in New Mexico.

3. The Community Health Center Authorization is, of course, very important to us. The proposed increases are exciting and quite necessary to assure those health centers can continue to meet the needs of providing basic health care services to the medically underserved.

The separate authorization for new community health centers is vital to meet the expanding needs. There has not been a new community health center funded in New Mexico since 1987.

We strongly encourage that some priority be given to National Health Service Corps sites and those that qualify as look alikes under the Federally Qualified Health Center Act.

We also ask that as these new starts become funded, the base budget for the C/MHC Program be increased to accommodate continued support.

We strongly support the inclusion of Medicare under the Federally Qualified Health Center Legislation. This will certainly increase access to preventive and primary care services for senior citizens.

4. Providing Medicare Reimbursement to Nurse Practitioners and Physician Assistants in rural areas regardless of the site of services will increase the number of available providers for those areas. Without mid-level providers in New Mexico many areas of the State whould be without health care services particularly in Frontier Areas.

5. Tax Incentive for health professionals to serve in rural areas is a great incentive. We suggest that the criteria for rural areas include Health Manpower Shortage Areas and Medically Underserved Areas.

6. Increased funding for Area Health Education Centers has excellent potential for enhancing primary care services. We recommend language which insures coordination with State Primary Care Associations and State Cooperative Agreements.

Thank you Mr. Chairman and Members of the Committee for inviting me to testify on behalf of the New Mexico Primary Care Association.

I would be happy to answer any questions you may have.

Senator DOMENICI. That was what Congress mandated, and I was told by the experts that are implementing it that it would be about 27 percent over 3 years, starting on the first day of January 1992. We will start moving in that direction. We think that's very good news.

Karen, we want you to talk to us as the executive director of the New Mexico Association for Home Care. Pleased to have you here.

STATEMENT OF KAREN WELLS, EXECUTIVE DIRECTOR, NEW MEXICO ASSOCIATION FOR HOME CARE, SANTA FE, NM

Ms. WELLS. Thank you, Senator, and thank you for inviting me to testify and to bring to you the comments and ideas of the New Mexico Association for Home Care. I have tried to focus the remarks that I am going to make on the issues that you are addressing today, primarily primary care and access to care, although there are many other aspects of home care which are important to us as well.

Primary care for the elderly is comprised of two major facets; the first being health promotion and the second prevention of complications of existing medical problems. Elders who engage in health promotion activities, and who are exposed to health teaching relative to chronic conditions that already exist, have an increased potential of remaining in their own homes, and avoiding costly institutionalization. Their quality of life is enhanced as well, as the effects of loss and dislocation from families and friends in reduced or eliminated when people remain in their own homes.

When we think of lack of access to health care, we most commonly think of lack of coverage of lack of availability of services. The elderly, and most especially the rural elderly, however, face particular barriers to access to care that are different and are a direct result of the health care system—which actually is a nonsystem—that we have in our country today. Access is limited sometimes by the system itself, and a system that is as fragmented and inefficient as the one we have provides a disincentive to seeking and obtaining appropriate care.

Imagine, if you will, a poor elderly person in rural New Mexico who thinks he might be eligible for some public assistance with his health care needs. He visits the local office to apply for Medicaid and fills out the necessary forms. The person reviewing the application notices he may also be eligible for coordinated community in-home care services, energy assistance, weatherization, food stamps, and meals on wheels.

Application for these services involves visits to different locations, interviews with different people, different forms to fill out, and literally hours of driving from place to place and waiting in line.

If he perseveres and becomes eligible for these programs, there is no assurance that he will receive them, because they all have waiting lists, they are administered from different State agencies, and they all involve additional steps, such as obtaining a doctor's examination and subsequent orders before he can receive them. The time to process these innumerable forms and documents is lengthy,

as they all must travel through several layers of bureaucratic approval before a provider of services can actually deliver them.

Meanwhile, we must assume that the gentleman so described not only has the health and stamina to endure this convoluted process, but that he has available transportation to visit the various offices required. Someone who is infirm can quite literally die before all this can be accomplished.

It is inexcusable, in my view, that someone can be denied access to care simply because bureaucratic and regulatory hoops and tangles have become so pervasive that the services that are available are inaccessible. Correcting problems as widespread as these will not occur overnight, and will require national comprehensive attention.

The debate on how this should develop is already underway, and reports such as that issued by the Pepper Commission provide a framework within which that discussion can be pursued. There are intermediary steps, however, that can be taken that will move us along the continuum, to what should be a basic right to every American, access to affordable health care.

I would like to see Federal legislation that mandates the following three things: (1) Uniform definitions of terms across agency and program lines; (2) uniform standards of program operation; and (3) a single point of entry for the beneficiary of publicly assisted programs.

Currently, there exists a melange of terms and definitions that vary so widely it is nearly impossible to identity who qualifies for what services and under what circumstances.

We do not even have a uniform definition for what constitutes an elderly person. Terms as seemingly simple as "home health aide" are mired in controversy as each program defines different services that may be provided by a home health aide and/or applies different labels to what is, essentially the same service.

Further, each program provides different standards of operation and compliance on the provider of services so that multiple surveys, audits, and reviews are necessitated to assure that the proper rules are being followed by the proper provider under the proper set of circumstances.

It is truly an environment of "let the buyer beware," only as we have seen the buyer is so overwhelmed by this bewildering array of rules, definitions, eligibility criteria, and forms that he is often discouraged from even attempting to acquire it.

The rural elderly recipient of services should be able to access needed care through "one stop shopping." One visit to one office to fill out one set of forms should be sufficient to identify the programs and services for which he qualifies.

Once that identification is made, it is a simple and logical step to identify which of those services are available in that local community. Development of uniform standards and definitions is a vital precursor to establishment of a single point of entry, for data management and form consolidation would otherwise be virtually impossible.

The achievement of these goals would create an environment in which home- and community-based services could be used to their maximum potential. The ideal team of primary care physician and

home care agency could then function to provide the promotion and prevention that is so critical to the health of our elders.

Home care should be a consistent alternative to institutionalization, not an add-on service, and in many parts of New Mexico, this is already occurring. In Clovis, for example, a home care agency routinely provides pre- and post-natal care to high-risk moms and their infants.

In Hobbs, a primary care clinic and home care agency have teamed up successfully to provide intravenous chemotherapy to cancer patients. In Santa Fe, the Visiting Nurse Service operates the AIDS Wellness Clinic, providing primary care to persons with AIDS/ARC.

In Ruidoso, the home care agency routinely identifies environmental and social problems which beset their patients and arranges for the needed services, thus saving their patients from the experiences I have described earlier. And these examples are by no means isolated. All over the State home care agencies are looking for and finding innovative ways to engage in outreach with other community-based programs and primary care physicians to meet the acute and long-term needs of their patients.

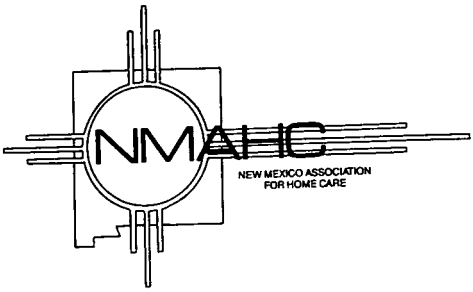
Home care addresses the problem of lack of access due to geography as well. Patients who lack adequate transportation, who are too frail to withstand visits to their physicians, can have health care services brought to them. In Alamogordo, for example, the home care agency serves the entire county. And this example is repeated in county after county all over New Mexico. In essence, the mobile health system that you referenced earlier, Senator, is already happening in New Mexico, with home care agencies.

This not necessarily an inexpensive way to provide health care, but it is probably less expensive than waiting until the health problem is of such magnitude that it can only be dealt with in a critical care hospital, and is probably less expensive to resolve health problems with short-term intervention than to slowly deplete someone's resources in a nursing home and then pay for their care with Medicaid dollars. The main focus of home care indeed is to promote optimal health and independence in the home, goals which are remarkably similar to those of primary care physicians.

Home care is, and should be, a critical part of the health care continuum. We are not new. We have been around for a long time. We have been covered by Medicare since its onset and we are becoming more integrated into the whole network of health services that are available in this country.

With ideal communication and coordination of those services, which are already available, and with protection from cuts of funding, and with the simplified procedure for the beneficiaries seeking to receive services, home care can be the glue which cements the network of community-based programs. It can be the basis for a national program to provide much needed long-term care services. And it can serve to substantially improve access to health care for those in need, whatever their age. Thank you, Senator. I will be glad to answer any questions.

[The prepared statement of Karen Wells follows:]



TESTIMONY
to the
SENATE SPECIAL COMMITTEE on AGING

FIELD HEARING
August 28, 1990

Albuquerque, N.M.

by:
KAREN S. WELLS, EXECUTIVE DIRECTOR
NEW MEXICO ASSOCIATION FOR HOME CARE

Improving Access to Primary Health Care for the Elderly

Mr. Chairman, Senator Domenici, Members of the Committee, Esteemed Guests:

My name is Karen Wells. I am a Registered Nurse, and the Executive Director of the New Mexico Association for Home Care. I have been involved in home health care for the last ten years, as a visiting nurse, a hospice nurse, a director of education and quality assurance, the director of a non-profit home health agency, and now as director of the statewide association for home care. I would like to speak to you today about the role of home care in improving access to primary health care services to the elderly of New Mexico.

There is no question that the availability of health care services to the elderly is less than ideal, particularly in rural areas of this state. We know that many areas are lacking needed services altogether, or are able to provide them only in geographically inaccessible places or to a limited degree. Improving the availability of these services is certainly something which deserves the attention of this Committee and of our elected officials. There is another sort of access problem, however, that should not be overlooked.

The current Federal system of health care services has supported the development of a patchwork of programs, an almost incomprehensible array of categories of eligibility, duplication of some services, and woefully inadequate provision of others, lack of coordination and communication between providers and payors of services, and mountains of required paperwork. Not surprisingly, the cost of this "non-system" has become almost unbearable. Compounding the problems has been the inherent bias towards institutional care. These barriers also have an effect on access to care for the elderly.

Primary care for the elderly is comprised of two major facets; health promotion and prevention of complications of existing medical problems. Elders who engage in health promotion activities, and who are exposed to health teaching relative to chronic conditions that already exist, have an increased potential of remaining in their own homes, and avoiding costly institutionalization. Their quality of life is enhanced as well, as the effects of loss and dislocation from families and friends is reduced or eliminated when people remain in their own homes.

When we think of lack of access to health care, we most commonly think of lack of coverage or lack of availability of services. The elderly, and most especially the rural elderly, however, face particular barriers to access to care, that are different, and are a direct result of the "non-system" previously mentioned. Access to care can be limited by the system itself, and a system that is as fragmented and inefficient as the one we have provides a disincentive to seeking and obtaining appropriate care.

Imagine, if you will, a poor elderly person in rural New Mexico who thinks he might be eligible for some public assistance with his health care needs. He visits the local office to apply for Medicaid and fills out the necessary forms. The person reviewing the application notices he may also be eligible for coordinated community in-home care services, energy assistance, weatherization, food stamps and meals on wheels. Application for these services involves visits to different locations, interviews with different people, different forms to fill out, and literally hours of driving from place to place and waiting in line. If he perseveres and becomes eligible for these programs, there is no assurance that he will receive them, because they all have

waiting lists, they are administered from different state agencies, and they all involve additional steps, such as obtaining a doctor's examination and subsequent orders before he can receive them. The time to process these innumerable forms and documents is lengthy as they all must travel through several layers of bureaucratic approval before a provider of services can actually deliver them. Meanwhile, we must assume that the gentleman so described not only has the health and stamina to endure this convoluted process, but that he has available transportation to visit the various offices required. Someone who is infirm can, quite literally, die before all this can be accomplished.

It is inexcusable, in my view, that someone can be denied access to care simply because bureaucratic and regulatory hoops and tangles have become so pervasive that the services that are available are inaccessible! Correcting problems as widespread as these will not occur overnight, and will require comprehensive national legislation. The debate on how this should develop is already underway, and reports such as that issued by the Pepper Commission provide a framework within which that discussion can be pursued. There are intermediary steps, however, that can be taken that will move us along the continuum toward assuring what should be a basic right of every American: access to affordable health care.

I would like to see federal legislation that mandates the following three things: 1.) uniform definitions of terms across agency and program lines; 2.) uniform standards of program operation; and 3.) a single point of entry for the beneficiary of publicly assisted programs.

Currently there exists a melange of terms and definitions that vary so widely it is nearly impossible to identify who qualifies for what services and under what circumstances! We do not even have a uniform definition for what constitutes an elderly person. Terms as seemingly simple as "home health aide" are mired in controversy as each program defines different services that may be provided by a home health aide, and/or applies different labels to what is, essentially, the same service. Further, each program applies different standards of operation and compliance on the provider of services, so that multiple surveys, audits and reviews are necessitated to assure

that the proper rules are being followed by the proper provider under the proper set of circumstances. It is truly an environment of "let the buyer beware" only, as we have seen, the buyer is so overwhelmed by this bewildering array of rules, definitions, eligibility criteria, and forms that he is often discouraged from even attempting to acquire it.

The rural, elderly recipient of services should be able to access needed care through "one stop shopping". One visit to one office to fill out one set of forms should suffice to identify the programs and services for which he qualifies. Once that identification is made, it is a simple and logical step to identify which of those services are available in that community. Development of uniform standards and definitions is a vital precursor to establishment of a single point of entry, for data management and form consolidation would otherwise be virtually impossible.

The achievement of these goals would create an environment in which home and community based services could be used to their maximum potential. The ideal team of primary care physician and home care agency could then function to provide the promotion and prevention that is so critical to the health of our elders.

Home care should be a consistent alternative to institutionalization, not an add-on service, and in many parts of New Mexico this is already occurring. In Clovis, for example, a home care agency routinely provides pre and post natal care to high risk moms and their infants. In Hobbs, a primary care clinic and home care agency have successfully teamed up to provide intravenous chemotherapy to cancer patients. In Santa Fe the Visiting Nurse Service operates the AIDS Wellness Clinic, providing primary care to persons with AIDS/ARC. In Ruidoso the home care agency routinely identifies environmental and social problems which beset their patients and arranges for the needed services, thus saving their patients from the experiences I described earlier. And these examples are by no means isolated. All over the state home care agencies are looking for, and finding innovative ways to engage in outreach with other community based programs and primary care physicians to meet the acute and long term care needs of their patients.

Home care addresses the problem of lack of access due to geography as well. Patients who lack adequate transportation, or who are too frail to withstand visits to their physicians, can

have health care services brought to them. In Alamagordo, for example, the home care agency serves the entire county encompassing some 5,600 square miles, and this example is repeated in county after county all over New Mexico.

This is not an inexpensive way to provide health care. But it is less expensive than waiting until the health problem is of such a magnitude that it can only be dealt with in a hospital. It is less expensive to resolve health problems with short term intervention than to slowly deplete someone's resources in a nursing home, and then pay for their care with Medicaid dollars. The main focus of home care is to promote optimal health and independence in the home. The goals are remarkably similar to those of the primary care physician.

Home care is, and should be, a critical part of the health care continuum. We are not new. We have been around for as long as our country has been in existence. People have been receiving health care services at home since long before there were hospitals and nursing homes in which to treat them. Physicians providing primary care began that practice hundreds of years ago by visiting patients in their own homes. The tradition of combining the best efforts of doctors and home care providers to meet the health care needs of their patients is well established. It is basic. Home and community based services, given the right chance, can be an important part of the solution to the health care problems which beset our nation. It is true that there are not enough services currently available, and funding for these services is fragile. But with ideal communication and coordination of those services which are available, with protection from unbearable cuts to funding such as the Gramm-Rudman-Hollings sequestrations, and with a simplified procedure for the beneficiaries seeking to receive services, home care can be the glue which cements the network of community based programs. It can be the basis for a national program to provide much needed long term care services. And it can serve to substantially improve access to health care for those in need, whatever their age.

Senator DOMENICI. Just one quick question of you, Karen. In addition to everything else you have said, is it still true, as a general proposition, that people prefer to be treated at home, if possible? Just attitudinally, is that still so?

Ms. WELLS. Yes, Senator, that is true. We know that intuitively, and there are studies—although I can't cite you the exact name of the studies—that support this. There are also studies which seem to indicate that if people receive health care services in their own homes that they actually recover more quickly and may use less of the other kinds of services we are currently looking for ways to provide, such as prescription drugs.

Senator DOMENICI. Before we go to Winnifred, let me ask. Seferino Montano is here. Seferino is the President of the New Mexico NMPCA, which is the New Mexico Primary Care Association. He is not testifying, but he is here with Peggy, who is the one who is giving the testimony. Could I ask a question, Peggy, of you or of Seferino, either of you? Are you aware of the problem that is occurring with the Family Health Center in Albuquerque?

Ms. FOLK. Yes, sir.

Senator DOMENICI. Would you have a few minutes when we are finished this afternoon to spend with me, then, on that issue?

Ms. FOLK. Certainly.

Senator DOMENICI. I am concerned. If you have any ideas, I would very much, Seferino, I would like to hear from you. All right. Winnifred Connor, New Mexico Seniors Coalition, from Clovis, NM, we are delighted to have you. Thank you for all the trouble you have gone through to be with us. We very much appreciate it. I hope you know that.

STATEMENT OF WINNIFRED CONNOR, NEW MEXICO SENIORS COALITION, CLOVIS, NM

Ms. CONNOR. Thank you. Thank you, Honorable Senator Chairman and members of the Committee for the opportunity to express my concerns for the plight of the older rural New Mexicans in the very rural or frontier areas with special emphasis on programs supported by the Older American Act.

I am Winnifred Connor of Clovis, an advocate for the needs of the rural elderly. I am representing the New Mexico Senior Coalition, a senior advocacy group of over a thousand members who are mostly grass-roots individuals, many of whom do not belong to other organizations or special interest groups, but who are concerned with the needs of the elderly.

Since April, I have been a working advocate on a State ad-hoc subcommittee concerned with the lack of access to the minimum level of service for rural New Mexicans. A comprehensive, cost effective system for rural areas needs to be developed.

High quality health care that is affordable and accessible is a goal which most New Mexicans would agree is one worth striving for. In reality, however, this level of care is often unattainable, especially for high-risk elders living in rural areas.

Additional funding is needed to provide the services of transportation, information and referral, supportive services, medical/

health care, long-distance telephone services and mental health services.

The Older Americans Act is due for reauthorization. This is an opportunity to request an increase in funds that would be set aside to provide a minimum level of transportation, information and referral and supportive services in rural areas.

New Mexico is predominately a rural State—approximately 51.6 percent of the State's population lives in rural areas and 10 percent of these are elderly. In these areas, most employers are farmers or very small businesses with only a few employees and, therefore, provide very few benefits. Many workers work less than 30 hours a week and have no health care benefits at all.

There are 459 communities with less than 5,000 population. Health care programs are very limited and often nonexistent in sparsely populated communities of 500 or less. By the year 2000, the largest group of senior citizens in New Mexico will be 85 years old or older. Over half of New Mexico's 1½ million population live in rural areas and 150,000 of these, it is projected, will be elderly. Problems of isolation and lack of transportation in vast areas which lack hospitals or medical services will pose an ever-increasing problem for these communities.

All phases of transportation service to health facilities is limited in rural areas statewide. Often the elderly do not have cars in sufficient repair to make a trip to distant areas to obtain any type of needed service, nor are they able to afford the travel expense. Many have had to give up the use of their cars because they cannot afford the insurance, the license, and general upkeep, or they are no longer physically able to drive. Public transportation is not available. On the other hand, the expense and time and transportation costs for the health care providers to deliver the needed services already puts a strain on their budgets.

In most rural areas, a request for every service requires a long-distance call. Presently, many of the elderly give up trying to obtain health services because they do not know how to reach the services they need. An easily contacted centralized information and referral system is needed to serve the people in every community. A statewide system accessed by an 800 number should also be considered as it would be more easily kept up to date and could be available around the clock with volunteers.

There is a shortage of personnel in the home health care field due largely to lack of trained personnel in these areas and the time and the funding required by urban care givers to visit these remote areas. Neither Hildalgo or Catron Counties have a full-time doctor, and Harding County has no doctor. Lack of available funding, shortage of staff and travel time required, caused health care providers and social service staff to limit services to these remote areas. The rural are disadvantaged due to the remoteness of their location, and sparseness of population, which prevents them from receiving grants available to urban areas.

To support a quality of life, a health system must provide a coninuum of service which includes service to develop and maintain health as well as services which diagnose and treat pathological functioning and disease. While some physical and mental changes

are normal to aging, total loss of function is often preventable with early intervention.

Another problem which continues to surface in small hospitals is the threat of closure if solutions to their funding and staff problems are not found. If they are forced to close who is going to take care of the health care services when the doctors and other health care providers move on to greener pastures?

There are 5,000 inhabitants or less in each of six counties in New Mexico, according to the Health Resources Registry, 1988, and these encompass many very small, and often remote, communities. Some of the less populated counties are Catron, DeBaca, Guadalupe, Harding, Mora, and Union. There are many more communities and many more counties that also have small populations. But these were the smaller numbers and populations that I was able to obtain.

Most "frontier" areas, as they are sometimes referred to, have no doctors, dentists, hospitals, clinics, pharmacies, optometrists, or health or social services agencies. Often the nearest "mom and pop" grocery store is 20 miles away. There are no health services available in remote areas of a population of 200 or less. When population numbers are considered for program funding, rural areas fall through the cracks.

Community forums recently have been conducted jointly by the communities, senior citizens providers and area Agencies on Aging showed that the elderly that participate in forums were concerned about inadequate home care services and showed that home care for seniors was inadequate and should be increased in rural areas.

Attendees were evenly divided between a desire for nationalized health care and a desire for affordable national health insurance. Reports from the statewide forums indicated there is a need for comprehensive information and a referral system for all elderly as well as the frail and low income. In-home care programs, especially CCIC, have long waiting lists and were unable to respond quickly to the needs. People often die before they can be taken care of. The application process was cited as one of the reasons that the program could not respond quickly to the applicant's need for care.

The forum reports stressed the need for a minimum standard of service to be available to all areas, and resources should be provided to meet these standards.

Northern New Mexico forums were concerned with the availability and access to health care. Mora is one of the poorest counties in the State of New Mexico, and probably one of the poorest counties in the United States. Health care is available 30 miles away in Las Vegas. Cimarron in Colfax County is also a very remote area, and the nearest health facility is 41 miles away in Raton.

Many eligible elderly persons in need of service are not being reached because of the lack of funds for vehicles, maintenance, and drivers. Senior centers have been outgrown and they cannot handle the added seniors due to the lack of facilities and funding to provide the service for these added seniors.

We must start now to plan for the rising number of frail, elderly persons who pose an increasing problem to lack of services, by isolation, by long distances to be traveled, by lack of transportation,

or lack of funds for transportation and long distance telephone calls.

The notion that an extended family or friends can replace a service delivery system is not realistic, because many families are having a hard time surviving the high cost of living and keeping their own immediate family going. Needs extend across age lines and affect families, not just individuals. The diversity of need is as great in rural areas as in urban areas, but the numbers of persons affected under each "label" are fewer. This limits the funding availability and necessitates creative measures.

Volunteers, neighbors, and friends would be more willing to provide transportation if they knew they would be paid for their mileage costs.

Senator Domenici, your draft proposal on access to primary and preventive care is exciting. And although it be somewhat ambitious, I believe there will still be a significant number of seniors who will remain isolated and unserved. I urge you to include in your proposal a means to provide service to this segment of the population by providing the resources to transport them to the access point.

I submit herewith to you the written report with the documentation which is attached, for a part of the record, and I wish to thank you for inviting me and for the opportunity to express my concerns. Thank you.

[The prepared statement with attachments of Winnifred Connor follows:]

"PROBLEMS FACED BY THE NEW MEXICO RURAL ELDERLY
TO ACCESS HEALTH SERVICES"

Thank you, Honorable Senator Domenici and members of the committee for the opportunity to express my concerns for the plight of the older rural New Mexicans in the very rural or frontier areas with special emphasis on programs supported by the Older American Act.

I am Winnifred Conner of Clovis, an advocate for the needs of the rural elderly. I am representing the New Mexico Senior Coalition, a senior advocacy group of over 1,000 members who are mostly grassroots individuals, many of whom do not belong to other organizations or special interest groups, but who are concerned with the needs of the elderly.

Since April, I have been a working advocate on a state AD Hoc sub committee concerned with the lack of access to the minimum level of service for rural New Mexicans. A comprehensive, cost effective system for rural areas needs to be developed.

High quality health care that is affordable and accessible is a goal which most New Mexicans would agree is one worth striving for. In reality, however, this level of care is often unattainable, especially for high-risk elders living in rural areas.

Additional funding is needed to provide access to these services:

Transportation	Medical/Health Care
Information and Referral	Long-Distance Telephone
Supportive Services	Mental Health Services

The Older American Act is due for reauthorization. This is an opportunity to request an increase in funds that would be set aside to provide a minimum level of Transportation, Information and Referral and Supportive Services in rural areas.

New Mexico is predominately a rural state - approximately 51.6% of the state's population live in rural areas and 10% of these are elderly. (see attachments B and G) In these areas, most employers are farmers or very small businesses with only a few employees and, therefore, provide very few benefits. Many workers work less than 30 hours a week and have no health care benefits.

There are 459 communities with less than 5,000 population. Health care programs are very limited and often non-existent in sparsely populated communities of 500 or less. By the year 2000, the largest group of senior citizens in New Mexico will be 85 years old or older. Over half of New Mexico's 1¾ million population live in rural areas, and 150,000 of these will be elderly. Problems of isolation and lack of transportation in vast areas which lack hospitals or medical services will pose an ever increasing problem for these communities.

All phases of transportation service to health facilities is limited in rural areas state-wide. Often the elderly do not have cars in sufficient repair to make a trip to distant areas to obtain any type of needed service, nor are they able to afford the travel expense. Many have had to give up use of their cars because they cannot afford the insurance, license and general upkeep, or they are physically unable to drive. Public transportation is not available. On the other hand, the expense in time and transportation costs for the Health Care Providers to deliver the needed services already strains the budgets.

In most rural areas, a request for every service requires a long-distance call. Presently, many of the elderly give up trying to obtain health services because they do not know how to reach the services they need. An easily contacted centralized Information and Referral System is needed to serve the people in every community. A state-wide system accessed by an 800 number should also be considered as it would be more easily kept up to date and could be available around the clock.

There is a shortage of personnel in the home-care field due largely to lack of trained personnel in these areas and the time and funding required by urban care givers to visit these remote areas. Neither Hildalgo or Catron Counties have a full time doctor, and Harding County has no doctor. (see attachment E, F and G) Lack of available funding, shortage of staff and travel time required, cause Health Care Providers and Social Service staff persons to limit services to these remote areas. The Rural are disadvantaged due to the remoteness of their location, and sparseness of population prevent them from receiving grants available to urban areas.

To support a quality of life, a health system must provide a continuum of services which include service to develop and maintain health as well as services which diagnose and treat pathological functioning and disease. While some physical and mental changes are normal to aging, total loss of function is often preventable with early intervention!

Another problem which continues to surface in small hospitals is the threat of closure if solutions to their funding and staff problems are not found. If hospitals and clinics are forced to close, who will provide essential health care service when the doctors and other health care providers move on to greener pastures?

There are 5,000 inhabitants or less in each of six Counties in New Mexico listed below according to the New Mexico Health Resources Registry, 1988, and these encompass many very small, and often remote, communities.

COUNTY	1990 POPULATION PROJECTION
Catron	2,858
DeBaca	2,400
Guadalupe	4,500
Harding	1,000
Mora	4,600
Union	5,000

The projected population for 1990 in Hildalgo County is 6,758.

Most "frontier" areas, as they are sometimes referred to, have no doctors, dentists, hospitals, clinics, pharmacies, optometrists or health or social service agencies. Often the nearest "mom & pop" grocery store is 20 miles away. There are no health services available in remote areas of a population of 200 or less. When population numbers are considered for program funding, rural areas fall through the cracks.

Community forums recently conducted jointly by the Communities, Senior Citizens Providers and Area Agencies on Aging showed the elderly participating in the forums were concerned about inadequate home care services and showed that home-care for seniors was inadequate and should be increased in rural areas.

Attendees were evenly divided between a desire for nationalized health care and a desire for affordable national health insurance. Reports from the statewide forums indicated there is a need for a comprehensive Information and Referral System for all elderly as well as the frail and low income. In-Home care programs, especially CCIC have long waiting lists and were unable to respond quickly to the needs. People often die before they can be taken care of. The application process was cited as a problem for elderly to quickly receive needed care.

The Forum reports stressed the need for a minimum standard of service to be available to the rural areas, and resources should be provided to meet these standards.

Northern New Mexico Forums were concerned about the availability and access to health care. Mora is one of the poorest counties in the State. Health care is available thirty miles away in Las Vegas. Cimarron in Colfax County is also a very remote area and the nearest health facility is 41 miles in Raton. Many eligible elderly persons in need of service are not being reached because of the lack of funds for vehicles, maintenance and drivers. Senior Centers have been outgrown and they can not handle these added seniors due to lack of facilities and funding to provide the service.

The Director of Catron County Commission on Aging Nan Burns testified at the Select Committee on Aging Field Hearing held in Santa Fe on June 23, 1990, that Catron County is the most sparsely populated area in the state. There are 600 senior citizens in 7,000 square miles of mostly mountainous terrain. Funds and staffing will not permit full services. Catron County, for example, has only one senior center to service all of their communities.

Transportation is provided by only two vans from Reserve which often must make 100 mile trips, one way. A round trip north to Gallup is about 260 miles and to Socorro is 250 miles. One large van is usually full each week and travels about 1,000 miles a month. (see attachment map and full report in attachment A)

Transportation and home making services are very important as there is no other home making service in Catron County. CCIC programs would help Catron County greatly with In-Home care if available.

We must start now to plan for the rising numbers of frail, elderly persons who pose an increasing problem due to lack of services, by isolation, by long distances to be traveled, by lack of transportation, or lack of funds for transportation and long distance telephone calls.

The notion that an extended family or friends can replace a service delivery system is not realistic because many families are having a hard time surviving the high cost of living and keeping their own immediate family going. Needs extend across age lines and affect families, not just individuals. The diversity of need is as great in rural areas as in urban areas, but the numbers of persons affected under each "label" are fewer. This limits the funding available and necessitates creative measures.

Volunteers, neighbors and friends would be more willing to provide transportation if they knew they would be paid for their mileage costs.

Senator Domenici, your Draft Proposal on Access to Primary and Preventive Care is exciting and ambitious. However, I believe there will be a significant number of seniors that will remain isolated. I urge you to include in your proposal a means to provide service to this segment by providing the resources to transport them to the access point.

ATTACHMENTS:

A Catron County Map and Testimony
B New Mexico Population by Counties
C New Mexico Physicians in practice
D New Mexico Pharmacists and Pharmacies
E Health Manpower shortage by County
F Population of Rural New Mexico

Catron County Commission on Aging

Nan Burns Director
P.O. BOX 481 RESERVE, NEW MEXICO 87830
(505) 533-6676

June 18, 1990

Testimony-ACCESS to SERVICES for RURAL ELDERLY NEW MEXICANS.

My name is Nan Burns. I am Director of the Catron County Commission on Aging and have been for 7 years. Thank you for asking me to testify at this hearing. I feel very honored to be able to do so. I hope that I might be able to offer some insight into the needs of rural elderly and the problems that exist in providing services to them.

I would like to begin by first giving you some details,many of which you may already know of the county . Catron County is the largest county in New Mexico and the most sparsely populated with a total of 2700 people, 600 of which are Senior Citizens. The county consists of 7,000 sq. miles,much of which is very mountainous. Catron County is one of the most rural counties in the United States and probably one of the most economically deprived. Cattle and logging have been the major industry in the area but desire to decrease grazing land and the study of the spotted owl have cut cattle ranching and the operation of logging in the county.

Catron County is deprived of many things, but fresh air is not one of them. There is one Doctor in the county. A few years ago a new medical clinic was built in Reserve, the county seat of Catron County, but poor management and lack of funds have assisted in problems that have prevented it from being very successful. Medical attention if much more than a cold requires a 100 mile drive to Silver City, 125 miles to Socorro, or 65 miles to Springerville, Arizona. In Catron County there are no dentists, eye doctors, pharmacy's, lawyers, food stamp offices, and only a few very small grocery stores where one might shop. There is no radio station and until about 2 years ago there was no newspaper. The nearest metropolitan area is Albuquerque, about 200 miles away.

Catron County has one Senior Center and from and through there, services are provided to the elderly.

Because of the rurality of the area and the distance to less rural areas transportation is one of the most important services that we provide. Our program has 2 vans to cover the needs of the entire county. One of the vans, a 14 passanger, carries the seniors on the long distance trips. Each week during the month the van will cover a certain designated area to transport those seniors to the nearest town for shopping, medical attention, human service assistance, and recreation. The trip south from Reserve to Silver City is 200 miles round trip, the trip west takes that group to Springerville, Arizona and that trip is 130 miles round trip, the shortest run made. The trip north to Gallup is about 260 miles round trip and the trip to Socorro is 250 miles round trip. (Map included) Our 1 large van that carries 14 passangers is usually full each week and on a regular basis travels about 1,000 miles per month.

Another 12 passanger van is used at the Center in Reserve to transport Seniors to and from the Center for meals and . for home delivery. Volunteers also provide many miles of transportation and is an invaluable inkind service to our program. To date from July 1 of 1989 we have put 112,222 on our vans. Transportation is also provided to a lesser degree for recreation, educational and health promotion activities both to the Center and to other areas.

Homemaking Services is another service provided by our program and a very important one also. Since there is no other In Home Care in our county this is of extreme importance to frail elderly and even those with short term illnesses. 5 Homemakers provide services to the entire county. Their job includes light housekeeping, preperation of a meal while there, assistance in dressing, hair care and erranda if necessary. Each homemaker is only a 20 hour employee. At this time there are 50 frail elderly in the county and adding the short term illness needs to this magnifies the problem.

A Congregate meal is provided 5 days per week at the Center in Reserve and Home Delivered meals are prepared and delivered in an 8 mile area of Reserve. Meals are needed throught the county but miles and $'s will not permit at this time.

Health Promotion, Education, Information and Referral, Outreach and Recreation are provided through the Senior Center in Reserve. Like most other Senior Programs throughout the State our Seniors are encouraged to maintain a healthy lifestyle and many activities at the Senior Center reflect that. Whenever possible our Seniors are transported to other areas for recreation and they are very active in Senior Olympics and find the Glorietta Conference very informative and educational. However, there are many elderly left out of these activities because of a transportation problem and because of a communication problem.

Meaningful Volunteer opportunities is a vital part of this program. Services such as shopping assistance, home visiting letter writing and telephoning is only possible because of volunteers. Additional transportation that cannot be covered by the regular bus runs such as trips to Albuquerque to medical appointments are often handled by a volunteer. Volunteers also provide help in kitchen, and hours of manpower for fundraisers that are held to help support this program.

The State Legislature was very good to us this year and if the voters of New Mexico see fit to vote for the ammendment we will be getting a new center in Quemado in about June of 1991.

Starting July 1 we will getting a new Senior Companion program and we will be placing Volunteers throughout the county.

There are problems and many challanges in providing services to a rural area such as ours. Since our greatest need is services of Transportation and In Home Care our problem is not enough vans, not enough van drivers and not enough homemakers and no where persons that are trained with enough hours to give around-the-clock care to those elderly needing it. Seniors if unable to care for themselves or have no family to help them if they become ill must be placed in nursing homes before they should.

I do not have a solution to all of these problems. I would like to make a few suggestions that I think might help the rural areas. When money and employment slots are dispursed rural areas fall through the cracks because of numbers. It is hard to argue 600 seniors verses large numbers when in actuality in rural areas distance and larger costs are the issue. More employees are needed to provide services because of the greater distances they must cover out in the field and they are only allowed 20 hours per week each. I also feel very strongly that such programs as SCIC would help our county greatly with the In Home Care service if it were properly run. A month is to long to wait while an ill person is approved for a service.

I thank you for your concern for the Rural Elderly. I feel that every dollar spent in rural areas is well spent when it concerns these people because they are at a much greater risk of ending up in a Nursing Home than Urban Seniors and this in the end will be of a much greater cost to our Government than keeping them as comfortable as possible in their homes for as long as possible.

Catron County Commission on Aging

Nan Burns Director
P.O. BOX 481 RESERVE, NEW MEXICO 87830
(505) 533-6676

July 2, 1990

Congressman Edward R. Roybal
Chairman, Select Committee on Aging
712 House Annex 1
Washington, D.C. 20515

Dear Chairman Roybal:

At the hearing in Santa Fe, New Mexico on June 23rd, you requested that I submit to you in writing a letter with my suggestions on how the Federal Government could better assist in serving rural elderly with transportation.

I submit these suggestions:

1. An agreed upon definition of "Rural" with degrees of rurality to include: 1. Rural Areas
   2. Greater Rural Areas
   3. Frontier Areas

2. Provide funds in Capitol Outlay under the Older Americans Act earmarked for rural areas.

3. Provide funds for drivers of vans in rural areas through title III expansion.

4. Increase Title V slots for drivers of vans earmarked for rural areas and or increased funds set aside for rural transportation.

5. Adequate funding for operation and maintenance expenses.

6. Develop pools to decrease costs of insurance in rural areas.

I am convinced that action in these areas would alleviate some transportation problems in rural areas.

Thank you for your interest and consideration in this matter. I feel certain that with the efforts of this committee great improvements will be made in the furture of the Older Americans Act.

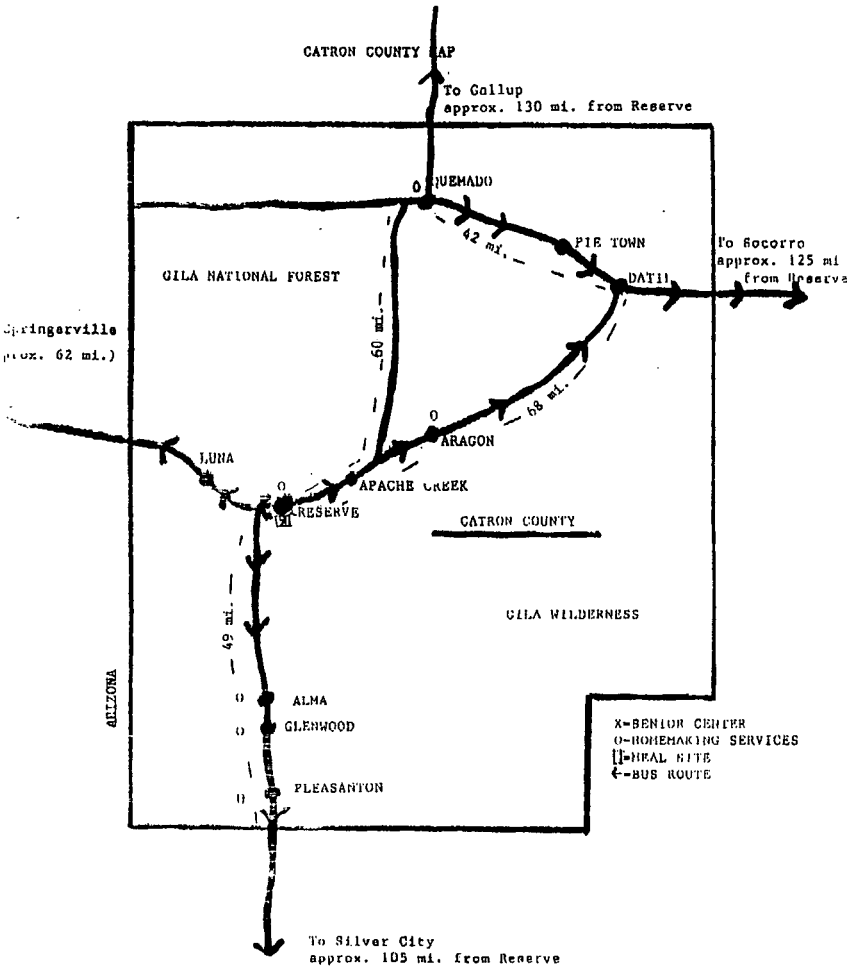
Sincerely,

Nan Burns

Nan Burns
Director

ATTACHMENT A

NB:jp



ATTACHMENT: A

TABLE 1 - NEW MEXICO POPULATION AND SELECTED CHARACTERISTICS, BY COUNTIES

COUNTY	Population April 1, 1980 Revised	Population 1990 Projections	Other Characteristics, 1980 Persons in Poverty	% Urban	% Over 65	Median Age (Yr)	1980 % Indian	% Spanish
Bernalillo	420,262	508,300	13.2	96.4	8.1	28.1	2.7	36.8
Catron	2,720	2,858	23.0	0.0	13.5	30.7	1.5	28.7
Chaves	51,103	58,200	19.2[1]	77.6[1]	14.1[1]	30.4[2]	0.6[1]	30.6[1]
Cibola	30,346	20,700	15.4[1]	50.0[1]	4.5[1]	--[2]	25.8[1]	37.0[1]
Colfax	13,667	14,700	17.0	60.2	13.0	29.5	0.5	47.4
Curry	42,019	45,000	15.1	83.3	9.6	26.1	0.4[3]	19.5
De Baca	2,454	2,400	20.1	0.0	21.0	39.1	0.0[3]	30.9
Dona Ana	96,340	140,300	22.7	67.3	7.2	24.7	0.8	52.1
Eddy	47,855	52,000	13.5	75.0	12.5	29.1	0.4	30.7[1]
Grant	26,204	28,000	14.4	49.3	10.5	28.4	0.5	51.3
Guadalupe	4,496	4,500	30.5	0.0	12.2	27.4	0.2	82.7
Harding	1,090	1,000	19.0	0.0	17.5	35.2	0.0[3]	44.3
Hidalgo	6,049	6,758	17.0	52.8	9.3	26.0	0.1	47.1
Lea	55,993	66,000	12.2	79.5	8.0	26.6	0.5	21.3
Lincoln	10,997	14,000	17.0	38.7	12.2	32.0	0.6	26.6
Los Alamos	17,599	18,600	4.1	100.0	4.1	33.1	0.6	11.5
Luna	15,585	19,700	23.3	63.9	16.8	33.7	0.5	39.5
McKinley	56,536	72,000	36.8	42.0	4.9	22.0	65.7	13.5
Mora	4,205	4,600	38.3	0.0	14.8	29.2	0.2	86.6
Otero	44,665	55,500	14.5	75.7	6.6	25.6	4.8	21.7
Quay	10,577	11,700	18.2	64.0	15.7	32.6	0.4	35.5
Rio Arriba	29,282	36,100	28.3	19.3	8.2	25.6	11.4	74.4
Roosevelt	15,695	17,000	27.2	63.3	12.9	26.8	0.7	21.5
Sandoval	34,400	60,800	18.6	47.5	9.8	28.2	27.3	27.5
San Juan	81,433	98,000	20.9	60.0	5.8	24.2	33.0	11.8
San Miguel	22,751	27,000	30.8	63.0	11.6	27.2	0.4	81.4
Santa Fe	75,519	94,600	13.7	70.6	9.0	29.3	2.8	55.6
Sierra	8,454	9,666	22.4	61.7	29.5	50.0	0.6	25.3
Socorro	12,566	16,000	29.6	57.1	8.8	25.3	9.9	46.7
Taos	19,456	23,100	27.5	17.3	9.7	28.3	6.4	69.1
Torrance	7,491	9,700	23.3	0.0	12.0	30.0	0.5	41.1
Union	4,725	5,000	21.3[1]	62.8[1]	17.2[1]	33.7[2]	0.3[1]	31.2[1]
Valencia	30,769	41,200	14.4[1]	40.7[1]	10.3[1]	25.5[2]	2.6[1]	50.8[1]
NEW MEXICO	1,303,303	1,584,982	17.6	72.1	8.9	27.3	8.1	36.6

1 Estimates are derived by aggregating data in census county divisions contained in the new Cibola and Valencia County boundaries.

2 Cibola and Valencia counties are combined.

3 Less than 0.05 percent.

SOURCES: HRR, BBER and US Bureau of Census

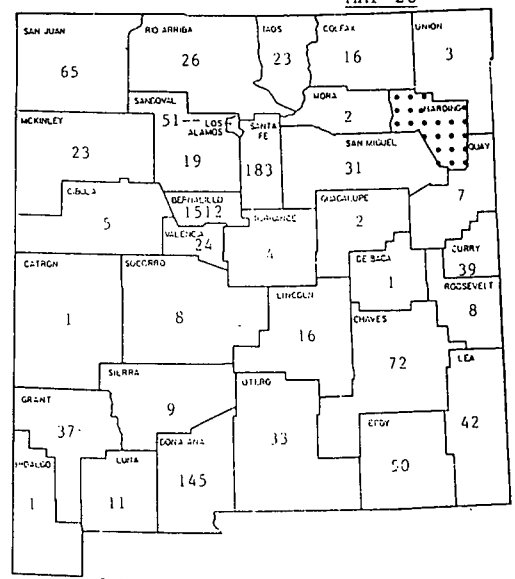
NEW MEXICO HEALTH RESOURCES REGISTRY, 1988/89

Attachment B

TABLE 35 - NEW MEXICO PHYSICIANS IN PRACTICE (MDs and DOs), 1989

COUNTY	(1) Total Phys	(2) Nonfed Phys	(3) 1990 Pop/ Nonfed Phys
Bernalillo	1,617	1,512	336
Catron	1	1	2,858
Chaves	72	72	808
Cibola	13	5	4,140
Colfax	16	16	919
Curry	54	39	1,154
De Baca	1	1	2,400
Dona Ana	154	148	948
Eddy	51	50	1,040
Grant	37	37	757
Guadalupe	2	2	2,250
Harding	0	0	--
Hidalgo	1	1	6,758
Lea	42	42	1,571
Lincoln	16	16	875
Los Alamos	51	51	365
Luna	11	11	1,791
McKinley	91	23	3,130
Mora	2	2	2,300
Otero	52	33	1,682
Quay	7	7	1,671
Rio Arriba	32	26	1,388
Roosevelt	10	8	2,125
Sandoval	21	19	3,200
San Juan	96	65	1,508
San Miguel	33	31	871
Santa Fe	197	183	517
Sierra	9	9	1,074
Socorro	9	8	2,000
Taos	23	23	1,004
Torrance	4	4	2,425
Union	3	3	1,667
Valencia	25	24	1,717
NEW MEXICO	2,753	2,472	641

MAP 28



= No Physicians in County

NOTES: MD and DO information current as of February, 1989. Nonfederal Physicians exclude military, PHS, IHS, NHSC, and VA Hospital. Included are all nonfederal MDs and DOs in New Mexico whose type of practice is: (see NOTES on page 46).

NEW MEXICO HEALTH RESOURCES REGISTRY, 1988/89

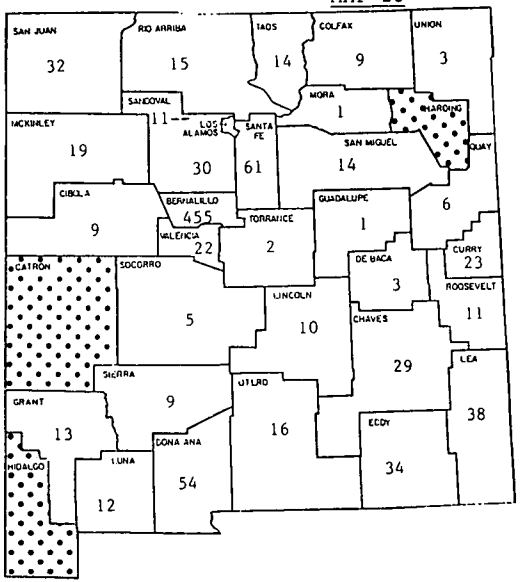
Attachment C

TABLE 32 - NEW MEXICO PHARMACISTS AND PHARMACIES, 1989

COUNTY	Total Pharmacists Licensed	1990 Pop/ Pharmacist	Total Pharmacies
Bernalillo	455	1,117	101
Catron	0	--	0
Chaves	29	2,007	13
Cibola	9	2,300	3
Colfax	9	1,633	5
Curry	23	1,957	11
De Baca	3	800	1
Dona Ana	54	2,598	16
Eddy	34	1,529	14
Grant	13	2,154	8
Guadalupe	1	4,500	2
Harding	0	--	0
Hidalgo	1	6,758	1
Lea	38	1,737	16
Lincoln	10	1,400	5
Los Alamos	11	1,691	5
Luna	12	1,642	3
McKinley	19	3,789	7
Mora	1	4,600	0
Otero	16	3,469	6
Quay	6	1,950	3
Rio Arriba	15	2,407	6
Roosevelt	11	1,545	5
Sandoval	30	2,027	6
San Juan	32	3,063	14
San Miguel	14	1,929	5
Santa Fe	61	1,551	16
Sierra	9	1,074	3
Socorro	5	3,200	3
Taos	14	1,650	6
Torrance	2	4,850	2
Union	3	1,667	3
Valencia	22	1,873	8
NEW MEXICO	962	1,648	297

NEW MEXICO HEALTH RESOURCES REGISTRY, 1988/89

MAP 25



= No Pharmacists in County

NOTES: Includes only Pharmacists licensed to practice in New Mexico. Military and IHS Pharmacists are not required to hold New Mexico licenses.

Employment status for Pharmacists is unknown

SOURCES: BBER, 1990 Population Projections
New Mexico Board of Pharmacy

Attachment D

HEALTH MANPOWER SHORTAGE AREAS/PRIMARY CARE, NEW MEXICO (September, 1989)

Designated by the Secretary of Health and Human Services.

PURPOSE: Designation makes these areas eligible (1) to apply for placement of NHSC personnel, (2) for repayment or cancellation of educational loans to health professionals who practice in designated areas and (3) for scholarship support of health profession students who thereby become obligated to practice after graduation in designated areas.

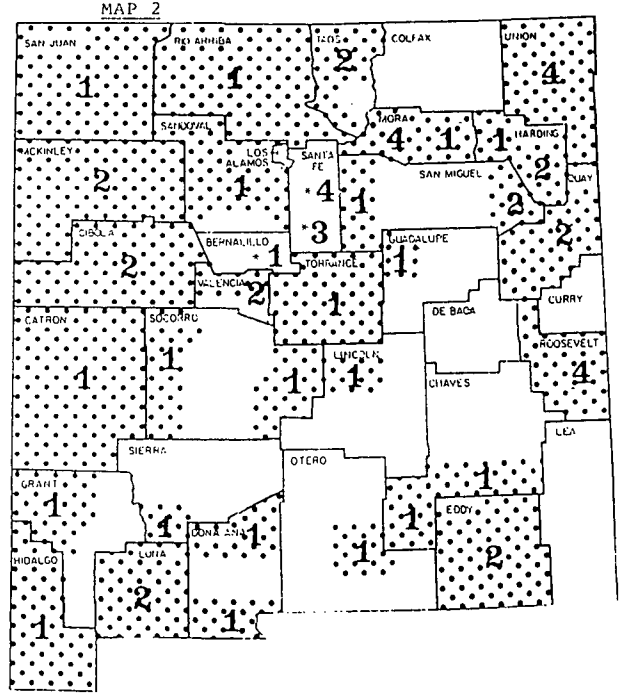
DEGREE OF SHORTAGE: Each area population is ranked from 1 to 4 with 1 being highest level of shortage.

CRITERIA:

1. It is a rational area for the delivery of primary medical care services.
2. One of the following conditions prevails within the area:
   a. Population-to-Primary Care physician (FTE) of at least 3,500:1 or,
   b. Population-to-Primary Care physician (FTE) of less than 3,500 but has either unusually high needs for services or insufficient capaciaty of existing providers.
3. Primary medical care manpower in contiguous areas in overly utilized, excessively distant or inaccessible to the population.

NEW MEXICO HEALTH RESOURCES REGISTRY, 1988/1989

MAP 2



SOURCE: PRIMARY CARE SECTION, PHD, HED

= Medical shortage

* = (see following page for specific designations within counties)

THE POPULATION OF RURAL NEW MEXICO

(A report on how many New Mexicans live in the real rural areas of the state.)

By
Andres S. Hernandez
Rural Development Advisor (Retired)

Santa Rosa, N.M. July 1990

A publication of THE ADVOCATES FOR RURAL NEW MEXICO.

INTRODUCTION

The ADVOCATES FOR RURAL NEW MEXICO are dedicated to help improve the quality of life in the small communities of the State. They hold that the services and facilities, necessary for a pleasant and comfortable life, are more plentiful in communities with 5,000 or more inhabitants. This paper seeks to identify the communities and populations of less than 5,000.

Santa Rosa, N.M.
July, 1990

a.s.h.

COUNTY POPULATIONS
NEW MEXICO
July 1, 1986 (1)

1.	Bernalillo	474,400
2.	Catron	2,700
3.	Chaves	56,700
4.	Cibola	23,000
5.	Colfax	14,300
6.	Curry	43,400
7.	De Baca	2,400
8.	Dona Ana	123,000
9.	Eddy	52,400
10.	Grant	27,000
11.	Guadalupe	4,400
12.	Harding	1,000
13.	Hidalgo	6,100
14.	Lea	64,900
15.	Lincoln	13,600
16.	Los Alamos	18,200
17.	Luna	17,800
18.	McKinley	65,800
19.	Mora	4,600
20.	Otero	50,200
21.	Quay	11,600
22.	Rio Arriba	33,200
23.	Roosevelt	16,500
24.	Sandoval	51,100
25.	San Juan	92,000
26.	San Miguel	25,300
27.	Santa Fe	87,600
28.	Sierra	9,400
29.	Socorro	14,700
30.	Taos	22,000
31.	Torrance	9,000
32.	Union	5,100
33.	Valencia	36,400

Total State Population: 1,479,800

(1) N.M. Statistical Abstract, 1989, Bureau of Business and Economic Research, University of New Mexico, p. 88.

COMMUNITIES WITH A POPULATION OF 5,000 OR MORE
NEW MEXICO
July 1, 1986
(1)

1.	Albuquerque	462,304	
2.	Santa Fe	55,980	
3.	Las Cruces	54,090	
4.	Roswell	44,110	
5.	Farmington	39,050	
6.	Hobbs	34,870	
7.	Clovis	33,780	
8.	Alamogordo	27,930	
9.	Carlsbad	27,850	
10.	Rio Rancho	26,520	
11.	Gallup	22,470	
12.	Las Vegas	15,620	
13.	Lovington	11,800	
14.	Artesia	11,620	
15.	Deming	11,330	
16.	Silver City	11,190	
17.	Portales	10,180	
18.	Grants	8,520	
19.	Raton	8,460	
20.	Socorro	8,120	
21.	Espanola	7,900	
22.	Tucumcari	7,630	
23.	Aztec	7,360	
24.	Bloomfield	6,980	
25.	Belen	6,530	
26.	Truth or Con.	5,880	
27.	Sunland Park	5,570	
28.	Los Lunas	5,420	
29.	Ruidoso	5,260	
30.	Los Alamos	11,039	)
			)
31.	Shiprock	7,237	)
32.	White Rock	6,560	)- 1980 population
33.	Zuni Pueblo	5,511	)
34.	Sandia Pueblo	5,288	)
35.	Paradise Hills	5,096	)
	Total Urban population:		1,025,055

(1) NM Statistical Abstract, 1989, pp 103-106.

POPULATION DISTRIBUTION
NEW MEXICO
July 1, 1986

NUMBERS

URBAN (5000 or more population)		
Albuquerque (urban)	467,400	
34 other N.M. cities	566,900	
Total Urban		1,034,300
RURAL		445,500
Total State population		1,479,800

PERCENT

URBAN (5000 or more population)	
Albuquerque	32%
34 other N.M. cities	38%
Total Urban	70%
RURAL	30%
Total State population	100%

35-735 - 91 - 3

URBAN/RURAL POPULATION
NEW MEXICO
July 1, 1986

BY COUNTY

	URBAN	RURAL	TOTAL
1. Bernalillo	467,400	7,000	474,400
2. Catron	-0-	2,700	2,700
3. Chaves	44,110	12,590	56,700
4. Cibola	8,520	14,480	23,000
5. Colfax	8,460	5,840	14,300
6. Curry	33,780	9,620	43,400
7. De Baca	-0-	2,400	2,400
8. Dona Ana	59,660	63,340	123,000
9. Eddy	39,470	12,930	52,400
10. Grant	11,190	15,810	27,000
11. Guadalupe	-0-	4,400	4,400
12. Harding	-0-	1,000	1,000
13. Hidalgo	-0-	6,100	6,100
14. Lea	46,670	18,230	64,900
15. Lincoln	5,260	8,340	13,600
16. Los Alamos	17,599	601	18,200
17. Luna	11,330	6,470	17,800
18. McKinley	27,981	37,819	65,800
19. Mora	-0-	4,600	4,600
20. Otero	37,175	13,025	50,200
21. Quay	7,630	3,970	11,600
22. Rio Arriba	7,900	25,300	33,200
23. Roosevelt	10,180	6,320	16,500
24. Sandoval	31,808	19,292	51,100
25. San Juan	60,627	31,373	92,000
26. San Miguel	15,620	9,680	25,300
27. Santa Fe	55,980	31,620	87,600
28. Sierra	5,880	3,520	9,400
29. Socorro	8,120	6,580	14,700
30. Taos	-0-	22,000	22,000
31. Torrance	-0-	9,000	9,000
32. Union	-0-	5,100	5,100
33. Valencia	11,950	24,450	36,400
	1,034,300	445,500	1,479,800

PERCENT OF COUNTY POPULATION RESIDING IN COMMUNITIES
WITH LESS THAN 5,000 INHABITANTS
NEW MEXICO
July 1, 1986

By County

1.	Catron	100%
2.	De Baca	100%
3.	Guadalupe	100%
4.	Hidalgo	100%
5.	Harding	100%
6.	Mora	100%
7.	Taos	100%
8.	Torrance	100%
9.	Union	100%
10.	Rio Arriba	76%
11.	Valencia	67%
12.	Cibola	63%
13.	Lincoln	61%
14.	Grant	59%
15.	McKinley	57%
16.	Dona Ana	51%
17.	Socorro	45%
18.	Colfax	41%
19.	Roosevelt	38%
20.	Sandoval	38%
21.	San Miguel	38%
22.	Sierra	37%
23.	Luna	36%
24.	Santa Fe	36%
25.	Quay	34%
26.	San Juan	34%
27.	Lea	28%
28.	Otero	26%
29.	Eddy	25%
30.	Curry	22%
31.	Chaves	22%
32.	Los Alamos	3%
33.	Bernalillo	1%

SMALL COMMUNITIES

The official map of the State of New Mexico, issued jointly by the N.M. State Highway Department and the Department for Economic Development and Tourism, contains an index that lists the cities and towns in the State. There are 495 communities on the list. Since there are only 35 communities with a population of 5,000 or more, the remaining 460, or 93% of the communities of the State, have less than 5,000 inhabitants each.

Senator DOMENICI. Thank you very much, Winnifred. Let me just say, with reference to the proposal that I made, I think I made it clear in the opening remarks that it is ambitious. One could gear it in different ways as to how it is phased in, but clearly Congress is looking for some reform, and it does appear to me that with the help of some wonderful people to work on it that it does offer a starting point for us to move in the direction of covering a lot of people that aren't covered, and maybe in a more reasonable cost manner than other proposals that are around.

So we are going to pursue it with a degree of vigor but we are not going to get it out even before this year is over. Nobody should think Congress is going to do this kind of dramatic change this year.

Ms. CONNOR. We are so excited over your proposal. It looks like a means to better service for the elders in the rural area as well as other frail elderly.

Senator DOMENICI. I also think that there are an awful lot of poor people that are not currently covered that would get covered by it, not necessarily seniors. We might be able to do it in a more reasonable manner than expanding programs we now have. I think that is what some of you-all told me; is that right?

Ms. FOLK. Absolutely.

Senator DOMENICI. In fact, depending on how you phase it in, it can be as reasonable, or it can offset as one wants to gear it. It can then change over time, but getting it started is important. Let me ask. Did you have anything that you would like to add, Seferino, to what Peggy testified to on behalf of your association.

Mr. MONTANO. No, sir.

Senator DOMENICI. Fine. Let me thank all three of you. Let me say to Karen, I am fully aware of the tremendously important role that home health care is playing. When we first started working together, it seems like only yesterday, but it was many years ago, and I think in spite of the difficulties, that we have to admit home health care has certainly grown. And everybody is aware of the fact that it is a mature and vibrant player in this delivery system. And I think it's clear, even if you look at the last report, the Pepper report, that some dramatic ideas about home health care and the expansion of it are beginning to get into the public arena.

I am not sure where we are going, but at least people understand that it might be one way to take care of the elderly in lieu of everybody having nursing homes that we have to pay for. And I think you ought to be excited about the new scope and new emphasis that's being given to it.

I understand it's still treated very differently from anything else. With regard to reimbursement, we have a lot of complaints. We work hard with—you and your members to deal with that, but I think it's coming of age and doing a wonderful thing.

Ms. WELLS. I also want to publicly thank you, Senator, for all your ongoing support and interest in home health care. You absolutely have been a great friend to us for a great many years. Thank you for that and thank you again for the opportunity to testify today.

Senator DOMENICI. Thank you, ladies. Our last panel, if we can get Lucy Montoya, from La Casa de Buena Salud from Portales—

Lucy, are you here? Come on. Let's get as many of you as we can to sit here. How are you, Lucy? I haven't seen you in 3 or 4 days. We have Margaret Burton, who is not feeling very well and is very frail, and I am going to let her go first. I think you can stay right there. You can get Margaret seated. Let me ask, is Paula Thomas still here? Paula, would you stand up? I didn't introduce Paula. If you would, look back, and shortly we are going to applaud her. She is with the University of New Mexico Geriatrics Center. We would have served ourselves well if we would have had her tell us all the wonderful things the University is doing in their Geriatrics Center, but I want to say that it's been my privilege to be helpful to you all and to be part of your effort. I am very proud of it. And I think you are doing a wonderful job in training those who treat our elderly and in may aspects of educating the elderly, and I thank you for it. And I thank you for coming here today.

Before we go to the other witnesses—which are going to be Lucy Montoya, Mary Aguilar, Olivia Reed—maybe, Olivia, you can get it where you can come in shortly—Jim Riebsomer, Presbyterian Medical Service—we are going to ask Margaret Burton, from Albuquerque, to tell us a little bit about the problems she has with transportation and the like. This is Margaret Burton. Margaret, you are how old?

Ms. BURTON. 62

Senator DOMENICI. 62 years old. And you have had trouble getting transportation to health care services?

Ms. BURTON. As you can see——

Senator DOMENICI. Why don't you tell us what you would like to tell us.

STATEMENT OF MARGARET BURTON, ALBUQUERQUE, NM

Ms. BURTON. Well, I fell, the first of the year, and broke my hip and wrist. And getting back and forth to and from the hospital and doctors and all, senior citizens' transportation has provided that for me, otherwise I don't know how I would have managed.

And in getting medical forms filled out to received my disability check has been quite a problem, due to the fact that the physicians wouldn't be able to sign it or fill the form out. The hospital has lost my records, or misplaced them, and we had a hassle trying to get information back to my insurance company.

And in May, when the disability through my employer went into long-term disability, they advised me to turn to Social Security and try to get my disability through Social Security. And I have done that, but I have been denied the first two steps already, and I have appealed for the administrative judge hearing, in which I have not had any indication on yet.

And it has just been a long hassle in trying to get my income available to live on. And in between the Medicare and Medicaid agencies, I am too rich for Medicaid and too young yet to get Medicare.

Senator DOMENICI. Unless your disability comes under Social Security?

Ms. BURTON. Right.

Senator DOMENICI. And you are applying for that now but have been denied?

Ms. BURTON. Yes, sir.

Senator DOMENICI. I don't want to make any promises, but if you need our office, we will be delighted to try to help you. I assume you have received professional assistance?

Ms. BURTON. Through Social Security——

Senator DOMENICI. All right. And your transportation, if you would not have had something from the senior citizens——

Ms. BURTON. I wouldn't have been able to have gone to the doctor as many times as I have. And it's a blessing to have the senior citizens.

Senator DOMENICI. Thank you very much, Margaret. We don't need you making your life difficult here. We are finished. We will go with the other witnesses and you do what is most pleasant for you at this point.

Ms. BURTON. Thank you very kindly.

Senator DOMENICI. Let's go to Lucy now, please. If the other witnesses want to join? Olivia, do you want to join? Mary Aguilar? All right, Mary. Lucy, would you start, please?

STATEMENT OF LUCY MONTOYA, LA CASA DE BUENA SALUD, PORTALES, NM

Ms. MONTOYA. Senator, I am here today in behalf of the elders. I am Lucy Montoya, Elderly Health Coordinator for La Casa de Buena Salud. We are a primary health clinic. I am here to testify how the primary care clinics are meeting the needs of the elderly.

La Casa has been in existence since 1976. And how it got started in Roosevelt County was due to the high infant mortality rate. And a lot of the people, concerned citizens in Portales, decided to get together and applied for a campaign for human development grant. It's a Catholic grant. That's how it got started.

I have been working for La Casa for 15 years. You know, it started out in a two-bedroom little house. We just had two little rooms to examine people. And now we have five examining rooms with three doctors and nurses. And I think we have, altogether, 20 staff. And our clinic offers the WIC program serving 540 women and children. We also have a comprehensive perinatal care program for the teenage population. We also have our senior center that is housed in the clinic, and the social services that we do for the community.

Senator DOMENICI. So you have put all those together?

Ms. MONTOYA. Yes, we have all that in-house.

Senator DOMENICI. Is there one board for everything, Lucy?

Ms. MONTOYA. There are two boards, on board for La Casa de Buena Salud that oversees over all. Then we have a senior citizens body that oversees the senior citizens center in its daily operation.

Senator DOMENICI. Does the board that oversees La Casa de Buena Salud also oversee the WIC program?

Ms. MONTOYA. Yes.

Senator DOMENICI. So all those workers are under that corporation?

Ms. MONTOYA. Yes.

Senator DOMENICI. That's very good.

Ms. MONTOYA. We do have a very good board, especially this year. However, you know, the various problems that I have seen working with La Casa, and since I do all the coordination of social services for the clinic, and run the senior citizens program, the problems I see is where they have Medicare problems and Medicaid problems, getting them into the Medicaid and Medicare.

The forms and application process takes—like this lady that was testifying—it takes about 6 months to a year before these people can get any kind of assistance. In the meantime, if there wasn't a primary care clinic like ours to take care of them, oversee them for a whole year for medication, for health care, these people would be without anything.

We also provide transportation to the clinic. We also provide transportation to doctors outside the clinic that we have to refer to. And because there are so many doctors in Portales that do not want to take care of Medicare or Medicaid, because of the paper work, then we have to transport them to Clovis, find out who takes them. This is provided through the senior center, and La Casa takes a lot of Medicare-Medicaid patients because we do all the paper work for them.

In my office, I do all the Social Security benefits for Roosevelt County. I do some for Curry County, because the people don't understand the forms and because they don't have transportation to go 25 miles one way to Clovis, and as many trips as they have to make with the paper work.

So I learned the paper work. I do all the paper work from the beginning until the yearly process, and hearing as their representative. I fill out all the forms for them. I provide transportation for them. And I still keep on after they get on the benefits, because they get all these notices that they don't know what to do.

"Like we are overpaid. You need to pay us back. We are cutting down your check because you didn't report this." You know, it's just a lengthy thing. So we feel if there were more senior citizen centers that could have directors like myself, trained to do all this paper work for them, they would be covering the majority of the people for all these processes.

Like other people here that testified, you know, by the time you go to one office, and you go to five more, you know, that person just does not have the stamina to keep up with it. I think one solution would be, if the State could get some money, to get senior center administrators trained to do this paper work and have it in-house, you know, that person could go to one place to get everything done.

Senator DOMENICI. What you are saying, Lucy, is if we are redoing the Older Americans Act, and we are involved in some aspects of centers, if I read you right, that we ought to provide flexibility to use the resources to establish within the center a one-stop shop for this kind of professional advice and assistance?

Ms. MONTOYA. Yes.

Senator DOMENICI. That's kind of what you are recommending, if I read you right?

Ms. MONTOYA. Since we have a transportation van, if we could get more money to transport these people. You know, you really

have one central place for the elderly to go to in each county and that person would try to provide, you know, the various assistance on the paper work and then transportation. But, of course, we need more staff, you know.

Senator DOMENICI. Lucy, do you think that the paper work for Medicare and Medicaid that you have to fill in—I assume it's predominantly for minorities; right?

Ms. MONTOYA. Well, I do it for even the younger generation that is disabled. So I either apply for help for them, apply for SSI, if they are indigent, and I do the Social Security benefits for people that are disabled, like this lady that has been testifying. We do the paper work for you, too, because she doesn't understand it, you know, and then the lengthy process and having somebody represent them. They can't afford to pay a lawyer. So I do that, too. You know.

Senator DOMENICI. I am just wondering if the problem you have—because I understood before you came here today because you told me about it—that this is a very important function at this center, and that you have to spend a great deal of time and effort, and it's a fight all the time. I wonder if this is a common problem, or in a bigger city, like Albuquerque, are people having that kind of trouble? Is this common to every area in the State? I don't know the answer to that.

Ms. MONTOYA. I think it is, because, like I said, the people that are applying for SSI, they have to be very indigent. That person is not going to have the money to pay a lawyer to represent her, so somebody has to go with her, or she represents herself, but they don't know what they have to do most of the time.

When they get the first denial, then they are discouraged and they don't go on, and they rely on their kids to support them. And, you know, families, where both have to work, and they really can't afford it. So a lot of them are not taking good care of themselves. They won't go to doctors, unless they have a clinic, where they can go to and they get all this help.

Senator DOMENICI. All right. You also wanted to tell me something about drugs, I think.

Ms. MONTOYA. The prescriptions. La Casa has had some money available to help people with prescriptions. And one problem that we see is that Medicare, you know, the people on Medicare, since the Medicare card does not pay for prescriptions, those are the people that are accessing our clinics. But because we have a limited prescription fund, we cannot help everybody.

There are elderly that are on Medicare, and Medicare pays for 80 percent of the hospitalization and doctor, but it doesn't pay for medication. They have a $200 to $300 bill for prescriptions that the clinic is having to foot the bill for them. We have got two patients right now I can think of that are on life-saving medication.

They had liver transplants. You know, the government has helped them pay for a $50,000, $60,000 operation, but if the clinics were not helping them with the life-saving medication, those people would be dead and it would be worthless to see that much money go down the drain when we can keep that person alive.

So if we could see some changes—I know your proposal is addressing some of it—to where Medicare, you know, would pay a

portion of that medication, especially for people that need life-saving, you know, medication that they depend on.

Another problem with Medicare is that when they get these new catastrophic changes, they up the Medicare deductible for hospitalization, and what happened was that now, every 60 days, if a person is sick, after every 60 days they have to pay the $592 deductible every time they go to the hospital. Back in 1989 it was just a once-a-year thing. They changed the hospital deductible, the 20 percent on top of that, and all medication costs.

So, you know we need to see a change there. And then people on Medicaid have problems even getting doctors to accept them, you know. They don't want to do the paper work. So they have to shop around. And it's hard, when they don't have ways of going to different doctors.

So I know that our clinics are real important. But we do need to have them expanded, more funding. Also the overload of what's going to happen when we get more people qualified for SSI assistance is the clinics don't have enough doctors to cover the population.

I mean we only have three doctors. We only have one primary care person that is so overloaded there is no way that we could take care of everybody in the community.

What is happening, the clinics are losing out on some of the Medicaid apportionment because they have to make an appointment with some other doctor when they need it. Before, we used to have a walk-in business. When Dr. George Lemon left, who was the very first full-time doctor we had back in 1976, he could see up to 70 persons a day. Now, since we have so many different doctors, and they are so specialized, we can't even see—maybe we can see half what he saw by himself.

Another problem is that the State is going to give some money for an outreach progam to try to qualify at least 30 percent more of the elderly, rural elderly, into Medicaid, get them into applying for SSI and all the benefits that they need. Well, with this increase, we know that primary care health clinics are really going to be overloaded, so we need to see that we have enough doctors available for these clinics and that we have enough money to support the medication process of it while they are waiting on the year's time.

That is why we have proposed a letter that we composed from the center that if the Medicaid would be on an as-need basis, those people would be taken care of their medication, you know. And I know your proposal at least tried to address some of the problems in rural areas and we are thankful for that.

Mary, I think, is one of my witnesses that can testify about what her problem is. You know, she had Medicare but she has a lot of problems.

Senator DOMENICI. Right.

Ms. MONTOYA. I will pass that on to her and thank you for trying to put something together that will help us.

[The prepared statement of Lucy Montoya follows:]

August 24, 1990

Senator Domenici & Hearing Panel:

My Name is Lucy Montoya, Elderly Health Coordinator for La Casa de Buena Salud, Inc. I am here to testify in behalf of the Primary Health Clinic on how they are meeting the health needs of the elderly population.

La Casa has been in existance since 1976. The reason it got started in Roosevelt County was for the high infant mortality rate. The low income people were not able to have prenatal care resulting in infant death at birth. People in the community got together and applied for Campaing for Human Development grant to start a Primary Health Clinic to serve the low income people.

I have worked for La Casa de Buena Salud, Inc. for 15 years. La Casa was started in a two bedroom house with one doctor, one receptionist, outreach worker and an Executive Director. Fifteen years later La Casa now has five exam rooms, three doctors, one RN, one LPN, two nurses aids. Other programs offered through La Casa is the WIC program serving 540 infants, children & pregnant women per month, Comprehensive Perinatal Care Program serving the teenage pregnant OB patients of La Casa and the community. Also offered through La Casa is the Senior Center and social services. As Senior Health Coordinator, I have found various problems that La Casa does try to assist in such as prescription cost, and medical needs. However, due to doctor shortage we have not been able to meet all the needs of the elderly population. My opinion is that Rural Health Clinics seem to be the cheapest way to meet the low income and elderly medical needs. With the new SSI outreach programs that the state is starting clinics like ours will be overloaded by taking care of these people until their SSI benefits get started. The waiting period for benefits is six months to one year. It is my feeling that if each Senior Center has a trained individual to do the paper work for the elderly we can help them to get their benefits sooner.

Other problems I see in my everyday contact with the elderly are the people who are on medicaid that go to other doctors due to the shortage of doctors at La Casa. Our doctors are booked one month in advance and our walkin policy is four people a day for each doctor. Another problem the elderly are facing is the hospital deductible of $592.00 per 60 days per ailment and an additional cost of 20% plus the high medication cost which medicare does not pay for. If La Casa was not around to absorb the cost of prescriptions, most of the elderly would be without their needed medication.

I have testimonies from various elderly who need for the hospital deductible under medicare to change to once a year like before. Also, if we could get an expansion on the medicaid program to serve those in need, a surtax or other means would have to be considered to fund the expansion. If the medicaid card could be issued on a needed basis we would not need a catastrophic insurance. The need for a Primary Health Clinic like La Casa needs to be expanded due to services that are provided to the elderly and low income population.

On behalf of the elderly and myself we would appreciate it if congress would take into consideration my testimony for a Primary Health Clinic and the elderly needs. With this I close my testimony.

Thank you,

Lucy Montoya
Elderly Health Coordinator

Senator DOMENICI. Next we have Jim Riebsomer with Presbyterian Medical Service. They oversee five rural clinics in northern New Mexico, principally in the Santa Fe area. And you are going to talk about some of the problems as it relates to seniors and generally the field of health care.

STATEMENT OF JIM RIEBSOMER, PRESBYTERIAN MEDICAL SERVICE, SANTA FE, NM

Mr. RIEBSOMER. That's correct. Thank you very much for the introduction. I appreciate it. Presbyterian Medical Service is a New Mexico nonprofit organization which provides comprehensive health and human services to central, southwestern, and northern New Mexico communities. Although the PMS organization is not a part of, nor does it receive any direct financial support from, the Presbyterian church, its programs are based on the historical "Medical Mission of the Church," that is, to respond to the unmet needs of rural New Mexico by providing services to those who would otherwise be without.

Senator DOMENICI. You have to move that mike up closer.

Ms. RIEBSOMER. Or talk louder? Is that better?

Senator DOMENICI. That's better.

Mr. RIEBSOMER. Presently, PMS provides services in the counties of San Juan, Catron, Rio Arriba, Santa Fe, Sandoval, McKinley, Taos, and Torrance.

Of our catchment population, 39.7 percent are Hispanic and 18.6 percent are Native American, and we provide some 70,000 outpatient visits per year.

Most of the PMS primary care sites are designated as Health Manpower Shortage Areas because of the problem of accessibility and provider shortages.

The rural areas where our clinics are located, not only serve those particular communities, but also surrounding remote areas that are sparsely populated and economically depressed. Consequently, there is limited access to health care. Housing, sanitation, unimproved roads, and telephones are often primitive and the majority of families have limited access.

Many of these rural areas are also geographically isolated from primary medical services, some by as much as 60 miles. To illustrate the types of problems patients experience in accessing medical care, I would like to relate an incident that is not at all a typical of our rural populations. Joe lives in Starlake, NM, which is 40 miles away from Cuba, a major metropolitan area of some 1,500 people. Joe fell and suffered a laceration of his leg. He waited 4 days before he could get a ride and then was transported in the back of a pickup to our facility in Cuba.

Transportation, difficult in optimal conditions, becomes impossible in the winter months. The frozen dirt roads become wet and muddy as the day warms up, making these roads impassable. Joe must leave his home early in the morning, before the sun warms the ground, and stay late or overnight so that he can return when the roads refreeze and again are passable.

This is an enormous inconvenience and expense for rural populations. By the time Joe arrived at the clinic, he had obviously com-

pounded his health problems. In addition to the laceration, his leg was grossly infected and was dehydrated, having gone untreated for so long. It was difficult for him to be treated on his initial visit, but for him to return for scheduled follow-up visits is almost impossible.

Food, health care, and social needs all depend on transportation. Yet in 1984, 75 percent of the rural elderly lacked adequate transportation. Transportation access can be somewhat improved by linkages with other agencies, where available. PMS has an additional problem in the provision of care to Native Americans. This population will seek care either from our physicians or the Indian Health Service, depending on which location they can obtain transportation to when they need medical attention.

Keeping track of this interagency flow is difficult. Also, many of the elderly Native Americans speak only limited English. And I might add, very few physicians speak much Navajo.

The reason cited most frequently by the elderly for not utilizing primary and preventative medical services is cost. The gap between what is covered by insurance and Medicare, and actual charges, leaves many elderly in dread of medical and dental bills which might wipe them out financially.

The elderly comprise 12 percent of the user base in the PMS clinic; however, the actual contact time with the medical providers often extends to an average of 30 minutes as compared to 10 to 15 minutes for most other patients. The medical needs of the elderly are complex and often require referrals to specialists in urban areas, further impacting their financial woes.

It is imperative that the elderly receive a managed case approach, and it is our supposition that by emphasizing the preventative, maintenance care, the total cost of care could be somewhat contained. This would require an implementation of a concept similar to perinatal care where a case manager is involved in monitoring the medical and social status of the patient and coordinating linkages with other agenices in the community.

The severity of the medical problems often warrant the need for multiple pharmaceuticals which again compound the problems of living on a limited fixed income. Clients often see a variety of medical providers, and if complete histories are not taken, or not given accurately, the result is poor medication management, complicating the medical condition and sometimes the mental condition. In our clinics, it is also apparent that the elderly are proud people and will hesitate to report the severity of their financial situation which often compromises the medical regimen.

For example, Catherine is a 74-year-old widow with no living relatives, who resides in a two-room, 50-year-old home, 12 miles from a clinic site. She has high blood pressure and is on Minipress with an order to take it three times a day. A month's supply costs $45. And since medication is not covered by Medicare she elected to only take one pill per day to extend her resources. Her blood pressure is not controlled and the possibility of a stroke or internal organ damage is not controlled and the possibility of a stroke or internal organ damage is possible.

Additional funds to assist her in meeting the cost of her care is critical. The cost of maintaining a post-stroke victim in an acute

hospital, or skilled nursing facility, or a nursing home for the remainder of her life often runs $20,000 to $30,000 a year.

For the elderly who live at or near poverty, for the millions of additional elderly who are medically indigent, and for those elderly who wish to remain in their communities, affordable medical services are essential. Clearly, changes in Medicare and Medicaid coverage and reimbursement should be implemented. The elderly must be assured that primary and preventative medical care is not a financial burden that they must avoid as long as possible. This, Senator, is, in our opinion, where your plan will help.

While rural Americans comprise 25 percent of the population, they are served by only 12 percent of the Nation's doctors and 18 percent of its nurses. The National Rural Health Association has as one of its top priorities rural health and the aging.

The medically underserved areas in this country continue to grow. Options to retain and improve medical personnel is a priority. Since salaries are often lower in rural areas, the perception is that there is less opportunity for professional growth and advancement. Additionally, the rural community is often viewed as a less attractive place to live and work.

The reality of the rural elderly is that they are grossly deficient in receiving services such as medical care, nursing homes, social services, Meals on Wheels, and transportation. Despite the population stereotype that "old age means dependency," the overwhelming majority of older people are never institutionalized, and lead productive and independent lives.

Senator, your goal to expand cost-effective preventive and primary care is also a top priority of ours.

Community health centers are certainly a partial answer in rural and underserved areas, but they cannot operate without appropriate funding. Funding must be adequate to ensure the availability of modern equipment, qualified personnel, and a high standard of care. Local communities and businesses are sometimes uninterested, or do not possess the financial support or tax base to establish and maintain social and health-related services for the rural elderly.

I wholeheartedly support your proposed legislation. We all realize it will not solve all your problems, but the time for new community health centers is here. The rural areas are in need of services, need to be funded. We have one set aside in Torrance County. Each year we submit our application, only to be told by the regional office that they agree with the need but there is no money.

Resources are needed to provide preventive health services. Additionally, expansion of the National Health Service Corps will help bring professionals back into our communities. However, as a part of that, we must accept the responsibility, as employers, we must keep them there. We must make sure that they have progressive pay, benefits, and continuing education, appropriate staffing. On-call schedules must be monitored to avoid practitioners from becoming burned out.

While health care may be big business in affluent communities, let you not forget it is also a vital need. Access to adequate medical care is a basic human need and should be available to all people,

regardless of their economic circumstances, geographic location, and age. Thank you.

Senator DOMENICI. Thank you very much, Jim. You know we have this growing shortage in rural areas of medical professionals. And I just haven't read up on it or asked. So let me just ask you. Is this peculiarly rural or is there a major change occurring in the availability of health professionals in the country?

Mr. RIEBSOMER. I think there are a lot of physicians available. I think that it's very, very difficult for them to go to rural areas. For spouses, it's difficult to get them to move away from things, especially when they know their husbands will be called on—depending on the situations—every weekend. To move them into remote areas, we are actually finding the majority of ours want to go, to commute from whatever the metropolitan area is, which is almost impossible.

Senator DOMENICI. Olivia, would you please give us your testimony? You gave me your written remarks and I will make them part of the record.

STATEMENT OF OLIVIA REID, CHAVES COUNTY J.O.Y. CENTERS, INC., ROSWELL, NM

Ms. REID. Good afternoon, Senator Domenici. I bring you greetings from our senior citizens in the great Pecos Valley. And I want to thank you on behalf of the senior citizens and our board of directors for the opportunity to address the Committee. Our seniors are suffering in the area of health care. Your neverending concern of our elderly population in New Mexico is greatly appreciated. I was asked to present the consumer perspective. And in a day when we should be progressive in our health care, we are actually regressing.

I want to read a letter from our elderly in Chaves County. These are their concerns:

"Our Most Honorable Senator Domenici: It is with great concern that we, the senior citizens of Chaves County, address the following issues regarding primary health care in our State: The new law charging doctors to fill out Medicare forms for patients is causing a threat to access to medical care for us. Please refer to Exhibit I."

And it's in the pink section in this book where they've got a notice that they got that effective September 1 the doctors have to fill out the forms for them.

"Some doctors have refused and warned us they will not take Medicare patients. We must pay cash in order to receive service" and therapy. There also is a letter from Casa De Medicina doctors, referring to that they might not be able to take Medicare patients. That letter is after the green section in the book.

"Most doctors are already charging us $5 to fill out Medicare forms and $5 more to fill out our supplement insurance," if we have it. "We are already having to pay cash for doctor's services and wait for Medicare and/or the supplement insurance to pay us.

"We simply cannot afford medical care anymore. Many of us suffer for lack of care due to lack of funds.

"Prescription costs have escalated immensely in the past year. We used to be able to purchase medication at affordable prices.

Today, most prescriptions exceed $20 and many are costing $40, $50 and $60 for one month's supply," or two weeks' supply. "Drugs are not covered by Medicare."

"Our Medicare insurance does not pay half of the cost of our medical care." If you will, refer to some of the exhibits after the orange section. "You will note the charge by the physician or service," and then it shows "less the Medicare approved accepted amount; less the 80 percent covered by Medicare, less the Gramm-Rudman percent cut." You will see that some of our people are having to pay more than half of the cost of the medical care.

"Medicaid eligibility has recently changed and, in some cases, is not paying for the medication. Many of us have not had an explanation of what the medical management physician or pharmacy block means." And that's in the form. "Many of us thought it meant Medicaid did not pay the physician or pharmacy. It took six telephone calls to get a definition. We found it means that certain persons can only see the physician or use the pharmacy that is indicated in the block. The bureaucracy is very confusing and leads us to have mental aggravations."

The small rural towns of Dexter, Hagerman, and Lake Arthur do not have a doctor. Hagerman and Dexter have the buildings, the equipment and all that is necessary for a nice clinic, but have not been able to recruit a physician. Where are the physicians that owe the Federal Government for their education?" And the health corps will certainly answer this question, part of it.

Senator DOMENICI. Part of it.

Ms. REID. Part of it, maybe. "Why are they not available to us? The City of Roswell is losing physicians to other communities. There are only one or two physicians in Roswell that will accept Medicare assignment.

"Our County Health Department only has limited facilities available to the elderly." The problems of the youth and prenatal are so great that they are trying to address those.

"Those services are only available on certain days and hours and some only once per month," if that often.

"Senator Domenici, we firmly believe that our primary health care begins with accessibility. We are in fear of losing that very important privilege. Our senior centers provide us transportation, assistance in filling out countless forms, making our appointments, interpreting for us," and so on and so on. And "we firmly believe that if not for our Older American's programs, we would have great unnecessary anxiety and lack of assistance in order to receive medical services. We are aware that Older American's program funds were cut and those cuts will affect our services. At a time when our health care is being threatened, so are our very necessary programs.

These programs are very necessary and important to us and have saved our State and Federal Government many dollars in the area of health care. Without these programs, our government would not have sufficient funds for nursing homes to care for us.

"We ask your assistance in helping us to obtain and maintain primary health care. Thank you most sincerely for your continued support and ever-caring assistance."

You will know there are 216 signatures on this letter, just in a period of 1 day at the forum insights we have.

I read with great interest your primary intervention health care proposal and I firmly believe that the items that are being addressed there, for health care in our rural communities, is a start toward progress. And I was going to offer the substitution of the mobile health units. I feel that this is very needed and will be able to serve more people. It's very difficult for us to take seniors to the doctor because each one has a different doctor at different appointed times, a different date, and especially when we are going 20, 30 miles from the city to take people, that we have a great problem in getting them there at the time that they have to be there.

One of the things that we have noticed at the senior centers is that active elderly have less health problems, and seniors living in the HUD housing programs have less health problems, and that is a very beneficial service for them. They are no longer isolated. They feel needed. They can visit with each other. They help each other out. And we have noticed that our seniors that live in these housing projects have less health problems.

One last thing I would like to address, CCI. Coordinated community and home care in our county has two providers to serve 47 people. And we have asked why we have to have two different administrations, two offices, two directors, two telephone lines, and so on, and so on, and so on. And we are told that this is to give the persons that are receiving the service the choice of service.

Those people need the service worse than they need the choice. And if we had one, and could use all that administrative cost to provide services to more than 47, we could do a much better job with that program.

Thank you, Senator Domenici. There are so many more things I could say. A lot of them have been said. We thank you for the opportunity.

Senator DOMENICI. Thank you. Thank you for all you do for the seniors. It is really a pleasure working with you. Now, Mary, did you want to talk with us a little bit about your problems? We understand that you came up with Lucy.

Ms. MONTOYA. Yes.

STATEMENT OF MARY AGUILAR, PORTALES, NM

Ms. AGUILAR. Senator Domenici, my name is Mary Aguilar. I am 79 years old. While I am working, I always sit down to talk to my members. I work, through Title V, with the Center of Los Abuelitos

as part-time director, 4 hours a day. I have been in this program going on 12 years this coming November. That's how long I have been there.

Senator DOMENICI. What is the program?

Ms. AGUILAR. Director of the Los Abuelitos Center in Portales.

Senator DOMENICI. All right.

Ms. AGUILAR. We are under La Casa de Buena Salud. Many complained about Medicaid and their medicines. So I got concerned about this. With me, I haven't gone through these problems. I never had gone through the Medicaid.

My husband, when he was alive, didn't have any Medicaid. All he had was Medicare and his Social Security check, which didn't amount to very much. He had $126 a month. We couldn't even afford insurance of any kind. All we depended on was his check and medicines. When he got sick he was 82 years old, and going on 83, and I started taking him to the doctor and putting him in and out of the hospital.

We paid for his medications out of our own money. He had his own Social Security and I had my own Social Security. So we shared what we could. He passed away November 3, 1989. That day I called Social Security to see if I could cash his check to use it for the mortuary cost and they said I could. So I used it that day. After that they called me. I was getting another check, $250. We used it for his funeral bills and that was the last of his check.

I kept my own and stretched it for my house rent and utility bills. Funerals cost a lot. So was the hospital and doctor. Medicare helped me with the X-rays. They send me two checks. I used them to pay for X-rays, and still I couldn't catch up. But with the help of my Lord, my God, I will, some day. That's why I am listening to the people in Medicaid. And thanks to the clinic, La Casa de Buena Salud, who has helped a lot of the elderly with medications and accepting their Medicaid, which absorbs the cost of 20 percent.

Also, La Casa de Buena Salud helped a lot of the elderly through the growing wiser program. Last year, Dr. Lemon gave 75 free physicals to older seniors in Roosevelt County, and they all appreciated this service.

According to the clinic of La Casa de Buena Salud, it can continue because it's the cheapest way for providing medical care, and it's accessible for the elderly.

Another concern is the hospital's deductible bill which is $592 every time they go into the hospital. Some elderly have to be hospitalized four times a year, and add to that 20 percent since the Medicare cards don't pay for medications. They have to depend on the clinic for help.

That's why I am concerned about the elderly and am always trying to listen because I went through it, as I had no Medicaid cards. I feel sorry for them. I never had been to hospitals or doctors. I just have my Social Security, and Medicare—I don't have Medicaid, and I haven't used my Medicare. Maybe some day I will, no telling when. And thank you very much for listening to my problems and God will be with you.

Senator DOMENICI. Thank you very much. I gather that it is generally agreed that the biggest problem you see on the senior citizen

primary care area is the fact that the program does not provide drugs?

Ms. MONTOYA. Yes, Medicare.

Senator DOMENICI. So if they don't qualify under Medicaid, then drugs is the biggest problem you see? And you have even added, specifically, you wonder why we perform a very, very expensive operation. You gave an example. And there are probably more. I think when I saw you before you gave me two examples, today you gave us one. Would you agree, Jim, that this is a major problem.

Mr. RIEBSOMER. Yes.

Senator DOMENICI. Olivia, you faced a number of problems but, obviously, pervading through it was, in addition to the bureaucracy, the doctors; they don't do prescription drugs which is a big problem?

Ms. REID. Big problem. Now we've got a new form that Medicaid will not cover the drugs. We don't know where we stand there on some of them.

Senator DOMENICI. Okay. Well, I really thank all of you. In particular, I thank you, Mary, for coming so far. You are the youngest traveler we have.

Ms. AGUILAR. I didn't answer the letter before because I was too upset. I'm sorry.

Senator DOMENICI. No, you are fine. Thank you for coming. And, Lucy, thanks for bringing her. Thanks to all of you. And for you who have been here this afternoon, we very much appreciate your opinion, attendance, and your listening.

So you know, there will be no significant health care changes in the next 60 days, which is about all we have got left in Congress. But there is a very, very dynamic activity, and dynamism, I should say, about where we go with reference to health care in the country. And I do believe we learn from hearings like this. I am very pleased with the comprehensive package that I have been presenting to New Mexicans.

Obviously, we don't know where the reform is going to go, but we all have to be aware of the fact that we have to find ways to deliver health care at the cheapest possible way. I don't think anybody is suggesting anything to the contrary. We don't know how to control costs yet. Every major program that we have, you-all should know, the costs are just incredible.

You want to know about Medicare, Part B? Not the hospital part, but the other part of which many people are totally unaware. Under that program the senior pays 25 percent, the Federal Government pays 75. We used to think it might cost $15 or $20 million. You should know that this year, just that program—which has nothing to do with hospitalization—that program is in the budget for $40 billion all by itself. And it is growing at 17 percent a year.

We figure in 2 years, just the Federal Government's portion of the Part B coverage for seniors will be $77 billion. Seniors pay 25, we will pay 75. It continues to have a $75 deductible, after which everything for the year is paid for out of this program. We don't know what's going to happen. How can we continue to pay for it? As I was telling Lucy, we have no idea where we are going to get the kind of money that is in that area.

The same Medicare program, the one in the trust fund, the one we take out of the paychecks, it is growing enormously. It looks like it will be bankrupt in 13, 14 years if we don't make any changes. So we are all looking for ways to reduce the costs so that we can add more coverage. Because we know access is a very big problem.

I personally want to tell you that I started being an advocate of the community health centers and I am not here today nor should I be talking about these centers as if they are the biggest delivery system in the Nation. Nonetheless, I have been interested from the early days, when they were formed, when I was working in the city government when we first started putting block grants together. I exerted my influence way back in 1980 and said "Let's leave the centers alone, not put them in any block." I think we saved them.

But, frankly, most health care programs have gone up 200, 300 percent. Yet, community health care funding has stayed almost constant, somewhere between $400 million and $440 million for the whole Nation. And about 4 months ago, we started putting the pencil to this proposal, saying, "What's the matter? Why is this? What is the absolute most economic way to deliver primary health care, in particular, in rural areas?" And in many places the only one.

It's no longer as controversial as it used to be. You remember, Lucy, when we started it? The doctors didn't want it. The pharmacists didn't want it. We started them here. Everybody fought them. It looks like there is kind of a new calm occurring because there is a place for this. And so what I want to do is increase it, by basically increasing Medicaid coverage for primary health care, and in a gradual way.

If we build more centers, they can be the providers. I am very concerned that in some cases the management doesn't go right, and I think those of you who are from Albuquerque know we have a very serious concern right here in our own community with one of the largest in the State. Not as large as some combined, but 40,000 served is a pretty good clinic. We have got something going wrong in the management and we can't afford to lose the program. What happens if we lose the Federal Government support? Where do all these poor people go?

So with all of this I want to thank you for attending and for your help. Many of you sacrificed to be here, and I thank you for it. We stand adjourned. If you need anything from the record, write myself and we will give you excerpts or whatever you might need.

[The proceedings were adjourned at 4:10 p.m.]

APPENDIX

Item 1

August 24, 1990

Dear Senator Domenici & Hearing Panel:

My name is Dr. George Lemon, I was the first full time doctor employed by La Casa de Buena Salud. A group of concerned citizens started the clinic after they received a grant from the Campaign for Human Development from the Catholic church to provide medical care for the low income people. The hispanic people of the community were not receiving the proper medical care. I moved to Portales because I had a heart attack and was looking for a place where I could treat people with my medical knowledge yet not something to demanding. I received my medical license from the Medical Board on February 15, 1977. I agreed to provide medical services for La Casa if they would agree to furnish me with an apartment, pay my malpractice insurance and move my belongings.

On the first day, we made a policy to see everyone who needed care. I did not speak spanish but my nurse would take the history and I would do the physical and she would translate for me. All of La Casa's staff were dedicated to the purpose of their jobs so we were able on many days to see 75 patients. The first two years working at La Casa I delivered 160 babies until the other providers in the community felt I was not qualified to do this service.

After July 1977, we were certified by the government and I received a small salary. After that, the clinic could obtain doctors who needed to work out their obligation for repayment of loans. Since my heart attack, I felt it best to resign and let the clinic get healthy full time doctors.

This type of clinic needs to see everyone who presents with a medical condition whether by a doctor, physician assistant, or a nurse practitioner. If patients can receive proper medical attention when needed at the clinic, it would be much cheaper then being treated in the emergency room or hospital.

Last year 1989, I was employed by La Casa once again to do the growing wiser health assessment for the elderly. Through this I found that most of the elderly patients had various medical problems such as diabetes, arthritis, and hypertension. All the physicals were provided free of charge to the elderly. This program was funded by a grant from the State Agency on Aging. This grant was a one time thing only but I feel it should be offered yearly to better the elderly population.

I feel dedicated to helping people and I regret that I have given up my medical license and cannot help these people get medical care. If you can help get monies to help clinics serve the people properly, it will be of real service.

Sincerely,

George Lemon, M.D.

Item 2

THE NEW MEXICO
SENIOR COALITION

LAS PERSONAS UNIDAS POR
LOS ANCIANOS de NUEVO MEJICO

fall 1990 newsletter

THE NEW MEXICO SENIOR COALITION is your state-wide non-partisan, voluntary membership organization to inform our legislators and others about important senior issues. By individuals and organizations joining forces to study measures designed to protect and advance the social and economic well-being of older persons, the Coalition seeks to mobilize, coordinate and provide a team format because "together we stand, divided we fall!"

PROPOSED OUTREACH PROJECT

Twenty percent of New Mexico elders (almost twice the national average) live at or below Federal poverty level. About 40% of those elders receive SSI. The New Mexico State Agency on Aging (SAoA) will oversee a statewide SSI Outreach Project to increase the SSI application rate by 30% and increase the SSI recipient rate by 10%.

These increases will result from the proposed project. The Incentive and Training Phase will provide cash incentives to eligible community organizations who identify, assist and refer potential SSI recipients. The training of participating community organizations staff, outreach workers and SSI* volunteers will occur in this phase.

Phase 2 - Project Institutionalization will continue the training of outreach workers and SSI volunteers to be located in 200 outreach sites throughout the state. Outreach workers and SSI volunteers will provide ongoing identification of, assistance to and referral of potential SSI recipients. Approximately 1,000 staff and volunteers will be trained in this very rural state where population density is only 12.2 persons per square mile. Notification of the award will not be released until late September.

THE PEER REVIEW ORGANIZATION

Are you eligible for Medicare? Do you know or believe you are being denied necessary medical care or receiving poor or inappropriate care? For a free basic consumer information booklet, send your name and address to : Pro Study Team, PO Box 36606, Albuquerque, NM 87176.

AD HOC COMMITTEE ON ADULT SERVICES

The fragmentation of adult services, and the lack of access for obtaining those services, especially in rural areas, has prompted the formation of a Ad. Hoc Committee to study and make recommendations for a more accessible and cost effective service delivery system.

The Committee, co-chaired by Corinne Wolfe, New Mexico Human Services Coalition, and Sarah Miller of the State Agency on Aging, will study information on a variety of plans used in eight model states for evaluation and possible implementation for use in New Mexico. Several sub-committees have been formed to work on nine areas of concern such as Continuum of Care, Access of Care for the Rural Elderly, Acute and Long Term Care, and other issues of concern.

language in the Older American Act at the time of award to deal more effectively with the rural elderly. There should be a set-aside in the Older Americans Act to distinguish between urban areas. Language should include percentages for rural transportation. In many rural areas transportation is not available on weekends because insurance does not cover Saturdays and Sundays. The funds earmarked for rural areas should include the insurance coverage cost.

Less than one half of the people in New Mexico who are eligible for SSI receive it. Many who are aware of the SSI program decline to participate for cultural reasons.

Funds for Volunteer mileage reimbursement are not available unless allocations are included for it in the appropriation. Middle income volunteers should be reimbursed for their expenses.

Howard Shaver, Director of New Mexico Hospital Association, testified as to what to expect or not to expect from a Health Delivery System. A National Health Policy should cover.

1. Transportation, both emergency and non emergency.
2. Adequate Health Care man-power. The present shortage is critical. There is a great need for mid-level practitioners.
3. Infrastructure is also very important. Access to base level care, regardless of income or location, is desirable. There are six or less persons per square mile in the frontier areas.
4. Access to base level care should be available regardless of income. To illustrate his point, Shaver referred to the status of the hospital in Cuba. following his testimony, Representative Roybal asked him to write a proposal to fund the health care facility in Cuba.

Henrietta Esquibel of Rio Arriba County testified that 20% of the population is underinsured. 77% of the residents are hispanic. Better reimbursement in order to improve the quality of life for seniors is needed. She was questioned as to whether, with two-year funding, La Clinica could again be a Demonstrative Project Model. She was also requested to prepare a proposal for consideration of federal funding and submit it to the Committee.

Nan Burns of Reserve in Catron County, one of New Mexico's most isolated rural areas, testified as to the need for rural access to services in her county. There are 600 Senior Citizens in 7,000 square miles of mountains. Catron County has one medical doctor, no dentist, no legal service, no social service or welfare office and no radio stations. Transportation is provided by one van from Reserve which makes 100 mile trips, one-way, to provide services. Homemaker service is very important as Catron County has no in-home care program. Dollars and staff will not permit full services in this county.

More vehicles and transportation funds, as well as more homemakers, are needed.

When applying for funds, and population numbers are considered, rural area services fall through the cracks. Every dollar spent in rural areas is important. There is greater risk of older persons for older persons to wind up in more costly nursing homes.

Jose Gander, an AARP representative, Also testified concerning the needs of rural areas in New Mexico. Medical care costs have spiraled upward due to inflation. There is a shortage of health care personnel in rural areas and a lack of geriatric training. Funding has not kept pace with inflation, and block grants are in danger of being cut or curtailed. Adult Home Care under Title 20 is underfunded.

NMSC LEGISLATIVE ISSUES FOR 1990 1991

1. Support for the State Agency on Aging Budget request.
2. In-Home Care Services and Continuum of Care.
3. Affordable housing for the elderly, especially room and board facilities that are needed in small cities in New Mexico to provide an alternative to nursing homes for many frail elderly. Help for the homeless is a special concern.
4. Support and improved transportation system, especially in rural areas.
5. General concern for the cost of health services which will provide comprehensive services to the elderly to prevent so many people from going unserved.

1990 SPECIAL LEGISLATIVE SESSION

The final budget for FY 1990-91 is $1.84 billion for the operation of all departments in State Government.

Coordinated Community In-Home Care has been allowed to keep the money it didn't spend last year, and is authorized to hire seven additional workers. This means there will not be cuts in the number of clients currently being served.

The CCIC program has had an 84% growth over the last five years. Consequently, there is a need in administrative staff to insure the program is properly administered.

--Don't send a boy to do a man's job--Send a woman!

SENATE BILL 185 requires all New Mexico Health Insurance Companies to provide coverage for mammograms.

SENATE BILL 293 Indigent Catastrophic Illness appropriated $1 million from the general fund to provide catastrophic hospital health assistance to medically indigent persons.

HOUSE BILL 488 PATIENT'S COMPENSATION FUND increased the amount of surcharge from 33% of the health care providers medical mal practice premium to 66% which will insure the solvency of that fund. It pays New Mexico medical malpractice claims in excess of $100,000.

--Some people won't admit their faults, but I would, if I had any.--

HB 124 PUBLIC EMPLOYEE RETIREE HEALTH CARE ACT - This Bill provides low cost health insurance for retired public employees. Many workshops have been held around the State to explain the implementation and provisions of this Act.

SB-310 INCOME AND CORPORATE INCOME TAX ACTS repeals all retiree pension exemptions for Federal, PERA and ERA retirees. The tax will start in the 1990 calendar year. No exemptions are allowed.

Stephanie Fallcreek, Director of the State Agency on Aging wants to alert us that the Older Americans Act is up for reauthorization. Senator Pete Domenici serves on the Senate Special Committee on Aging and would be interested in your comments. Representative Bill Richardson serves on the House Select Committee on Aging and would like to hear your comments too.

Among the many issues being considered are further efforts to improve targeting of resources to those who are in greatest need. Further the strengthening of the ombudsman program, consideration of the possibility of voluntary cost sharing of some services such as transportation, home care, nutrition, and instituting recommended donations or voluntary sliding fee scale for services under the Older American Act. Also possible increased federal funding for senior centers, senior programs and better coordination of community-based long-term care.

HEARING ON ACCESS TO SERVICES FOR THE RURAL ELDERLY

CONGRESSMEN Bill Richardson and Edward Roybal, Chairman of the Select Committee on Aging, conducted a hearing on Access to Services for Rural Elderly New Mexicans on June 23 in Santa Fe. Director of the State Agency on Aging Doctor Stephanie Fallcreek testified as to the social isolation of the rural elderly and the need to access all rural services. She pointed out that Transportation was the number one need to access services. The cost of doing business in rural areas is a problem in providing the delivery of services.

She stressed the need to amend the

THE NEW MEXICO SENIOR COALITION WILL ALSO SUPPORT OTHER CONCERNS AND NEEDS BENEFICIAL TO OLDER CITIZENS.

ENERGY ASSISTANCE FOR THE POOR

A significant proposed budget cut affecting older Americans is the presidents call for cut backs in aid for poor people who need help to pay their heating bills. The average LIHEAP benefit is about $200 a year. In 1989, only one of three households eligible for the fuel aid (six million of eighteen million households) actually received fuel assistance. Those eligible for fuel assistance are persons who receive a VA pension, food stamps or SSI will automatically qualify.

PASSIVE SMOKING-PASSIVE RISK

On June 25, the Environmental Protection Agency cited tobacco smoke inhaled by non smokers as one of the ten known carcinogens and estimated that it causes 3,800 U.S. lung cancer deaths each year.

EPA based its risk estimate on a review of 24 epidemiologic studies from eight countries and on two 1986 reports by the National Research Council and the Surgeon General, which blamed passive smoking as a cause of lung cancer and linked parents' smoking to lung disease in children.

DUNAGIN'S PEOPLE

"TWO FOR DINNER? SMOKING OR SECOND-HAND SMOKING?"

EPA simultaneously released another draft document recommending that employers either forbid indoor smoking or provide "enclosed, separately ventilated smoking rooms." Science News, Vol 138.

ENMU CONDUCTS 'UPWARD BOUND' AID PROGRAM

Eastern New Mexico University is conducting the "Upward Bound" program, a college-based program of academic instruction, tutoring and counseling for eligible high school students. Most of the students are the first generation of their families to consider a college education. Forty-six students from area high schools are participating in the six-week program. CNJ.

MEDICARE ANYONE?

Are you eligible for Medicare? Do you believe you are being denied necessary medical care or receiving poor or inappropriate care? For a free basic consumer information booklet, send your name and address to:

PRO Study Team
PO Box 36606
Albuquerque, NM 87176.

OLDER AMERICAN ACT ANNIVERSARY

WASHINGTON (AP) - The Older Americans Act marks its 25th anniversary next year and already is being used to call attention to a law that underpins the growing network of social services for the nation's elderly.

On Capitol Hill, where the act is widely viewed as a success story that has enhanced the independence and dignity of older Americans, Congress is preparing to do some fine tuning for the law's 1991 reauthorization.

But some supporters of improved aid to senior citizens say they are concerned that President Bush has yet to call the 1991 White House Conference on Aging, regarded as a once-in-a-decade spur to improving the nation's care network for the elderly.

In a letter to Bush late last year, members of the Senate Select Committee on Aging urged him to call the conference and focus it on long-term care for vulnerable people of all ages.

Since then, Sen. David Pryor, D-Ark., the committee chairman, and Sen. John Heinz, R-PA., have introduced a resolution calling on the president to move on the issue.

"I am perplexed and disturbed at the president's delay in calling this important conference," Pryor said.

The first White House Conference on Aging, held in 1961, is credited for laying the groundwork for the Medicaid program, adopted four years later. Conferences have been held every decade since with the aim of providing a look forward at the needs of the aging population.

Congress last took a comprehensive look at the problems of the elderly in 1987 when it overwhelmingly approved a four-year, $6.8 billion reauthorization of the Older Americans Act.

The Act provides funds for senior centers, meals on wheels, transportation for the elderly, legal assistance, health programs, adult cay care, counseling, employment opportunities and programs for the frail elderly at home, and for older Americans in nursing homes.

"Of the Act's many achievements, none is greater than the establishment of an aging network of committed federal, state and local agencies, as well as service providers, dedicated to providing desperately needed social services to our nation's elderly," Pryor said.

Pryor's committee has begun a series of workshops examining issues and options as work begins on the work of the basic law.

Two leading issues under discussion include:

- The possibility of voluntary cost sharing for the recipients of such services as meals on wheels who can afford it. Some worry this might lead to the establishment of a means test or to distorting basic services, with those able to pay receiving a higher quality of service than those who are not.

- Information and referral: creating a system to link people in need with existing services.

Pryor will hold workshops next week to explore the possibility of improvements in legal services for the elderly and in the existing system of ombudsmen who field complaints from senior citizens about the quality of services they receive.

Representatives from state and local ombudsmen's programs will examine such questions as whether the program should be expanded, how to recruit competent personnel, and what barriers exist to doing an effective job.

The program was added to the act by Congress in 1978 to help resolve the complaints of residents in nursing homes and other care facilities.

Pryor's committee also plans to examine the effectiveness of the U. S. Commission on the Aging, the prime coordinating group for government services for the elderly.

"I intend to make concrete proposals designed to improve and strengthen a number of services funded by the Older Americans Act," Pryor said. "These include transportation, information and referral, ombudsmen, legal services and nutrition programs."

As the time approaches for making changes in the Older Americans Act, suggestions also are coming from representatives of the private organizations with interest in the elderly and their problems.

The National Association of Area Agencies on Aging says it is coordinating a campaign to increase federal programs, complaining that a decline in spending over the decade has led to a gradual reduction of services and longer waiting lists.

The National Council on Aging is urging Congress to earmark at least $20 million to expand nutrition and exercise classes, information on the safe use of medication, and meals featuring low-fat, high fiber foods.

Daniel Thursz, the council's president, told a House Human Services subcommittee earlier this year that effective and widespread health promotion services would reduce the growth of funds being spent for treatment of health problems.

He complained that the $5 million authorized for such services when the Older Americans Act was renewed in 1987 has not yet been spent. "What is tragic is that thousands of centers are offering useful but thin preventive health services to the nation's most at-risk population." he said.

"With modest forms of support services, such as hot meals and help with basic home care needs, including bathing, dressing and grooming, these people can continue to live in the setting they

consider home," Pryor said.

CONFERENCE HIGHLIGHT OF THE YEAR

The twelfth annual New Mexico Conference on Aging will be held beginning at 1:30 PM, September 5 through noon on September 7, 1990 at the Glorieta Baptist Conference Center.

The Conference, entitled "Meeting Human Needs; an Agenda for the Nineties" will feature a wide range of 78 different subjects from which to select. This year's conference will focus on four areas:

1. Continuum of Care - includes health, mental health, social services, support services (eg Housing), quality of care issues, cost effectiveness, distribution of resources, integration systems.

2. Intergenerational Sharing - includes new directions, opportunities for mutual enrichment, problem solving in areas of mutual concern.

3. Personal Development - includes life long learning, self improvement, leisure and recreation.

4. Resource Development - includes financing, volunteers, providers, public/private partnerships.

Participants are invited to focus attention on one area or to sample them all.

Continuing Education Units will be available through the New Mexico Health Care Association and the University of New Mexico, division of Continuing Education.

The New Mexico Senior Coalition is one of the 20 Conference Sponsors.

For Application forms or information, contact your local Aging office, or call or write to the

State Agency on Aging
224 East Palace Avenue, 4th floor
Santa Fe, NM 87501 or
call TOLL FREE 1-800-432-2080

SMOKING TAKES 18 YEARS!

Men who smoke cigarettes throughout their lives will die nearly 18 years earlier than men who never start, according to a new study published in Contingencies, the journal of the American Academy of Actuaries. "The data... indicates that a 30-year old man who smokes will reduce his life expectancy, on average, from 82 to 64, the researchers say.

Earlier estimates had been between 5 and 12 years, but this study is considered far more accurate because it measures the effects in an entire community of Erie, PA. from 1972 to 1974.

ENVIRONMENTAL TOBACCO SMOKE

Nonsmokers who live with smokers have a 20-30% higher risk of dying from heart disease than do other nonsmokers, says a new study by Stanton Glantz.

In a presentation at the World Conference on Lung Health in Boston, he reported that "passive smoking causes heart disease, and the number of deaths due to heart disease is 10 times higher that the number due to cancer."

"The heart disease deaths (32,000) combined with the cancer deaths make passive smoking the third leading cause of preventable death, behind smoking and alcohol."

UNSUNG HEROS OF AMERICA

Public employees. The expression should immediately conjure the image of a valuable national resource. Yet many Americans are unaware of the remarkable range of skills our government workers bring to national life and the contributions they make to society

Public employees are scientists, social workers, health workers, teachers, brick masons, shipbuilders, doctors, lawyers, postal workers, electricians, secretaries, veterinarians, engineers and more. Federally employed mathematicians and physicists launch our spaceships and County agricultural agents recommend rotation practices to the nation's farmers.

Public employees develop treatment and cures for disease. They build and repair our Navy's ships. They make sure the food we eat is safe. They guide our commercial airliners, monitor the flow of commerce and provide for the timely payment of over 36 million social security checks each month.

RURAL ADVOCACY COALITION FORMED

CLAYTON - Concerned citizens in New Mexico's small towns and unincorporated areas are banding together in a newly formed rural advocacy coalition designed to promote common economic interest at the state and federal levels. After nearly a year of preliminary planning and organizing, more than 50 charter members formally adopted bylaws for Advocates for Rural New Mexico at the first annual meeting held in Clayton in March.

Joy Hopson of the Clayton/Union County Economic Development Commission was elected president of the new grassroots organization. Following the first executive board meeting held in Santa Fe in April, Hopson said the coming year will be dedicated to getting the organization off to a solid start by building a statewide membership and advocating fairer representation for rural areas.

"I'll do my best to promote cooperation among all small New Mexico communities, to attain recognition of rural areas by the state legislature and the congress, to help small communities realize their goals and to inform the public about the good quality of life in rural New Mexico," Hopson promised. "Rural residents represent 43 percent of the state's population and deserve to be heard!"

Other officers elected at the public conference were: Vice president, Eugenio Lujan of Santa Rosa; treasurer, Ron Graham of Estancia; and secretary, Poliqa Robisnon of Anton Chico. A total of 14 New Mexico counties are represented on the initial board which hopes to have representation from all 33 counties by the end of the first year.

The idea for Advocates for Rural New Mexico was initiated April 26, 1989 at a seminar for Rural Economic Development sponsored by the Santa Rosa Economic Development Commission. Andres S. Hernandez, a local leader and retired U.S. State Department employee who worked on rural development issues abroad, cultivated the organization. "We need to all be concerned about the economic welfare of small town in New Mexico," said Hernandez, who was appointed chairman of the membership committee at the meeting.

Individual memberships in the advocates organization were set at $20 annually. Anyone interested in becoming a member can obtain an application from ARNM Treasury, PO Box 407, Estancia, NM 87016. For more information on Advocates for Rural New Mexico, contact Hopson by phone at 374 9250.

"Membership in ARNM is targeted for residents of unincorporated areas and small communities with populations under 5,000" Hopson said, "This coalition will be taking a strong stand on issues which impact rural New Mexico economically and environmentally." Santa Rosa News

GET INVOLVED!

Now is the time to seek support or commitment from candidates for those issues of importance to your community. Contact your local Area Agency on Aging for a summary of the issues presented at the grassroots forums held in most communities in the state. Also, contact your Congressmen in person or by phone or write them letters asking them to support the Federal issues that affect your programs. They need to hear about New Mexico problems and your suggestions for improving services to you and your community. Let them know how they can best represent the people of New Mexico.

NEW MEXICO INCOME TAX ON RETIREMENT PAY

The New Mexico Legislature last session canceled all exemptions on retirement pay of the elderly. Previously, some retirement pay was totally exempt from income tax, other retirement pay was exempt up to $3000 and the retirement pay of others was not exempt.

Your support is needed to standardize an exemption for all retirees regardless of the source of their retirement pay. Our elderly retirees should receive a break. Most States exempt up to $10,000 or more of a retirees pay and many states exempt all retirement pay.

In New Mexico, we expect to organize an effort to get our Legislators to enact a measure that will provide for a $3000 retirement pay deduction regardless of the source of the retirement. If passed, mail carriers, railroaders, school teachers and all other retirees would then be able to have the first $3000 of their retirement pay exempt from income taxes.

Item 3

IMPORTANT CHANGES IN MEDICARE

If you have Medicare Part B, please read this notice.

BEGINNING SEPTEMBER 1, 1990, YOUR DOCTOR OR THE COMPANY THAT FURNISHES MEDICAL SERVICES, EQUIPMENT OR SUPPLIES MUST PREPARE AND SUBMIT YOUR MEDICARE CLAIMS FOR YOU FOR ALL PART B SERVICES.

- Your doctor or medical supply company MUST send in the claim even if they do not agree to accept the Medicare approved amount as payment in full.
- They CANNOT charge you extra for preparing and submitting the Medicare bill for you.
- If they do not agree to accept the Medicare approved amount as payment in full, you are responsible for paying the whole bill; the Medicare payment will be sent to you.
- If they refuse to prepare and submit your Medicare claim for you, you should contact your Medicare carrier.

If you have any questions about the information on this card, you can call or write your Medicare carrier. You can find the address and phone number in the Medicare Handbook.

U.S. Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Item 4

HOSPITAL INSURANCE (PART A):
BENEFIT PERIODS

Two segments of Medicare's Hospital Insurance--inpatient hospital care and skilled nursing facility care--are paid on the basis of benefit periods. (Hospice care also has benefit periods that differ from inpatient hospital and skilled nursing facility benefit periods.)

A benefit period begins when the beneficiary enters a qualified hospital and ends when the beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days. A new benefit period begins the next time the beneficiary enters the hospital. There is no limit to the number of benefit periods the beneficiary can have.

Within each benefit period the beneficiary is entitled to up to 90 days of inpatient hospital care and up to 100 days of inpatient skilled nursing care. These amounts are restored in full each time a new benefit period begins.

For the first 60 days of inpatient hospital care in a benefit period in 1990, the beneficiary is responsible for the first $592 of expenses (the inpatient hospital deductible) and for the cost or replacement of the first three pints of blood per benefit period. Except for these deductibles and the charges for a few noncovered services, Medicare hospital insurance pays for all the covered services that the beneficiary receives in the first 60 days in each benefit period.

For the 61st through the 90th day of inpatient hospital care in each benefit period in 1990, Medicare hospital insurance pays for all covered services except for $148 per day per benefit period.

The 90 days of inpatient hospital care in each benefit period does not have to be consecutive. As long as the beneficiary is never out of the hospital or skilled nursing facility for 60 consecutive days, he/she remains in the same benefit period and will not be liable for another $592 deductible upon readmission to the hospital.

If a beneficiary ever needs to use more than 90 days in a benefit period, he/she can use his/her lifetime "reserve days" which are 60 additional days of available inpatient hospital care. These 60 days are not renewable. Once a day is used, it is not replaced at the beginning of the next benefit period. For each "reserve" day used Medicare pays for all covered services in 1990 except for $296 per day per benefit period.

If a beneficiary remains hospitalized after the 90th day in a benefit period, he/she does not have to use "reserve" days. He/she can notify the hospital that some other method of payment will be used to pay for any days of inpatient hospitalization beyond the 90th day.

During 1989, inpatient hospital care and skilled nursing facility care did not have benefit periods. For inpatient hospital care the beneficiary was responsible for the first $560 of expenses per year (the inpatient hospital deductible) and for the cost or replacement of the first three pints of blood per year. The beneficiary was entitled to 365 days of inpatient hospital care with no coinsurance.

HOSPITAL INSURANCE (PART A):
BENEFIT PERIODS

1990

- Begins when a beneficiary enters a qualified hospital
- Ends when the beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days
- No limit to the number of benefit periods a beneficiary can have
- Coverage for up to 90 inpatient hospital days
- 190-day lifetime limit on inpatient pyschiatric hospital services
- Inpatient hospital deductibles
  - $592 per benefit period
  - Cost or replacement of the 1st 3 pints of blood per benefit period
- Inpatient hospital coinsurance
  - $148 per day for days 61-90
  - $296 per day for days 91-150 (lifetime "reserve" days)

1989

- Inpatient hospital and skilled nursing facility benefit periods eliminated
- Unlimited coverage for 365 days per year (except for 190-day lifetime limit on inpatient psychiatric hospital services)
- Inpatient hospital deductibles
  - $560 per calendar year
  - Cost or replacement of the 1st 3 pints of blood per calendar year
- Inpatient hospital coinsurance eliminated

Benefit Periods

A benefit period is a way of measuring your use of services under Medicare hospital insurance. Your first benefit period starts the first time you enter a hospital after your hospital insurance begins. A benefit period ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods you can have for hospital and skilled nursing facility care. However, special limited benefit periods apply to hospice care (see page 10).

Here are two examples of how the benefit period works:

Example 1: Mrs. Jones enters the hospital on January 5th. She is discharged on January 15th. She has used 10 days of her first benefit period. Mrs. Jones is not hospitalized again until July 20th. Since more than 60 days elapsed between her hospital stays, she begins a new benefit period, and her hospital insurance coverage is completely renewed.

Example 2: Mrs. Smith enters the hospital on August 14th. She is discharged on August 24th. She also has used 10 days of her first benefit period. However, she is then readmitted to the hospital on September 20th. Since fewer than 60 days elapsed between hospital stays, Mrs. Smith is still in her first benefit period and the first day of her second admission is counted as the 11th day of hospital care in that benefit period. Mrs. Smith will not begin a new benefit period until she has been out of the hospital (or skilled nursing facility) for 60 consecutive days.

Medicare hospital insurance helps pay for most but not all of the services you receive in a hospital or skilled nursing facility or from a home health agency or hospice program. There are covered services and noncovered services under each kind of care. Covered services are services and supplies that hospital insurance pays for.

Hospitals, skilled nursing facilities, home health agencies and hospices are participating providers under the Medicare hospital insurance program. They submit their claims directly to Medicare—you cannot submit claims for their services. The provider will charge you for any part of the hospital insurance deductible you have not met and any coinsurance payment you owe.

When a hospital, skilled nursing facility, home health agency, or hospice sends Medicare a hospital insurance claim for payment, you get a Medicare Benefit Notice that explains the decision made on the claim. If you have any questions about the notice, get in touch with the office shown on the notice.

WHEN YOU ARE A HOSPITAL INPATIENT

Medicare hospital insurance helps pay for inpatient hospital care if all of the following four conditions are met: (1) a doctor prescribes inpatient hospital care for treatment of your illness or injury, (2) you require the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare,* and (4) the Utilization Review Committee of the hospital or a Peer Review Organization does not disapprove your stay.

If you meet these four conditions, Medicare will pay** for up to 90 days of medically necessary inpatient hospital care in each benefit period.

During 1990, from the 1st day through the 60th day in a hospital during each benefit period, hospital insurance pays for all covered services except the first $592. This is called the hospital insurance deductible. (A deductible is an amount you owe before Medicare begins paying for services and supplies covered by the program.) The hospital may charge you the deductible only for your first admission in each benefit period. If you are discharged and then readmitted before the benefit period ends, you do not have to pay the deductible again. And if you paid a hospital deductible in December of 1989, you do not have to pay a deductible again in January if you are still a patient in or are readmitted to a hospital in January of 1990.

From the 61st through the 90th day in a hospital during each benefit period, hospital insurance pays for all covered services except for $148 a day. This daily amount is called hospital insurance coinsurance. The hospital charges you the $148.

Page 7 explains how hospital reserve days can help with your expenses if you need more than 90 days of inpatient hospital care in a benefit period.

*Under certain conditions, Medicare helps pay for emergency inpatient care you receive in a non-participating hospital.

**Medicare pays for only limited care in an inpatient psychiatric hospital (see page 8). The hospital can tell you about these limits.

Medicare hospital insurance does not help pay for your doctor's services even though you receive them in a hospital. Doctors' services are covered under Medicare medical insurance. Page 12 tells how Medicare helps with doctor bills.

Major services covered when you are a hospital inpatient

Medicare hospital insurance pays for these services:

- A semiprivate room (2 to 4 beds in a room)
- All your meals, including special diets
- Regular nursing services
- Costs of special care units, such as intensive care or coronary care unit
- Drugs furnished by the hospital during your stay
- Blood transfusions furnished by the hospital during your stay
- Lab tests included in your hospital bill
- X-rays and other radiology services, including radiation therapy, billed by the hospital
- Medical supplies such as casts, surgical dressings, and splints
- Use of appliances, such as a wheelchair
- Operating and recovery room costs, including hospital costs for anesthesia services
- Rehabilitation services, such as physical therapy occupational therapy, and speech pathology services

Some services not covered when you are a hospital inpatient

Medicare hospital insurance does not pay for these services:

- Personal convenience items that you request such as a telephone or television in your room
- Private duty nurses
- Any extra charges for a private room unless it is determined to be medically necessary

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 19.)

Hospital Inpatient Reserve Days

We said earlier that Medicare helps pay for your care in a hospital for up to 90 days in each benefit period. But Medicare hospital insurance includes an extra 60 hospital days you can use if you have a long illness and have to stay in the hospital for more than 90 days. These extra days are called reserve days. Once you use a reserve day you never get it back. Reserve days are not renewable like your 90 hospital days in each benefit period.

During 1990, hospital insurance pays for all covered services except $296 a day for each reserve day you use. You are responsible for paying this $296.

You have only 60 reserve days in your lifetime, and you can decide when you want to use them. After you have been in the hospital 90 days, you can use all or some of your 60 reserve days if you wish. But you do not have to use your reserve days right away if you do not want to. Some private insurance plans help pay Medicare hospital bills for illnesses that keep beneficiaries in the hospital for more than 90 days.

If you do not want to use your reserve days, you must tell the hospital in writing before your 90th day. Otherwise, the extra days you need to be in the hospital will automatically be taken from your reserve days.

Coverage of Blood Under Hospital Insurance

Hospital insurance helps pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration. If you receive blood as an inpatient of a hospital or skilled nursing facility, hospital insurance will pay for these blood costs, except for any nonreplacement fees charged for the first 3 pints of whole blood or units of packed red cells per calendar year. The nonreplacement fee is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

You are responsible for the nonreplacement fees for the first 3 pints or units of blood furnished by a hospital or skilled nursing facility. If you are charged nonreplacement fees, you have the option of either paying the fees or having the blood replaced. If you choose to have the blood replaced, you can either replace the blood personally or arrange to have another person or a blood assurance plan replace it for you. A hospital or skilled nursing facility cannot charge you for any of the first 3 pints of blood you replace or arrange to replace. (If you have already paid for or replaced blood under Medicare medical insurance during the

Item 5

(Date)

The Honorable (name of Senator or Representative)
(address)

Dear (Senator or Congressman) (name):

We, retirees and disabled people, depend on Social Security, Supplemental Security Income (SSI) and COLA's from pension income to survive financially. Congress is constantly threatening to freeze Social Security, SSI and COLA's in order to deal with the huge national debt we are facing.

We feel Congress should consider the following suggestion:

> Place a surtax on everyone who pays income tax. This surtax would be used exclusively to increase the budget of the Department of Health & Human Services. We also suggest that the present ceiling on eligibility guidelines for SSI and medicaid be changed to a need basis. The present ceiling now results in people refusing to take on employment and/or accepting COLA's which would put them over the eligibility guidelines and thus losing the benefits they now receive.
>
> Individuals who qualify for SSI and medicaid get medical care and other support services which help them to live productive lives. But, those individuals who are slightly above the eligibility guidelines receive nothing. We strongly believe there should be a sliding scale so those individuals who are slightly over the eligibility guideline would qualify for medicaid and SSI.

Congress may have other ways of addressing the national debt than the surtax we suggest. We do hope you agree, however, that we need to increase the budget for the Department of Health & Human Services so that more individuals can obtain SSI & Meddicaid. We urge you to do something because the elderly and the handicapped are being affected. The high cost of medical service and prescription medicine are leaving them poorer than they already are. The new changes in medicare will also impose a financial hardship on the elderly. The elderly will now have to pay a $592.00 deductible per benefit period. Since Congress adopted the new system that sets medicare payment on a "per ailment" basis, the elderly are faced with additional medical expenses. Under the present system, medicare's payment to a hospital will never exceed the Congressional established ceiling for a particular ailment. Because of the ceiling on payment, hospital's are discharging patients to nursing homes or similar extended facilities. Often, this results in the elderly or their family incurring the cost for this service.

In debating the problem of our national debt, we urge you not to affect those programs that help the elderly. We urge you to remember that the elderly are the majority of the population who vote. Congress needs to act in a responsible way. We hope you realize that enacting laws that negatively affect our Social Security, SSI or COLA's will result in our working to elect individuals to represent us in Congress who will be sympathetic to our needs.

Sincerely,

(name & address - need to have address)

8-27-90

My Name is Juan E. Borela
525-54-0926 I am 60 yrs old and
I get Social Security disablity
Benefits. I get the Medicare
Card But it dosent pay
for Medications. My athritis
Medication cost me $80.00 a
month. I do with out
Medicin Because there month
I Can't afford it due to
other expense. Every time
I have to go to the
hospital I have to pay
$592.00 Deductible, plus the $25.00
medical deductible. If somethin
is not done about all
the Cost, us disabled Senior
Can't not make ends meet.
If the Medicare Card could be
issued on need Basis then
us disabled, elderly could have
Better medical Care. I
Can't afford Supplemental Insurance.
Alot of Doctors dont accept Medicare
because they dont want to bother
with the paper work so we have
to find a Doctor that does.

or we go to La casa de Buen Salud Health Clinic, Because they do accept Both Cards. and we dont have to pay the 20%. Health Clinics like La Casa are very important to us elder and low in come people. So we need for this Clinic to get funded and expended to be able to serve the needs of the low income people and elderly.

Sincerely

Juan E Barela
1015 Calhoun
Clovis N.M. 88101

My name is Shirley Clingenpeel, S.S. number 525-80-9264, and I am 54 years old. As A child I had polio, which left me with a deformed pelvic bone and the left leg shorter. In 1974 I had 3 surgeries with a bone graft and a plate in the right leg.

In November of 1988 I filed for disability benefits as I could no longer stand for very long and was on pain medicine daily, but as of today, my hearing have been turned down. Also I tryed to work part-time, and have a letter from Cannon Air Force Base, saying that I wasn't qualified for clerical or physical work.

In regard to our clinic here, LA CASA DE BUENA SALUD, it is very much needed for the elderaly who have a very limited income, and also for the families of low income, otherwise these people would be forced to be without medical attention. Our Drs. have been very generous in giving of their time and attention, and I want to especially mention Dr. Helak, for treating my grandson and other children, of low - income families.

Thank you so much for representing the people of New Mexico in the Senate, we appreciate your time and effort very much.

Yours truly,

Shirley Clingenpeel
500 N. Ave. B
Portales, New Mexico 88130

August 23, 1990

TO: Senator
RE: MedicAre

Dear Senator,

I would like to request your assistance in helping me retain my medicade card.

I am a 47yr old man who was diagnosed with diabetes less than two years ago. I now suffer from Proliferative Diabetic Retinopathy which causes blindness. Aside from this, I also have hypertension and the diabetes is beginning to affect my kidneys. In order for me to continue improving or stablize my disease I need to be in doctor care constantly.

During this time of hardship I was being assistanced through the Supplemental Security Income I was furished with a medicade curd to help my medical finances.

I recently recieved a letter stating that I was entitled to recieve disability benefits from Social Security beginning in August 1990. I am to recieve a total of $518.00 monthly. In connection with this my medicarde would be

terminated. I find myself in a difficult situation unable to forsee how I can support my family of five and continue with my medical treatment on a limited income. My medication themself run between $50 to $70 dollars depending upon my health. I have enclosed a record of my prescriptions. If the situation was to arise that I needed to be hopitalized, I could by no means be able to cover my medical expenses. also I'm not entitle medicare coverge until 24 mos later.
This is why I ask for your assistance in helping me to keep my medicade.

Thank You,
Timoteo F. Hernandez

Timoteo F Hernandez
449-70-9605
1513 N. Main
Portales, NM 88130

08-23-90
07-01-90 TO 08-23-90

MARTY'S PHARMACY INC .
1400 SOUTH AVE Q
PORTALES,NM 88130
(505) 356-8551

PAGE 1

RECORD OF PRESCRIPTIONS FOR:
TIMOTEO HERNANDEZ
1513 N MAIN
PORTALES,NM 88130

RX #	DATE	DC DATE	DRUG		RPH	QTY	RFL
267983	8-10-90		AXID 300MG	77.10	JEE	30	3
			00002-3145-30 300MG C	.00	DR.DIXON, MD		
267215	7-21-90		PROCARDIA 10MG CAPS	10.34	MLM	10	99
			00069-2600-66 10MG C	.00	DR.TIMMONS, MD		
266855	7-11-90		CAPOTEN 25MG TABS	52.74	MLM	60	11
			00003-0452-50 25MG T	.00	DR.TIMMONS, MD		
266854	7-11-90		CALAN SR 240MG	51.57	MLM	30	10
			00025-1891-31 T	.00	DR.TIMMONS, MD		
	8-09-90		CALAN SR 240MG	51.57	MLM	30	
			00025-1891-31 T	.00	DR.TIMMONS, MD		

TOTAL FOR PRESCRIPTIONS LISTED: .00

1959 Last School LakArthur NM
or CO
Born { Feb-13-1948
Artesia New Mexico

My is Roy B. Rodriguez
1108 E. Canadian St. Portales, NM 88130
My Socal Security # 585-18-0864
My Spinal injury has been since 88 when working with J-H-Rose Truck line. Since working in a cold day loading drill pipes I was standing on the trailer when I slipped and fell to the ground and landed on my left side of the hip I got up leaping and hurting from my lower back and hip. Over the years my lower back hurts more and more. The pain at the hip becoming more and more painful upper thigh is beginning to cramp. After a while my calfs the left one began cramping too. In having back problems and hip. I moved to Hobbs NM when working with Nolen-H. Brunson INC. I was hammering a truck shift when a peice of metal fell in my right thigh. It was taken out by Dr. Stone 5/28/86 and was Hospitalice on the 6-9-86 to 7-9-86 in Seminole, Tex Infected wound with cellutitis and hymphangitis. C.V. Lele. M.D., FRCS - Attending Physician - when in the Hospital getting treatment for the wound the medicine felt good in my hip und leg cramps. Once laid-off I moved to Portales NM. My Back feels weaker and more painful my legs Both legs hurt. a lot my head hurts more than usual.

The Joints from my hips hurt more.
86to87 → Whet to La Casa to Dr. told Dr. Tima door about Pain she gave medicine and said it was the time (the weather) My Pain in the Back and legs still exit. I stopped trying to drive trucks (18 wheelers) because of the drug test. I began looking for contraction work for good Pay. When in Pain I tried to stay away for the supervisor When caught limping and in pain the supervisor asked what's wrong with me (working with K-Burnette & Sons.) got laid-off never been called back. While working with Valley Furniture standing making a door. I whet to bring a sheet of ply wood I slipt and fell and cracked my Rib on my right. Dr Alexander found Arthritis I was to get well in 3 to 6 weeks from feb 17-89 to present my rib still hurts and I'm infested to my stomach it's bloated. I don't have any funds to buy the medicine necessary to Relief the Pain nor the funds to see a Doctor. I When I was well I worked very hard to please my bosses and to better myself. this past years have been hell to me my lower back getting worse and legs and hip cramps. As a Citizen I love America and I love New Mexico. I pray Please please help — — — —

Over...

severe Diabetic
Lower back trouble
Pain in hips
Cramps in legs
Arthritis
Toxic Myositis
fractured Rib
left foot cramps
Bloated infected right side of stomach.
infected teeth
Need: Glucotril 5mg Diabetic pills.

Need Medicine but no funds.

My Nephews have some times help pay some bills. A copy of one of thier notes.

I thank ~~the~~ La Casa de Buena Salud for the help they have getten to me this clinic in portales is good and I am greatful for it. More Clinics like this should get more help.
I have been going to the D.V.R. for training but I have been very Painful walking around there.

cc Original To Senator Domenici

Senerely 8-24-90
Roy Rodriguez
Canadian, Portales, NM 88130

monthly Bills mom's income $526.00
6-29-1912- SS# 525-74-4466

House Payment Western Saving's 351.95
House ins Prematic Serv corp 37.~~89~~92
A.A.R.P. medicare Supp. 47.50
Bank of Americard Balance 1,322.06
U.S. west comm. last month 72.33
Citi Bank $2000 monthly Ballance 102.05
Roosevelt Gen Hosp Rob: 21400728 447.65 . 50.00
mom 226-3424 22648 50.00 month
22693424 ~~mom 229.0419~~ 276.48 - 50.00 month
Presbyterian Hosp. Ball 238.00
Poynor's Air conditioner 43285 75.00
City of Portales Arvage 23.00+-
S.P.S more in winter 70.86
Century cable of Portales 20.65
Marty's Professional Pharmacy 125.37 - Sept
Outmanil tab 23.35
DYAZIDE Cap's 16.15
Some month's more than others
Gas co of N.m more in winter 28.88 Sept
OPHTHALmic surgical Ass. 2,429.79
Mark L Schluter . M.D

This is what my mother Irene T Ortega owe's and Payes out each month, up Till Now my Daughter Robin L Gil has been Living with her and Paying All the utility's And Payed some Rent, But she moved out Now I will have to ask m Brother Lee C Ortega in Calif to help Till the Bill's Are Payed. I Am only Able to help Physical I have no in come AFDC. SSI Turned me down!! I'm Robert T Ortega

Irene T Ortega 1223 W Maple
Portales NM
88130

(Date) 8-24-90

The Honorable (name of Senator or Representative)
(address)

Dear (Senator or Congressman) (name) Pete Domenici

Sincerely, TONY ROMERO 1104 N Adeline
(name & address - need to have address) Portales, NM

Sincerely, AURELIO N. VIVIDA 201 E Juniper
(name & address - need to have address) Portales, NM. 88130

Sincerely, Gilberto D. Rivera
(name & address - need to have address) P.O. Box 402

Sincerely, Lelloyd Rutledge
(name & address - need to have address) 1917 South Main Street Portales new mexico 88130

Sincerely, Susie Silva
(name & address - need to have address) Rt 1 Box 59 Portales, N Mex

Dear (Senator or Congressman) (name) Ruby Pate & Cecil Pate
Rt 2 Box 95 Portales N.M. 88130

Sincerely, Walter Watson
pho 356-8710 722 W. 17th Lane, Portales, N.M. 88130

Sincerely, Corine Chambers 408 S Ave A Portales N. Mex 88130

Sincerely, Elmer Chambers 408 S Ave A
(name & address - need to have address) Portales N. Mex 88130

Sincerely, Paul W. Garrish 463-72-2005
PO Box 54
(name & address - need to have address) Portales, N Mexico 88130

Sincerely, Aniceto López
916 Beta Clovis. N.M

Sincerely, Mr & Mrs Louis A. Armijo 723 N Ave I Portales N mex

Sincerely, Mr Alberto Mendoza
P.O Box 381 Portales, N. Mex

Sincerely, Mrs Maggie Ortega
(name & address - need to have address) 112 E Maple Box 12 Portales, N mex

(Date) 8-24-90

The Honorable (name of Senator or Representative)
(address)

Dear (Senator or Congressman) (name) Pete Domenici

Sincerely,

Andrew Ramos 217-S ave. H. Portales NM 88130
(name & address - need to have address)

Sincerely,
Pabla Lopez 916-Beta Clovis N.M.

Sincerely, [illegible]
217 S. Ave. H Portales, NM 88130
(name & address - need to have address)

Sincerely, [illegible] 1234 N Main Portales N.M.
(name & address - need to have address)

Sincerely, Sarah L. Lee
912 E. Elm St. Portales, N.M.

Sincerely, [illegible] 513 South Boston

Sincerely, Ruby Gardner
2105 W Aspen
Portales NM

Sincerely, [illegible]

(name & address - need to have address) 1813 S M R

Sincerely, Ben Fuller
1305 South Ave A Portales N.M.

Sincerely, Everett Gardner
2105 Aspen
Portales NM

Sincerely,
[illegible] 121 W 1.4 Portales NM
(name & address - need to have address)

Sincerely,
Clyde A. Powell
2004 Aspen
Portales, N.M. 88130
(name & address - need to have address)

Sincerely, Larene Turner Rt 2. Box 111
Portales N.M. 88130

(name & address - need to have address)

Sincerely, [illegible]
921 E Danube Portales NM 88130
(name & address - need to have address)

Sincerely,
Rita Villa P.O. BOX 1031
Portales NMEX 88130
(name & address - need to have address)

Sincerely, Tranquilino Martinez
N Ave I Portales N.M.
(name & address - need to have address)

Sincerely, Matias Gutierrez
1016 N Ave I Portales NM.
(name & address - need to have address)

Sincerely, Alberto Villa 1222 W. F'R
(name & address - need to have address) Portales N.M. 88130

Sincerely, Florentino Cano
1001 N Ave A Portales NM. 88130
(name & address - need to have address)

Sincerely, Jaime Tarango Rt 2 P.O Box 207
(name & address - need to have address) Portales, N.M. 88130

Sincerely, Mary Olguin
(name & address - need to have address) 1219 N. ave A. Place

Sincerely, Henry Galvan
(name & address - need to have address) 1105 N. ave A. Portales

Sincerely, Dennis Abey 515 N Ave B.
(name & address - need to have address) Portales NM.

Sincerely, Lourdes Sem. 605 N Ave S Portales
(name & address - need to have address)

Sincerely,
George Thomas 300 E Rose St Portales
(name & address - need to have address)

Sincerely, Benito Gonzales 923 Brazos
(name & address - need to have address) Portales NM

Sincerely, Cleofas Baca 720 N K Portales

Sincerely, Celestino Dominguez 212 W Ivy Portales N Mexico 88130

Sincerely, Mary Aguilar 1401 N Ave K. P.O Box 175
(name & address - need to have address) Portales NM 88130

Sincerely, [illegible] 1223 W Maple Portales NM. 88130

Sincerely, Roy Rodriguez 1107 E - Canadian St.
(name & address - need to have address) Portales, NM 88130

Sincerely,
(name & address - need to have address) 1513 N. Main
Portales, N.M. 88130

Item 6

CHAVES COUNTY J.O.Y. CENTERS, INC.

P.O. BOX 2585, 1120 SOUTH GRAND ● ROSWELL ● NEW MEXICO ● 88202
(505) 623-5008

UNITED STATES SENATOR PETE V. DOMENICI

UNITED STATES SELECT COMMITTEE ON AGING
PRIMARY HEALTH CARE HEARING
TUESDAY, AUGUST 28, 1990

Testimony by Olivia G. Reid
Executive Director
CHAVES COUNTY J.O.Y. CENTERS, INC.

AUGUST 27, 1990

The Honorable Pete V. Domenici
United States Senate
Washington, D.C. 20510

Our Most Honorable Senator Domenici:

It is with great concern that we, the Senior Citizens of Chaves County address the following issues regarding Primary Health Care in our State:

The new law charging doctors to fill out medicare forms for patients is causing a threat to access to medical care for us.
....Please refer to Exhibit I (Pink Section)

Some doctors have refused and warned us they will not take Medicare patients. We must pay cash in order to receive service. Please refer to attached letter from Casa De Medicina Doctors. Exhibit II (Green Section)

Most doctors are already charging us $5.00 to fill out Medicare forms and $5.00 more to fill out our Supplement Insurance.

We are already having to pay cash for doctor's services and wait for medicare and/or the supplement to pay us.

We simply cannot afford medical care any more. Many of us suffer for lack of care due to lack of funds.

Prescription costs have escalated immensely in the past year. We used to be able to purchase medication at affordable prices. Today, most prescriptions exceed $20.00 and many are costing $40.00 plus for one month's supply. Drugs are not covered by Medicare.

Our Medicare Insurance does not pay half of the cost of our medical care. You will note the charge by the physician or service, LESS the Medicare approved accepted amount; LESS the 80% covered by Medicare LESS the Gramm Rudman percent cut. Please refer to attached invoices from some of our claims. Exhibit III (Orange Section)

Medicaid Eligibility has recently changed and, in some cases,is NOT paying for the medication. Many of us have not had an explanation of what the Medical Management Physician or

Pharmacy block means. Many of us thought it meant Medicaid did not pay the physician or pharmacy. It took six (6) telephone calls to get a definition. We found it means that certain persons can only see the physician or ~~use the pharmacy~~ that is indicated in the block. The bureaucracy is ~~very confusing~~ and leads us to have mental aggravations. Please refer to Exhibit IV (Yellow Section).

The small rural towns of Dexter, Hagerman and Lake Arthur do not have a doctor. Hagerman and Dexter have the buildings, the equipment and all that is necessary for a clinic, but, have not been able to recruit a physician. Where are the physicians that owe the Federal Government for their education? Why are they not available to us?

The City of Roswell is losing Physicians to other communities. There are only one or two Physicians in Roswell that will accept Medicare Assignment.

Our County Health Department only has limited services available to the Elderly. Those services are only available on certain days and hours and some only once per month.

Senator Domenici, we firmly believe that our Primary Health Care begins with accessibility. We are in fear of losing that very important privilege. Our Senior Centers provide us transportation, assistance in filling out countless forms, making our appointments, interpreting for us etc. etc. We firmly believe that if not for our Older American's Programs, we would have great unnecessary anxiety and lack of assistance in order to receive Medical Services. We are aware that Older American's Program funds were cut and those cuts will affect our Services. At a time when we our Health care is being threatened, so are our very necessary programs. These programs are very necessary and important to us and have saved our State and Federal Government many dollars in the area of Health Care. Without these programs, our Government would not have sufficient funds for nursing home care for us.

We ask your assistance in helping us to obtain and maintain Primary Health Care. Thank You Most Sincerely, for your continued support and ever caring assistance.

VERY TRULY YOURS,
CONCERNED SENIOR Citizens OF
CHAVES COUNTY

CHAVES COUNTY SENIOR CITIZENS

NAME	ADDRESS
Cecile ~~Kostal~~ Kuzbw	322 E. Eighth
Johnnie Wynn	Roswell
Rosie Duran	1015 S. Mulberry Roswell
Thera Caraballo	325 E Sonny
Consuelo ~~Gonzales~~ Gonzales	Roswell N.M.
Pedro Cardenas	
Josie Cardenas	1700 W. Hendricks Roswell
Concha Aguilar	1307 E Mathy Roswell
Inez Sanchez	1219 Johnson St Roswell
Della King	1414 S. Union, Roswell

Mary Organ	1414 S. Union Apt E 14 Roswell
Lou Curtis	118 W Alameda st
Velma Lively	1513 S. Miss. Roswell
Altagracia Mata	202 S. Poplar ave
Delia Lucero	717 E Hendricks
Adelaida H Wilson	1503 W Walnut
Teodoro G Wilson	1503 W Walnut
Charlie Smith	2307 So Sunset
Jerry Jones	908 S. Mulberry
Wilma Swinney	201 S. Sherman
Ruth Hegman	1600 S Sunset
Clyde C. McHay	Roswell
Vick Lopez	400 E Dencing City
Fern Kelley	1600 So. Sunset st
[illegible]	118 E Hendricks Roswell
[illegible] Horton	[illegible]
Al Froberg	910 S. Penn.
Lidia Gonzales	1502 S Missouri
Maurelio Sandoval	211 E Wildy
Maeotta Ridgill	1801 N. Kansas
Sonny Swinney	201 S. Sherman
JC McDerman	201 Sherrill Lane
Claude Lindbloom	1811 N. Mich.
Verdie M Patterson	704 E Third
Mamie Burke	902 Caminito

Ira & Margaret Stevens	3108 N. Richardson
MR & MRS RALPH T WALTON	508 S KANSAS
Charlie & Goofrey	904 North Richardson
Marcelina Reyes	E Church Roswell
Carlos Pena	#9 Richmond Dexter
Mary Sena	1405 So poplar st
Mr. F G Sena	1405 So poplar st.
Maria P. De La Rosa	716 E Tilden
Delfina Pintia	1405 So. Stanton Roswell
Bessie Patane	
Mary Rose	1405 Tulane Dr Roswell N.M.
Jack Rose	1405 Tulane Dr Roswell N.M.
Callie Mae Bush	733 E Alameda St
Alice Cannon	2021 Mulberry
Abel Torin	1413 W. Hendricks Roswell
Pearl Brown	321 E Pear
Imogene Wallace	1006 N. Missouri
Virginia Hawthorne	2304 N. Cole Ave, Roswell
Ramona Greenberry	Rt. 1 Box 159-B Dexter N Mex 88230
Ben Greenberry	Rt 1 Box 159-B Dexter N.M. 88230
Frank Ventura	1108 W. College
Ray Harris DC	111 E. Lewis st
Wanda Jo Curry	
Nancy L. DeWillis	707 A Plaza Dr Roswell N.M.
Genevieve Hitchcock	706 S. Plaza Dr. Roswell
Viana Haskins	1509 W. Tilden

Ann Potyrala	1208 Rancho Rd 88201
Edward Potyrala	1208 Rancho Rd. 88201
Wanda Brown	
Donna Higginbotham	100 N. Atkinson
Eva Zafarano	631 E. 6th Roswell
Richard Zafarano	631 E 6th Roswell
Earl A. O'Neal	1204 W. 4th Roswell
Eva Rogers	904 W. Summit St Roswell
Velma Franklin	823 E. Hendricks
Michael Patane	713 So. Plaza Dr., Roswell
Walter W. Keller	402 La Fonda Roswell
Agnes M. Patterson	1311 No. Montana
A.C. Patterson	1311 No. Montana
[illegible]	1408 No Michigan
Lorene M. Griffin	702 S. Heights
[illegible]	507 E 3rd
Teodoro G. Wilson	1503 W. Walnut
Adela V. Wilson	1503 W Walnut
Sophie Ortiz	304 E Mathews
Kathryn W. Hindle	345 E. 8th
Katherine Daniels	#20 ½ W. 17th St.
Wanda Brown	1600 W. Summit K-4 Roswell N.M.
LaVerne Naylor	Rt 4403 W. McGaffey
K.L. Naylor	" " " "
R.J. Willey	1927 N. Maryland

Carlos Matta	Dexter N. Mex.
Adela Salcido	[illegible] Stuckfield
Charlie Stone	Dexter
Joey Stone	Dexter
Octavio Madrid Sr.	Hagerman N. M.
Lupe Medrano	Dexter N Mex
[illegible]	Hagermen.
Francisca S Salinas	Hagermen
Carmen L Munoz	[illegible]
Florencio Salas	P.O. Box 185 Hagerman
Eufemia Salas	P.O. Box 185 Hagerman
Shirley & Vivian Utterback	Hagerman
Lorenzo Madrid	Hagerman
Joe Madrid	Hagerman
Bea Salas	Hagerman
Reda Wilmeth	Rt 4 6033 N Atkinson Roswell
Felicita Chavez	Roswell N. M.
Natividad Sosa	601 East 6 th
Alex Garcia	601 East 6 th
Alton Grill	2301 S Union av. Roswell
Vern D. Grill	2301 S. Union av. Roswell
John M Bauman	907 N Atkinson # 80 Roswell
Rowena L Bauman	" " " "
Joe Tydlaska	508 Hermosa Dr. Roswell
Opal Tydlaska	508 Hermosa Dr Roswell
Wallace Hayes	#24 H. Street Roswell

Orda McDaman	905 N Orchard Roswell NM 88201
Leo W Thale	
Mrs Leo W Thale	1518 N Dela.
Leona Squire	211 S. Ohio
Sidney Squire	211 S Ohio
Dale V Bryant	1421 W TILDEN
Lois Bryant	1421 W, Tilden
Delbert L Anderson	1207-so washington Roswell
Geraldine E. Bain	P.O.Box 33 Lake Arthur 88253
Wanda M. Whatley	101 E. 9th Lake Arthur, NM 88253
Tempie S. Funk	804 N. Main. Lake Arthur N.M 88253
Mamie Caffall	Box 194 Dexter N Mex 88230
Lee R. Caffall	1701 West Grand Artesia, NM 88210
Charles Edwards	Lake Arthur, N.M
August Diesel	Artesia, N.M
Isabel Diesel	Artesia N.M.
Laura H. Allen	Lake Arthur, N.Mex
Annie Lee Williams	Lake Arthur N.Mex.
Lydie Shirley	Lake Arthur N mex
Hallie B. Richardson	Lake Arthur N.M.
Antonio Silva	Rt. 1 Box 110 Lake Arthur, N.M.
Ruth Evans	Box 152, Lake Arthur N.M. 88253
[illegible]	Box 22 Lake Arthur N.M. 88253
Frank B. [illegible]	Box 22 Lake Arthur N.M 88253
Juan Chavez	1505 N. Kansas Roswell

Josephine Orlinski	3741 E. G. P. Rd
Petra R Espinoza	Rt. 1. Box-116. Dexter N. Mex
Rigoberto. Espinoza.	Rt. 1. Box-116 dexter N. Mex
Narciso Rodriguez	Rt-1- Box-117 dexter N. Mex
Juanita Ch. Rodriguez	Rt-1- Box-117 dexter N. Mex
Paula R Sanchez	Rt 1 Box 139 T 2 17 Tume [illegible]
Rafelo Berner	290 Lopez-Morley Ln Dexter NM
Mary Sanchez	Rt Dexter N M Lopez Morley
Luis Sanchez	" 28 S Dexter NM
Christobal A Sanchez	" # Dexter NM
Bernardo D [illegible]	Box 81. Dexter N M
Clara Chavez	141 Sloan Dexter NM.
Isabel Perez	107½ S. Miss. Roswell
George Pearse	503 So Spruce Roswell
Bess Duran	1520 W Pontiac
Billie Benham	EAST GRAND PLAINS
Dorothy L Pearse	503 S Spruce Roswell, N.M.
Oena M. Picard	Rt #1 84 Lupton Rd Dexter
Minnie Morley	R 3 Box 146, Roswell, N Mex.
Louis E. Picard	Rt #1 84 Lupton Rd. Dexter
Viola B Cole	123 Yakima Dexter
Lola Norton	6481 Templeton Dexter
Ruth Scramble	6481 Templeton Dexter
[illegible]	511 N. Lea St. Roswell NM
Simon Garcia	1511 North Union
Jose Baeza	1403 E. McGaffey
Beulah Clements	1717 W. Walnut

Harry Boggs	Box 99 Hagerman, N.M. 88232
Frances West	" "
Dorothy West	Box 280 " "
Frances Wier	Dexter
John Wier	Dexter
Estelle Mehlhop	Dexter
John C. Mehlhop	Dexter
Jack Hubbard	Dexter
Howard E. Ehlert	"
Ruth Nelly Adair	Hagerman
John Warner	Hagerman
Annie M. Doublefield	Hagerman N.M.
Ophelia Gibson	Hagerman N.M.
Clint Gibson	Hagerman N.M.
Gladys Gibson	Hagerman N.M.
Butch Gibson	Hagerman N.M.
Zilpha Graham	Hagerman, N.M.
Edgar Johnson	
Melba Willey	1822 N. Maryland Roswell
Abel Sundquist	
Celia B. Lucero	402 E Deming
Jean A. Hamberg	1510 W. Alameda Roswell
Steven Staedel	No 7 Morningside
Robert J. Dietz	49 E Well St
Emma Pineda	
Luis Castaño	1405 S. Stanton

May Ledbetter	Hagerman N.M.
Ellard Pilley	Hagerman, N.M.
Louise Rhodes	Hagerman, N.M.
Peggy Stone	Dexter, N. Mex.
Walter Stone	Dexter N. Mex
Remmo Haley	Hagerman
Oka Haley	Hagerman
Jewell Garner	Hagerman
Alta Rhodes	Hagerman
Mike Rhodes by Wife	Hagerman
Arcilia S. Morales	Hagerman, N. Mex.
Juanita Browning	Hagerman N. Mex.
Maria Sanchez	Hagerman N. Mex.
[illegible]	DEXTER, N.M.
John Rhodes	Hagerman New Mexico
Silas Selvas	~~Simon Selvas~~ Dexter
Elias Alvarez	Dexter
Simón Selbas	Dexter
Andres R Gonzales	N. Chadster Roswell
Jesus Barraza	Ohio 172 Roswell
PRUDENCIO PAZ ROBLERO	513 Cherry Roswell NM
Beatrice V. Quidili	1600 W Summit Box 4
Celina Sandoval	211 E Wildy Roswell
Cipriana Arango	1600 W summit apt no 2 Roswell
Flora Freeland	403 S. Montana
Edward Sanchez	110 S. Kansas Roswell
Demecia Trujillo	113 S Church
Amalia Romero	1509 S. Poplar. Roswell, N.Mex.

EXHIBIT I

MEDICARE CHANGES

IMPORTANT CHANGES IN MEDICARE

EXHIBIT I

If you have Medicare medical insurance (Part B), please read this notice.

BEGINNING SEPTEMBER 1, 1990, YOUR DOCTOR OR THE COMPANY THAT FURNISHES YOU MEDICAL SERVICES, EQUIPMENT OR SUPPLIES **MUST** PREPARE AND SUBMIT YOUR MEDICARE CLAIMS FOR YOU FOR ALL PART B SERVICES. THE CLAIM MUST BE SENT TO THE APPROPRIATE OFFICE OF THE TRAVELERS INSURANCE COMPANY.

- Your doctor or medical supply company **MUST** send in the claim even if they do not agree to accept the Medicare approved amount as payment in full.
- They **CANNOT** charge you extra for preparing and submitting the Medicare bill for you.

M29853 FR

- If they do not agree to accept the Medicare approved amount as payment in full, you are responsible for paying the whole bill; the Medicare payment will be sent to you.
- If they refuse to prepare and submit your Medicare claim for you, you should contact The Travelers Insurance Company.

If you have any questions about the information on this card, you can call or write The Travelers InsuranceCompany. The toll free number is 1-800-833-4455. If you write, you can find the address of The Travelers Insurance Company and the areas they serve in Your Medicare Handbook.

If you have questions about your Medicare entitlement, you should continue to contact the Railroad Retirement Board.

RAILROAD RETIREMENT BOARD
FORM T-15 (AUGUST 1990).

M29854 BK

EXHIBIT II

LETTER FROM PHYSICIANS

Casa De Medicina

1600 S.E. MAIN • ROSWELL, NEW MEXICO 88201
PHONE (505) 623-1370

July 10, 1990

DEAR MEDICARE PATIENTS:

It is important at this time to inform you of serious problems that we have been encountering with the Medicare system that may ultimately affect the manner in which we practice. Over the past several years we have seen the incompetence and irresponsibility of the system progress to a nearly intolerable point. This is not just a local or a regional problem but a truly national one. As you know for the past five years Medicare fees to physicians have been frozen and in many cases have progressively decreased. This has been accompanied by an increasingly complex and constant changing system of reporting and filing regulations requiring greatly increased overhead in terms of personnel and computer equipment. This has created incredible inefficiency, frustration and expense compared to the methods of dealing with private insurance carriers. Consequently, we are faced with an increased cost of running a medical office, decreasing payments for providing those services and intolerable aggravation with filing claims, a situation which cannot indefinitely exist. It would appear at times from their actions, Medicare is attempting to drive physicians out of practice situations such as ours.

Unless there are indications of a reversal of the current trend, each of the doctors in our group at a future point may be making a decision in regard to Medicare participation and more importantly whether he will continue to see Medicare patients at all unless they are willing to pay, independent of Medicare coverage. This will be a difficult decision for each of us and one that will not be made in haste. The effect of such a decision we realize could be devastating, creating considerable hardship for both the patient and the doctor. Simply stated the government through its careless and incompetent structuring of Medicare has created the problems outlined above and this in part has contributed to the current shortage of primary care physicians not only in Roswell but in similar communities across the country. Unless conditions change, this problem is only likely to worsen. Since the concerns of physicians generally go unrecognized, the impetus for changing and improving the system must come from the consumers of medical care, that is the patients. We need your help. The purpose of this letter is to inform you of the problems and to solicit your support in contacting your local, state and nationally elected officials to encourage them to legislate change. We will be happy to discuss these matters further with you.

Sincerely,

THOMAS D. RAMAGE, M.D.

JEROME A. DOMINIC, M.D.

FREDERICK B. FRENCH, M.D.

ORSON L. TRELOAR, M.D.

[redacted]

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

NM-U-005533

HEALTH CARE FINANCING ADMINISTRATION

THIS CONTINUES EXPLAINING BENEFITS ON CLAIM CONTROL NUMBER - 0092057630600
FOR HEALTH INSURANCE CLAIM NUMBER - 525-18-3190A

		BILLED	APPROVED
1-SURGERY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	JUL 7,1989	$ 397.75	$ 318.20
1-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	JUL 7,1989	$ 53.75	$ 49.10
TOTAL APPROVED AMOUNT			$ 572.33
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)			$ 457.86

680 ??
He pays $ 107.77 not approved

YOU ARE RESPONSIBLE FOR A TOTAL OF $ 222.14. THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND THE MEDICARE PAYMENT. YOU COULD HAVE AVOIDED PAYING $ 107.67, THE DIFFERENCE BETWEEN THE BILLED AND APPROVED AMOUNTS, IF THE CLAIM HAD BEEN ASSIGNED.

WE ARE PAYING A TOTAL OF $ 457.86 TO YOU ON THE ENCLOSED CHECK. PLEASE CASH IT AS SOON AS POSSIBLE.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET THE DEDUCTIBLE FOR 1989.) THE DATE AT THE TOP OF THIS EXPLANATION OF MEDICARE BENEFITS IS NOT ALWAYS THE DATE THE DEDUCTIBLE WAS APPLIED.

IMPORTANT IF YOU DO NOT AGREE WITH THE AMOUNTS APPROVED YOU MAY ASK FOR A REVIEW. TO DO THIS YOU MUST WRITE TO US BEFORE FEB 08 1990. (SEE ITEM 1 ON THE BACK.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? IF YOU BELIEVE MEDICARE PAID FOR A SERVICE YOU DID NOT RECEIVE, OR THERE IS AN ERROR, CONTACT US IMMEDIATELY. ALWAYS GIVE US THE:

MEDICARE CLAIM NO. 525-18-3190A CLAIM CONTROL NO. 0092057630600

PLEASE WRITE TO US AT THE ABOVE ADDRESS OR VISIT US AT:

600 SECOND STREET N W, 5TH FLOOR
ALBUQUERQUE, NM 87102

over — next page for the rest of the figures I used.

8/17/89

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

NM-U-005532

HEALTH CARE FINANCING ADMINISTRATION

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

AUGUST 08, 1989

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

Y C MCDERMAN
201 SHERRILL LANE #149
ROSWELL NM 88201-5824

YOUR HEALTH INSURANCE CLAIM NUMBER

525-18-3190A

YOUR DOCTOR OR SUPPLIER DID NOT ACCEPT ASSIGNMENT OF YOUR CLAIM(S) TOTALLING $ 680.00. (SEE ITEM 4 ON BACK).

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIMS. SEE THE BACK OF THIS NOTICE FOR AN EXPLANTION OF ASSIGNMENT. WRITE OR CALL US FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER OR FOR A FREE LIST OF PARTICIPATING DOCTORS AND SUPPLIERS.

			BILLED	APPROVED
C HOBBS MD				
1-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	JUL	3,1989	$ 93.25	$ 84.10
1-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5B ON BACK.	JUL	3,1989	$ 26.05	$ 22.56
1-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5B ON BACK.	JUL	4,1989	$ 36.40	$ 32.79
1-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5B ON BACK.	JUL	5,1989	$ 36.40	$ 32.79
1-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5B ON BACK.	JUL	6,1989	$ 36.40	$ 32.79

Billed 680.96
Medicare Pd 457.96
Patient. 222.14

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

NM-3P-000001

HEALTH CARE FINANCING ADMINISTRATION

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

MARCH 14, 1990

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

EDWARD A POTYRALA
1208 RANCHO ROAD
ROSWELL NM 88201-3716

YOUR HEALTH INSURANCE CLAIM NUMBER

389-05-5296A

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIMS. SEE THE BACK OF THIS NOTICE FOR AN EXPLANATION OF ASSIGNMENT. WRITE OR CALL US FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER OR FOR A FREE LIST OF PARTICIPATING DOCTORS AND SUPPLIERS.

YOUR DOCTOR OR SUPPLIER DID NOT ACCEPT ASSIGNMENT OF YOUR CLAIM(S) TOTALLING $ 739.81. (SEE ITEM 4 ON BACK).

		BILLED	APPROVED
M MCGUIRE MD			
1-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5B ON BACK.	NOV 14,1989	$ 91.81	$ 82.25
4-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK. CHARGES ARE REDUCED FOR THE SAME REASON AND BY THE SAME AMOUNT.	NOV 20-NOV 23,1989	$ 107.12	$ 96.80
3-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK. CHARGES ARE REDUCED FOR THE SAME REASON AND BY THE SAME AMOUNT.	NOV 15-NOV 17,1989	$ 162.24	$ 126.30
1-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5B ON BACK.	NOV 24,1989	$ 54.25	$ 41.00
		415.42	346.35

739.81 Total
337.37 Paid by M.
402.44 owed by Denise

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

NM-3P-000002

HEALTH CARE FINANCING ADMINISTRATION

THIS CONTINUES EXPLAINING BENEFITS ON CLAIM CONTROL NUMBER - 0093457152101
FOR HEALTH INSURANCE CLAIM NUMBER - 389-05-5296A

		BILLED	APPROVED
1-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	NOV 21,1989	$ 157.26	$ 105.30
1-INPATIENT SERVICES APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	NOV 21,1989	$ 167.13	$ 30.00

739.84 481.65

TOTAL APPROVED AMOUNT	$ 481.65
MINUS YOUR DEDUCTIBLE REMAINING FOR 1989	$ 50.94
AMOUNT REMAINING AFTER SUBTRACTING DEDUCTIBLE AMOUNT	$ 430.71
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT REMAINING)	$ 344.57
MEDICARE PAYMENT AFTER 2.092% GRAMM-RUDMAN REDUCTION	$ 337.37

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 2.092 PERCENT FOR SERVICES YOU RECEIVED BETWEEN OCTOBER 17, 1989 AND SEPTEMBER 1990.

We pay $ 402.44 !

REMARKS:

THIS REPRESENTS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM. IF AN UNDERPAYMENT WAS MADE, AN ATTACHED CHECK REIMBURSES THE TOTAL CLAIM ALLOWED AMOUNT MINUS THE AMOUNT ORIGINALLY PAID. IF AN OVERPAYMENT REQUIRING A REFUND WAS MADE AND A REFUND HAS NOT ALREADY BEEN SUBMITTED, YOU WILL BE CONTACTED BY LETTER FROM THE MEDICARE CLAIMS OFFICE.

YOUR CLAIM WAS SEPARATED FOR PROCESSING PURPOSES AND PROMPT HANDLING. YOU WILL RECEIVE MORE THAN ONE EXPLANATION OF BENEFITS.

YOU ARE RESPONSIBLE FOR A TOTAL OF $ 402.44, THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND THE MEDICARE PAYMENT. YOU COULD HAVE AVOIDED PAYING $ 258.16, THE DIFFERENCE BETWEEN THE BILLED AND APPROVED AMOUNTS, IF THE CLAIM(S) HAD BEEN ASSIGNED.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE NOW MET $ 75.00 OF THE $ 75.00 DEDUCTIBLE FOR 1989.) THE DATE AT THE TOP OF THIS EXPLANATION OF MEDICARE BENEFITS IS NOT ALWAYS THE DATE THE DEDUCTIBLE WAS APPLIED.

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

NM-U-000333

HEALTH CARE FINANCING ADMINISTRATION

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

JANUARY 17, 1990

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

EDWARD A POTYRALA
1208 RANCHO ROAD
ROSWELL NM 88201-3716

YOUR HEALTH INSURANCE CLAIM NUMBER

389-05-5296A

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIMS. SEE THE BACK OF THIS NOTICE FOR AN EXPLANATION OF ASSIGNMENT. WRITE OR CALL US FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER OR FOR A FREE LIST OF PARTICIPATING DOCTORS AND SUPPLIERS.

YOUR DOCTOR OR SUPPLIER DID NOT ACCEPT ASSIGNMENT OF YOUR CLAIM(S) TOTALLING $ 156.00. (SEE ITEM 4 ON BACK).

		BILLED	APPROVED
ROSWELL RADIOL			
1-DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	NOV 16,1989	$ 26.00	$ 13.24
1-DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	NOV 17,1989	$ 26.00	$ 13.24
1-DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	NOV 18,1989	$ 26.00	$ 13.24
1-DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	NOV 19,1989	$ 26.00	$ 13.24
1-DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	NOV 20,1989	$ 26.00	$ 13.24

Billed 156 — 62.32 / 93.78
Medicare
Patient

IMR-697511 1-89 CAT. 820121

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

NM-U-000334

HEALTH CARE FINANCING ADMINISTRATION

PAGE 2

THIS CONTINUES EXPLAINING BENEFITS ON CLAIM CONTROL NUMBER - 0000047062500
FOR HEALTH INSURANCE CLAIM NUMBER - 389-05-5296A

		BILLED	APPROVED
1-DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	NOV 21,1989	$ 26.00	$ 13.24
TOTAL APPROVED AMOUNT			$ 79.44
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)			$ 63.54
MEDICARE PAYMENT AFTER 2.092% GRAMM-RUDMAN REDUCTION			$ 62.22

156

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 2.092 PERCENT FOR SERVICES YOU RECEIVED BETWEEN OCTOBER 17, 1989 AND SEPTEMBER 1990.

He pays 93.78

YOU ARE RESPONSIBLE FOR A TOTAL OF $ 93.78, THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND THE MEDICARE PAYMENT. YOU COULD HAVE AVOIDED PAYING $ 76.56, THE DIFFERENCE BETWEEN THE BILLED AND APPROVED AMOUNTS, IF THE CLAIM(S) HAD BEEN ASSIGNED.

WE ARE PAYING A TOTAL OF $ 62.22 TO YOU ON THE ENCLOSED CHECK. PLEASE CASH IT AS SOON AS POSSIBLE.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET THE DEDUCTIBLE FOR 1989.) THE DATE AT THE TOP OF THIS EXPLANATION OF MEDICARE BENEFITS IS NOT ALWAYS THE DATE THE DEDUCTIBLE WAS APPLIED.

IMPORTANT IF YOU DO NOT AGREE WITH THE AMOUNTS APPROVED YOU MAY ASK FOR A REVIEW. TO DO THIS YOU MUST WRITE TO US BEFORE JUL 17 1990. (SEE ITEM 1 ON THE BACK.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? IF YOU BELIEVE MEDICARE PAID FOR A SERVICE YOU DID NOT RECEIVE, OR THERE IS AN ERROR, CONTACT US IMMEDIATELY. ALWAYS GIVE US THE:

MEDICARE CLAIM NO. 389-05-5296A CLAIM CONTROL NO. 0000047062500

PLEASE WRITE TO US AT THE ABOVE ADDRESS OR VISIT US AT:

600 SECOND STREET N W, 5TH FLOOR
ALBUQUERQUE, NM 87102

(MR-497511 1-89 CAT 820171

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

NM-U-002354

HEALTH CARE FINANCING ADMINISTRATION

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

AUGUST 03, 1989

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

MC Y DERMAN
201 W SHERRILL LN
#149
ROSWELL NM 88201-5848

YOUR HEALTH INSURANCE CLAIM NUMBER: 525-18-3190A

BENEFICIARY NAME: Y C MCDERMAN

YOUR DOCTOR OR SUPPLIER DID NOT ACCEPT ASSIGNMENT OF YOUR CLAIM(S) TOTALLING $ 259.04. (SEE ITEM 4 ON BACK).

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIMS. SEE THE BACK OF THIS NOTICE FOR AN EXPLANTION OF ASSIGNMENT. WRITE OR CALL US FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER OR FOR A FREE LIST OF PARTICIPATING DOCTORS AND SUPPLIERS.

		BILLED	APPROVED
ROSWELL RADIOL			
1-DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	JUL 3,1989	$ 26.00	$ 13.24
1-DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	JUL 5,1989	$ 67.00	$ 51.24
1-DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	JUL 6,1989	$ 26.52	$ 16.15
1-DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	JUL 7,1989	$ 26.52	$ 16.15
1-DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	JUL 7,1989	$ 113.00	$ 80.50

259.04

TOTAL APPROVED AMOUNT	$ 177.28
MINUS YOUR DEDUCTIBLE REMAINING FOR 1989	$ 75.00
AMOUNT REMAINING AFTER SUBTRACTING DEDUCTIBLE AMOUNT	$ 102.28
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT REMAINING)	$ 81.82

He pays 81.76
Medicare
not approved
UFW Ins not answered

FORM HCFA-1533 (U2) 1-89

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

NM-U-002352

HEALTH CARE FINANCING ADMINISTRATION

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

AUGUST 03, 1989

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

Y C MCDERMAN
201 SHERRILL LANE #149
ROSWELL NM 88201-5824

YOUR HEALTH INSURANCE CLAIM NUMBER

525-18-3190A

YOUR DOCTOR OR SUPPLIER DID NOT ACCEPT ASSIGNMENT OF YOUR CLAIM(S) TOTALLING $ 102.77. (SEE ITEM 4 ON BACK).

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIMS. SEE THE BACK OF THIS NOTICE FOR AN EXPLANTION OF ASSIGNMENT. WRITE OR CALL US FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER OR FOR A FREE LIST OF PARTICIPATING DOCTORS AND SUPPLIERS.

		BILLED	APPROVED
M MCGUIRE MD			
1-CONSULTATION APPROVED AMOUNT LIMITED BY ITEM 5B ON BACK.	JUL 12,1989	$ 102.77	$ 85.90
TOTAL APPROVED AMOUNT			$ 85.90
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)			$ 68.72

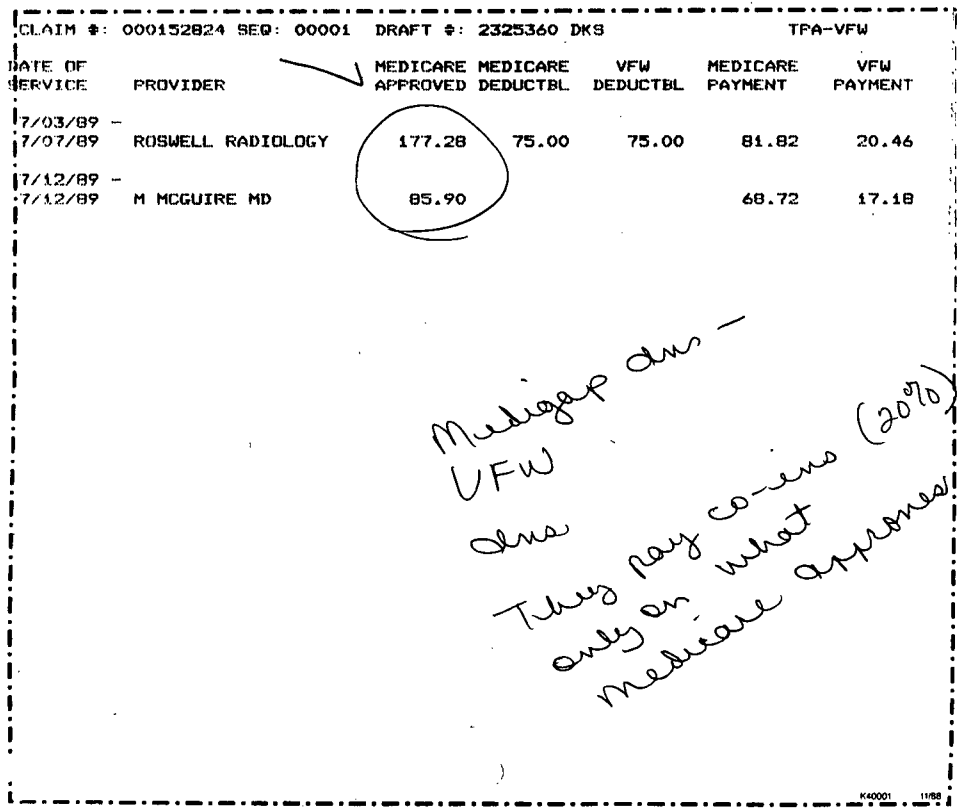
May 16 87 approved

YOU ARE RESPONSIBLE FOR A TOTAL OF $ 34.05, THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND THE MEDICARE PAYMENT. YOU COULD HAVE AVOIDED PAYING $ 16.87, THE DIFFERENCE BETWEEN THE BILLED AND APPROVED AMOUNTS, IF THE CLAIM HAD BEEN ASSIGNED.

WE ARE PAYING A TOTAL OF $ 68.72 TO YOU ON THE ENCLOSED CHECK. PLEASE CASH IT AS SOON AS POSSIBLE.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET THE DEDUCTIBLE FOR 1989.) THE DATE AT THE TOP OF THIS EXPLANATION OF MEDICARE BENEFITS IS NOT ALWAYS THE DATE THE DEDUCTIBLE WAS APPLIED.



CLAIM #: 000152824 SEQ: 00001 DRAFT #: 2325360 DKS TPA-VFW

DATE OF SERVICE	PROVIDER	MEDICARE APPROVED	MEDICARE DEDUCTBL	VFW DEDUCTBL	MEDICARE PAYMENT	VFW PAYMENT
7/03/89 - 7/07/89	ROSWELL RADIOLOGY	177.28	75.00	75.00	81.82	20.46
7/12/89 - 7/12/89	M MCGUIRE MD	85.90			68.72	17.18

Medigap dns – VFW dns

They pay co-ins (20%) only on what medicare approves

K40001 11/88

YOUR RECORD OF PART B MEDICARE BENEFITS USED
IN A HOSPITAL-SKILLED NURSING FACILITY-HOME HEALTH AGENCY-OR PHYSICAL THERAPY PROVIDER

Blue Cross
Blue Shield
of New Mexico
P.O. BOX 13597
ALBUQUERQUE, N.M. 87192-3597
505/291-5550

MEDICARE - CLAIMS INFORMATION

DATE: 05/08/90

HELEN REID
RT1 BOX 19
DEXTER NM 88230-0000

YOUR MEDICARE NUMBER
HEALTH INSURANCE CLAIM NUMBER
585269503A
ALWAYS USE THIS NUMBER WHEN WRITING ABOUT YOUR CLAIM

CONTROL NUMBER 1011404271

THIS IS NOT A BILL

OUR RECORDS SHOW YOU RECEIVED SERVICES FROM

PROVIDER NAME, ADDRESS, AND STATE
320006
EASTERN NM MED CTR
405 WEST COUNTRY CLUB RD
ROSWELL NM 88201

DATE OF FIRST SERVICE 01/25/90
DATE OF LAST SERVICE 01/25/90

TYPE OF SERVICE	TOTAL COVERED CHARGES	NONCOVERED CHARGES	REMARKS
LABORATORY OR (LAB)	6.10		BILLED 22.00

Due 15.90

A. TOTAL COVERED CHARGES	6.10	1. $ THIS DOES NOT APPLY DEDUCTIBLE HAS BEEN MET FOR
B. $ COUNTED TOWARD YOUR PART B CASH DEDUCTIBLE		ALL AMOUNTS PAYABLE BY YOU SHOULD BE PAID DIRECTLY TO THE PROVIDER. DO NOT SEND PAYMENT TO NEW MEXICO BLUE CROSS & BLUE SHIELD, INC.
C. $ PART B BLOOD DEDUCTIBLE CHARGE		
D. $ COINSURANCE, 20% OF (A. MINUS SUM OF B + C)		
E. $ TOTAL DEDUCTIBLE AND COINSURANCE PAYABLE BY YOU		2. NONE ← AMOUNT YOU PAID PROVIDER
F.		3. NONE ← AMOUNT OWED PROVIDER
G.		4. NONE ← REFUND (ENCLOSED)
SEE SPECIAL MESSAGES ON THE BACK OF THIS FORM,		# 2
I. BALANCE OF COVERED CHARGES	6.10	← MEDICARE PAID FOR THESE SERVICES NM

UP 01211

PLEASE READ OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION

YOUR RECORD OF PART B MEDICARE BENEFITS USED
IN A HOSPITAL-SKILLED NURSING FACILITY-HOME HEALTH AGENCY-OR PHYSICAL THERAPY PROVIDER

Blue Cross
Blue Shield
of New Mexico
P.O. BOX 13597
ALBUQUERQUE, N.M. 87192-3597
505/291-3550

MEDICARE - CLAIMS INFORMATION

DATE: 05/03/90

HELEN REID
RT1 BOX 19
DEXTER NM 88230-0000

YOUR MEDICARE NUMBER
HEALTH INSURANCE CLAIM NUMBER
585269503A
ALWAYS USE THIS NUMBER WHEN WRITING ABOUT YOUR CLAIM

CONTROL NUMBER 1010909751

THIS IS NOT A BILL

OUR RECORDS SHOW YOU RECEIVED SERVICES FROM ➡	PROVIDER NAME, ADDRESS, AND STATE 320006 EASTERN NM MED CTR 405 WEST COUNTRY CLUB RD ROSWELL NM 88201	DATE OF FIRST SERVICE 02/08/90 DATE OF LAST SERVICE 02/08/90

TYPE OF SERVICE	TOTAL COVERED CHARGES	NONCOVERED CHARGES	REMARKS
LABORATORY OR (LAB)	6.10	BILLED 22.00	Due 15.90

A.	TOTAL COVERED CHARGES	6.10	1. $ THIS DOES NOT APPLY DEDUCTIBLE HAS BEEN MET FOR OUR
B. $	COUNTED TOWARD YOUR PART B CASH DEDUCTIBLE		ALL AMOUNTS PAYABLE BY YOU SHOULD BE PAID DIRECTLY TO THE PROVIDER. DO NOT SEND PAYMENT TO NEW MEXICO BLUE CROSS & BLUE SHIELD, INC.
C. $	PART B BLOOD DEDUCTIBLE CHARGE		
D. $	COINSURANCE, 20% OF (A. MINUS SUM OF B + C)		
E. $	TOTAL DEDUCTIBLE AND COINSURANCE PAYABLE BY YOU ➡		2. NONE ⬅ AMOUNT YOU PAID PROVIDER
F.			3. NONE ⬅ AMOUNT OWED PROVIDER
G.			4. NONE ⬅ REFUND (ENCLOSED)
SEE SPECIAL MESSAGES ON THE BACK OF THIS FORM,			# 2
I.	BALANCE OF COVERED CHARGES	6.10	⬅ MEDICARE PAID FOR THESE SERVICES NM

UP 01211

PLEASE READ OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

NM-2S-063471

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

MAY 18, 1990

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

HELEN C REID
RT 1 BOX 19
DEXTER NM 88230-9718

YOUR HEALTH INSURANCE CLAIM NUMBER

585-26-9503A

ASSIGNMENT WAS TAKEN ON YOUR CLAIM (CONTROL NO:0001205811800 FOR
$ 147.17 FROM ROSWELL HM MED.) SEE ITEM 4 ON BACK

		BILLED	APPROVED
1-DURABLE EQUIPMENT APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	APR 1,1990	$ 147.17	$ 113.46

YOU ARE NOT LIABLE FOR THIS REDUCTION UNDER THE
ASSIGNMENT AGREEMENT.

ROSWELL HM MED AGREED TO CHARGE NO MORE FOR THE APPROVED
SERVICES THAN THE AMOUNT APPROVED BY MEDICARE.

TOTAL APPROVED AMOUNT	$ 113.46
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)	$ 90.77
MEDICARE PAYMENT AFTER 1.4% GRAMM-RUDMAN REDUCTION	$ 89.50

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 1.4
PERCENT FOR SERVICES YOU RECEIVED BETWEEN APRIL 1, 1990 AND
SEPTEMBER 30, 1990. SINCE YOUR DOCTOR (SUPPLIER) TOOK YOUR CLAIM ON
ASSIGNMENT, THE DOCTOR (SUPPLIER) AGREES TO ACCEPT THIS LOWER
PAYMENT.

REMARKS:

IF YOU ARE NO LONGER USING THIS EQUIPMENT, PLEASE NOTIFY US
IMMEDIATELY.

BEGINNING APRIL 1, 1989, THE NAME AND PHYSICIAN IDENTIFICATION
NUMBER OF THE REFERRING OR ORDERING PHYSICIAN IS REQUIRED. WE PAID
THIS CLAIM WITHOUT THE REQUIRED INFORMATION. HOWEVER, FUTURE CLAIMS
MAY BE DELAYED OR DENIED IF THE INFORMATION IS NOT SUBMITTED.

WE ARE PAYING A TOTAL OF $ 89.50 TO ROSWELL HM MED.

57.67 Dua

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

NM-2S-063472

THIS CONTINUES EXPLAINING BENEFITS ON CLAIM CONTROL NUMBER - 0001205811800
FOR HEALTH INSURANCE CLAIM NUMBER - 585-26-9503A

YOU ARE RESPONSIBLE FOR THE DIFFERENCE OF $ 22.69 BETWEEN THE APPROVED AMOUNT AND THE MEDICARE PAYMENT.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET THE DEDUCTIBLE FOR 1990.) THE DATE AT THE TOP OF THIS EXPLANATION OF MEDICARE BENEFITS IS NOT ALWAYS THE DATE THE DEDUCTIBLE WAS APPLIED.

IMPORTANT IF YOU DO NOT AGREE WITH THE AMOUNTS APPROVED YOU MAY ASK FOR A REVIEW. TO DO THIS YOU MUST WRITE TO US BEFORE NOV 18 1990. (SEE ITEM 1 ON THE BACK.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? IF YOU BELIEVE MEDICARE PAID FOR A SERVICE YOU DID NOT RECEIVE, OR THERE IS AN ERROR, CONTACT US IMMEDIATELY. ALWAYS GIVE US THE:

MEDICARE CLAIM NO. 585-26-9503A CLAIM CONTROL NO. FOR CLAIM IN QUESTI

PLEASE WRITE TO US AT THE ABOVE ADDRESS OR VISIT US AT:

600 SECOND STREET N W, 5TH FLOOR
ALBUQUERQUE, NM 87102

YOUR RECORD OF PART B MEDICARE BENEFITS USED
IN A HOSPITAL-SKILLED NURSING FACILITY-HOME HEALTH AGENCY-OR PHYSICAL THERAPY PROVIDER

Blue Cross
Blue Shield
of New Mexico
P.O. BOX 13597
ALBUQUERQUE, N.M. 87192-3597
505/291-3550

MEDICARE - CLAIMS INFORMATION

DATE: 06/13/90

HELEN REID
RT 1
DEXTER NM 88230-0000

YOUR MEDICARE NUMBER
HEALTH INSURANCE CLAIM NUMBER
585269503A
ALWAYS USE THIS NUMBER WHEN WRITING ABOUT YOUR CLAIM

CONTROL NUMBER 1015008891

THIS IS NOT A BILL

OUR RECORDS SHOW YOU RECEIVED SERVICES FROM ➡

PROVIDER NAME, ADDRESS, AND STATE
320006
EASTERN NM MED CTR
405 WEST COUNTRY CLUB RD
ROSWELL NM 88201

DATE OF FIRST SERVICE 03/08/90
DATE OF LAST SERVICE 03/08/90

TYPE OF SERVICE	TOTAL COVERED CHARGES	NONCOVERED CHARGES	REMARKS
LABORATORY OR (LAB)	6.10	BILLED 44.00	Due 37.90

A.	TOTAL COVERED CHARGES	6.10	1. $ THIS DOES NOT APPLY HAS BEEN MET FOR DEDUCTIBLE
B. $	COUNTED TOWARD YOUR PART B CASH DEDUCTIBLE		ALL AMOUNTS PAYABLE BY YOU SHOULD BE PAID DIRECTLY TO THE PROVIDER. DO NOT SEND PAYMENT TO NEW MEXICO BLUE CROSS & BLUE SHIELD, INC.
C. $	PART B BLOOD DEDUCTIBLE CHARGE		
D. $	COINSURANCE, 20% OF (A. MINUS SUM OF B + C)		
E. $	TOTAL DEDUCTIBLE AND COINSURANCE PAYABLE BY YOU ➡		2. NONE ⬅ AMOUNT YOU PAID PROVIDER
F.			3. NONE ⬅ AMOUNT OWED PROVIDER
			4. NONE ⬅ REFUND (ENCLOSED)
SEE SPECIAL MESSAGES ON THE BACK OF THIS FORM,			# 2
I.	BALANCE OF COVERED CHARGES	6.10	⬅ MEDICARE PAID FOR THESE SERVICES NM

UP 01211

PLEASE READ OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

NM-2S-053567

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

AUGUST 03, 1990

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

HELEN C REID
RT 1 BOX 19
DEXTER NM 88230-9718

YOUR HEALTH INSURANCE CLAIM NUMBER

585-26-9503A

ASSIGNMENT WAS TAKEN ON YOUR CLAIM (CONTROL NO:0001905734200 FOR $ 294.34 FROM ROSWELL HM MED.) SEE ITEM 4 ON BACK

		BILLED	APPROVED
1-DURABLE EQUIPMENT APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	MAY 1,1990	$ 147.17	$ 113.46
YOU ARE NOT LIABLE FOR THIS REDUCTION UNDER THE ASSIGNMENT AGREEMENT.			
1-DURABLE EQUIPMENT APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	JUN 1,1990	$ 147.17	$ 113.46
YOU ARE NOT LIABLE FOR THIS REDUCTION UNDER THE ASSIGNMENT AGREEMENT.			

294.34

ROSWELL HM MED AGREED TO CHARGE NO MORE FOR THE APPROVED SERVICES THAN THE AMOUNT APPROVED BY MEDICARE.

TOTAL APPROVED AMOUNT	$ 226.92
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)	$ 181.54
MEDICARE PAYMENT AFTER 1.4% GRAMM-RUDMAN REDUCTION	$ 179.00

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 1.4 PERCENT FOR SERVICES YOU RECEIVED BETWEEN APRIL 1, 1990 AND SEPTEMBER 30, 1990. SINCE YOUR DOCTOR (SUPPLIER) TOOK YOUR CLAIM ON ASSIGNMENT, THE DOCTOR (SUPPLIER) AGREES TO ACCEPT THIS LOWER PAYMENT.

Billed 294.34
Medicare Paid 179.00
115.34 Due

Due [redacted]

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

NM-2S-053568

THIS CONTINUES EXPLAINING BENEFITS ON CLAIM CONTROL NUMBER - 0001905734200
FOR HEALTH INSURANCE CLAIM NUMBER - 585-26-9503A

REMARKS:

IF YOU ARE NO LONGER USING THIS EQUIPMENT, PLEASE NOTIFY US IMMEDIATELY.

BEGINNING APRIL 1, 1989, THE NAME AND PHYSICIAN IDENTIFICATION NUMBER OF THE REFERRING OR ORDERING PHYSICIAN IS REQUIRED. WE PAID THIS CLAIM WITHOUT THE REQUIRED INFORMATION. HOWEVER, FUTURE CLAIMS MAY BE DELAYED OR DENIED IF THE INFORMATION IS NOT SUBMITTED.

WE ARE PAYING A TOTAL OF $ 179.00 TO ROSWELL HM MED.

YOU ARE RESPONSIBLE FOR THE DIFFERENCE OF $ 45.38 BETWEEN THE APPROVED AMOUNT AND THE MEDICARE PAYMENT.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET THE DEDUCTIBLE FOR 1990.) THE DATE AT THE TOP OF THIS EXPLANATION OF MEDICARE BENEFITS IS NOT ALWAYS THE DATE THE DEDUCTIBLE WAS APPLIED.

IMPORTANT IF YOU DO NOT AGREE WITH THE AMOUNTS APPROVED YOU MAY ASK FOR A REVIEW. TO DO THIS YOU MUST WRITE TO US BEFORE FEB 03 1991. (SEE ITEM 1 ON THE BACK.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? IF YOU BELIEVE MEDICARE PAID FOR A SERVICE YOU DID NOT RECEIVE, OR THERE IS AN ERROR, CONTACT US IMMEDIATELY. ALWAYS GIVE US THE:

MEDICARE CLAIM NO. 585-26-9503A CLAIM CONTROL NO. FOR CLAIM IN QUESTION

PLEASE WRITE TO US AT THE ABOVE ADDRESS OR VISIT US AT:

600 SECOND STREET N W, 5TH FLOOR
ALBUQUERQUE, NM 87102

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

NM-2S-057979

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

APRIL 01, 1990

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

HELEN C REID
RT 1 BOX 19
DEXTER NM 88230-9718

YOUR HEALTH INSURANCE CLAIM NUMBER

585-26-9503A

ASSIGNMENT WAS TAKEN ON YOUR CLAIM (CONTROL NO:0000255352110 FOR $ 79.41 FROM ROSWELL HM MED.) SEE ITEM 4 ON BACK

MEDICARE DENIED PAYMENT FOR ALL OF THESE SERVICES.

		BILLED	APPROVED
1-DURABLE EQUIPMENT THE PRESCRIPTION ON FILE IS NOT IN EFFECT FOR THIS DATE OF RVICE.	DEC 29,1989	$ 79.41	$ 0.00
TOTAL APPROVED AMOUNT			$ 0.00
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)			$ 0.00

REMARKS:

IF YOU ARE NO LONGER USING THIS EQUIPMENT, PLEASE NOTIFY US IMMEDIATELY.

BEGINNING APRIL 1, 1989, THE NAME AND PHYSICIAN IDENTIFICATION NUMBER OF THE REFERRING OR ORDERING PHYSICIAN IS REQUIRED. WE PAID THIS CLAIM WITHOUT THE REQUIRED INFORMATION. HOWEVER, FUTURE CLAIMS MAY BE DELAYED OR DENIED IF THE INFORMATION IS NOT SUBMITTED.

NO PAYMENT IS BEING MADE TO ROSWELL HM MED BECAUSE THE TOTAL APPROVED AMOUNT OF $ 0.00 WAS APPLIED TOWARD YOUR ANNUAL $ 75.00 DEDUCTIBLE. THE DATE AT THE TOP OF THIS EXPLANATION OF MEDICARE BENEFITS IS NOT ALWAYS THE DATE THE DEDUCTIBLE WAS APPLIED.

YOU ARE RESPONSIBLE FOR THE TOTAL APPROVED AMOUNT OF $ 0.00 PLUS $ 79.41 FOR NONCOVERED SERVICES FOR A TOTAL OF $ 79.41.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

Total Due 4/1/90

Submitted to Premier 8-16-90.

79.41

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

NM-3S-025057

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

APRIL 20, 1990

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

HELEN C REID
RT 1 BOX 19
DEXTER NM 88230-9718

YOUR HEALTH INSURANCE CLAIM NUMBER

585-26-9503A

ASSIGNMENT WAS TAKEN ON YOUR CLAIM (CONTROL NO:0000815151700 FOR
$ 147.17 FROM ROSWELL HM MED.) SEE ITEM 4 ON BACK

		BILLED	APPROVED
1-DURABLE EQUIPMENT	MAR 1,1990	$ 147.17	$ 113.46
APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.			
YOU ARE NOT LIABLE FOR THIS REDUCTION UNDER THE AS GNMENT AGREEMENT.			
ROSWELL HM MED AGREED TO CHARGE NO MORE FOR THE APPROVED SERVICES THAN THE AMOUNT APPROVED BY MEDICARE.			
TOTAL APPROVED AMOUNT			$ 113.46
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)			$ 90.77
MEDICARE PAYMENT AFTER 2.092% GRAMM-RUDMAN REDUCTION			$ 88.87

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 2.092 PERCENT FOR SERVICES YOU RECEIVED BETWEEN OCTOBER 17, 1989 AND MARCH 31, 1990. SINCE YOUR DOCTOR (SUPPLIER) TOOK YOUR CLAIM ON ASSIGNMENT, THE DOCTOR (SUPPLIER) AGREES TO ACCEPT THIS LOWER PAYMENT.

REMARKS:

IF YOU ARE NO LONGER USING THIS EQUIPMENT, PLEASE NOTIFY US IMMEDIATELY.

BEGINNING APRIL 1, 1989, THE NAME AND PHYSICIAN IDENTIFICATION NUMBER OF THE REFERRING OR ORDERING PHYSICIAN IS REQUIRED. WE PAID THIS CLAIM WITHOUT THE REQUIRED INFORMATION. HOWEVER, FUTURE CLAIMS MAY BE DELAYED OR DENIED IF THE INFORMATION IS NOT SUBMITTED.

58.30 due

YOUR RECORD OF PART B MEDICARE BENEFITS USED
IN A HOSPITAL-SKILLED NURSING FACILITY-HOME HEALTH AGENCY-OR PHYSICAL THERAPY PROVIDER

Blue Cross
Blue Shield
of New Mexico
P.O. BOX 13597
ALBUQUERQUE, N.M. 87192-3597
505/291-3550

MEDICARE - CLAIMS INFORMATION

DATE: 04/25/90

HELEN REID
RT1 BOX 19
DEXTER NM 88230-0000

YOUR MEDICARE NUMBER
HEALTH INSURANCE CLAIM NUMBER
585269503A
ALWAYS USE THIS NUMBER WHEN WRITING ABOUT YOUR CLAIM

THIS IS NOT A BILL

CONTROL NUMBER 1010102881

OUR RECORDS SHOW YOU RECEIVED SERVICES FROM	PROVIDER NAME, ADDRESS, AND STATE	DATE OF FIRST SERVICE / DATE OF LAST SERVICE
	320006 EASTERN NM MED CTR 405 WEST COUNTRY CLUB RD ROSWELL NM 88201	12/07/89 12/28/89

TYPE OF SERVICE	TOTAL COVERED CHARGES	NONCOVERED CHARGES / REMARKS
LABORATORY OR (LA8)	28.92	BILLED 88.00

59.08 deny

A.	TOTAL COVERED CHARGES	28.92
B. $	COUNTED TOWARD YOUR PART B CASH DEDUCTIBLE	
C. $	PART B BLOOD DEDUCTIBLE CHARGE	
D. $	COINSURANCE, 20% OF (A. MINUS SUM OF B + C)	
E. $	TOTAL DEDUCTIBLE AND COINSURANCE PAYABLE BY YOU	
F.		
G.		
H.	SPECIAL MESSAGES ON THE BACK OF THIS FORM,	# 2
I.	BALANCE OF COVERED CHARGES	28.92

1. $ 75.00 OF YOUR 75.00 DEDUCTIBLE HAS BEEN MET FOR 1989

ALL AMOUNTS PAYABLE BY YOU SHOULD BE PAID DIRECTLY TO THE PROVIDER. DO NOT SEND PAYMENT TO NEW MEXICO BLUE CROSS & BLUE SHIELD, INC.

2. NONE ← AMOUNT YOU PAID PROVIDER
3. NONE ← AMOUNT OWED PROVIDER
4. NONE ← REFUND (ENCLOSED)

← MEDICARE PAID FOR THESE SERVICES NM

UP 01211

PLEASE READ OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

NM-3S-025058

ASSIGNMENT WAS TAKEN ON YOUR CLAIM (CONTROL NO:0000815153300 FOR $ 634.19 FROM ROSWELL HM MED.) SEE ITEM 4 ON BACK

MEDICARE DENIED PAYMENT FOR ALL OF THESE SERVICES.

		BILLED	APPROVED
1-DURABLE EQUIPMENT THE PRESCRIPTION ON FILE IS NOT IN EFFECT FOR THIS DATE OF SERVICE.	MAR 1,1990	$ 634.19	$ 0.00
TOTAL APPROVED AMOUNT			$ 0.00
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)			$ 0.00

REMARKS:

IF YOU ARE NO LONGER USING THIS EQUIPMENT, PLEASE NOTIFY US IMMEDIATELY.

BEGINNING APRIL 1, 1989, THE NAME AND PHYSICIAN IDENTIFICATION NUMBER OF THE REFERRING OR ORDERING PHYSICIAN IS REQUIRED. WE PAID THIS CLAIM WITHOUT THE REQUIRED INFORMATION. HOWEVER, FUTURE CLAIMS MAY BE DELAYED OR DENIED IF THE INFORMATION IS NOT SUBMITTED.

ASSIGNMENT WAS TAKEN ON YOUR CLAIM (CONTROL NO:0000815153310 FOR $ 23.24 FROM ROSWELL HM MED.) SEE ITEM 4 ON BACK

MEDICARE DENIED PAYMENT FOR ALL OF THESE SERVICES.

		BILLED	APPROVED
1-SUPPLY MEDICARE DOES NOT PAY FOR THIS SUPPLY OR SERVICE.	MAR 8,1990	$ 23.24	$ 0.00
TOTAL APPROVED AMOUNT			$ 0.00
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)			$ 0.00

REMARKS:

BEGINNING APRIL 1, 1989, THE NAME AND PHYSICIAN IDENTIFICATION NUMBER OF THE REFERRING OR ORDERING PHYSICIAN IS REQUIRED. WE PAID THIS CLAIM WITHOUT THE REQUIRED INFORMATION. HOWEVER, FUTURE CLAIMS MAY BE DELAYED OR DENIED IF THE INFORMATION IS NOT SUBMITTED.

634.19 due

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

NM-3S-025059

PAGE 3

ASSIGNMENT WAS TAKEN ON YOUR CLAIM (CONTROL NO:0000885501200 FOR $ 51.52 FROM ST MARYS REGIO.) SEE ITEM 4 ON BACK

		BILLED	APPROVED
1-COVERED SERVICE APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	AUG 18,1989	$ 51.52	$ 36.70

YOU ARE NOT LIABLE FOR THIS REDUCTION UNDER THE ASSIGNMENT AGREEMENT.

ST MARYS REGIO AGREED TO CHARGE NO MORE FOR THE APPROVED SERVICES THAN THE AMOUNT APPROVED BY MEDICARE.

TOTAL APPROVED AMOUNT	$ 36.70
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)	$ 29.36

WE ARE PAYING A TOTAL OF $ 118.23 TO THOSE WHO PROVIDED THE ABOVE SERVICES. THEY AGREED TO CHARGE NO MORE FOR THE APPROVED SERVICES THAN THE AMOUNT APPROVED BY MEDICARE. YOU ARE RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE APPROVED AMOUNTS AND THE MEDICARE PAYMENTS.

YOU ARE RESPONSIBLE FOR THE DIFFERENCE OF $ 30.03 BETWEEN THE APPROVED AMOUNT AND THE MEDICARE PAYMENT.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET THE DEDUCTIBLE FOR 1989.) THE DATE AT THE TOP OF THIS EXPLANATION OF MEDICARE BENEFITS IS NOT ALWAYS THE DATE THE DEDUCTIBLE WAS APPLIED.

IMPORTANT IF YOU DO NOT AGREE WITH THE AMOUNTS APPROVED YOU MAY ASK FOR A REVIEW. TO DO THIS YOU MUST WRITE TO US BEFORE OCT 20 1990. (SEE ITEM 1 ON THE BACK.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? IF YOU BELIEVE MEDICARE PAID FOR A SERVICE YOU DID NOT RECEIVE, OR THERE IS AN ERROR, CONTACT US IMMEDIATELY. ALWAYS GIVE US THE:

MEDICARE CLAIM NO. 585-26-9503A CLAIM CONTROL NO. FOR CLAIM IN QUESTION

PLEASE WRITE TO US AT THE ABOVE ADDRESS OR VISIT US AT:

600 SECOND STREET N W, 5TH FLOOR
ALBUQUERQUE, NM 87102

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

NM-2S-057980

HEALTH CARE FINANCING ADMINISTRATION

THIS CONTINUES EXPLAINING BENEFITS ON CLAIM CONTROL NUMBER - 0000255352110
FOR HEALTH INSURANCE CLAIM NUMBER - 585-26-9503A

IMPORTANT IF YOU DO NOT AGREE WITH THE AMOUNTS APPROVED YOU MAY ASK FOR A REVIEW. TO DO THIS YOU MUST WRITE TO US BEFORE OCT 01 1990. (SEE ITEM 1 ON THE BACK.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? IF YOU BELIEVE MEDICARE PAID FOR A SERVICE YOU DID NOT RECEIVE, OR THERE IS AN ERROR, CONTACT US IMMEDIATELY. ALWAYS GIVE US THE:

MEDICARE CLAIM NO. 585-26-9503A CLAIM CONTROL NO. FOR CLAIM IN QUESTION

PLEASE WRITE TO US AT THE ABOVE ADDRESS OR VISIT US AT:

600 SECOND STREET N W, 5TH FLOOR
ALBUQUERQUE, NM 87102

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

NM-U-000528

HEALTH CARE FINANCING ADMINISTRATION

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

JULY 24, 1990

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

MARION S HOPKINS
1502 W TILDEN
ROSWELL NM 88201-1977

YOUR HEALTH INSURANCE CLAIM NUMBER

440-10-6190A

FOR MEDICAL SERVICES YOU RECEIVE ON OR AFTER SEPTEMBER 1, 1990, YOUR DOCTOR OR THE COMPANY THAT PROVIDES YOUR MEDICAL SERVICES , EQUIPMENT OR SUPPLIES MUST PREPARE AND SUBMIT YOUR PART B MEDICARE CLAIMS.

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIMS. SEE THE BACK OF THIS NOTICE FOR AN EXPLANATION OF ASSIGNMENT. WRITE OR CALL US FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER OR FOR A FREE LIST OF PARTICIPATING DOCTORS AND SUPPLIERS.

\ R DOCTOR OR SUPPLIER DID NOT ACCEPT ASSIGNMENT OF YOUR CLAIM(S) TOTALLING $ 91.80. (SEE ITEM 4 ON BACK). CLAIM CONTROL NUMBER IS 00019472321OO.

		BILLED	APPROVED
ROSWELL RADIOL			
1-DIAGNOSTIC X-RAY THIS SERVICE WAS PAID UNDER A FEE SCHEDULE.	JUN 11,1990	$ 91.80	$ 46.52
TOTAL APPROVED AMOUNT			$ 46.52
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)			$ 37.22
MEDICARE PAYMENT AFTER 1.4% GRAMM-RUDMAN REDUCTION			$ 36.70

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 1.4 PERCENT FOR SERVICES YOU RECEIVED BETWEEN APRIL 1, 1990 AND SEPTEMBER 30, 1990.

YOU ARE RESPONSIBLE FOR A TOTAL OF $ 55.10, THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND THE MEDICARE PAYMENT. YOU COULD HAVE AVOIDED PAYING $ 45.28, THE DIFFERENCE BETWEEN THE BILLED AND APPROVED AMOUNTS, IF THE CLAIM(S) HAD BEEN ASSIGNED.

55.10 Due

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

NM-U-000529

THIS CONTINUES EXPLAINING BENEFITS ON CLAIM CONTROL NUMBER - 0001947232100
FOR HEALTH INSURANCE CLAIM NUMBER - 440-10-6190A

- WE ARE PAYING A TOTAL OF $ 36.70 TO YOU ON THE ENCLOSED CHECK.
PLEASE CASH IT AS SOON AS POSSIBLE.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET THE DEDUCTIBLE FOR 1990.) THE DATE AT THE TOP OF THIS EXPLANATION OF MEDICARE BENEFITS IS NOT ALWAYS THE DATE THE DEDUCTIBLE WAS APPLIED.

IMPORTANT IF YOU DO NOT AGREE WITH THE AMOUNTS APPROVED YOU MAY ASK FOR A REVIEW. TO DO THIS YOU MUST WRITE TO US BEFORE JAN 24 1991. (SEE ITEM 1 ON THE BACK.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? IF YOU BELIEVE MEDICARE PAID FOR A SERVICE YOU DID NOT RECEIVE, OR THERE IS AN ERROR, CONTACT US IMMEDIATELY. ALWAYS GIVE US THE:

MEDICARE CLAIM NO. 440-10-6190A CLAIM CONTROL NO. 0001947232100

PLEASE WRITE TO US AT THE ABOVE ADDRESS OR VISIT US AT:

600 SECOND STREET N W, 5TH FLOOR
ALBUQUERQUE, NM 87102

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

NM-2S-048881

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

JULY 13, 1990

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

ROSIE DURAN
1015 S MULBERRY
ROSWELL NM 88201-6887

YOUR HEALTH INSURANCE CLAIM NUMBER

525-50-6608A

ASSIGNMENT WAS TAKEN ON YOUR CLAIM (CONTROL NO:0001766441000 FOR $ 22.50 FROM P KELLEY DO .) SEE ITEM 4 ON BACK

		BILLED	APPROVED
1-OFFICE SERVICES	JUN 19,1990	$ 22.50	$ 22.50

TOTAL APPROVED AMOUNT	$ 22.50
MINUS YOUR DEDUCTIBLE REMAINING FOR 1990	$ 10.00
AMOUNT REMAINING AFTER SUBTRACTING DEDUCTIBLE AMOUNT	$ 12.50
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT REMAINING)	$ 10.00
MEDICARE PAYMENT AFTER 1.4% GRAMM-RUDMAN REDUCTION	$ 9.86

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 1.4 PERCENT FOR SERVICES YOU RECEIVED BETWEEN APRIL 1, 1990 AND SEPTEMBER 30, 1990. SINCE YOUR DOCTOR (SUPPLIER) TOOK YOUR CLAIM ON ASSIGNMENT, THE DOCTOR (SUPPLIER) AGREES TO ACCEPT THIS LOWER PAYMENT.

REMARKS:

INFORMATION REGARDING THIS CLAIM WILL BE FORWARDED TO YOUR MEDICARE SUPPLEMENTAL INSURER WITHIN THE NEXT 30 DAYS. QUESTIONS REGARDING PAYMENT OF SUPPLEMENTAL BENEFITS SHOULD BE DIRECTED TO THAT INSURER.

WE ARE PAYING A TOTAL OF $ 9.86 TO P KELLEY DO .

YOU ARE RESPONSIBLE FOR THE DIFFERENCE OF $ 12.50 BETWEEN THE APPROVED AMOUNT AND THE MEDICARE PAYMENT.

A COPY OF THIS EOMB HAS BEEN FORWARDED TO YOUR MEDICARE SUPPLEMENTAL INSURER. QUESTIONS REGARDING PAYMENT OF SUPPLEMENTAL BENEFITS SHOULD BE DIRECTED TO THAT INSURER.

12.64 Due

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

NM-U-000890

HEALTH CARE FINANCING ADMINISTRATION

AETNA MEDICARE
MEDICARE CLAIMS ADMIN
POST OFFICE BOX 25500
OKLAHOMA CITY OK 73125

MAY 10, 1990

HAVE MEDICARE QUESTIONS? CONTACT:
(505) 843-7771 OR TOLL
FREE 1-800-423-2925.

MARION S HOPKINS
1502 W TILDEN
ROSWELL NM 88201-1977

YOUR HEALTH INSURANCE CLAIM NUMBER

440-10-6190A

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIMS. SEE THE BACK OF THIS NOTICE FOR AN EXPLANATION OF ASSIGNMENT. WRITE OR CALL US FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER OR FOR A FREE LIST OF PARTICIPATING DOCTORS AND SUPPLIERS.

YOUR DOCTOR OR SUPPLIER DID NOT ACCEPT ASSIGNMENT OF YOUR CLAIM(S) TOTALLING $ 26.52. (SEE ITEM 4 ON BACK).

		BILLED	APPROVED
ROSWELL RADIOL			
1-DIAGNOSTIC X-RAY THIS SERVICE WAS PAID UNDER A FEE SCHEDULE.	JAN 23,1990	$ 26.52	$ 16.15

TOTAL APPROVED AMOUNT	$ 16.15
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)	$ 12.92
MEDICARE PAYMENT AFTER 2.092% GRAMM-RUDMAN REDUCTION	$ 12.65

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 2.092 PERCENT FOR SERVICES YOU RECEIVED BETWEEN OCTOBER 17, 1989 AND MARCH 31, 1990.

YOU ARE RESPONSIBLE FOR A TOTAL OF $ 13.87, THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND THE MEDICARE PAYMENT. YOU COULD HAVE AVOIDED PAYING $ 10.37, THE DIFFERENCE BETWEEN THE BILLED AND APPROVED AMOUNTS, IF THE CLAIM(S) HAD BEEN ASSIGNED.

WE ARE PAYING A TOTAL OF $ 12.65 TO YOU ON THE ENCLOSED CHECK. PLEASE CASH IT AS SOON AS POSSIBLE.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

13.87 due

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS - THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

NM-U-000891

THIS CONTINUES EXPLAINING BENEFITS ON CLAIM CONTROL NUMBER - 0001167094900
FOR HEALTH INSURANCE CLAIM NUMBER - 440-10-6190A

(YOU HAVE MET THE DEDUCTIBLE FOR 1990.) THE DATE AT THE TOP OF THIS EXPLANATION OF MEDICARE BENEFITS IS NOT ALWAYS THE DATE THE DEDUCTIBLE WAS APPLIED.

IMPORTANT IF YOU DO NOT AGREE WITH THE AMOUNTS APPROVED YOU MAY ASK FOR A REVIEW. TO DO THIS YOU MUST WRITE TO US BEFORE NOV 10 1990. (SEE ITEM 1 ON THE BACK.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? IF YOU BELIEVE MEDICARE PAID FOR A SERVICE YOU DID NOT RECEIVE, OR THERE IS AN ERROR, CONTACT US IMMEDIATELY. ALWAYS GIVE US THE:

MEDICARE CLAIM NO. 440-10-6190A CLAIM CONTROL NO. 0001167094900

PLEASE WRITE TO US AT THE ABOVE ADDRESS OR VISIT US AT:

600 SECOND STREET N W, 5TH FLOOR
ALBUQUERQUE, NM 87102

Notice Federal Employees Coverage in Comparison to Medicare –

STATEMENT

RICHARD J. SIDD, M.D.
OPHTHALMOLOGY, EYE DISEASE, OCULAR PLASTIC SURGERY
207 NORTH UNION
ROSWELL, NEW MEXICO 88201

TELEPHONE (505) 622-7295

ORGAN, MARY L.
1414 S. Union, #E-14
Roswell, NM 88201

623-4819

DATE	FAMILY MEMBER	PROFESSIONAL SERVICE	CHARGE	CREDITS PAYM'TS	CREDITS ADJ.	BALANCE
		BALANCE FORWARD				
4/5/89	Mary	OV	55.00	55.00		-0-
5/2/90	Mary	[illegible]	180.00			180.00
5/22/90	Mary	[illegible] 5/22	2000.00			2180.00
6/14/90		[illegible] Surgery 5/22	200.00			2380.00
7/1/90		[illegible] 5/22 [illegible]		1522.50	100.00	757.50
8/21/90		adjust			200.00	557.50

PAY LAST AMOUNT IN THIS COLUMN

Medicare

BLUE CROSS – [illegible]

[illegible]74572

[illegible] $350 deductible

DOB-11/28/11

1209 290 Blue Cross • Blue Shield •

FEDERAL EMPLOYEE PROGRAM

EXPLANATION OF BENEFITS

BATCH 72069

DATES:
RECEIVED 08/08/90
PROCESSED 08/22/90
PAID 08/22/90

NEW MEXICO BLUE CROSS AND BLUE SHIELD
12800 INDIAN SCHOOL ROAD N.E.
ALBUQUERQUE NEW MEXICO 87112

ID NUMBER
R50744572

SUBSCRIBER
ML ORGAN

CLAIM NUMBER
902250183

PATIENT NAME
MARY ORGAN

ML ORGAN
1414 S UNION APT E14
ROSWELL NM
88201

CHECK NO 00766084

We are pleased to provide you with a record of your recent claim transactions. This notice describes benefit payments and denials under your Federal Employee Program coverage.
Please keep this notice for income tax purposes.

Any resubmission of eligible expenses must be received no later than December 31 of the year following the date of service, or 90 days from the date of the form, whichever is later.
Please contact us if you have any questions.

SUMMARY OF STANDARD OPTION BENEFITS ON THIS CLAIM

TOTAL CHARGES SUBMITTED:	224.68
LESS OTHER CHARGES:	13.73
LESS COINSURANCE:	52.72
TOTAL AMOUNT OF FEP BENEFITS ON THIS CLAIM	158.23

BENEFIT CHECK ENCLOSED

BENEFITS SUBJECT TO CALENDAR YEAR DEDUCTIBLE AND COINSURANCE

PROVIDER	TYPE OF SERVICE	PLACE OF SERVICE	FROM AND TO SERVICE DATES		COINS. %	PROVIDER CHARGES	COVERED CHARGES	OTHER CHARGES
SAFEWAY	DRUGS MEDICINES	CO	03/07	03/07/90	25	5.28	5.28	
STRANGEB	LABORATORY	30	03/12	03/12/90	25	43.39	36.30	7.09
STRANGEB	SURGERY	30	03/12	03/12/90	25	11.64	5.00	6.64
STRANGEB	MEDICAL CARE	30	03/19	03/19/90	25	70.20	70.20	
STRANGEB	DIAGNOSTIC TEST	30	03/19	03/19/90	25	38.22	38.22	
FURRSPHA	DRUGS MEDICINES	CO	05/21	05/21/90	25	22.95	22.95	
IKAREOPT	DURABLE MED EQUIP PURCHASE	30	07/25	07/25/90	25	33.00	33.00	
				TOTALS:		$224.68	$210.95	$13.73

TOTAL OF COVERED CHARGES:	210.95
LESS COINSURANCE:	52.72
AMOUNT OF BENEFITS:	158.23

FOR YOUR INFORMATION

THIS IS NOT A BILL

TO DATE THIS PERSON HAS SATISFIED $250.00 OF HIS/HER DEDUCTIBLE OR $250.00 FOR THE YEAR 1990.

$565 PROVIDED TOWARD THE $2,500 CATASTROPHIC PROTECTION BENEFIT FOR 1990.

THE CHARGE SUBMITTED EXCEEDS THE UCR ALLOWANCE FOR THESE SERVICES BY $13.73. YOU ARE NOT RESPONSIBLE FOR THIS DIFFERENCE. SEE A BELOW.

FOR MORE INFORMATION, PLEASE READ THE FOLLOWING SECTION(S) OF YOUR SERVICE BENEFIT BROCHURE, WHICH IS THE OFFICIAL EXPLANATION OF YOUR COVERAGE.
A. SURGICAL-MEDICAL BENEFITS

4C1-67012 Rev. 01/28/89

(CONTINUED)

1429 290 Blue Cross • Blue Shield •

FEDERAL EMPLOYEE PROGRAM

EXPLANATION OF BENEFITS

BATCH 78917

DATES:
RECEIVED 06/19/90
PROCESSED 07/19/90
PAID 07/19/90

NEW MEXICO BLUE CROSS AND BLUE SHIELD
12800 INDIAN SCHOOL ROAD N.E.
ALBUQUERQUE NEW MEXICO 87112

ID NUMBER
R50744572

SUBSCRIBER
ML ORGAN

ML ORGAN
1414 S UNION APT E14
ROSWELL NM
88201

CLAIM NUMBER
901700I512

PATIENT NAME
MARY ORGAN

CHECK NO 00748868

We are pleased to provide you with a record of your recent claim transactions. This notice describes benefit payments and denials under your Federal Employee Program coverage.
Please keep this notice for income tax purposes.

Any resubmission of eligible expenses must be received no later than December 31 of the year following the date of service, or 90 days from the date of the form, whichever is later.
Please contact us if you have any questions.

SUMMARY OF STANDARD OPTION BENEFITS ON THIS CLAIM

TOTAL CHARGES SUBMITTED:	2,380.00
LESS OTHER CHARGES:	100.00
LESS CALENDAR YEAR DEDUCTIBLE APPLIED:	250.00
ESS COINSURANCE:	507.50
OTAL AMOUNT OF FEP BENEFITS ON THIS CLAIM	1,522.50

BENEFIT CHECK SENT TO RICHARD J SIDD MD

BENEFITS SUBJECT TO CALENDAR YEAR DEDUCTIBLE AND COINSURANCE

PROVIDER	TYPE OF SERVICE	PLACE OF SERVICE	FROM AND TO SERVICE DATES	COINS. %	PROVIDER CHARGES	COVERED CHARGES	OTHER CHARGES
SIDD	XRAY	30	05/02 05/02/90		140.00	140.00	
SIDD	MEDICAL CARE	30	05/02 05/02/90		40.00	40.00	
SIDD	SURGERY	20	05/22 05/22/90	25	2200.00	2100.00	100.00
			TOTALS:		$2380.00	$2280.00	$100.00

TOTAL OF COVERED CHARGES:	2,280.00
LESS DEDUCTIBLE NOT PREVIOUSLY SATISFIED:	250.00
LESS COINSURANCE:	507.50
AMOUNT OF BENEFITS:	1,522.50

FOR YOUR INFORMATION

TO DATE THIS PERSON HAS SATISFIED $250.00 OF HIS/HER DEDUCTIBLE OF $250.00 FOR THE YEAR 1990.

$508 PROVIDED TOWARD THE $2,500 CATASTROPHIC PROTECTION BENEFIT FOR 1990.

THE CHARGE SUBMITTED EXCEEDS THE UCR ALLOWANCE FOR THESE SERVICES BY $100.00. YOU ARE NOT RESPONSIBLE FOR THIS DIFFERENCE. SEE A BELOW.

FOR MORE INFORMATION, PLEASE READ THE FOLLOWING SECTION(S) OF YOUR SERVICE BENEFIT BROCHURE, WHICH IS THE OFFICIAL EXPLANATION OF YOUR COVERAGE.
A. SURGICAL-MEDICAL BENEFITS

EXPLANATION OF PLACE OF SERVICE CODES:
30 PROVIDER'S OFFICE
20 HOSPITAL OUTPATIENT

4C1-57012 Rev. 01/28/88

EXHIBIT IV

MEDICAID ELIGIBILITY I.D.

CASE NUMBER XXXXXXXX CATEGORY 040
PROVIDER: SEE BELOW

NM Human Services Department
MEDICAID ELIGIBILITY I.D.

EXPIRATION DATE: 08/31/90
START DATE: 08/01/90

NAME OF RECIPIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RECIPIENT INSURANCE INFORMATION 413017
01VELMA C RUSSELL	525809762	082712	
** *** SERVICES ARE LIMITED TO MEDICARE *** CO-INSURANCE AND DEDUCTIBLES. *** DRUGS ARE NOT A COVERED SERVICE.			POLICY HOLDER: *** *** POLICY NUMBER: GROUP NUMBER: FOR RECIPIENTS:
MEDICAL MANAGEMENT PHYSICIAN NAME	MEDICAL MANAGEMENT PHARMACY		PROVIDER INSTRUCTIONS: USE RECIPIENT'S OWN SOCIAL SECURITY NUMBER FOR BILLING PURPOSES.

This card certifies eligibility for Medicaid benefits for those persons whose names appear on this card. CAUTION: The Health Care Provider should verify identity of the recipient by requesting other documentation. This card is void after the expiration date. The card may also show limitations such as medical management, or pregnancy--related services only. Medicaid is a limited benefit program. Certain services require prior approval from the NMMRA. Contact the Medical Assistance Division, PO Box 2348, Santa Fe, New Mexico 87504-2348, Phone (505) 827-4315, for information.

Signature

EXHIBIT IV

01 03 295056948
MELVIN K JILES
211 MCGAFFEY
ROSWELL NM 88201

Receives $1.90 per month from SSI

CASE NUMBER 01 0392 950569 48 NM Human Services Department EXPIRATION DATE: 08/31/90
MEDICAID ELIGIBILITY I.D. START DATE: 03/01/90

NAME OF RECIPIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RECIPIENT INSURANCE INFORMATION
JILES MELVIN K MEDICAID BILLING NO: 01 0392 950569 48 * * MEDICARE ELIGIBLE * * HIC # 295056943A	295056948	031915	POLICY HOLDER: POLICY NUMBER: GROUP NUMBER: FOR RECIPIENTS:
MEDICAL MANAGEMENT PHYSICIAN NAME	MEDICAL MANAGEMENT PHARMACY		
NOT APPLICABLE	NOT APPLICABLE		

This card certifies eligibility for Medicaid benefits for those persons whose names appear on this card. CAUTION: The Health Care Provider should verify identity of the recipient by requesting other documentation. This card is void after the expiration date. The card may also show limitations such as medical management, or pregnancy--related services only. Medicaid is a limited benefit program. Certain services require prior approval from the NMMPA. Contact the Medical Assistance Division, PO Box 2348, Santa Fe, New Mexico 87504-2348, Phone (505) 827-4315, for information.

Signature

REMOVE MEDICAID I.D. BY SEPARATING ALONG PERFORATION

CLIENT IDENTIFICATION NUMBER	CHECK AMOUNT	BENEFIT MONTH
	$	

KEEP THIS STUB FOR YOUR RECORDS

MESSAGE

USE OF THIS CARD MEANS YOU GIVE TO THE STATE YOUR RIGHT TO GET INSURANCE OR OTHER PAYMENTS FOR MEDICAL TREATMENT WHICH HAS BEEN PAID BY THE STATE.

EXHIBIT IV (CONT'D)

01 03 585084090
ANNIE P JILES
211 MCGAFFEY
ROSWELL NM 88201

Receives 1.90 p/month from SSI

CASE NUMBER 01 0395 850840 90 NM Human Services Department
MEDICAID ELIGIBILITY I.D.
EXPIRATION DATE: 08/31/90
START DATE: 03/01/90

NAME OF RECIPIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RECIPIENT INSURANCE INFORMATION
JILES ANNIE P MEDICAID BILLING NO: 01 0395 850840 90 * * MEDICARE ELIGIBLE * * HIC # 295056948B	585084090	090210	POLICY HOLDER: POLICY NUMBER: GROUP NUMBER: FOR RECIPIENTS:
MEDICAL MANAGEMENT PHYSICIAN NAME	MEDICAL MANAGEMENT PHARMACY		
NOT APPLICABLE	NOT APPLICABLE		

This card certifies eligibility for Medicaid benefits for those persons whose names appear on this card. CAUTION: The Health Care Provider should verify identity of the recipient by requesting other documentation. This card is void after the expiration date. The card may also show limitations such as medical management, or pregnancy—related services only. Medicaid is a limited benefits program. Certain services require prior approval from the NMMRA. Contact the Medical Assistance Division, PO Box 2348, Santa Fe, New Mexico 87504-2348, Phone (505) 827-4313, for information.

Signature

REMOVE MEDICAID I.D. BY SEPARATING ALONG PERFORATION

CLIENT IDENTIFICATION NUMBER	CHECK AMOUNT	BENEFIT MONTH
	$	

KEEP THIS STUB FOR YOUR RECORDS

MESSAGE

USE OF THIS CARD MEANS YOU GIVE TO THE STATE YOUR RIGHT TO GET INSURANCE OR OTHER PAYMENTS FOR MEDICAL TREATMENT WHICH HAS BEEN PAID BY THE STATE.