MEMORANDUM

TO: John Arthur Smith, Chairman
Legislative Finance Committee

FROM: Charles Sallee, Deputy Director
Christine Boerner, Senior Fiscal Analyst
Dr. Jenny Felmley, Program Evaluator

DATE: May 12, 2016

SUBJECT: Medicaid Cost Containment

SUMMARY

Due to cost containment and other changes, last week HSD reported a $38.9 million reduction in state funds needed for FY17, reducing the projected shortfall to $24.5 million and bringing the FY17 projection in line with what the Legislature appropriated. The $24.5 million deficit is FY16 expenses being pushed forward, in part because HSD does not expect to receive $20 million in additional intergovernmental transfers from University New Mexico Hospital (UNM-H) in FY16. For FY17, the federal government will allow a moratorium on a health insurer fee, a federal tax which state actuaries are directed to build into MCO managed care premiums as a cost of doing business, saving the state about $18 million in general fund. The FY17 projection also includes $32 million in general fund savings anticipated from recently-proposed provider rate reductions. Ongoing risks include whether an additional $20 million of intergovernmental transfers from UNM-H will materialize in FY17 as budgeted and potential impacts of new federal requirements such as mental health and substance use disorder parity, managed care rules and access to care standards.

The General Appropriations Act of 2016 contains $928.6 million in general fund revenue for Medicaid (including about $15 million for administration), or about $21 million over the FY16 operating budget. With federal matching funds, appropriations to Medicaid will allow the program to spend $5.7 billion, or about $215 million more than the FY16 operating budget, but essentially flat with the FY16 projected level.

While FY17 pressures have eased, significant FY18 pressures continue. Changes in the state share of Medicaid expansion will increase again in FY18 and HSD expects a need to replace the $18 million temporary moratorium on insurer fees. While an FY18 projection is not yet available, the department estimates $60 million to $80 million in new general fund need above FY17 levels. These costs are before considering the costs of enrollment, price and utilization increases.

However, by FY18 the program could benefit from recommendations from the Medicaid Advisory Subcommittee tasked with saving $20 million in the areas of benefit package, eligibility verification and recipient cost-sharing (with an implementation target of January 1, 2017) as well as longer-term strategies such as targeted payment reform, expansion of health homes, workgroup efforts to reduce non-emergent use of ERs, and new ways to leverage Medicaid.

This memo provides additional detail regarding department cost containment efforts as well as the status of implementation or actions required. The memo also provides additional options for cost containment identified in recent LFC evaluations that would save an estimated $456 million in all funds; although, the department has disagreed with some of these findings. Finally, other options for consideration by the legislature are the ongoing tax expenditures for the health care sector, the fastest growing in the New Mexico's economy, which cost the general fund almost $300 million annually. Reducing these expenditures could help fund future Medicaid costs without significant burdens on citizens.

BACKGROUND

Medicaid: FY17 Budget. HSD's December 2015 FY17 Medicaid projection assumed spending would increase over $85 million ($519 million all funds) above the FY16 operating budget for a total budget of about $6 billion. This has since been revised downward by about $39 million in general fund need.

Similarly, HSD previously reported a structural deficit in Medicaid of $418 million in all funds, based on the results of the session and using a December Medicaid forecast; however, due to initial cost containment efforts and an estimated $18 million savings from a 2017 federal moratorium on a health insurer fee, that figure has been revised downward to about $93.5 million for FY17. The projection includes $161 million (all funds) in cost containment and $78.5 million (all funds) carried over from FY16.

Based on executive recommendations, the Legislature appropriated $21 million in other state funds for an FY16 supplemental funding request for Medicaid, in addition to $18 million from the general fund. The executive recommendation was to use intergovernmental transfer payments from UNM-H and Miners' Hospital. HSD indicated this month it is negotiating $1.3 million, slightly more than expected, from Miners' Hospital but that the $20 million additional IGT from UNM-H for FY16 is unlikely (over the existing IGT base of $23 million); consequently, HSD plans to "push forward" about $78.5 million (all funds) of expenditures into

FY17. HSD previously indicated it would seek a supplemental appropriation in the 2017 legislative session but has not specified an amount.

Authorized Deficit Spending. State law requires agencies to expend only amounts within authorized appropriations, and within the fiscal year the expenses were incurred, except for Medicaid. Section 6-10-4 authorizes DFA to approve agencies to spend money on prior year expenses for agencies but only if they had sufficient budget authority in the prior year. That same statute authorizes the Medicaid program to expend appropriations in the current year on prior year expenses, without DFA approval and even if the prior year had insufficient budget authority. When enacted, Medicaid relied more heavily on uncertain fee-for-service payments to providers and there was concern providers would not be paid for services at the end of the fiscal year due to timing issues. However, Medicaid operates largely under managed care where the state makes monthly premium payments to MCOs based on enrollment and has better forecasting of future expenses than in the past. Section 6-10-4 (B) essentially allows HSD to knowingly deficit spend and not live within legislatively authorized appropriations; however, in the event of a precipitous decline in revenues as happened in FY16, the flexibility allows the state to avoid serious interruptions to the program in order to live within the budget.

HSD requests and receives sizable supplemental and deficiency appropriations. The table below shows Medicaid received almost $182 million in appropriations from the general fund and other state funds since 2011 due to financial challenges in the program, including Medicaid shortfalls, reconciling cash, claiming federal funds or disallowed federal reimbursement.

Special, Supplemental, Deficiency Appropriations
(In thousands)

Fiscal Year	Amount Appropriated
2011	$5,500
2012	$7,000
2013	$54,700
2014	$0
2015	$0
2016	$75,745
2017	$39,000
Total	**$181,945**

Source: GAA

Note: 2017 includes $21 million in additional intergovernmental transfers

COST CONTAINMENT

Ways to Slow Spending Growth. While the projected $24.4 million ($93.5 million all funds) deficit for FY17 is much reduced from the $86 million shortfall projected earlier in the year, a significant portion of the savings is from a one-time (one year) moratorium on the federally required health insurer fee, which the state is required to build into MCO managed care rates as a

cost of doing business. That $18 million obligation will return in FY18 and likely increase somewhat since the federal government calculates the fees based on market share of premium revenue. Further, significant risks still exist for FY17, including the assumed additional $20 million additional intergovernmental transfer from UNM-H. Key drivers in HSD's projected spending include an additional 44 thousand New Mexicans onto the Medicaid rolls (for a total of 924,752 people) by June 2017, a reduction in federal matching funds for the expansion population, increased costs in the base Medicaid program, such as those associated with long term services and supports, and other revenue risks, such a declining tobacco revenue. Even small increases in costs to the base Medicaid program can result in very large dollar figures due to the sheer scale of the program.

HSD relies on managed care for the vast majority of clients. The cost of managed care to HSD is driven by enrollment and per member per month capitation payments (essentially a premium). The capitation payment amount per client is driven by historical and projected health prices (unit cost) for various services, what services are available (benefits), how much people use each service (utilization), and assumptions for administration, profit, taxes, fees and any other non-medical costs for the MCOs. To control spending, HSD has to make changes to any of these drivers, enrollment, prices (to providers and MCOs), utilization, or benefits.

HSD Efforts to Date. In December 2015, HSD negotiated MCO capitation rates effective January 2016 for a net reduction of 3.4 percent. Additional changes to be implemented July 1, 2016, are expected to reduce administration costs. This includes changes to care coordination to more effectively target high-needs/high cost members and changes to the member rewards program to better align rewards with the acuity of the Centennial Care population.

In April, following Medicaid Advisory Subcommittee deliberation and recommendations, HSD proposed provider rate reductions which, following a required public comment period and Centers for Medicare and Medicaid (CMS) approval, will become effective July 1, 2016 saving an estimated $26 million to $33.5 million in general fund.

Medicaid Advisory Committee. After the legislative session, HSD convened the MAC to brief members on the status of the projected deficit. The MAC formed three subcommittees to focus on provider rates; member benefits, copayments/premiums, and eligibility verification; and other long-term structural changes to the program. In early April the provider rate subcommittee forwarded recommendations to HSD estimated to save over $100 million in all funds, about $18-$25 million state match.

On April 26 the department released its final recommendations for rate reductions, which differed somewhat from the subcommittee proposal, in part because the subcommittee missed the $30 million savings target established by HSD. The department also sought to protect certain providers, such as behavioral health providers and long term care facilities to help reduce the impact on the fragile behavioral health system and other entities that have not experienced the significant gains from the ACA and the expansion of Medicaid that, for example, many hospitals have. The table below compares the final recommendations with the subcommittee proposals.

In general, HSD's estimated savings for cost containment rate reductions assume 80-20 federal-state matching rates; however, this could skew how much may really be needed in state funds

savings. Separating the expansion population (which continues to draw a much higher match rate) from the base program may be needed to get a better gauge on how much funding or cost containment is needed for each major component of the program.

Provider Rate Reductions - Targeted Reductions
(HSD Proposal in Bold)

	MAC Provider Payments Cost-Containment Subcommittee Phase 1 - Final Recommendation	HSD Proposed	Total Cost Savings	GF Savings	Implement Status
1	1% reduction for all services currently paid at 90% of Medicare (all codes except preventive and OB; includes BH therapies)	**2% reduction**	**$3-$4 million** $1.3-$1.5 million	**$650,000-$900,000** $260,000-$300,000	Public Comment and CMS approval
2	3% reduction for all services currently paid at 90-100% of Medicare (all codes except preventive and OB; includes BH therapies)	**4% reduction**	**$2-$3 million** $1-$1.2 million	**$400,000-$650,000** $200,000-$240,000	Public Comment and CMS approval
3	5% reduction for all services currently paid at greater than 100% of Medicare (all codes except preventive and OB; includes BH therapies) **Note: the GF savings in the original subcommittee estimate was found to be too low.**	**6% reduction**	**$24-$26 million** $3-$4 million	**$5-$6 million** $600,000-$800,000	Public Comment and CMS approval
4	Discontinue optional enhanced PCP rate increase established by the ACA	**Same as MAC Rec**	**$24-$26 million**	**$5-$6 million**	Public Comment and CMS approval
5	Adjust evaluation and management (E&M) codes to no less than 85% of Medicare rate OR **raise reimbursement for certain preventive service codes**	**5% raise for certain preventive service codes**	**($1-$1.5 million)**	**($200,000-$330,000)**	Public Comment and CMS approval
6	5% reduction - hospital inpatient	**Same as MAC Rec but 8% reduction for UNM Hospital**	**$38-$45 million** $34-$36 million	**$8-$10 million** $7-$9 million	Public Comment and CMS approval
7	3% reduction - hospital outpatient	**3% reduction for hospital OP; 5% reduction for UNM**	**$12.5-$17 million** $11-$13 million	**$3-$4 million** $2-$4 million	Public Comment and CMS approval
8	3% reduction - nursing facilities and ICF-IID	**Not proposed**	$7-$8 million	$2-$2.5 million	Public Comment and CMS approval
9	1% reduction - behavioral health providers and agencies (BH therapies and evaluations affected by items 1-3 above; this reduction applies to	**Not proposed**	$500,000-$750,000	$100,000-$150,000	Public Comment and CMS approval

	specialized BH services)				
10	1% reduction - community benefits providers and agencies	**Same as MAC**	**$3-$4 million**	**$850,000-$1.2 million** $900,000-$1.5 million	Public Comment and CMS approval
11	2% reduction - dental providers	**3% reduction for dental providers**	**$3-$4.5 million** $2-$3 million	**$600,000-$1 million** $400,000-$600,000	Public Comment and CMS approval
TOTAL:			***$136.5-$161 million*** *$101-114 million*	***$26-$33.5 million*** *$18.5-$25 million*	

Source: HSD

Other options that should be explored. While the department has made progress towards controlling costs, and the FY17 outlook is much improved, significant pressures exist for FY18. The state will likely have to continue investigating additional cost containment measures and revenue enhancements.

Rolling Back Provider Price Increases. Since 2012, the legislature appropriated $29.6 million in provider rate increases. For primary care providers (#4 above), the federal government initially picked up 100 percent of the cost, but the state chose to continue this increase. Backfilling temporary federal promises across government, though popular, does not appear sustainable given the state's revenue picture. Further, there is no evidence this bump in rates had any impact of bringing more primary care providers into the Medicaid network, as there is no evidence. In general, New Mexico Medicaid already paid most doctors better than surrounding states so the prospect of them leaving was low to begin with. The state's use of managed care provides an opportunity to pay variable rates to ensure MCOs have adequate networks of doctors – if they need to pay more to get more then they can and do. The federally funded rate increase was always intended to be temporary. The HSD recommendation for recurring doctors rate reductions (totaling about $7.6 million GF in items 1-3 above) are deeper than the MAC recommendations, but could be revisited by HSD and potentially reduced further.

The state also chose to pick up part of the cost previously born by local counties for rural hospital spending as part of the Uncompensated Care pool program (rate increases/supplemental payments). HSD used another $8 million in its budget to cover the remaining gap in county revenue for the program; an amount contributing to today's projected deficit. In its recommendations for rate reductions HSD proposes to reduce the Safety Net Care Pool (SNCP) enhanced rates to the level of matching funds available from counties and the $9 million general fund appropriation.

Rescinding Historical Rate Increases
FY13 to FY16

Session	Description	State Share	Federal Share	Total Savings	Implement. Status
Laws 2012, Ch. 19	Nursing Home Rate Increase	$8,100	$39,130	$47,230	Reduction Not proposed by HSD
Laws 2013, Ch. 227	Primary Care Rate Increase	$5,500	$26,570	$32,070	Same as MAC
Laws 2014, Ch. 63	Rate Increase for Nursing Home and Personal Care Providers	$5,000	$24,155	$29,155	Reduction Not proposed by HSD
Laws 2014, Ch. 63	GF for Safety Net Care Pool	$9,000	$43,478	$52,478	Reduction Not proposed by HSD
Laws 2015, Ch. 101	Medicaid Hospital Rate Increase	$1,000	$4,831	$5,831	HSD Proposed Reduction More than MAC
Laws 2015, Ch. 101	Medicaid Nursing Facility Rate Increase	$1,000	$4,831	$5,831	Reduction Not proposed by HSD
Total		**$29,600.0**	**$142,995**	**$172,595**	

Source: General Appropriations Acts

Managed Care Efficiencies. Numerous LFC staff reports have recommended continued efforts to lower the cost of managed care and ensure this finance approach works in the state's best interests. HSD to various degrees has implemented many of the recommendations but more is needed given the size of the projected Medicaid deficit. Some needed changes include:

- Ensuring Medicaid MCO rates are at the very bottom of federally allowable rate ranges wherever possible. HSD last fall did move in this direction, but additional savings could be had by going all the way to bottom and ensuring this is done for the long-term services portion of the program which still does not have 2016 agreed upon rates. However, the department has maintained that rates are not risk adjusted for the respective population in each MCO. For instance, one MCO may have a disproportionately higher rate of births, including high-risk births, than another and require a higher rate for that population. Consequently, if all MCO rates were at the bottom of the actuarially sound rate range, an individual MCO experiencing more risk could have no margin for this additional cost.

- Continue to take into account scale efficiencies in MCO administration; for example, the department reports a 15 percent cost growth in administration, care coordination and Centennial Rewards programs from CY14 to CY15. HSD has moved in this direction within care coordination and member rewards program (saving an estimated $3.5 million) but more is needed given the magnitude of enrollment growth.
- Reduce amounts built into rates for MCO profit/capital. HSD loads 2.25 percent into premiums currently. Projected managed care premiums are about $4.7 billion for FY17. Three MCOs reported net underwriting gains in their 2015 annual financial statements on Medicaid of $15.5 million, or 1.2 percent; $16.5 million, or 1.8 percent; and $58.6 million, or 5.4 percent. Blue Cross/Blue Shield does not file financial statements with New Mexico. One MCO made an extraordinary dividend payment of $72.5 million and another $20 million to parent companies. One MCO which contracts with a parent company for administration reported spending almost 20 percent of premiums on admin/taxes versus 15 percent like the other two. HSD has noted it plans to lower the profit ratio from 15 percent to 14 percent but doesn't anticipate savings because ***average*** administrative costs for MCOs are currently below 14 percent.
- Revisit pricing assumptions for Hepatitis C drugs. Both NMCD and IBAC agencies report lower average prices ($40-$60 thousand per treatment) for Hepatitis C drugs than HSD assumes MCOs can obtain ($80 thousand). HSD has built in an estimated $260 million into managed care rates for Hepatitis C treatment drugs. New lower cost drugs are emerging onto the market providing better price competition. To date the MCOs have treated far fewer people than had been assumed when the rates were developed. While a "risk corridor" will allow the department to recoup the majority of the additional funds allocated for Hep C treatment, HSD recently indicated it is investing the possibility that MCOs are not treating enough patients.
- Revisit profitability of sub-capitation payments for children. Previous LFC reports have found one MCO pays unusually large amounts (over $100 million) in premiums to its own provider group without enough scrutiny on the value to the state for this arrangement since kids tend to be inexpensive to care for and do not use many services.

Managed Care Efficiencies

Description	State Share	Federal Share	Total Savings	Implement. Status
MCO Rate Ranges	$15,000	$72,464	$87,464	Some but less than LFC
MCO Administration Efficiencies /Reductions – 10%	$6,100	$29,469	$35,569	Pending - Some but less than LFC
MCO Capital/Profit – Reduce by 20%	$3,400	$16,425	$19,825	Pending - Some but less than LFC
Hep C Pricing – 20%*	$7,800	$44,200	$52,000	Not clear beyond the "risk corridor"
Subcapitations for Kids – 5%	$1,035	$3,965	$5,000	None
Total	**$33,335**	**$166,523**	**$199,858**	

Source: LFC Estimates
*Assume 85% FMAP since population in need skewed towards Expansion program.

Suspending/ Reducing New Programs. The state has implemented three major new initiatives with Centennial Care that, given projected Medicaid deficits, should be revisited.

- A new program to pay hospitals for performance on quality of care indicators was part of the revamp of the sole community provider program. HSD projections, despite a current year deficit, assumed implementation of this program and more than doubles funding for FY17 to a projected $5.7 million. Given the scale of spending on hospitals in Medicaid and pending rate reductions, and that these types of programs have mixed evidence of effectiveness warrants HSD revisiting this program.
- Care coordination is costly with questionable results and a universal approach has proven difficult to implement and unlikely to save much. HSD should continue to evaluate care coordination and use software such as PRISM to identify high need/high risk populations based on claims and other criteria. The department conducted a small, 15 month pilot project for the top 10 "super utilizers" and noted average monthly ER visits dropped significantly. Reducing care coordination obligations on MCOs could allow more innovative management of utilization which is the whole point of privatizing Medicaid with MCOs.
- Eliminate Centennial Rewards program. This was an expansion program under Centennial care that could be suspended or eliminated. This program gives prizes to clients for completing certain health screenings and taking responsibility for their care in other ways, but few clients were using it. While HSD is moving to better align rewards with the acuity of the Centennial Care population, evidence of these types of wellness programs effectiveness is mixed at best.

New Programs

Description	State Share	Federal Share	Total Savings	Implement. Status
Hospital P4P	$1,193	$4,572	$5,765	HSD maintains as part of payment reform initiatives
Care Coordination – Reduce by 15%	$3,100	$14,976	$18,076	Some (July 2016) not as much as LFC
Reduce/Eliminate Centennial Rewards	$4,140	$15,860	$20,000	Some (July 2016) not as much as LFC
Total	$8,433	$35,408	$43,841	HSD proposed changes save an estimated $15 million (all funds)

Source: LFC Estimates
*Assume FMAP of 85% since population in need skewed towards Expansion program.

Controlling Utilization. HSD documents, and LFC evaluations completed last year, confirm decreases in utilization in many high cost centers in the program, including inpatient hospital, but prices and care continue to increase. For example, in the physical health portion of the program, inpatient utilization and inpatient days are down 11 to 12 percent, but costs are up 6 to 8 percent. Use of the emergency room, particularly for nonemergency health care continues to increase

according to HSD, driving costs higher. Co-pays could signal to clients the need to take more responsibility for accessing appropriate care and are being considered for recommendation by the Medicaid Advisory Subcommittee; however, this phenomenon could also signal access to primary care problems. HSD has built in, but never implemented, ER co-pays as part of Centennial Care. HSD has indicated expanding this authority might prove difficult given the federal restrictions.

Additionally and potentially more costly, the process and criteria to access personal care option services in long-term care portion of the program is resulting in substantial increases in costs to MCOs and to HSD to the tune of an estimated $118 million in capitation payments. More people than previously thought are accessing these services, many of whom have not ever received any long term care supports, which means the state must pay a physical health, behavioral health and now an additional long term services capitation payment that costs an average of $20 thousand per year. HSD audited the MCOs last fall to ensure appropriate eligibility for long term care services and confirmed they were all complying. It turns out changes in Centennial care lowered the eligibility bar for this service, which should be revisited given past experiences with PCO.

Finally, HB 2 assumes HSD would keep its utilization review contract flat in FY17 rather than increasing it by 119 percent from $4.8 million to $10.5 million. Again, most clients are in managed care, which already performs utilization review, and an increase of this magnitude for the small remaining fee-for-service population does not appear prudent given the financial circumstances facing the program. HSD has subsequently maintained the contract flat.

Controlling Utilization

Description	State Share	Federal Share	Total Savings	Implement. Status
ER Co-Pays	$621	$2,379	$3,000	Under consideration by MAC
PCO Eligibility	$5,300	$25,604	$30,904	None
Flat UR Contract	$1,425	$4,275	$5,700	Implemented
Total	$7,346	$32,258	$39,604	

Source: LFC Estimate

Other HB 2 assumptions not in current Medicaid projection. The Legislature considered other factors not included in HSD's current budget projection. As HSD updates its projections, it should revisit some of these assumptions and their applicability and impact on the projection. Many of the HB 2 assumptions would slow growth in the program (lower enrollment) or offset general fund need. For example, the federal government is implementing a new rule for Native Americans that would result in the federal government paying 100 percent of their medical care for not only services delivered by Indian Health Services (IHS), but also service provided by non-IHS providers as long as their care is coordinated. Other states with large Native American populations are planning significant savings. The department indicated this month that it joined a national workgroup of states to determine how it might best leverage the new rule for increased reimbursement for the 150,000 Native Americans enrolled in Medicaid. For a population this size even modest changes to payer mix could result in million of general fund savings. HB 2 assumes a modest general fund savings of $3 million. South Dakota, also a workgroup member,

is considering taking Medicaid expansion and using the savings from IHS and this rule to finance it.

OTHER REVENUE OPTIONS

Revisit Tax Code for Health Care Industry. The health care industry is one of the fastest, if not the fastest, growth sectors of New Mexico's economy due to a rapidly aging population and now Medicaid expansion. The legislature may wish to revisit tax expenditures for the health care industry and reduce or eliminate some of these expenditures that total nearly $300 million in forgone revenue. Previous LFC staff reports have not confirmed a clear benefit to some of these. And LFC reports have recommended a more aggressive phase out of the hold harmless distribution given the base is adjusted for inflation before TRD applies the incremental reduction required in statute. Local governments will be facing a large "cliff" at the end of the phase out. The state also exempts MCOs from the gross receipts tax and instead imposes a lower premium tax. And the state exempts non-profit health care providers, including hospitals. Given that the federal government pays the vast majority of health care expenses, the state is forgoing significant opportunity to capture revenue at significantly less burden to its citizens that other sectors of the economy.

Health Care Incentive Expenditures - 2015

Name of Expenditure	Amount
DOH-Licensed Hospitals Credit against GRT	$13,700
DOH-Licensed Hospitals Fifty Percent Deduction from GRT	$37,150
Health Care Practitioner Services Deduction from GRT	$38,665
Hold Harmless Distribution	$31,431
Prescription Drugs and Oxygen Deduction from GRT and GGRT	$68,000
Rural Health Care Practitioner Credit against PIT*	$6,377
Medical and Health Care Services Deduction from GRT	$55,000
Premium Tax Credit for NMMIP	$41,400
Total	$291,632

Source: TRD, LFC Vol III

Leveraging Medicaid. LFC staff issued a report last fall detailing opportunities to better leverage Medicaid for other programs and reduce general fund appropriations as shown in Appendix B. Some of these recommendations were adopted in HB 2 but significant opportunities still remain. HB 2 took credit for savings in the public health program at the Department of Health but the state has not done the same for community corrections at NMCD. Community corrections primarily pays for behavioral health services for offenders, but with the state now enrolling these individuals into Medicaid those general fund investments should be repurposed to Medicaid behavioral health. Similar exercises could play out with other programs as well, including the LDWI program.

HSD has major general fund savings in its non-Medicaid behavioral health program totaling more than $20 million over the past three years. HSD has been allowed to re-invest almost all of this money into expanding new non-Medicaid services. This last session the Legislature did take credit for two million of the $5.2 million in projected savings, but more work is needed to better understand how HSD is using these reinvestments, if they are evidence-based, and if they are yielding good results and whether they should be rolled into the Medicaid benefit package for federal match.

Some of these re-investments appear as expansion and new services and the fiscal situation of Medicaid. As such, HSD has the opportunity to suspend them, and use HB 2 authority to request a program transfer to Medicaid to reduce the projected deficit. The same scenario should be played out across the department.

	(Net Savings or New State Revenue in Parentheses)			
Leveraging Medicaid Scenario	**General Fund**	**Federal Funds**	**Local Funds**	**Other**
Department of Health - Improved Billing and Replacement of General Fund with Local Funds and MCO Payments	($25,835)	$20,143	$7,920	($1,566)
Corrections Department	($10,396)	$10,396		
CYFD - Home Visiting State Plan Amendment	($4,620)	$6,720		
HSD - Behavioral Health Services Division	($70)			
HSD - Reduce MCO Administration and Profit	($14,364)			
NMMIP - Collect Previously Forgone Revenues*	($47,700)			
LDWI				($2,445)
County Indigent Funds			($7,920)	
Total	**($102,985)**	**$37,259**	**$0**	**($4,011)**

Note: The report assumed a reinvestment of almost all general fund savings in HSD-Behavioral Health Services Division would be transferred to Medicaid the table presents “net” savings.