HUMAN SERVICES DEPARTMENT

MEDICAID BUDGET UPDATE: EXECUTIVE SUMMARY

JULY 17, 2020

SECRETARY DAVID R. SCRASE, M.D.

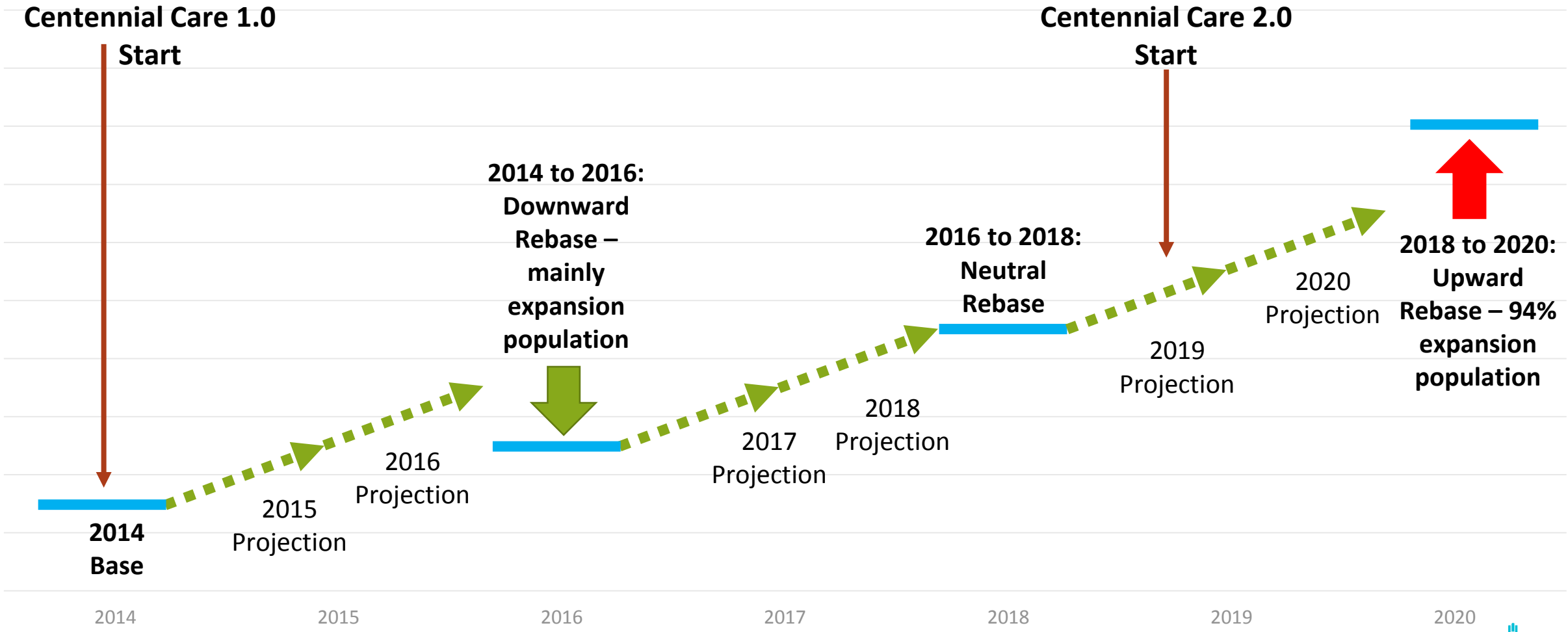
INVESTING FOR TOMORROW, DELIVERING TODAY.

AGENDA

- Medicaid Projection Process Review
- Federal Coronavirus Relief Overview
- Special Session Medicaid Budget Changes
- Variables to Reduce Medicaid Spending
  - Enrollment
  - Benefit Plans
  - MCO Contracts
  - Provider Payment Rates
  - Utilization Reductions
- Revenue Generating Options

MEDICAID PROJECTION PROCESS REVIEW

TIMELINE OF HSD PROJECTION AND REBASING PROCESS



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HOW THE MEDICAID PROJECTION PROCESS WORKS

- Formal quarterly projections (January, April, July, October)
  - Next Medicaid Projection is **Friday, July 31, 2020**
- Utilization and expenditure data has a 9-month lag
- Every 2 years, each managed care population undergoes a "rebase" that incorporates all prior data:
  - Physical health - pregnant mothers and children
  - ACA expansion population
  - Long term supports/service

- **There is more uncertainty and variability**:
  - the further we get from the "base year;" and,
  - the "newer" the population is to Medicaid (e.g., expansion population is 6 years old, physical health population is 22 years old)
- When rebasing has occurred in the past there have been large changes (tens of millions)

WHAT VARIABLES DRIVE MEDICAID EXPENSES

Variable	HSD Usually Able to Influence	HSD Able to Influence Under FFCR*
Enrollment	Yes	No
Benefit Plans	Yes	No
MCO Contracts	Yes	Within actuarial limits
Provider Rates	Yes	Yes
Utilization	Yes	Yes

*Families First Coronavirus Response Act

FEDERAL CORONAVIRUS RELIEF OVERVIEW

CORONAVIRUS FEDERAL LEGISLATION SUMMARY

- Phase 1 Bill – Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (H.R. 6074)
- Phase 2 Bill – Families First Coronavirus Response Act (FFCRA) (H.R. 6201)
- Phase 3 Bill – Coronavirus Aid, Relief, and Economic Security (CARES) Act (H.R. 748)
- Phase 3.5 Bill – Paycheck Protection Program and Health Care Enhancement Act (H.R. 266)

FFCR Act – 3/18/2020

- **Safeguards Medicaid Benefits** – temporarily increased the federal Medicaid matching rate (FMAP) by 6.2 percentage points with requirements
- **Free testing for Coronavirus** – no cost sharing allowed & allowed states to extend Medicaid coverage for testing to the uninsured
- Strengthens food assistance
- Enhances unemployment aid
- Establishes paid leave

CARES Act – 3/27/2020

- $500B financial assistance for companies in need
- $380B economic support for small businesses
- $300B various tax incentives
- $290B direct payments to taxpayers
- $270B expansion of unemployment benefits
- **$150B federal aid to hospitals & healthcare providers**
- **$150B support to state, local, & territorial governments**
- $2.3T total

MEDICAID INCREASED MATCH: MAINTENANCE OF EFFORT REQUIREMENT

- States must attest compliance with the statutory requirements below to receive this increase and if they violate these terms, they will be required to return all additional federal funds:
  - **No new eligibility and enrollment** requirements that are more restrictive than were in place prior to the Public Health Emergency (PHE)
  - No cost-sharing for testing
  - No increases in premiums
  - **No disenrollment** during PHE declaration
    - Prior to the emergency, NM averaged 7,000 disenrollments per month = 0.84% of membership

FEDERAL PROVIDER RELIEF FUND (PRF)

Provider Relief Fund Distribution (PRF) (amount)	Recipients
First General Allocation ($30B)	All Medicare-billing providers
Second General Allocation ($20B)	All Medicare-billing providers
High Impact Allocation ($12B)	Hospitals with at least 100 COVID-19-related admissions
Rural Allocation ($10B)	Rural acute general hospitals, CAHs, RHCs, and rural CHCs
Second Rural Allocation ($1B)	Specialty rural Medicare designation hospitals in urban areas and hospitals in smaller non-rural communities
Nursing Homes ($4.9B)	SNFs
Indian Health Service Support ($500M)	Tribal hospitals, clinics, and urban health centers
Safety Net ($25B)	Medicaid and CHIP Providers, Safety Net Hospitals
Second Safety Net Allocation ($3B)	Acute care hospitals that have less than 3% profitability averaged over 2 or more of its last 5 cost report filings
Total Allocated: $106.4 billion (see more detail from HHS here)	

- HHS has dispersed or announced disbursement of approximately **$106 billion** of the total **$175 billion** appropriated to the PRF.
- This leaves approximately **$69 billion** for reimbursement to dentists and the uninsured, as well as subsequent funding tranches.
- HHS had stated it would issue another **$10 billion to hotspots** but with cases dramatically increasing across the country, the agency may need to tweak the previous formula or increase the amount of the tranche.

FFRCA IMPACT ON STATE BUDGETS

- **FMAP increases during public health crises, natural disasters, or economic downturns are intended to help states address higher Medicaid costs resulting from higher enrollment** as people lose their jobs or see their hours or wages reduced and become eligible for Medicaid.
- **Also allows for greater financial support to the health care safety net that disproportionately serves Medicaid beneficiaries** (and the uninsured) and is likely to face growing, severe stress in coming weeks and months.

Source: https://ccf.georgetown.edu/wp-content/uploads/2020/03/Families-First-Final-3.30-V2.pdf

GROUPS THAT BELIEVE THAT 6.2% FMAP IS INSUFFICIENT TO FUND MEDICAID COST GROWTH IN THIS PANDEMIC

- Georgetown University
  https://ccf.georgetown.edu/2020/05/04/critical-need-for-further-large-fmap-increases-to-sustain-state-medicaid-programs-during-economic-crisis/
- Manatt
  https://www.shvs.org/analyzing-the-fiscal-impact-of-covid-19-the-economic-downturn-and-recent-policy-changes-50-state-databook/
- Urban Institute
  https://www.urban.org/sites/default/files/publication/102098/increasing-federal-medicaid-matching-rates-to-provide-fiscal-relief-to-states-during-the-covid-19-pandem_0_0.pdf
- Center for Budget and Policy Priorities
  https://www.cbpp.org/blog/medicaid-funding-boost-for-states-cant-wait

HUMAN SERVICE DIVISION COVID-19 RESPONSE EFFORTS

Income Support Division COVID-19 Response	
11	Approved Waivers
4	Program Flexibilities Granted

Medical Assistance Division COVID-19 Response	
18	Approved Waivers
5	Approved State Plan Amendments

SPECIAL SESSION BUDGET REVIEW

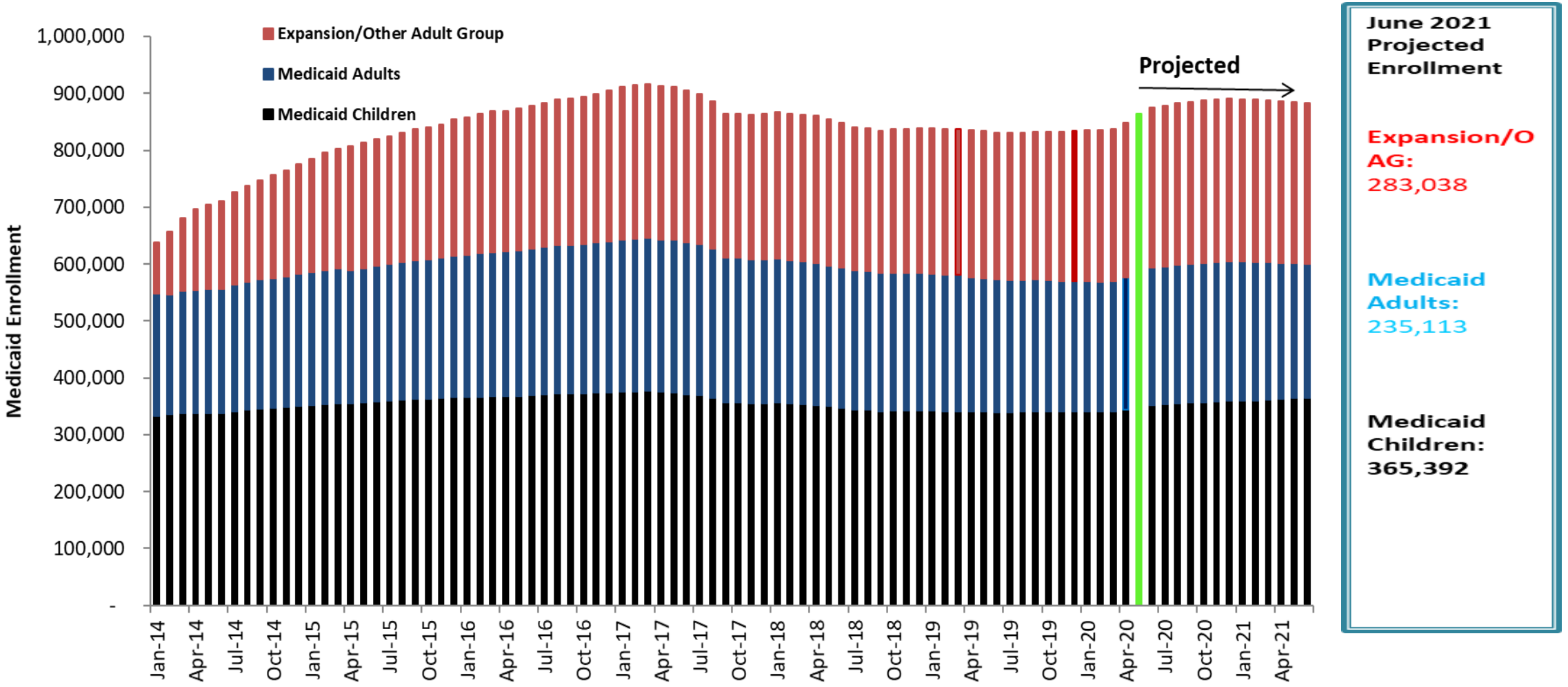
Scenario 1. 6.2% Increased FMAP (July to Dec)			Scenario 2. 6.2% Increased FMAP (July to Sept)		
Original Bill	LFC Rec HB1		Alternate Scenario HB1 Amended	LFC Rec HB1A	
Proposed FY2020 Cuts in Medicaid Budget 000s			Proposed FY2020 Cuts in Medicaid Budget 000s		
FY2020 GF Appropriation	1,019,697		FY2020 GF Appropriation	1,019,697	
FY2020 Surplus	53,861		FY2020 Surplus	53,861	
FY2020 Reversion	(53,861)		FY2020 Reversion	(53,861)	
Total FY2020 Cuts			Total FY2020 Cuts		
Proposed FY2021 Cuts in Medicaid Budget	$000s		Proposed FY2021 Cuts in Medicaid Budget	$000s	
FY2021 GF Appropriation	1,076,462	5.6%	FY2021 GF Appropriation	1,076,462	5.6%
3% cut in GF Appropriation	(32,294)	-3.0%	3% cut in GF Appropriation	(32,294)	-3.0%
Existing GF Shortfall	(73,864)	-6.9%	Existing GF Shortfall	(73,864)	-6.9%
HSD/MAD cut	(17,000)	-1.6%	HSD/MAD cut	(17,000)	-1.6%
Transfer from Tobacco Settlement	17,000	1.6%	Transfer from Tobacco Settlement	17,000	1.6%
HSD/MAD General Fund Swap	(75,000)	-7.0%	HSD/MAD General Fund Swap	(75,000)	-7.0%
Total FY2021 Difference	(181,158)	-16.8%	Total FY2021 Difference	(181,158)	-16.8%
July-September 2020 6.2% FMAP	66,000	6.1%	July-September 2020 6.2% FMAP	66,000	6.1%
October-December 2020 6.2% FMAP	66,000	6.1%	Transfer from Tax Stabilization Fund	37,500	3.5%
Total FY2021 Proposed Adds	132,000	12.3%	Total FY2021 Proposed Adds	103,500	9.6%
FY2021 Proposed Cuts + 6.2% 2 Qtrs	(49,158)	-4.6%	FY2021 Proposed Cuts + 6.2% 1 Qtr	(77,658)	-7.2%
Federal Funds Associated	(204,364)		Federal Funds Associated	(322,847)	
Total Expenditures needed to cut	(253,522)		Total Expenditures needed to cut	(400,505)	
FY21 Blended FFP w/ 6.2%	80.61%		FY21 Blended FFP w/ 6.2%	80.61%	

VARIABLES TO REDUCE MEDICAID SPENDING

VARIABLES TO REDUCE MEDICAID SPENDING

- **Enrollment**
- Benefit Plans
- MCO Contracts
- Provider Payment Rates
- Utilization Reductions

NEW MEXICO MEDICAID ENROLLMENT



Overall Medicaid enrollment peaked in March 2017 with 916,729 and by June 2020, the enrollment will reach 874,449.
The MCO enrollment previously peaked in March 2017 with 708,719 and the estimate for June 2020 has exceed that at 720,104.

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MANAGED CARE ENROLLMENT CHANGES BY PROGRAM

Centennial Care 2.0 CY 2020 Projected Enrollment Distribution by Program				
	Jan.-March Avg. (CY Q1)	April-June Avg. (CY Q2)	July-Sept. Avg. (CY Q3)	Oct.-Dec. Avg. (CY Q4)
Physical Health Program	391,369	399,859	420,207	424,124
Other Adult Group Program	238,330	245,340	257,786	259,885
Long Term Supports and Services Program	48,759	48,791	50,233	50,485
All Managed Care Programs	678,458	693,990	728,226	734,494

Centennial Care 2.0 CY 2020 Projected Enrollment Changes by Program				
	CY 2020 Q2 vs CY Q1		CY 2020 Q4 vs CY Q1	
	Δ	%Δ	Δ	%Δ
Physical Health Program	8,490	2.2%	32,755	8.4%
Other Adult Group Program	7,010	2.9%	21,555	9.0%
Long Term Supports and Services Program	32	0.1%	1,726	3.5%
All Managed Care Programs	15,532	2.3%	56,036	8.3%
Source: MAD BPRB May Enrollment Projections				

ADDED MEDICAID ENROLLMENT OFFSETS LOSSES OF EMPLOYER SPONSORED INSURANCE AND UNCOMPENSATED CARE COSTS

	Labor Force, NM (1,000)	Unemployment Rate, NM
February 2020	961.8	4.8%
May 2020	905.0	9.2%
Change correlates with loss of employer sponsored insurance	-56.8	4.4%

- **Projecting added enrollment of 56,000 by Q4 CY2020**.
- Added Medicaid enrollment avoids surge in provider uncompensated care costs, **approximately $166 million**.

Sources: US Bureau of Labor and Statistics (6/26/2020 data extract); Center for Budget and Policy Priorities (May 23, 2018).

IMPACT OF HEALTH EMERGENCY ON MCO ENROLLMENT, COSTS, AND STATE GENERAL FUND

	Total Computable $M	GF $M
2nd Half FY 2020 COVID-19 MCO Enrollment Cost March-June: additional 78,355 member months, Average PMPM $596.54	$46.74	$8.48
FY 2021 COVID-19 MCO Enrollment Cost Additional 538,575 member months Average PMPM $586.35	$315.79	$63.75
2nd Half FY2021 Potential 2nd surge	$17.10	$2.90

CURRENT & FUTURE OPTIONS TO MANAGE ENROLLMENT COSTS

CURRENT OPTIONS

- NONE
  - Disenrollment would violate federal requirements and endanger 6.2% increased FMAP, requiring HSD to potentially return $204.5 million for three quarters to CMS and defeat intent of the sanding and federal swap

FUTURE OPTIONS

- HSD is analyzing cost savings related to enrollment changes now and will have multiple options costed in the next several weeks

VARIABLES TO REDUCE MEDICAID SPENDING

- Enrollment
- **Benefit Plans**
- MCO Contracts
- Provider Payment Rates
- Utilization Reductions

CURRENT & FUTURE OPTIONS TO MANAGE BENEFIT COSTS

CURRENT OPTIONS

- NONE
  - Benefit impacts, in form of diminished services, or copays/premiums would violate federal requirements and endanger 6.2% increased FMAP, requiring HSD to potentially return $204.5 million for three quarters to CMS and defeat intent of the sanding and federal swap.

FUTURE OPTIONS

- HSD is analyzing cost savings related to multiple benefit changes now and will have multiple options costed in the next several weeks

OPTIONS FOR EXPENSE REDUCTIONS: **BENEFITS**

#	Option	Aggressive	GF Savings ($M)	Very Aggressive	GF Savings ($M)	Total Computable ($M)
1	Copays	Moderate premiums	$1.0	High premiums	$3.0	$10 - $30
2	Premiums for the Adult Group	Implement moderate premiums	$2.5	Implement high premiums	$5.0	$25 - $50
3	Reduce or eliminate adult dental services	Reduce adult dental services	$4.0	Eliminate adult dental services	$8.0	$40 - $80
4	Reduce or eliminate adult vision benefits	Reduce adult vision benefits	$1.5	Eliminate adult vision benefits	$3.0	$15 - $30
5	Reduce or eliminate coverage for adult hearing aids	Reduce coverage for adult hearing aids	$0.3	Eliminate coverage for adult hearing aids	$0.6	$3 - $6

* Not all options can be simultaneously implemented and therefore $ values are not additive.

- Employing any of the options in this table would violate the Maintenance of effort requirement and would result in loss of 6.2% match – up to $204.52 million GF for 3 quarters (January – September 2020)

OPTIONS FOR EXPENSE REDUCTIONS:
OTHER PROGRAM OPTIONS – POTENTIAL BENEFIT IMPACT

#	Option	Aggressive	GF Savings ($M)	Very Aggressive	GF Savings ($M)	Total Computable ($M)
6	Reduce Centennial Rewards program (incentives for preventive services and medication adherence)	50% reduction	$1.7	Eliminate program	$3.4	$8.8 - $17.7
7	Home Visiting Program	Postpone statewide expansion	TBD	Eliminate pilot	$0.15	$0.78
8	Behavior Management Skills Pilot			Postpone	$1.40	$7.29

* Not all options can be simultaneously implemented and therefore $ values are not additive.
- Awaiting CMS response on if these changes would violate Maintenance of Effort requirement from Families First Act.

VARIABLES TO REDUCE MEDICAID SPENDING

- Enrollment
- Benefit Plans
- **MCO Contracts**
- Provider Payment Rates
- Utilization Reductions

3 YEARS OF UNDERWRITING GAIN ("PROFIT MARGIN") FOR CENTENNIAL CARE

	A	B	C	D	E
Final 2017	-5.1%	0.6%	4.5%	3.5%	N/A
Prelim. 2018	-5.4%	-0.3%	1.3%	1.3%	N/A
DRAFT 2019	-11.9%	N/A	0.8%	N/A	-6.1%

- Medicaid capitation rates nationally include an amount for margin of up to 3%.
- Milliman reported an average Medicaid underwriting gain of over 2% for 2014 and 2015 and less than 1% each year since then.
- New Mexico Medicaid capitation rates reflect an assumption of 1.25% to 2.25% gain.
- HSD Centennial Care MCO contracts include an underwriting gain cap that returns half of all gains above 3% back to the state.
  - No MCOs are expected to hit this limit for 2018 or 2019.
  - There is no similar limit or sharing of MCO losses.

CURRENT OPTIONS TO MANAGE MCO CONTRACTS COSTS

CURRENT OPTIONS

- Move to bottom of actuarially sound rate range (rates must be certified)
- Reduce care coordination staff working at MCOs
- Cap drug pricing in managed care to 340B rate

FUTURE OPTIONS

- Conduct and analysis of administrative costs

OPTIONS FOR EXPENSE REDUCTIONS: MANAGED CARE ORGANIZATIONS

#	Option	Aggressive	GF Savings ($M)	Very Aggressive	GF Savings ($M)	Total Computable ($M)
9	Move MCOs down to the bottom of the rate range (12 month)*	6 months	$3.54	12 months	$7.83	$18.43 - $40.76
10	MCO care coordination staffing levels	Reduce halfway to minimum	$0.7	Reduce to minimum	$1.40	$3.64 - $7.29
11	Require MCOs to pay 340B prices for drugs		TBD		TBD	
12	Recoupment unused CAP amount (calculated based on assumptions – not actual)*	Recoup half the amount	$5.0	Recoup Full amount	$10.8	$26.03 - $52.06

*Not all options can be simultaneously implemented and therefore $ values are not additive.

VARIABLES TO REDUCE MEDICAID SPENDING

- Enrollment
- Benefit Plans
- MCO Contracts
- **Provider Payment Rates**
- Utilization Reductions

MEDICAID PROVIDER RATE INCREASES RELATED TO COVID

- In March, when major portions of hospital functions were closed, it was quickly identified that hospitals would face severe revenue shortfalls.
- In addition, other providers cited cost of care increases for PPE, electronic communications systems (e.g., for televisits and telecommuting staff).
- The Federal Government provided financial relief for some, but not all providers.
- HSD calculated that the temporary aggregate provider revenue shortfall would be ~$65 M, and submitted CMS waivers to increase provider payments.
- In the past, we have increased capitation rates to MCOs to cover the increased provider rates; in this case we did not.

DID MCOS RECEIVE A "WINDFALL" FOR CALENDAR YEAR QUARTER 2?

- HSD did not pass on any rate increase to MCOs when it set provider rates higher for:
  - Hospital DRG increase for inpatient and ICU admissions = $66.8 M
  - Non-hospital providers to 98% of Medicare = $36.6M
  - NFs = 30% add-on for COVID positive admissions
  - ALF = 5% increase
  - PACE = 5% increase
  - Home and Community Based Waiver rate increases
  - Retainer Payments for PCS services
  - $1 Dispensing Fee Increase for Curbside Pick Up (30% take-up)
  - Telehealth: rate = to face-to-face visit for duration of emergency

MEDICAID PROVIDER RATE INCREASES RELATED TO COVID-19

Waiver Type	Policy Change	Reflected in the Budget Projection	Estimated Total Cost (millions)	Estimated GF Cost (millions)
Appendix K for HCBS	Retainer Payments for PCS services (1 quarter)	NO	$0.0	$0.0
Appendix K for Mi Via, Med Frag & DD Waiver	Increase assistive technology budget from $250.00 to $500.00 (1 quarter)	NO	$0.03	$0.01
	Support waiver participants (personal care) in an acute care hospital or short term institutional stay (DD waiver, Med Frag waiver, and Mi Via Waiver) (1 quarter)	NO	-	-
	Increase rates for supported living, intensive medical living, family living (DD waiver) (1 quarter)	YES	$9.1	$1.9
Disaster SPA	Delayed reconciliation of SBHC cost reports for FFY18	YES	$0.0	$0.0
	EMSA – to cover COVID-19 testing	YES	$1.9	$0.5
	COVID-19 testing uninsured group for uninsured beginning 3/18	YES	$1.3	$0.0
	Targeted Access Payments (Disaster SPA)	YES	$16.8	$3.5
	Hospital Access Payments	YES	$57.6	$12.1
	Advance payment of DSH for first 2 quarters of 2020	YES	$16.4	$3.5
	DRG ICU 50% rate increase (1 quarter) for 201 Acute Care Hospitals	YES	$50.6	$7.1
	DRG inpatient stays 12.4% rate increase (1 quarter) for 201 Acute Care Hospitals	YES	$16.2	$2.3
	12.4% rate increase (1 quarter) for providers 202-205	YES	$3.5	$0.6
	30% rate increase to short term skilled & custodial nursing facility services for COVID-19 + patients (1Q)	YES	$6.7	$1.4
	30% rate increase for Assisted Living Facilities (ALFs) for COVID-19 positive patients (1 quarter)	YES	$0.06	$0.01
	$1 rate increase to pharmacies for curbside pickup (1 quarter)	YES	$1.9	$0.3
	Other Provider Rate Increases (1 quarter)	YES	$13.1	$2.4
Managed Care	Increase non-emergency ground transportation (NEMT) rates (1 quarter)	YES	$1.6	$0.4
	E&M/Non E&M/Medicaid only rate increase (1 quarter)	YES	$36.6	$6.3
	Targeted Access Payments (Regular SPA)	YES	$7.2	$1.5
	TOTAL Medicaid Costs		**$240.5**	**$43.8**

CURRENT OPTIONS TO MANAGE PROVIDER RATE COSTS

CURRENT OPTIONS

- Resubmit CMS waivers to rescind emergency provider rate increases and determine level of additional cuts necessary to address the projected FY21 shortfall.
  - Most state Medicaid programs have sought to find ways to increase financial support for providers who are struggling during the pandemic rather than cut their rates.
  - HSD is concerned that it risks losing providers from an already fragile provider network.

FUTURE OPTIONS

- HSD has conducted an analysis of what a 1% rate cut across the board would equate to so that it can determine what cuts may be necessary to address the projected FY21 shortfall.
- HSD has calculated what a uniform reduction to Medicare levels would equate to so that when it has a better revenue outlook it can uniformly increase rates for all providers again.

OPTIONS FOR EXPENSE REDUCTIONS: **PROVIDER RATES**

#	Option	GF Savings ($M)	Total Computable ($M)
13	Each 1% reduction in hospital inpatient rates	$3.0	$15.62
14	Each 1% reduction in hospital outpatient rates	$0.8	$4.16
15	Each 1% across-the-board reduction to physician and other professional services rates	$3.0	$15.62
16	Each 1% reduction to hospitals in Medicaid FFS	$0.27	$1.41
17	Each 1% all other providers in Medicaid FFS	$0.40	$2.08
18	Update cost-to-charge-ratio (CCR) for hospital outlier claims ($9.6 - $12.5)	$11.0	$57.52
19	All Medicare type codes to 90% of Medicare (Medicaid only codes excluded)	$2.47	$12.87
20	All Medicaid only codes equivalent to 90% of Medicare (1.24% rate decrease)	$2.37	$12.32
21	All Medicare type codes to 85% of Medicare (Medicaid codes only excluded)	$12.55	$65.32
22	All Medicaid only codes equivalent to 85% of Medicare (6.27% rate decrease)	$12.01	$62.52

- Not all options can be simultaneously implemented and therefore $ values are not additive.
- **Sum of 1% provider rate reductions (Options 12 to 16): $7.47 million GF**

OPTIONS FOR EXPENSE REDUCTIONS:
OTHER PROGRAM OPTIONS – POTENTIAL RATE IMPACT

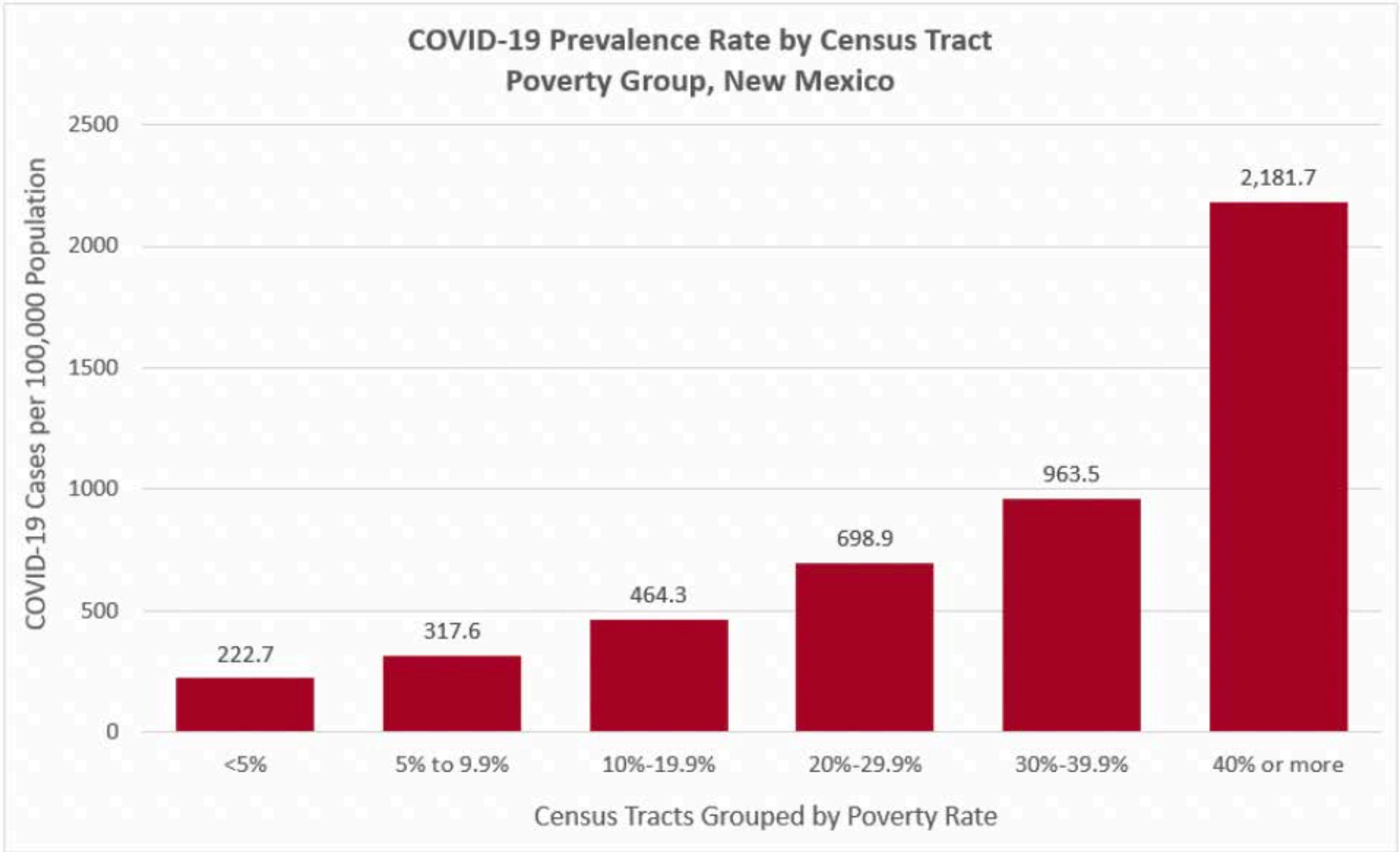
#	Option	Aggressive	GF Savings ($M)	Very Aggressive	GF Savings ($M)	Total Computable ($M)
23	Medicare Premium Savings from 6.2%			2 QTRS in FY20 1 QTR in FY21	$4.68 FY20 $2.68 FY21	$4.68 FY20 $2.68 FY21
24	Hospital Access Program (formerly SNCP) Reduction from $69 M to $34 M	2 years	$3.5	Effective 1/1/2021	$7.0	$35 - $69

- Not all options can be simultaneously implemented and therefore $ values are not additive.

VARIABLES TO REDUCE MEDICAID SPENDING

- Enrollment
- Benefit Plans
- MCO Contracts
- Provider Payment Rates
- **Utilization Reductions**

New Mexico COVID-19 Prevalence by Poverty Rate: COVID-19 Cases per 100,000 Population by Census Tract Poverty Rate



ISSUES WITH REPORTING ACCURATE UTILIZATION DATA

- **Providers**: delays in claims submission due to disruption of pandemic.
- **MCOs**: delays in processing due to emergency programming for COVID related rate increases.
- **HSD**: less complete data to compare current data to last year.

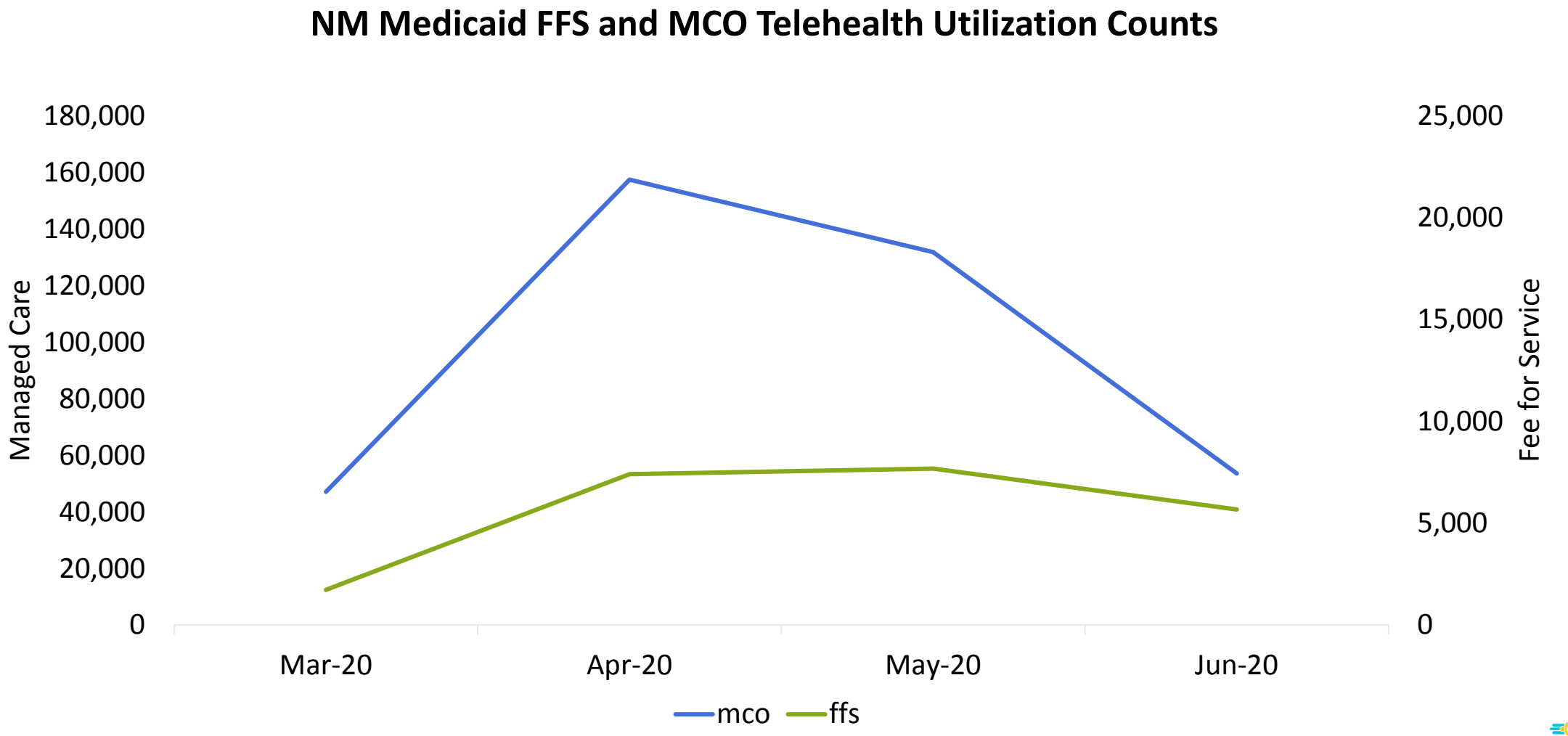
Comparisons of March – June as of July 7 should significantly underestimate 2020 data when compared to 2019.

UTILIZATION AND EXPENDITURES

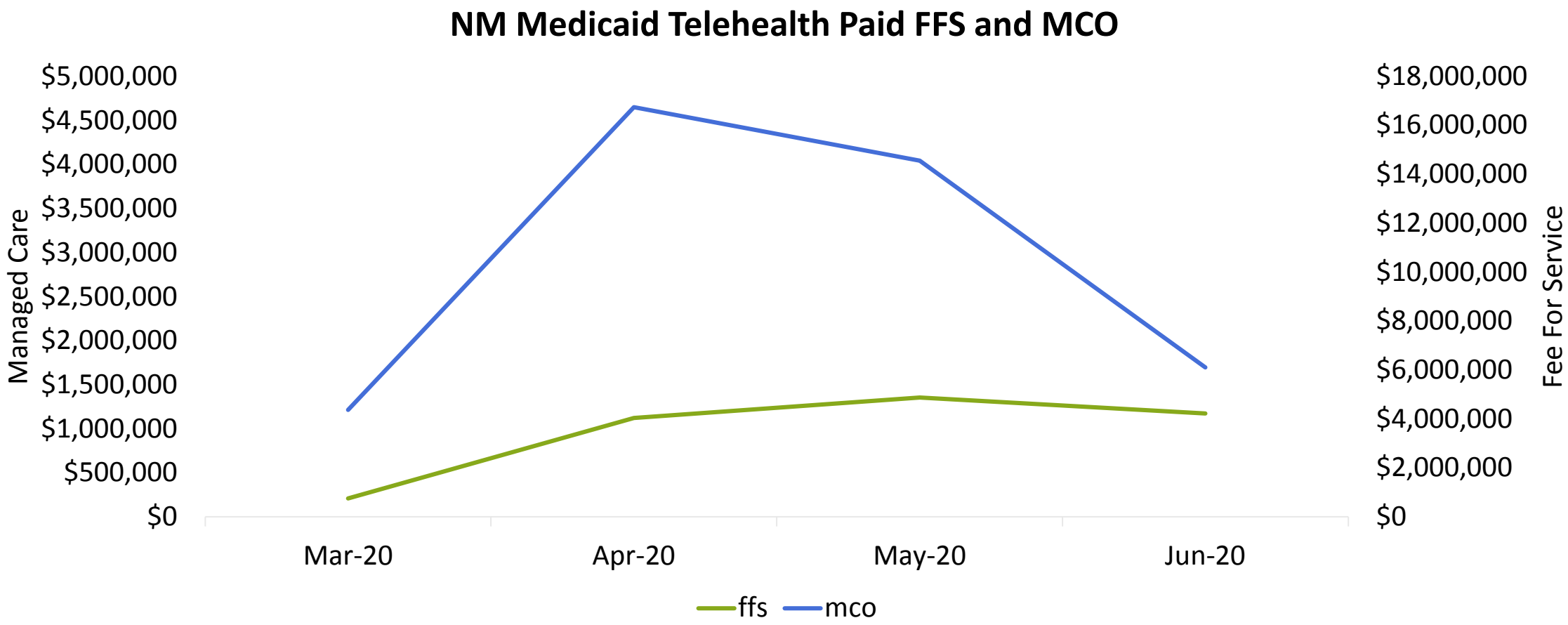
Centennial Care 2.0 Provider Utilization: Encounter Claim Counts & Changes by Plan, March-June, 2020 vs 2019				
	BCBS	PHP	WSCC	ALL MCO
2020 (March-June)	1,711,531	2,331,973	307,248	4,350,752
2019 (March-June)	1,901,379	2,510,657	226,404	4,638,440
Δ	-189,848	-178,684	80,844	-287,688
% Δ	-10.00%	-7.10%	36%	-6.20%
MCO Encounter Expenditures & Changes by Plan, March-June, 2020 vs 2019				
	BCBS	PHP	WSCC	ALL MCO
2020 (March-June)	$342,909,312	$457,665,330	$57,862,060	$858,436,702
2019 (March-June)	$320,822,864	$400,338,408	$29,998,320	$751,159,592
Δ	$22,086,448	$57,326,922	$27,863,740	$107,277,110
% Δ	7%	14%	93%	14%

Source: OMNICAID, March to June 2020, MAD Systems Bureau

TELEHEALTH UTILIZATION DURING THE PUBLIC HEALTH EMERGENCY



TELEHEALTH EXPENDITURES DURING THE PUBLIC HEALTH EMERGENCY



PRELIMINARY INFO ON DECREASED UTILIZATION

There are many factors that could cause the capitation rate impact to be **greater** or **less** than the decreases observed initially.

- Significant program changes must be accounted for, such as large fee schedule increases. For example:
  - Effective 7/1/2019, reimbursement to in-state hospitals was increased approx. 14%
  - Effective 10/1/2019, behavioral health outpatient rates were increased approx. 30%
- Increasing enrollment will account for some increase in dollar spend over time

- Provider billing disruptions during the public health emergency may lengthen the time for claim submissions
- Deferred services during the public health emergency may lead to increased services later in 2020
- Additional costs may result from PPE requirements, hazard costs, and increased testing for COVID-19

Public sources of information, such as the Kaiser Family Foundation[1], are summarizing early data on COVID-19 cost impacts. This data indicates declines in hospital and physician utilization.

OPTIONS FOR ADJUSTING 2020 MCO CAPITATION RATES

MCOs may implement changes voluntarily (ex. NEMT),through similar contract mechanisms as FFS (ex. DRG increase), or through directed payments (ex. NF rate increase)

- CMS will require 2-sided risk mitigation for new directed payments on all medical services, likely for full calendar year

Increase or decrease rates up to 1.5% per rate cell without requiring new certification; requires contract amendment

- May not fully account for the expected impact of changes

Review rate setting assumptions retrospectively with more recent experience as it becomes available

- Takes time for complete data to become available for analysis

CMS may require certification amendments and/or additional documentation under many of these approaches

CURRENT OPTIONS TO MANAGE UTILIZATION COSTS

CURRENT OPTIONS

- MCOs manage utilization through promoting preventative care
- HSD is working with sister agencies to increase immunizations in an effort to ensure preventative vaccinations and avoid acute outbreaks in respiratory season

FUTURE OPTIONS

- HSD will continue to explore these options and provide updates
- HSD is conducting an analysis of the primary care network in the state

HUMAN SERVICES DEPARTMENT

QUESTIONS AND COMMENTS

INVESTING FOR TOMORROW, DELIVERING TODAY.

APPENDIX

MAD COVID-19 RESPONSE: PROTECTING AND EXTENDING ACCESS TO COVERAGE AND CARE FOR NEW MEXICANS

- Allowing coverage of COVID-19 testing for uninsured New Mexicans (100% federally funded).
- Expanding types of entities able to provide Presumptive Eligibility Determinations for new Medicaid enrollees.
- Suspending automatic eligibility redeterminations for current Medicaid enrollees.
- Ceasing suspension of Medicaid enrollees' benefits when they have been incarcerated for more than 30 days.
- Increasing telehealth and phone visit options (Physical/Speech/Occupational Therapies and Behavioral Health).
- Allowing Medicaid enrollees more time to file appeals and request Fair Hearings.
- Allowing payment for certain services provided by family caregivers or other legally responsible individuals.
- Suspending recertification requirements for patients to receive home and community-based care.
- Relaxing restrictions on early prescription refills.
- Coordinating outreach and education with beWellnm, NM Medical Insurance Pool, and Office of Superintendent of Insurance.

MAD COVID-19 RESPONSE: REDUCING ADMINISTRATIVE BURDEN AND FINANCIAL SUPPORT FOR PROVIDERS

- Over $120 million in provider relief (e.g. hospital & nursing facility increase, E&M codes, pharmacy add-on).
- Suspending sanctions for non-compliance with HIPAA when providing telehealth services.
- Easing provider enrollment and re-enrollment requirements.
- Temporarily ceasing revalidation of in-state providers.
- Waiving in-state licensure requirements when out-of-state provider holds similar, valid license in another state.
- Allowing facilities to provide services in Alternative Care Sites (Albuquerque, McKinley and San Juan Areas).
- Requiring expedited claims payments by MCOs to ensure health care providers are paid as quickly as possible.
- Requiring MCOs to provide same level of reimbursement for out-of-network care for Medicaid members.
- Suspending prior authorization requirements for specific services.
- Extended existing prior authorizations for duration of the public health emergency.
- Temporarily suspending supervision requirements for home health agencies.

POTENTIAL SAVINGS FROM DECREASED UTILIZATION

	A	B	C	D = A * (1 + B) * (1 + C)	E	F = E / D - 1	G
Provider Type	**HSD Analysis April 2019[1]**	**Program Changes[2]**	**Enrollment Growth[3]**	**Projected April 2020[4]**	**HSD Analysis April 2020[1]**	**Calculated Cost Reduction (min 0% reduction)**	**Applied Cost Reductions[5]**
Hospital	$ 51,798,355	17.2%	1.5%	$ 61,638,236	$ 50,339,956	-18.3%	-30.0%
SNF/HCBS/PCS	$ 35,569,967	11.2%	1.5%	$ 40,152,287	$ 52,143,120	NA	0.0%
Physician/FQHC	$ 39,174,616	8.6%	1.5%	$ 43,178,938	$ 30,324,123	-29.8%	-35.0%
Dental	$ 9,649,701	1.9%	1.5%	$ 9,977,969	$ 858,484	-91.4%	-80.0%
BH	$ 13,687,170	29.1%	1.5%	$ 17,931,395	$ 17,883,452	-0.3%	0.0%
Pharmacy	$ 32,217,417	3.8%	1.5%	$ 33,927,044	$ 40,315,002	NA	0.0%
All Other	$ 19,055,739	1.5%	1.5%	$ 19,624,026	$ 16,373,045	-16.6%	-20.0%
Total	**$ 201,152,964**			**$ 226,429,894**	**$ 208,237,182**	**-16.2%**	**-20.1%**

	H	I = H * G	J	K	L = I * J * K	M	N = M * (1 + G)
Provider Type	**Projected Monthly CY2020 Medical[6, 7]**	**Estimated One-Month Cost Reduction**	**Estimated # of Months Impacted[8]**	**Cost Offset[9]**	**Estimated CY2020 Cost Reductions**	**Managed Care Budget Impact Before Cost Reductions**	**Adjusted Budget Impact10**
Hospital	$ 116,681,859	$ (35,004,558)	2.3	50.0%	$ (40,389,874)	$ 57,924,957	$ 40,547,470
SNF/HCBS/PCS	$ 61,915,107	$ -	2.3	50.0%	$ -	$ -	$ -
Physician/FQHC	$ 48,187,528	$ (16,865,635)	2.3	50.0%	$ (19,460,348)	$ 34,536,346	$ 22,448,625
Dental	$ 12,178,672	$ (9,742,937)	2.3	50.0%	$ (11,241,851)	$ -	$ -
BH	$ 35,647,800	$ -	2.3	50.0%	$ -	$ 1,293,396	$ 1,293,396
Pharmacy	$ 32,603,007	$ -	2.3	50.0%	$ -	$ 1,770,505	$ 1,770,505
All Other	$ 25,592,404	$ (5,118,481)	2.3	50.0%	$ (5,905,939)	$ 1,522,572	$ 1,218,058
Total	**$ 332,806,377**	**$ (66,731,611)**			**$ (76,998,012)**	**$ 97,047,776**	**$ 67,278,054**
				General Fund:	**$ (10,802,821)**	**$ 13,615,803**	**$ 9,439,111**

New Proposed Initiatives:	$ 67,278,054
Estimated Cost Reductions:	$ (76,998,012)
Net Impact:	**$ (9,719,959)**
General Fund:	**$ (1,363,710)**

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Investing for tomorrow, delivering today.

MEDICAL LOSS RATIO

- 85% minimum MLR is a common standard across markets, it is used in both Medicare Advantage and commercial large group health plans.
- The 2016 Final Rule adopted a similar 85% minimum MLR for Medicaid and CHIP. The requirement is related to reporting and directs that capitation rates must be developed to reasonably achieve an MLR of at least 85%.
- States are not required to collect remittance from Medicaid and CHIP MCOs if they fail to achieve this minimum MLR.
- Currently, New Mexico's minimum MLR in the MCO contracts is 86%. None of the plans fell below this minimum in 2017 or are anticipated to fall below this minimum in 2018 or 2019 based on preliminary experience.
- The minimum MLR provides one-sided risk mitigation for the state. Currently, there is no similar "maximum" to mitigate losses on medical costs for the MCOs.
- Increasing the minimum MLR would only result in additional savings to HSD if the MCO MLR fell below the higher minimum. Consideration should be given to maintaining a reasonable MLR that allows MCOs an opportunity to operate successfully in the marketplace.
- Recent MLR reporting for Centennial Care.

BCBSNM change to reinsurance arrangement in 2019 requires additional review for potential impacts to their reported MLR.

	BCBSNM	MHC	PHP	UHC	WSCC
Final 2017	94.2%	90.1%	88.7%	88.1%	N/A
Prelim. 2018	93.8%	91.1%	91.4%	89.4%	N/A
DRAFT 2019	99.3%	N/A	91.8%	N/A	90.8%

RECENT UNDERWRITING GAIN FOR CENTENNIAL CARE

- According to publicly available reports, capitation rates commonly include an amount for margin of up to 2.5%. Actual Medicaid MCO underwriting gains vary, but commonly fall below 3%. Data summarized by Milliman reported an average underwriting gain of over 2% for 2014 and 2015 and less than 1% each year since then.
- Program characteristics may vary significantly and may contribute to considerations for UW gain, including benefits and populations covered in managed care and approaches to risk mitigation.
- For New Mexico, the capitation rates reflect an assumption of 2.25% at the Maximum rate and 1.25% at the Minimum rate.
- The Centennial Care MCO contracts include a limitation on the underwriting gain that returns half of all gains above 3% back to the state. No MCOs are expected to hit this limit for 2018 or 2019 based on preliminary financial experience reported by the MCOs.
- This provides one-sided risk mitigation for the state. There is no similar limit or sharing of MCO losses.
- Lowering the limit to increase the gains shared with the state would only result in additional savings to HSD if the MCOs earned an underwriting gain above the lower limit. Alternatively, HSD may also increase the rate of sharing above the limit (currently 50%). Consideration should be given to allowing the MCOs an opportunity to operate successfully in the marketplace.

- *BCBSNM change to reinsurance arrangement in 2019 requires additional review for potential impacts to their reported UW gain.*

	BCBSNM	MHC	PHP	UHC	WSCC
Final 2017	-5.1%	0.6%	4.5%	3.5%	N/A
Prelim. 2018	-5.4%	-0.3%	1.3%	1.3%	N/A
DRAFT 2019	-11.9%	N/A	0.8%	N/A	-6.1%

ADMINISTRATIVE EXPENSE

- Data summarized by Milliman reported an average Administrative loss ratio of 11.0% - 12.2% between 2014 and 2018. This amount includes taxes and assessments, which are excluded from the Centennial Care information summarized in the table below.
- MCOs who operate across multiple lines of business or across states may allocate administrative expense across businesses. Additionally, each MCO's operating structure will influence their cost profile, such as corporate overhead allocations or start-up costs for new entrants.
- There has been an increased focus on PBM administrative costs. Pass through PBM contracting arrangements provide more transparency than previous spread pricing arrangements. This increases the ability to review PBM administrative costs for reasonability. All Centennial Care MCOs are now expected to use pass through arrangements, but the PBM administrative costs have not been separately reviewed in the past as a part of rate setting.
- The Centennial Care rates remove unallowed administrative expenses (such as sanctions) when developing the administrative expense loads.

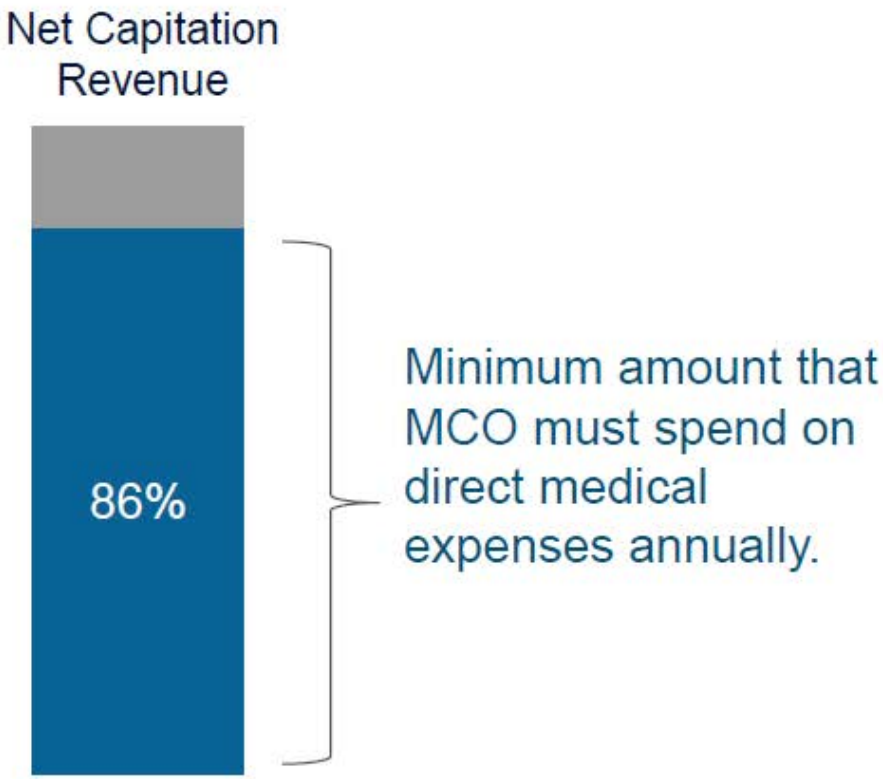
	BCBSNM	MHC	PHP	UHC	WSCC
Final 2017	11.2%	14.3%	7.0%	9.1%	N/A
Prelim. 2018	12.1%	10.0%	7.8%	9.3%	N/A
DRAFT 2019	12.6%	N/A	7.4%	N/A	15.4%

MLR/UW GAIN LIMIT PROCESS AND TIMING

Centennial Care MCO Contract Requirements

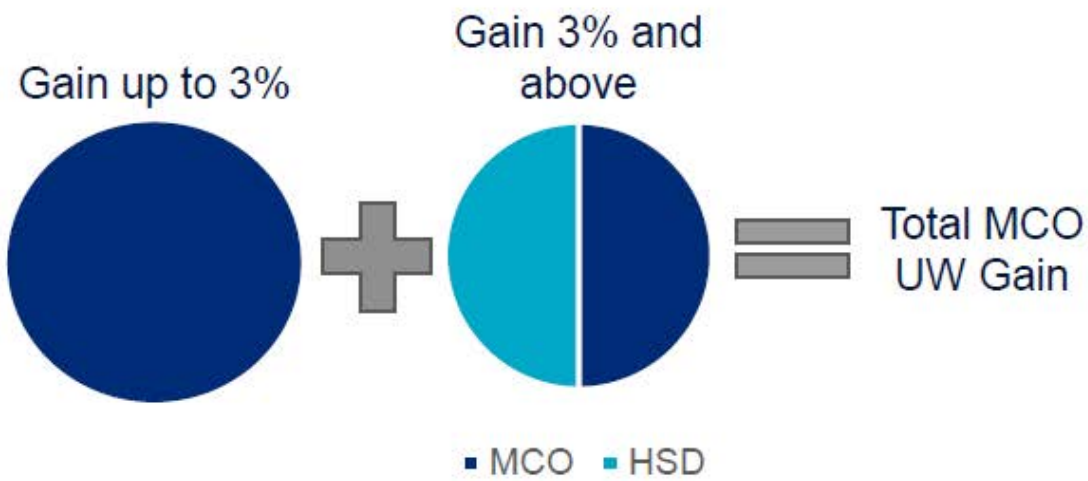
7.2.10 Medical Expense Ratio

The CONTRACTOR shall spend no less than eighty-six percent (86%) of net Medicaid line of business Net Capitation Revenue on direct medical expenses on an annual basis.



7.2.1 Underwriting Gain Limitation

The CONTRACTOR is permitted to retain one-hundred percent (100%) of any underwriting gain generated under this Agreement up to three percent (3.0%) of net capitation revenue generated annually as defined in Section 7.2.2 of this Agreement. The CONTRACTOR shall share fifty percent (50%) of any underwriting gain generated in excess of three percent (3.0%) with HSD.



MLR/UW GAIN LIMIT PROCESS AND TIMING

High level rate-setting timeline for CY2020 UW gain limit process

July - September 2021
Interim Reconciliation Evaluations Completed
(Contract Requirement: Attachment 7)

July - September 2022
Final Reconciliation Evaluations Completed
(Contract Requirement: Attachment 7)

January – December 2020	January – June 2021	July – December 2021	January – June 2022	July – December 2022
Contract Period	Interim Evaluation Run-out Period		Final Evaluation Run-out Period	

Contract states the UW Gain Limitation Calculation will be performed within 180 days following the close of the contract year (Section 7.2.9). Due to other contract reconciliations, the final MLR and UW gain limitation evaluations are performed after final reconciliation evaluations are completed.

July 2021
MCOs submit MLR Calculation Report
(Contract Requirement Reference: 7.2.10.2)

September - October 2021
Interim MLR/UW gain following interim Reconciliation Evaluations

September - October 2022
Final MLR/UW gain Completed following Final Reconciliation Evaluations

May potentially perform interim recoupment based on preliminary results (similar to Attachment 7 for reconciliations)

HUMAN SERVICES DEPARTMENT

Telehealth Paid Non-Crossover Claims*									
	Fee-for-Service				Managed Care Encounters				
Month	Mar-20	Apr-20	May-20	Jun-20	Mar-20	Apr-20	May-20	Jun-20	**Total**
Utilization Counts	1,729	7,406	7,675	5,675	47,103	157,342	131,761	53,522	**412,213**
Total Paid Amount	$208,716	$1,121,233	$1,353,753	$1,172,327	$4,367,719	$16,736,262	$14,551,024	$6,102,240	**$45,613,273**

*Notes:

1. Data is based on paid non-crossover fee-for-service and managed care encounter claims.
2. Data reflects telehealth utilization during the ongoing public health emergency.
3. Both fee-for-service and managed care encounter claims are subject to a 90-day reporting lag since providers are required to submit claims to Medicaid within a 90-day span from the date-of service. Therefore, the data may not reflect complete sets of claims for each month. Note that this means that the downward trend shown on the graphs between mid-May and June does not necessarily mean that a decrease in the utilization of telehealth services. Below is the link to the New Mexico Administrative Code (NMAC) for provider billing.

https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20302/8_302_2%20Rule.pdf