Progress Report

Program Evaluation Unit
Legislative Finance Committee
December 7, 2016

Leveraging Medicaid

The Evaluation: The evaluation, *Opportunities to Leverage Federal Medicaid Funds* (October 2015), identified three main methods for leveraging the ability to draw down federal Medicaid reimbursements in light of expansion under the Affordable Care Act (ACA) and general fund revenue constraints. These are increasing Medicaid billings for eligible services funded by state or local funds, expanding Medicaid-eligible services for certain programs, and reallocating resources related to programs with diminished roles under the ACA. LFC staff reviewed 16 programs across seven agencies where these opportunities may exist and identified potential savings or new revenue opportunities of between $82 million and $103 million.

AT A GLANCE

Enrollment in New Mexico's Medicaid program totaled 892 thousand as of November 2016, an increase of roughly 6 percent over a year earlier, when the LFC published its evaluation *Opportunities to Leverage Federal Medicaid Funds.* According to the most recent projections from the Human Services Department (HSD), enrollment is expected to continue to grow to 957 thousand by the end of FY18, at a total cost of $6.1 billion.

This steady growth in Medicaid enrollment and costs continues to underscore the need to efficiently and effectively use state funds to maximize the ability to draw down the federal Medicaid match, especially in light of uncertain state revenues. The FY17 general fund appropriation for Medicaid is $914 million, but HSD projects a need of $996 million in FY18.

The 2015 LFC report identified potential net savings or new revenues of between $82 million and $103 million from various strategies to leverage federal Medicaid dollars. While some progress has been made, including $13 million in additional Medicaid revenues to rural and primary health clinics and a $28 million reduction in New Mexico Medical Insurance Pool tax credits claimed due to enrollees finding other coverage, a number of challenges and difficult decisions remain. However, the state has actively engaged in assessing options to better leverage Medicaid, including through the Medicaid Advisory Committee's Long-Term Leveraging Medicaid Subcommittee, which issued a list of recommendations in September 2016 (Appendix A).

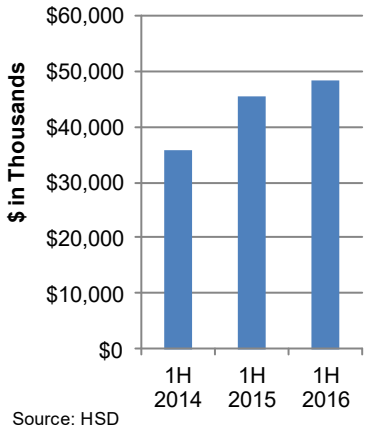
Progress Reports foster accountability by assessing the implementation status of previous program evaluation reports' recommendations and need for further changes.

New Mexico Legislative Finance Committee

Rural and Primary Health Care

Medicaid utilization at federally qualified health centers (FQHCs) and rural health clinics (RHCs) continue to grow, indicating less of a need for general fund support. The 2015 LFC evaluation found the need for state general fund appropriations to support rural primary health care is decreasing due to increasing Medicaid utilization. The state provides support to local clinics that meet certain requirements, including policies that ensure no client is denied service due to an inability of pay, under the Rural Primary Health Care Act (RPHCA). Most individual clinic sites receiving RPHCA funding are operated by one of the 16 FQHCs in New Mexico. Historically, most RPHCA funding has come from the general fund, with a portion from the County-Supported Medicaid Fund under statute, as well as a small amount of federal funding.

Chart 1. Year-Over-Year Medicaid Spending on FQHCs and RHCs

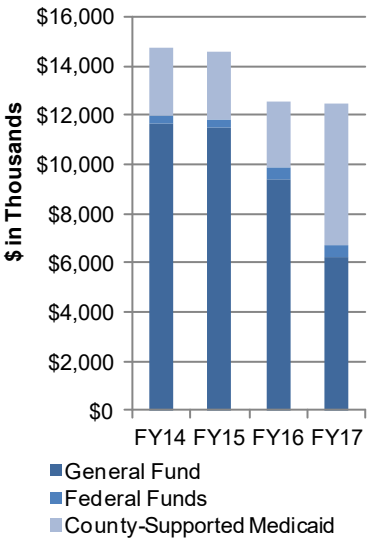


Source: HSD

The number of patient encounters at RPHCA clinics increased by slightly under 2 percent from FY15 to FY16, and an increasing percentage of patients are covered by Medicaid. Between FY14 and FY15, the percentage of visits paid for by Medicaid increased from 27 percent to 42 percent, with a slight uptick to 43 percent in FY16. Meanwhile, the percentage of visits paid for by sliding fees fell from 15 percent in FY15 to 14 percent in FY16, and the percentage of self-pay clients fell from 4 percent to 3 percent during the same period.

In CY15, Centennial Care managed care organizations (MCOs) paid $96.6 million to FQHCs and RHCs, including RPHCA clinics. This is an increase of $13.3 million, or 16 percent over the $83.3 million paid in CY14. Based on recent trends and data for the first two quarters of CY16, Medicaid MCOs are on pace to pay $107 million this year. Medicaid payments have increased faster than the 2 percent growth in patient encounters at RPHCA clinics, suggesting patients are enrolling in and using Medicaid for these services at higher rates or paying higher prices.

Chart 2. RPHCA Funding, FY14-FY17



Source: SHARE

The mix of revenue for RPHCA has shifted in FY17, as recommended by the 2015 LFC report. The general fund provided about three-quarters of RPHCA funding in FY16, which fell to 50 percent in the FY17 budget. General fund support for RPHCA is $6.2 million in FY17, 46 percent less than FY16 at $9.4 million. Meanwhile, County-Supported Medicaid funding was $2.7 million, or 21 percent of RPHCA, in FY16, but is $5.7 million, or 46 percent, in FY17 due to a one-time allocation of $2.9 million from fund balances. This revenue is not guaranteed to continue after FY17, underscoring the importance of clinics maximizing revenue under Medicaid expansion. Overall, RPHCA funding in FY17 totals $12.4 million, compared to $14.8 million in FY14 (Chart 2).

The 2015 LFC report also recommended that DOH continue to monitor the revenues of clinics receiving funding under RPHCA and require providers to justify the necessity of state funds for the coverage of uninsured clients. DOH states that it does not monitor RPHCA clinic revenues, even though RPHCA funding is issued through the DOH budget. DOH further notes that state funds are used for wrap-around services that support the department's priority

health indicators, including mental health, obesity prevention, tobacco prevention, and substance misuse.

Public Health Offices

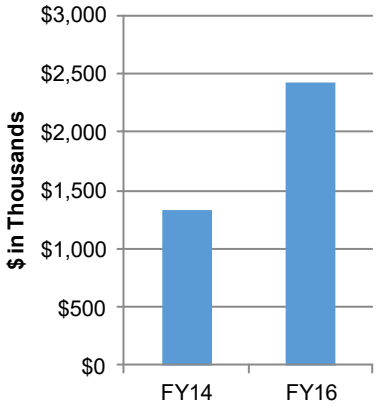
DOH's Public Health Division (PHD) is a contracted provider for certain services under Medicaid, including the Children's Medical Services, Family Planning, and Families First programs. Other services provided through public health offices, such as the Breast and Cervical Cancer, Immunizations, Harm Reduction, Sexually Transmitted Disease Intervention, and Tuberculosis programs, also bill Medicaid for certain services.

In FY16, DOH reported a 15 percent drop in patients using public health offices.

The 2015 LFC evaluation found that Medicaid utilization for these services is increasing while the number of self-pay clients is decreasing. However, FY16 data provided by DOH shows 15 percent fewer total patients using public health offices than in FY15. Despite this decrease, however, the share of these covered by Medicaid continued to grow modestly, increasing from 35 percent in FY15 to 37 percent in FY16.

The LFC report recommended DOH work to maximize Medicaid billing for covered services provided to eligible individuals through public health offices and work with the Medicaid MCOs to allow the MCOs' private plans to reimburse for public health office services currently covered by Medicaid managed care. LFC staff estimated DOH may be able to replace up to $3.5 million in general fund revenues with federal Medicaid reimbursements through increased Medicaid billing of self-pay clients. DOH states that it has maximized Medicaid billing for such services, and Medicaid revenues to PHD grew 81 percent between FY14 and FY16, from $1.3 million to $2.4 million, largely in the Family Planning and Sexually Transmitted Disease Intervention and Treatment programs (Chart 3). PHD attributes this to improved billing practices, although it does not expect growth to continue due to declining utilization at public health offices.

Chart 3. Public Health Office Medicaid Revenues



Source: DOH

Additionally, DOH has held discussions with insurance carriers regarding private plan coverage of public health services and to date, one private insurer, New Mexico Health Connections, has expressed willingness to cover these services.

Tobacco Settlement Revenue Programs

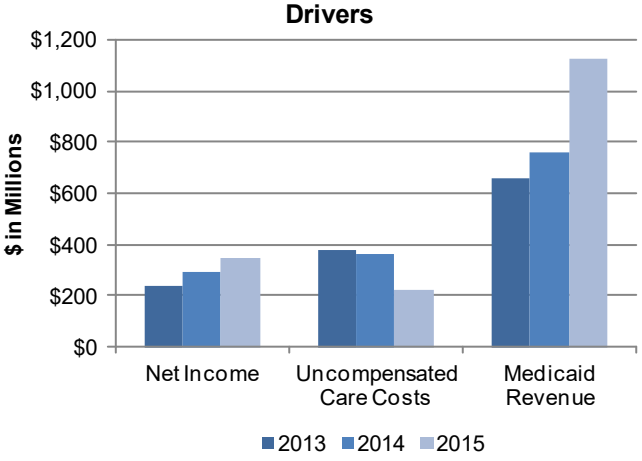
The 2015 LFC report found the state may be able to free up tobacco settlement revenues for other purposes by leveraging Medicaid for certain targeted services, including Tobacco Use Prevention and Control (TUPAC) services. According to the TUPAC program, 38 percent of enrollees in DOH cessation services are Medicaid beneficiaries. The LFC evaluation recommended DOH pursue a 50 percent Medicaid administrative match for operating the state's tobacco quitline, alongside HSD and the MCOs. DOH reports the TUPAC program

has explored this possibility and notes that some larger states have realized roughly $50 thousand from such a match, but that limited staff has prevented further research on the recommendation. Additionally, HSD notes that tobacco cessation services are covered by the MCOs and that federal Medicaid rules require counseling services to be provided by licensed counselors, which may require additional funding if TUPAC counselors need to be licensed. TUPAC and Medicaid MCOs should coordinate efforts to ensure Medicaid beneficiaries are directed to Medicaid-funded services through the MCOs and that they are not receiving services not paid for by Medicaid if similar services are available with Medicaid reimbursement.

Trauma System Funding

In light of increasing hospital revenues and decreasing uncompensated care under Medicaid expansion, there is less of a need to provide general fund support for the Trauma System Fund Authority. As pointed out in the 2015 LFC report, this funding does not support direct patient care at hospital trauma centers, and the state's trauma network has not seen significant improvements with these funds. Of the 12 hospitals with designated trauma centers in New Mexico, only one, the University of New Mexico Hospital, is classified as a level 1 trauma center, the highest designation, by the American College of Surgeons.

Chart 4. NM Hospital Key Economic Drivers



Source: Medicaid cost reports

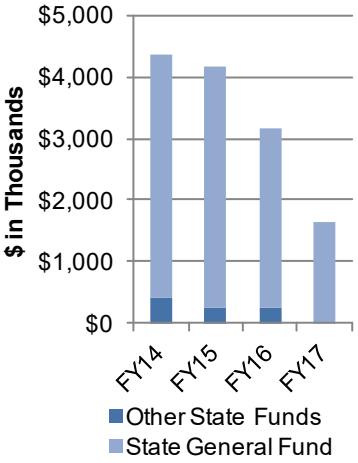
Between CY13 and CY15, Medicaid revenue at New Mexico hospitals increased by 70 percent, from $660 million to over $1.1 billion, owing in large part to Medicaid expansion. This has contributed to significant growth in hospital net income and accompanying reductions in uncompensated care. Total net income at New Mexico hospitals rose by 49 percent during this period, while uncompensated care costs fell by 40 percent (Chart 4). Additionally, a 2014 LFC report found significant reductions in uncompensated care for Medicaid and uninsured patients at hospitals under the Safety Net Care Pool.

The 2015 LFC report recommended the Legislature consider reducing funding for the Trauma System Fund by $500 thousand. However, state general fund support for the fund decreased by a total of $2.3 million, or 58 percent, between FY15 and FY17, from $3.9 million to $1.6 million. This included a decrease of 25 percent between FY15 and FY16, and a further decrease of 44 percent from FY16 to FY17 (Chart 5). The current total budget of $1.6 million for FY17 reflects a fund sweep resulting from the 2016 special legislative session that reduced trauma funding by $800 thousand. The Trauma System Fund Authority will allocate funding to hospital trauma centers based on this reduction.

In light of improving Medicaid hospital revenues, reduced uncompensated care, and cuts in state funding, the Authority should consider the extent to

which continued assistance from the fund would benefit trauma centers. The 2015 LFC evaluation recommended DOH evaluate the need for continuing to fund the Trauma System Fund in consideration of the lack of development in the trauma system, as evidenced by the absence of Level 2 trauma centers in key geographic areas, including Las Cruces, the state's second largest city. Medicaid should also consider whether this type of activity is needed to ensure a robust network of quality hospitals, and if so, direct MCOs to use Medicaid's substantial purchasing power to work with hospitals, especially rural hospitals, to build and maintain such a network and meet necessary certifications.

Chart 5. Trauma System Fund Budget, FY14-FY17

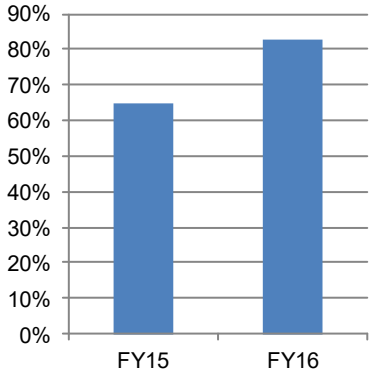


Source: SHARE

Corrections Department

HSD and the Corrections Department have made progress on enrolling and tracking Medicaid utilization of released inmates. In the 2015 session, the Legislature passed SB 42, which permits an incarcerated person who was not enrolled in Medicaid at the time of incarceration to apply prior to the person's release. The October 2015 LFC report found that during the first nine months of pre-release Medicaid applications for New Mexico Corrections Department (NMCD) inmates, 65 percent of eligible inmates applied for Medicaid. In FY16, NMCD reported determining eligibility for 83 percent of inmates (Chart 6). This percentage falls in line with estimates of roughly 80 to 90 percent eligibility in other states according to a 2014 Government Accountability Office (GAO) report on Medicaid-eligible inmates and allowable costs.

Chart 6. Percent of Inmates with Medicaid Eligibility Determined



Note: FY15 data is only from October 1, 2014 to June 30, 2015
Source: NMCD

Actual enrollment data is less certain, and NMCD does not track these numbers. However, according to HSD, the two departments have been working together to update information systems to be able to interface with each other and share information between agencies so HSD can collect data on former inmates who are enrolled in Medicaid and can determine which services they are receiving. This trend of growth in Medicaid enrollment among released inmates indicates less of a need for general fund support of behavioral health services through probation, parole, and community corrections programs. The FY17 operating budget includes $6.3 million for outpatient services contracts for probation and parole clients, down roughly 15 percent from $7.3 million in FY16. Most of these funds support contracts with providers of both behavioral health and transitional living services, the latter of which may not be Medicaid reimbursable if they are not associated with Medicaid-eligible behavioral health services. NMCD should work with HSD and the MCOs to identify strategies for billing Medicaid for all eligible outpatient services to enrolled beneficiaries.

Early Childhood Home Visiting

In FY17, general fund revenues for early childhood home visiting programs at the Children, Youth, and Families Department (CYFD) total $7.7 million. Previous LFC evaluations have found Medicaid pays for as many as 80 per-

cent of births in New Mexico. The 2015 LFC report found potentially Medicaid-eligible home visiting services make up approximately 20 percent of all home visiting funding, and other states provide examples of opportunities for Medicaid to pay for early childhood home visiting services. In March 2016, CMS and the Health Resources and Services Administration (HRSA) released a joint informational bulletin on coverage of maternal, infant, and early childhood home visiting services. This document includes discussion of options available to states for financing various components of home visiting through Medicaid, as long as participating programs meet requirements for comparability, freedom of choice, and statewideness. Benefit categories identified by CMS and HRSA that may be included in home visiting programs are case management services, other licensed practitioner services, preventive services, rehabilitative services, therapy services, home health services, early and period screening, diagnosis, and treatment services (EPSDT), extended services to pregnant women, and health homes. Appendix B lists these benefit categories and describes them in more detail.

According to recent guidance to states from the federal Health Resources and Services Administration, states may incorporate benefits such as case management, preventive services, and EPSDT into Medicaid funding mechanisms for home visiting programs.

The 2015 LFC report recommended HSD work with CYFD to propose a Medicaid state plan amendment for qualified home visiting services and require MCOs to cover such services in Medicaid contracts. The Long-Term Leveraging Medicaid Subcommittee of the Medicaid Advisory Committee reiterated the recommendation to explore Medicaid coverage of certain home visiting benefits. However, HSD states it currently has no plans to submit a state plan amendment or require MCO coverage of home visiting services.

HSD Behavioral Health Services Division

The 2015 LFC report recommended general fund savings realized to HSD's Behavioral Health Services Division (BHSD) due to Medicaid expansion be reallocated to support growth in Medicaid, and that management of the non-Medicaid behavioral health services currently performed by a third party contractor be brought in-house. Funding for BHSD from the general fund has decreased 12 percent between FY13 and FY17, from $42.1 million to $37.2 million, accounting for FY17 reductions made during the 2016 special session. The FY17 budget includes $2.7 million in general fund savings reinvested into BHSD. Meanwhile, funding for the state share of Medicaid behavioral health grew by 23 percent, from $87.3 million to $107.5 million, during the same period.

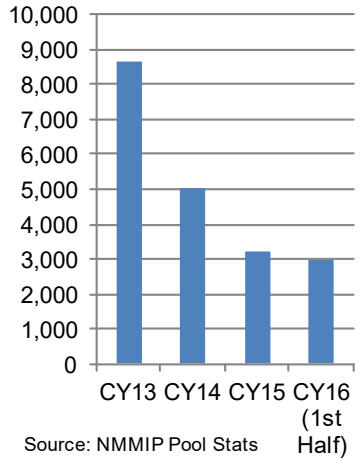
HSD reports it is exploring the option of bringing management of such non-Medicaid programs into BHSD, which LFC staff estimated could result in savings to the general fund from administrative costs paid to the statewide behavioral health contractor. However, the department does not plan to reallocate savings to BHSD toward the state share of Medicaid, instead reinvesting them in expanded non-Medicaid services. Furthermore, while bringing management of non-Medicaid programs into BHSD would reduce contractual services costs, HSD notes these would be replaced to some extent with payroll and other costs associated with bringing these services in-house. To this end,

the Legislature appropriated $217.4 thousand in FY17 for BHSD to hire additional employees and start to facilitate the transfer of certain behavioral health administrative services into BHSD.

New Mexico Medical Insurance Pool

Enrollment in the New Mexico Medical Insurance Pool (NMMIP) continues its decline, but barriers remain to full closure. NMMIP was established in 1987 as a safety net to provide health insurance to individuals who were denied or otherwise ineligible for other health coverage, including many individuals with the most severe health needs. As pointed out in the 2015 LFC report, NMMIP has seen reduced enrollment due to the availability of other forms of coverage for this population under the Affordable Care Act. NMMIP enrollment fell from nearly 8,700 at the end of CY13 to just over 3,200 at the end of CY15. As of the midpoint of CY16, enrollment was 2,967, for a total decrease of 66 percent since CY13 (Chart 7).

Chart 7. NMMIP Enrollment, CY13-CY16 YTD



Source: NMMIP Pool Stats

The 2015 report recommended NMMIP extend its open enrollment and recertify all enrollees in one open enrollment cycle for the 2016 plan year to identify who should be transitioned to other coverage and be better informed of how to address coverage needs of remaining members. According to NMMIP, approximately 1,000 enrollees would not be able to transition to other coverage because of conditions that would preclude coverage, including Medicaid. These groups include Medicare enrollees under age 65 who have a disability or end-stage renal disease, medically fragile children, and people living with HIV/AIDS. Currently, while individuals age 65 and over have a guaranteed right to purchase supplemental plans for Medicare Part B under federal law, and some states require insurers to offer similar plans for the under-65 population as well, New Mexico does not have such a requirement.

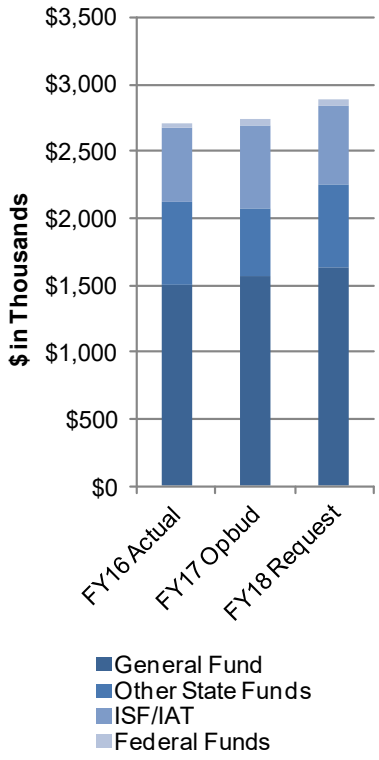
In September 2016, the Long-Term Leveraging Medicaid Subcommittee of the Medicaid Advisory Committee issued a set of eight recommendations, including that NMMIP work with the state to establish a firm deadline for transitioning all members eligible for other coverage. This would still leave the roughly 1,000 members who could not be transitioned. The previous LFC report included a recommendation that the Legislature consider requiring licensed health insurers in New Mexico to offer Medicare supplemental coverage for individuals under age 65 as a condition of licensure with the Superintendent of Insurance.

Additionally, while NMMIP membership has ramped down over the last few years, the timing of transitioning enrollees to Medicaid or other coverage remains uncertain, as does the cost of Pool coverage. The most recent projections show expected losses to the Pool of $75 million in CY16, above the $61 million in CY15. Currently, health insurers doing business in New Mexico must pay an assessment for NMMIP based on their share of premium business in the state. Insurers may claim a credit against their premium taxes

equal to a share of the assessments they pay to NMMIP. In some cases this may be as much as 50 percent of an insurer's premium tax liability. In CY15, these tax credits totaled $34.4 million, or about 55 percent of the $62.6 million in assessments collected and 42 percent below the $59.7 million in tax credits in CY14.

The 2016 LFC Progress Report on Select Healthcare Tax Expenditures further recommended the Legislature consider eliminating the NMMIP Premium Tax Deduction while keeping the pool open as part of a larger reform of healthcare tax expenditures.

Chart 8. Drug and Treatment Court Contract Spending



Note: Excludes Bernalillo County Metro Court and Magistrate Courts
Source: FY18 Appropriation Request for District Courts

Problem-Solving Courts

Opportunities remain to leverage Medicaid for treatment by drug courts and other problem-solving courts. There are 51 problem-solving courts in New Mexico designed to serve specific populations, including adult, juvenile, and family drug courts, DWI courts, and mental health and treatment courts. These courts aim to divert offenders from incarceration through collaboration between the judiciary and treatment providers in the community, with a 24 percent recidivism rate for adult drug courts in FY15. The 2015 LFC report recommended district and magistrate courts, with the support and oversight of the Administrative Office of the Courts, continue to expand problem-solving courts as well as the number of people served by these courts by using increased federal funding made available through leveraging Medicaid for treatment services.

Some district courts contract for certain drug court services, such as drug testing, counseling, and treatment services. Medicaid may be able to be used for some of these services. For example, substance abuse testing is covered under care coordination provisions in HSD's contracts with Centennial Care MCOs, and certain types of treatment may be included in Medicaid's behavioral health coverage. Appendix C contains a list of services provided to problem-solving court participants that are or may be covered by Medicaid.

According to analysis by LFC staff, the general fund accounts for over half of this funding, about 56 percent in FY16, or $1.5 million out of $2.7 million total. In the FY18 budget request, general fund appropriations would make up 57 percent, or $1.6 million out of total funding of $2.9 million. It is unclear how much of this contract funding supports direct treatment of drug court participants or the extent to which treatment providers bill and receive reimbursement from other sources, such as Medicaid or private insurance. More comprehensive reporting of how contracted providers allocate funds to services would help to identify costs that may be Medicaid-reimbursable.

The Administrative Office of the Courts (AOC) has proposed contract language for drug and problem-solving court providers that would require the provider to assist uninsured participants with obtaining coverage through

Medicaid or other available insurers, and would prohibit billing courts for medical services unless a participant was denied coverage or the insurer denied payment. Currently, AOC cannot verify how many courts have incorporated this language into their contracts and notes that several courts do not have contracts with a Medicaid-certified provider.

Furthermore, the structure of drug court appropriations does not allow for effective tracking of how resources support services. Currently, the General Appropriation Act does not list all appropriations for drug courts and other problem-solving courts under a single program, making it difficult to determine the amounts being spent. Instead, funding is allocated to each court's base budget and to the Administrative Office of the Courts, and other funding is included in language under the Department of Finance and Administration and as special appropriations. A consolidated program item for all drug and problem-solving court funding would serve to highlight how resources are used for these programs, particularly to identify contractual services costs in the budget that go toward providers of screening and treatment services.

County Indigent Funds

The 2015 LFC report found declining indigent care expenditures resulting from increased health coverage under the Affordable Care Act have contributed to growing fund balances in county indigent funds. Aggregate balances at the end of FY16 reached nearly $31.5 million, 24 percent higher than the $25.4 million at the end of FY13. Additionally, three counties, Doña Ana, McKinley, and Rio Arriba, collectively had a total of $8.5 million from county indigent funds placed in separate investment pools, rather than cash, according to annual DFA budget recapitulation reports.

FY16 year-end county indigent fund balances were 24 percent above the level at the end of FY13, indicating less demand for indigent care under Medicaid expansion.

The evaluation also recommended the Legislature amend the Indigent Hospital and County Health Care Act to require counties to contribute gross receipts tax revenue from the Health Care Assistance Fund as an intergovernmental transfer (IGT) to leverage federal Medicaid matching funds to fund uncompensated care at FQHCs and public health offices, and recommended HSD initiate any required state plan amendments to create a Safety Net Care Pool for FQHCs and public health offices. However, HSD states that CMS is unlikely to approve any plan for rate increases or supplemental payments to FQHCs without including additional services to be provided. However, the Long-Term Leveraging Medicaid Subcommittee of the Medicaid Advisory Committee recommended the New Mexico Association of Counties and HSD work together to determine whether opportunities to leverage federal dollars from county expenditures through waivers, IGTs, and pilot programs exist and are mutually beneficial.

Certified Public Expenditures

The 2015 LFC evaluation found New Mexico may be able to leverage local funding for Medicaid through expanded use of certified public expenditures

Roughly $14 million of the state share of Medicaid in FY17 consists of CPEs from school districts and rural educational cooperatives that provide certain Medicaid-funded services to eligible students.

(CPEs), a mechanism under which public funds from local entities may be counted toward the state's nonfederal share of Medicaid. According to a federal study, New Mexico contributes a smaller percentage of local funds toward Medicaid than the nation in general, and LFC staff found Medicaid support from non-state public entities in New Mexico fell by $18.5 million between FY13 and FY15 due in part to changes in local hospital funding.

The LFC report recommended HSD consider adopting a state plan amendment and cost protocol for using CPEs from public hospitals toward the state share of Disproportionate Share Hospital (DSH) payments, as demonstrated in other states. HSD states it is considering CPEs as a means of contributing to the state share of Medicaid under both the current program structure and in its waiver renewal discussions.

One example of incorporating CPEs into New Mexico's current Medicaid program is for Medicaid School-Based Services (MSBS), which reimburses school districts and rural educational cooperatives for allowable costs associated with students receiving certain health services under an Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP). HSD began using a CPE methodology for MSBS in FY16. This structure contributed $13.3 million from schools toward the state share in FY16, $14.4 million in FY17, and an expected $14.2 million in FY18.

Updated Recommendations

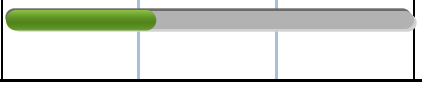
In light of state fiscal conditions, significant increases in Medicaid funding for providers, and lack of progress in some areas, the Legislature should consider the following recommendations.

- Appropriate all county-supported Medicaid funding to Medicaid in FY18 and thereafter.
- Phase out RPHCA funding from the general fund over FY18 and FY19. These clinics can continue to pursue county indigent funding as appropriate.
- Reduce general fund appropriations by $2.7 million over two years in BHSD and reallocate the reduction to Medicaid behavioral health.
- Increase the gross receipts tax increment for county-supported Medicaid to 1/12 in light of reduced need for indigent funds locally.
- Phase out the NMMIP assessment tax credit over three years.

Collectively, these changes could result in net savings or new revenues to the general fund totaling approximately $18 million in FY18, $35 million in FY19, and $53 million in FY20. Of these amounts, roughly $14 million in each of FY18 and FY19, and $13 million in FY20 would be allocated to fund increased costs in Medicaid from BHSD reallocations and County-Supported Medicaid revenues.

Status of Key Recommendations

Finding: The need for state general fund appropriations to support rural primary health care is decreasing.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
DOH should continue to monitor the revenues of clinics receiving funding under RPHCA and require providers to justify the necessity of state funds for the coverage of uninsured clients.				DOH does not monitor RHPCA clinic revenues, despite funding them through its budget.

Finding: Improved Medicaid billing for self-pay clients of certain public health services could reduce the need for state general fund appropriations.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
DOH should work to maximize Medicaid billing for covered services provided to eligible individuals through public health offices and work with Centennial Care MCOs to allow for the private plans operated by the MCOs to reimburse for public health office services currently covered by Medicaid managed care.				DOH states PHD has maximized Medicaid billing for covered services provided through public health offices. Medicaid revenues for Family Planning and Sexually Transmitted Disease programs have grown 81 percent since FY14. However, DOH expects the trend of increasing Medicaid revenues will reverse due to declining public health office visits.

Finding: Tobacco settlement revenues could be freed up for other purposes by better leveraging Medicaid to support certain targeted public health programs at DOH.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
DOH should work with HSD and Centennial Care MCOs to develop a methodology for billing Medicaid for eligible services provided to TUPAC clients, including cost allocation for being able to claim the 50 percent Medicaid administrative quitline match.				The TUPAC program has looked into whether the effort of a Medicaid administrative claim is warranted. HSD states additional funding may be necessary for licensure of cessation counselors, which is required under federal Medicaid rules.

Finding: Although NMCD is assisting pre-release inmates and newly incarcerated individuals in applying for Medicaid benefits, the department does not have the ability to track actual enrollment.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
HSD should work with NMCD to develop a process to collect data on former inmates who enroll in Medicaid and receive services after eligibility is determined.				HSD has automated data collection for NMCD inmates and has updated IT systems to share information between agencies. HSD can now collect data on former inmates who are enrolled and can determine which services they receive.

Finding: Other states provide examples of opportunities for using Medicaid to pay for early childhood home visiting services.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
HSD should work with CYFD to propose a state plan amendment to add qualified home visiting services to the list of Medicaid-eligible services or alternately, create a pilot program for using Medicaid managed care to fund medically based home visiting services.				HSD does not plan to submit a state plan amendment to expand Medicaid services. However, the Long-Term Leveraging Medicaid Subcommittee reiterated the recommendation for HSD to work with CYFD to explore Medicaid coverage of certain home visiting benefits.
HSD should require MCOs to cover services related to home visiting in their Medicaid contracts, but consider requiring preauthorization to manage costs.				HSD does not plan to submit a state plan amendment to expand Medicaid services.

Finding: Medicaid expansion is reducing the need for general funds to support non-Medicaid behavioral health initiatives.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
HSD should reallocate Medicaid expansion savings in the Behavioral Health Services Division to support the state share of Medicaid and bring management of non-Medicaid behavioral health funds into BHSD.				HSD is exploring the option of bringing management of non-Medicaid behavioral health services into BHSD. The Legislature appropriated $217.4 thousand for this purpose in FY17. However, HSD disagrees with the recommendation to reallocate savings to BHSD from Medicaid expansion to support the state share of Medicaid.

Finding: As NMMIP enrollment declines, decreases in assessment revenue and associated insurer premium tax credits allow the general fund to collect previously forgone revenue that could be dedicated to Medicaid.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
The Legislature should consider enacting statute to close the New Mexico Medical Insurance Pool by the end of CY17 and eliminate the NMMIP Assessment Tax Credit against premium taxes for health insurers licensed in New Mexico.				The Legislature has not acted on this recommendation. LFC staff now propose an alternative recommendation to phase out the NMMIP assessment tax credit over three years in light of the decline in NMMIP membership.
NMMIP should re-certify all NMMIP enrollees in one open enrollment cycle to fully identify who should be transitioned to other available coverage options and be better informed of how to address coverage needs of remaining pool members.				The Long-Term Leveraging Medicaid Subcommittee of the Medicaid Advisory Committee recommended NMMIP work with the state to set a firm deadline for transitioning members to other coverage with the exception of two identified categories where members are unable to obtain other coverage. Additionally, NMMIP and the state will consider setting the NMMIP assessment at a fixed rate to direct the differential between assessments and lower losses to the general fund.

Finding: Problem-solving courts in New Mexico present a prime opportunity to leverage Medicaid to expand this cost-effective, evidence-based model.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
District and Magistrate courts should, with the support and oversight of the Administrative Office of the Courts, continue to expand problem-solving courts as well as the number of people served through these courts by using increased federal funding made available through leveraging of Medicaid for treatment services.				The Administrative Office of the Courts has proposed contract language for providers of problem-solving court services to maximize Medicaid enrollment and payment for participants.

Finding: Increasing revenues from the County Indigent gross receipts tax increment could serve as a funding source for health care initiatives currently supported by the general fund.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
HSD should initiate any required state plan amendments to create a safety net care pool for federally-qualified health centers and public health offices to leverage federal Medicaid matching funds and establish reporting requirements for applying for funds and reporting uncompensated care data similar to current requirements for hospitals receiving funding through the Safety Net Care Pool				According to HSD, CMS is unlikely to approve any plan for rate increases or supplemental payments to FQHCs without including additional services to be provided. The Long-Term Leveraging Medicaid Subcommittee recommended HSD and the New Mexico Association of Counties work together to determine whether opportunities to leverage federal dollars from county expenditures through waivers, IGTs, and pilot projects exists and are mutually beneficial.

Finding: New Mexico may be able to leverage local funding for Medicaid through increased use of certified public expenditures.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
HSD should consider adopting a state plan amendment and cost protocol for using certified public expenditures from public hospitals toward the state share of Disproportionate Share Hospital payments				HSD is considering certified public expenditures as a means to contribute to the state share of Medicaid both in the current program and its waiver renewal discussion.

Appendix A: Recommendations of the Long-Term Leveraging Medicaid Subcommittee of the Medicaid Advisory Committee

1. NMMIP should work with the state to develop a firm deadline to transition remaining members eligible for other coverage and enrolled in the Pool with the exception of two identified categories that total approximately 1,000 NMMIP members who are unable to obtain coverage. Additionally, NMMIP and the state will explore the possibility of setting the NMMIP assessment at a fixed rate so that when losses are diminished, the differential between the fixed assessment and lower losses will be directed by the insurance carriers to the state general fund, contingent upon the resulting rates remaining actuarially sound.
2. The New Mexico Association of Counties and HSD will work together to determine whether opportunities to leverage federal dollars from county expenditures through waivers, IGTs, and Medicare pilots exist and are mutually beneficial.
3. HSD should leverage provider assessments to obtain federal matching funds from CMS and explore ways of restructuring gross receipts taxes for health care providers to generate additional revenue that may be leveraged by HSD to obtain federal Medicaid funds from CMS.
4. HSD and the Managed Care Organizations (MCOs) shall formalize value-based purchasing arrangements as a Delivery System Performance Target in their contractual agreement to improve value, quality, and cost over the remaining years of the current MCO procurement.
5. The state should implement one or more provider fees (or similar revenue enhancement measures) in order to maximize federal Medicaid funds and benefit health care in New Mexico, consistent with federal statutes and regulations. As part of this implementation, the state shall engage with affected provider groups. The measure shall be at least revenue neutral as to any provider class.
6. The state should explore a full range of options to enhance revenue and maximize federal match while maintaining adequate provider care and access to care.
7. HSD will collaborate with CYFD to explore Medicaid coverage of certain home visiting benefits for children in order to leverage the state appropriation for home visiting as a match for additional federal dollars.
8. HSD and the MCOs will continue to explore strategies to better manage the high need, high cost population, including ways to address the social determinants of health and reduce costs to the healthcare system such as the Accountable Health Communities model.

Source: Long-Term Leveraging Medicaid Subcommittee

Appendix B: Potential Medicaid Benefit Categories for Home Visiting Services

Benefit Category	Description	Use in Home Visiting
Case Management Services	Services that assist eligible individuals with gaining access to needed medical, social, educational, and other services, including comprehensive assessment, development of a care plan, referral to services, and monitoring activities. Services may be targeted to specific populations (targeted case management).	Targeted case management could include specific groups such as pregnant women and infants. May complement other direct services. Use of this benefit in a home visiting program requires a case manager to provide all required elements of the benefit.
Other Licensed Practitioner Services	Medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under state law.	States may cover licensed counseling or clinical social worker services in the home under home visiting programs.
Preventive Services	Services recommended by a physician or other licensed practitioner with the scope of practice to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health efficiency.	States may cover services such as counseling and screening provided in the home.
Rehabilitative Services	Includes any medical or remedial services recommended by a physician or other licensed practitioner within the scope of practice for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.	States could include family therapy and counseling in the home, if required elements are met, including restorative nature of the service.
Therapy Services	Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.	States could include these services if performed as part of a home visiting program.
Home Health Services	Includes mandatory components of nursing services, home health aide services, and medical supplies, equipment, and appliances. Physical therapy, occupational therapy, and certain other therapy services are optional.	Must be ordered by a physician according to a written plan of care.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Comprehensive array of prevention, diagnostic, and treatment services for individuals under age 21.	States may target services to children, including those provided in the home.
Extended Services to Pregnant Women	Extended services for pregnancy-related conditions and other conditions which may complicate pregnancy.	States may target home visiting services to pregnant and postpartum women to help ensure the delivery of prenatal and postpartum services.
Health Homes	Services to integrate primary care, behavioral health, and long-term services and supports for Medicaid beneficiaries with chronic conditions.	Services are based on the condition and not the type of beneficiary (e.g. pregnant women). However, states may elect to cover services to pregnant women or children in the home under this authority.
Source: CMS and HRSA		

Appendix C. Problem-Solving Court Services Covered by Medicaid

Covered by Medicaid	Screening and assessment for: Substance abuse Mental health Individual counseling Group counseling Comprehensive community support services (CCSS) Medication management Intensive outpatient treatment Drug testing and lab confirmations
Potentially Covered by Medicaid under the Above Categories	Family/couples counseling Supplemental group therapy Gender-based group therapy Moral reconation therapy (MRT) Psychiatric services Anger management Life skills coaching
Not Covered by Medicaid	Parenting education Case management Job skills development
Source: AOC	