F I S C A L I M P A C T R E P O R T

SPONSOR Madalena **ORIGINAL DATE** 02/10/14 **LAST UPDATED** 02/18/14 **HB** 337/aHAFC

SHORT TITLE Native Americans in Medicaid Managed Care **SB**

ANALYST Geisler

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY14	FY15	FY16	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
IT Costs	$341.0	$0.0	$0.0	$341.0	Nonrecurring	SGF and Federal matching Funds
Centennial Care Costs	$0.0	Unable to Determine/ Potentially Significant	Unable to Determine/ Potentially Significant	Unable to Determine/ Potentially Significant	Recurring	SGF and Federal matching Funds
Targeted Outreach Costs	$0.0	$90.7	$90.7	$181.4	Recurring	SGF and Federal Matching Funds
Actuarial and Education Costs	$165.2	$0.0	$0.0	$165.2	Nonrecurring	SGF and Federal matching Funds
Ongoing Administrative Costs	$0.0	$88.0	$88.0	$176.0	Recurring	SGF and Federal matching funds

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates SB 284
Relates to HB 60

SOURCES OF INFORMATION
LFC Files

Responses Received From
Indian Affairs Department (IAD)
Human Services Department (HSD)

SUMMARY

Synopsis of HAFC Amendments

The House Appropriation and Finance Committee amendments to House Bill 337 strike the $100

thousand appropriation contained to implement the provisions of the bill.

Synopsis of Original Bill

House Bill 337 amends the Public Assistance Act to remove Native Americans from mandatory enrollment in Medicaid managed care. Specifically, any recipient who self-identifies as a Native American shall not be required to enroll in a Medicaid managed care program. The Department shall afford any recipient who self-identifies as a Native American the option of enrolling in a Medicaid managed care or medical fee-for-service program upon determination of eligibility. Also, the department shall enroll a Native American into Medicaid fee-for-service unless the recipient affirmatively chooses to enroll in a Medicaid managed care organization. Additionally, Native Americans have an opportunity every six months to enroll or disenroll in either a Medicaid managed care program or a Medicaid fee-for-service program. HB 337 also includes a requirement for HSD to conduct targeted outreach to enroll Native Americans into Medicaid and includes a general fund appropriation of $100 thousand to implement the provisions of the bill.

FISCAL IMPLICATIONS

HB 337 includes a $100 thousand appropriation to implement the provisions of the bill, which HSD notes can be matched with $100 thousand in federal funds. Because section 2 of the bill requires the department to conduct Medicaid outreach, the appropriation should be considered recurring. HSD has provided an estimated FY14 impact of $506.2 thousand from changes needed due to HB 337 contained in section 1 of the bill, comprised of $341 thousand for IT system changes and $165.2 in costs to amend the Medicaid waiver and for statewide outreach to notify Native Americans of the change in their options. Starting in FY15, on-going administrative costs would be $88 thousand annually and outreach costs would be $90.7 thousand.

However, advocates for HB 337 believe that the changes proposed in the bill may actually save the state money by allowing Native Americans to opt-out of managed care.

HSD Input

Centennial Care requires all Medicaid recipients, including Native Americans, who receive long term care services or who are enrolled in both Medicare and Medicaid (dual eligibles) to enroll in Centennial Care managed care. All other recipients, except for Native Americans, are also required to be in managed care. Native American Medicaid recipients who are not otherwise required to be in managed care are placed in fee-for-service Medicaid unless they choose to be in Centennial Care managed care.

The bill's requirement to place all Native Americans in fee-for-service would require significant changes to the ASPEN eligibility system and the Medicaid Management Information System (MMIS). The ASPEN system and MMIS are currently programmed to support Centennial Care as it now operates, as described above. The MMIS would have to be re-programmed to not automatically enroll any Native American into Centennial Care managed care. It would also have to be re-programmed to accommodate the ability of Native Americans to switch between fee-for-service and managed care every six months. It is estimated this programming would take between three and six months and other important work would be delayed in order to make the programming changes. The YES-NM web portal and its interface with the ASPEN eligibility

system would require changes to allow Native Americans "to identify themselves as Native Americans" in response to communications from the department requesting the selection of an MCO; this self-identification generally occurs today at the time of application.

The estimated combined programming costs for OmniCaid, ASPEN and YES-NM is $341,000 – this is funding that is not currently budgeted. There are also the opportunity costs of having to postpone other work, such as making changes to receive more complete and accurate encounters. Such a project could also affect New Mexico's ability to comply with the federal government's ICD-10 code mandate, which has a deadline of October 1, 2014, and to develop the complex interfaces between ASPEN and the State-Based Health Insurance Exchange.

Additional operational costs include periodic mailings to notify Native Americans of their opportunity to enroll in or disenroll from a Centennial Care MCO and higher fee-for-service claim volume processed by the Medicaid fiscal agent contractor. These functions are estimated to cost $88,000 per year. The Medicaid budget has been developed to include the budget neutrality calculation as agreed upon with the Centers for Medicare and Medicaid Services (CMS) in the department's approved Section 1115 Centennial Care waiver. The waiver's budget neutrality calculation included Native Americans who are dual eligibles or who receive long-term services and supports being in managed care. Not requiring Native Americans who meet these criteria to enroll in managed care would necessitate revising the budget neutrality calculation and amending the current Section 1115 Centennial Care waiver agreement. The current waiver took well over a full year to negotiate and opening it to this change would also open it to other changes. This would likely take at least several months to accomplish at a one-time cost of $133,000, which was not contemplated in the budget. In addition, the overall Medicaid budget would have to be redeveloped to account for a larger fee-for-service population.

Among the goals of Centennial Care is to ensure the sustainability of the Medicaid program given Medicaid expansion and the steady upward pressure of health care costs. No managed care program can be sustained when members are able to move in and out of the program every six months. Managed care rates are based on an expected number of member months of enrollees over a 12-month period. Allowing more than 100,000 Native American Medicaid recipients to switch between managed care and fee-for-service on a regular basis will make the development of actuarially sound rates extremely difficult and would most likely result in increased rates to the plans, which will in turn increase the cost of the program.

To ensure that Native American recipients understand their options and the implications (particularly for recipients requiring long-term care services) of receiving Medicaid benefits via fee-for-service, statewide mailings and education events must be planned and executed prior to the effective date of the change. These one-time costs are estimated at $32,200. Finally, the department estimates that the targeted outreach statewide that would be required under Section 2 of the bill would require approximately $90,000 for personnel and travel costs.

Perspective of Advocates and IAD

Advocates for HB 337, including the Center for Law and Poverty, note that under the current system the state saves money on Native Americans not enrolled in managed care who receive services at Indian Health Service (IHS) or Tribal organizations, because these services are reimbursed at 100 percent by the federal government. By this logic, moving Native Americans into managed care and paying a monthly capitated rate of several hundred dollars to a managed care company may cost the state due to a lower federal match, particularly for children. At the

same time, managed care companies have struggled to provide an adequate network of providers in rural New Mexico, so there is a risk that capitated payments will be made for clients who will not receive the same level of service that is available in urban areas. Advocates argue that moving Native Americans to managed care is likely to have a negative impact on the finances at IHS and Tribal health facilities.

SIGNIFICANT ISSUES

Native American Concerns on HSD's Medicaid Program (Centennial Care)

Advocates for Native Americans note that the bill is aimed at maintaining fee-for-service Medicaid for Native Americans and supports the continuation of the managed care "opt out" option currently in place. The Centers for Medicare and Medicaid Services (CMS) held a tribal consultation with tribal representatives on November 27, 2012 regarding the Centennial Care proposed 1115 Medicaid waiver. Tribal leaders observed that numerous acts of Congress have established the federal responsibility for health care for members of tribes not only in principle but also in practice and questioned state authority to mandate fundamental changes in the delivery of health care to Native Americans. Tribal leaders called the waiver an infringement of tribal sovereignty and noted that the State had not produced data to support its claim of improved outcomes in managed care.

Many tribal leaders explained they live in very rural and remote communities. They expressed the concern that the Primary Care Physicians (PCPs) will reside in urban communities which may be as far as 200 miles away. Indian people are comfortable with IHS, tribal leaders noted, and they are not inclined to travel to long distances to obtain their health care. Tribal leaders described Native people in Salud! managed care program who were assigned PCPs in distant cities. They said these health care providers never physically see their patients, who as a matter of course seek their health care from the local service unit. They complained of the delays in the delivery of care when the service unit has to obtain permission from patients' PCPs. Tribal leaders noted that when Native people received an opt out option for Medicaid managed care, the system worked relatively well, because community members could access their health care from MCOs if it personally worked for them.

HSD Input on Significant Issues

HSD notes the department's Section 1115 Centennial Care waiver was approved by the Obama Administration on July 12, 2013. CMS approved the required enrollment of dually eligible Native Americans and Native Americans who receive long-term services into Centennial Care managed care. If enacted, this bill would require the waiver to be amended, which would take a number of months, at best, to complete. The department's Centennial Care waiver covers long-term care services (home and community-based services and nursing home services) only in the Centennial Care managed care program. Individuals who need these services but choose to be in fee-for-service will not be able to get these services through the Medicaid program. There is a question as to whether this bill really provides Native American recipients the choice it intends since not all services are available on a fee-for-service basis. People who, in spite of outreach and education, do not understand that they need to choose to be in managed care to get their services will risk a disruption in essential care

Enrollment in Centennial Care will increase provider choice for all Medicaid recipients. Specifically, in Centennial Care, Native Americans may access care at the IHS, a Tribal 638

provider, an urban Indian program (together known as I/T/Us), as well as at a patient-centered medical home, a health home, or any other contracted provider in the member's MCO's network. In Centennial Care, Native Americans will be able to access care at any I/T/U provider they choose, whether the provider has a contract with the member's MCO or not, and the Native American member can choose any I/T/U provider, contracted or not, as their primary care provider (PCP). Very few services are available in a Fee for Service program

DUPLICATION AND RELATIONSHIP

HB 337 is a duplicate of SB 284. Additionally, Section 1 of HB 337 is a duplication of HB 60, although HB 337 adds Sections 2 and 3, including the appropriation of $100,000.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Advocates state that not passing House Bill 337 would mean that federal protections for Native Americans could be infringed upon by the state (assuming the state sought a waiver to require mandatory enrollment). This bill serves to preserve those federal protections while maintaining consistency with state Medicaid regulations. That preservation and consistency is crucial to protect the Native health system and ensure the best healthcare for tribal communities. HSD notes that Native American Medicaid recipients who receive long-term care services or who are dually eligible will continue to be required to enroll with a Centennial Care managed care organization and receive integrated health care services and care coordination in the Medicaid program, as approved by the Obama Administration. Other Native American Medicaid recipients will continue to be able to choose fee-for-service or managed care.

GG/ds:svb