Report
to
The LEGISLATIVE FINANCE COMMITTEE

Department of Human Services
Program Evaluation: Medicaid Managed Care (Physical Health)
January 14, 2009

Report #08-05

LEGISLATIVE FINANCE COMMITTEE

Senator John Arthur Smith, Chairman
Representative Luciano "Lucky" Varela, Vice Chairman
Senator Sue Wilson Beffort
Representative Donald E. Bratton
Senator Pete Campos
Senator Carlos R. Cisneros
Senator Phil A. Griego
Senator Stuart Ingle
Representative Rhonda S. King
Representative Brian K. Moore
Senator Mary Kay Papen
Senator Leonard Lee Rawson
Representative Henry "Kiki" Saavedra
Representative Nick L. Salazar
Representative Edward C. Sandoval
Representative Jeannette O. Wallace

DIRECTOR

David Abbey

DEPUTY DIRECTOR FOR PROGRAM EVALUATION

Manu Patel, CPA

PROGRAM EVALUATION STAFF

David Craig
Lawrence Davis
Brenda Fresquez, CICA
Pamela Galbraith
Donna Hill-Todd, CGFM
Craig Johnson
John Ketchens
Jordan Maril
Charles Sallee
Aurora B. Sánchez, CISA

State of New Mexico
LEGISLATIVE FINANCE COMMITTEE

325 Don Gaspar, Suite 101 • Santa Fe, New Mexico 87501
Phone: (505) 986-4550 • Fax: (505) 986-4545

DAVID ABBEY
DIRECTOR

January 14, 2009

Pamela Hyde, Cabinet Secretary
Human Services Department
PO Box 2348
Santa Fe, New Mexico 87504

Dear Secretary Hyde,

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the *Program Evaluation: Medicaid Managed Care (Physical Health).*

The program evaluation team reviewed the costs of the Medicaid managed care program and related performance outcomes; assessed the Human Services Department's oversight of Medicaid managed care organizations to ensure clients' access to cost-effective, high quality services; and assessed the availability of timely information on performance, quality and cost of Medicaid managed care to clients, the public and policymakers. The report will be presented to the Committee on January 14, 2009. An exit conference was conducted on January 7, 2009 in which we discussed the contents of the report with you and your respective staff.

I believe this report addresses issues the Committee asked us to evaluate and hope your department benefits from our efforts. We very much appreciate the cooperation and assistance we received from you and your staff.

Sincerely,

David Abbey

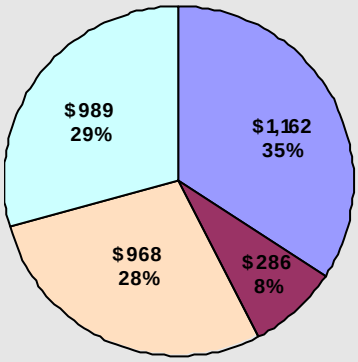
David Abbey, Director

DA:CS/svb

Table of Contents

Page No.

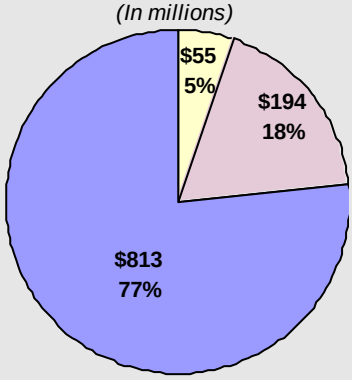
Total Medicaid Spending FY08
(In millions)



- Physical Health
- Behavioral Health
- Long-Term Care Services*
- Other Fee-for-Service

Source: HSD
*Long-Term Care Services includes waivers, PACE, personal care options, COLTS, and nursing home

Medicaid Managed Care Spending (Physicial Health) FY07
(In millions)



- HSD Adm
- MCO Adm/Taxes/Profit
- Medical Spending

Source: LFC Analysis

The Human Services Department (HSD) administers Medicaid, a federal-state funded program for financing health services for low-income groups, covering over 450 thousand New Mexicans. Total spending has reached over $3 billion, with the federal share exceeding 70 percent. Since FY04, appropriations from the general fund for Medicaid have nearly doubled from $408 million to almost $790 million in FY09, and now account for nearly 13 percent of state spending.

State law requires HSD to provide Medicaid to most clients through capitated managed care, in which the state prospectively pays managed care organizations (MCOs) a fixed monthly fee per client member to provide or arrange for most health care services. About 292 thousand New Mexicans, or 65 percent Medicaid clients, participate in managed care and may choose from among four MCOs for their physical health care needs.

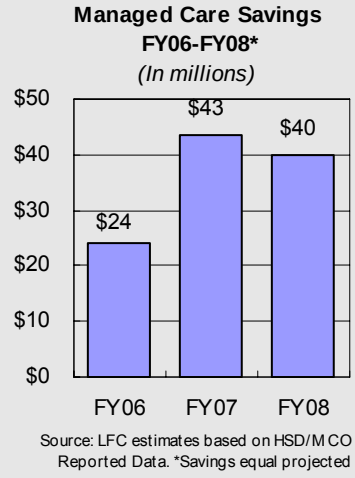
New Mexico, like most states, implemented managed care in an effort to improve the health status of recipients and to stabilize and lower costs. However, spending on the physical health portion of Medicaid managed care has increased almost 30 percent from about $888 million in FY06 to $1.1 billion in FY08 and now accounts for about 35 percent Medicaid spending. HSD experienced an annual rate of growth for this program of about 14 percent between FY06-FY07 and 13 percent between FY07-08.

The Legislative Finance Committee staff (LFC) evaluation reviewed the costs of the physical health portion of Medicaid managed care program and related performance outcomes; the availability of this information to clients, the public and policymakers; and assessed HSD's oversight of MCOs to ensure clients' access to cost-effective, high quality services. Generally, HSD has ensured MCOs provide clients with sufficient access to quality services and has extensive oversight mechanisms for monitoring service delivery.

Overall, significant opportunities exist to lower the cost of Medicaid managed care in the near term and slow future growth in program expenditures, without reducing enrollment or changing the benefit package. Medicaid managed care needs adjustments to MCO rates to bring state payments more in line with program costs; a modernized payment framework for outpatient services; additional oversight of certain MCO network costs to ensure cost-effective use of funding and a functioning market for purchasing services; and more competition between MCOs to continue HSD's ability to purchase high-quality care, but at a lower cost. During this evaluation, HSD started to take action to address some of these areas, but continued efforts are still needed.

Spending on physical health Medicaid managed care increased almost 30 percent, from about $888 million in FY06 to $1.1 billion in FY08.

Focused efforts are needed to lower the per member cost of managed care in order to afford serving additional needy New Mexicans.



Medicaid operates in a complex environment that sometimes produces conflicting policy objectives that reduce managed care's cost-effectiveness. For example, if Medicaid is viewed as an economic development engine for the healthcare system then expanding coverage to thousands of needy New Mexicans who qualify for Medicaid becomes cost-prohibitive, even with a favorable federal matching rate. Efforts to interject the State into provider rate setting may unnecessarily increase per member unit costs without improving access or quality of care, and eliminates a central cost-containment benefit of using managed care.

Focused efforts are needed by policymakers and HSD to collaboratively work together to lower the per member cost of managed care in order to afford serving additional needy New Mexicans. Making additional information on both the cost and quality of care in user friendly formats available to clients, the public and policymakers would increase transparency, aid in decision-making, strengthen confidence in administration of the program and improve accountability to taxpayers.

The recommendations in this report are intended to position the physical health Medicaid managed care program to continue providing quality services, but at more affordable and competitive prices.

KEY FINDINGS

Medicaid Managed Care Medical Costs Were About $107 Million Less Than Anticipated For FY06-FY08, Generating Savings That Should Accrue To The State.

- *HSD's actuarial analysis for developing contract rates anticipate that about 85 percent of MCOs premiums are needed to cover standard medical expenses for clients.* HSD also contractually requires at least this amount be spent on medical services.
- *The physical health Medicaid MCOs reported spending about 81 percent of funding on medical services, resulting in an estimated $107.4 million in savings between FY06-FY08.* The positive difference between the expected and actual medical costs indicates the MCOs received more funding than was needed to cover anticipated costs according to HSD actuarial and contract assumptions.
- *HSD has calculated the 85 percent spending requirement in a way that is not clearly outlined by the contracts and thus does not plan on recovering any of the estimated savings from MCOs.* Medicaid managed care appears to have been used to subsidize losses in State Coverage Insurance program.
- *For FY09, HSD has lowered the contract target for medical spending to about 80 percent of premium revenue.*

Transparency provides a foundation for government accountability.

Other states make more information available publicly, including rates, and up-to-date enrollment estimates on Medicaid websites.

New Mexico appropriates most of Medicaid in a lump sum block grant. This limits authority to set specific appropriations for major parts of Medicaid.

Increased Medicaid Managed Care Transparency By HSD Would Improve Budgeting And Oversight Responsibilities Of The Legislature. States are one of the country's largest healthcare purchasers through Medicaid and employee benefits. Transparency provides a foundation for government accountability, public confidence and information which the state policy makers and healthcare consumers can use to make responsible decisions. During the course of this evaluation, lack of key information from HSD on Medicaid managed care hampered LFC staff efforts to carry out Committee functions.

- *The Legislature intended for all government units to cooperate with the LFC so that it may carry out its intended functions, which include evaluation, oversight and budgeting responsibilities.* State laws provide the framework for LFC to inquire, investigate and obtain necessary information on the costs, effectiveness, and operations of state government so that it may carry out its duties. The fact that an "inquiry may also have other far reaching consequences is no justification for a limitation upon the scope of inquiry" by a governmental unit and thus LFC authority, according to Attorney General Opinion 57-118.
- *HSD has failed to provide LFC staff with information requested regarding Medicaid and its operations, citing exceptions related to the Inspection of Public Records Act (IPRA).* In an effort to resolve the matter, LFC staff requested guidance from the Office of the Attorney General (AGO).
- *The Office of the Attorney General issued an advisory letter concluding that LFC requests are not subject to IPRA.* The letter points out that only in a case where there is a law making the requested information confidential, can an agency deny an LFC request. No such law exists for the information requested from HSD. The full letter is included in Appendix A.
- *HSD, since its initial denial, has provided most of the requested information, but not information on contract rates, complete rate certification letters or amounts paid for different types of clients to MCOs.* HSD's response to our request after receiving the AGO advisory letter is included in Appendix B.
- *Other states, unlike HSD, make more information available publicly, including rates, actuarial studies, sanctions and up-to-date enrollment estimates on Medicaid websites.*
- *Finally, other states' Medicaid budgets are broken down by key spending categories which add significant budget transparency for lawmakers.* New Mexico appropriates most of Medicaid, including the physical health manage care portion, in a lump sum block grant. This limits authority to set specific appropriations for major parts of Medicaid.

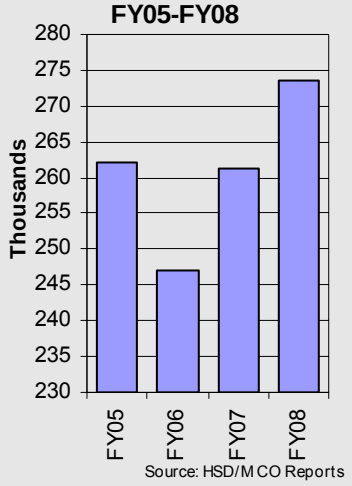
Low-income children (cohort 2) make up about 73 percent of all clients in managed care and account for about 40 percent of medical spending.

Sub-capitation PMPM Costs for Low-Income Children FY07

MCO	Without Sub-caps	Sub-caps	Total PMPM
#3	$119.90	$5.83	$125.73
#2	$142.55	$1.28	$143.82
#1	$113.61	$39.90	$153.50

Source: LFC Analysis of HSD/MCO Data

Average Monthly Membership FY05-FY08



Source: HSD/MCO Reports

Medicaid managed care programs face unique structural challenges of achieving savings or containing costs that private sector managed care may not.

Spending on medical services by MCOs has increased about 27 percent, from $730.7 million in FY06 to an estimated $929.7 million in FY08; driven in part by enrollment and medical price increases. Overall, significant growth has occurred in sub-capitation payments made to providers to manage the care of assigned clients, outpatient hospital and ambulatory surgical centers, physicians and prescription drugs. Low-income children (cohort 2) make up about 73 percent of all clients in managed care and account for about 40 percent of medical spending. This client group had an average medical cost of about $144 per member per month (PMPM) in FY07, up 12 percent from the FY06 PMPM medical cost of $128.

- *Total outpatient costs have increased almost 40 percent, from $178 million in FY06 to $246 million and are significantly more costly than inpatient services ($171 million).* However, modernizing payment methodology for some outpatient services could save millions and improve predictability of medical costs. Outpatient costs appear to be driven by price, since utilization has remained relatively stable. Medicaid requires MCOs to pay for outpatient services on a "percentage of billed charges," however other payers, such as Medicare, have moved to a fixed payment structure similar to those used for inpatient hospitals.
- *Sub-capitation payments have increased 77 percent since FY05 to about $67.8 million in FY08; more information is needed to determine the cost-effectiveness of this payment approach.* About 89 percent of sub-capitation payments, flat per member per month payments to providers for managing a client's care, are made to manage the care of low-income children (cohort 2). For example, in FY07 low-income children accounted for $49.5 million of the $55.7 million in reported spending on sub-capitations, with one MCO accounting for almost 90 percent of all spending on sub-capitations. As a result, this MCO has the most expensive medical costs for an otherwise relatively inexpensive client group to cover. In addition, for FY08 about 84 percent of this MCO's total sub-capitation costs were payments made to an affiliate provider group.
- *Enrollment appears to have rebounded from sharp declines in FY05, but didn't meet projected levels until FY08.* Large balances should have materialized at HSD during FY06 as a result of lower than expected managed care enrollment, and thus costs to Medicaid.

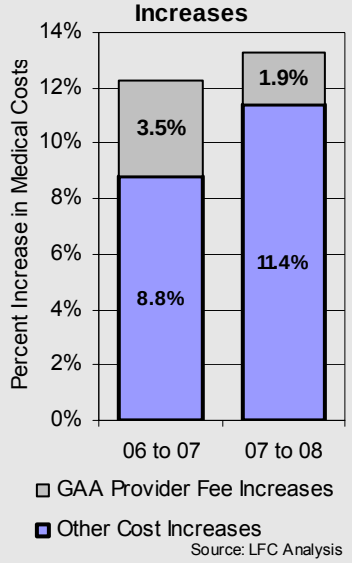
Realigning Incentives And Improving Efficiency Would Save Money And Create Better Value For Taxpayers Purchasing Healthcare For Low-Income New Mexicans. States, including New Mexico, have increasingly turned to managed care to control costs, to save money and to improve access and quality for their Medicaid programs. Medicaid managed care programs face unique structural challenges of achieving savings or containing costs that private sector managed care or even Medicaid fee-for-service may not.

For the FY09-FY12 procurement HSD awarded contracts to all four bidders, which limited the effectiveness of competition by not excluding higher priced bidders from being awarded a contract.

State resources are tied up in four companies performing the identical functions.

Clients have no price sensitivity (no co-pays or premiums) when choosing "free health care."

- *Federal rate making regulations no longer require Medicaid managed care to cost the same or less than if client were in the fee-for-service program.* Current regulations require a form of cost-plus contracting.
- *Historically, New Mexico has not fully exercised its authority to increase price competition and has limitations placed on it to assure the benefits of competitive procurement.* For the FY09-FY12 procurement HSD awarded contracts to all four bidders that in practice served as an "any willing provider" procurement. These procurement arrangements limit the effectiveness of competition because HSD did not exclude higher priced bidders from being awarded a contract. Clients have no price sensitivity (no co-pays or premiums) when choosing "free health care" and are not given the opportunity to examine comparative cost information when choosing an MCO. Medicaid clients have been choosing to enroll in the plan with the highest costs. When the state has the choice though auto-assignment it has not, up until November 2008, given preference to lower cost MCOs either.
- *Using four MCOs to manage care for the lowest cost population in Medicaid creates additional inefficiencies in administration.* More state resources are tied up in four companies performing the identical functions. Additional MCOs also add to HSD's administrative workload and costs including direct cost increases in contracts for additional external quality audits.
- *HSD can build on its best practice of requiring MCOs to earn a portion of their premiums by increasing financial ramifications of poor performance.* MCOs are required to set aside 0.5 percent of their premiums which must be earned by meeting contract performance measures. Penalties for poor performance on individual performance measures are relatively low, particularly in relation to publicly reported profit margins earned outside of this pay for performance process.
- *HSD allows MCOs to keep penalty amounts, but directs how they are spent.* It is unclear how penalties act as a deterrent if MCOs are allowed to spend the penalty amounts on initiatives presumably they are already contracted or have the flexibility to already perform. In addition, for FY09 all penalty expenditures will benefit MCOs in calculating their medical spending requirements.



The managed care rate development process already accounts for trends in medical prices, which may make additional fee increase appropriations unnecessary.

Provider Fee Increase Premium Balances* FY07-FY08
(In thousands)

MCO	FY07	FY08
Presbyterian	$0	$1,647
Molina	$0	$1,060
Lovelace	$1,004	$0
Total	$1,004	$2,708

Source: MCO reports to HSD.

Less than three percent of PCPs (47) accounted for almost 25 percent of Medicaid clients assigned to their care as of June 2008.

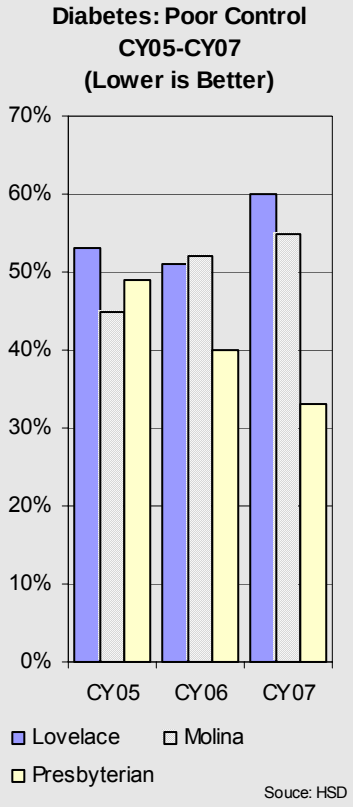
Additional Provider Fee Increases Do Not Appear Warranted At This Time; Not All Of Fee Increases In FY07 Or FY08 Were Needed And Should Be Recouped By HSD. The Legislature pumped more than $101 million in state and federal Medicaid funding for provider fee increases in FY07 and FY08 across the entire program.

- *The physical health MCOs received about 49 percent of the total provider fee increase funding for FY07, and about 40 percent in FY08.* MCOs were required to pass funding through to providers, less premium taxes.
- *The increases in provider fees increased overall medical costs by an estimated 3.5 percent between FY06 and FY07 and less than two percent between FY07 and FY08.*
- *The managed care rate development process already accounts for trends in medical prices, which may make additional fee increase appropriations unnecessary.*
- *New Mexico's Medicaid fee schedule for many common provider procedures appears adequate compared to neighboring states, Medicare and commercial lines.*
- *Relatively few primary care providers (PCPs) may have received a significant portion of fee increases since about 15 percent (about 300) of primary care providers serve over 70 percent of Medicaid managed care clients.* Less than three percent of PCPs (47) accounted for almost 25 percent of Medicaid clients assigned to their care as of June 2008.
- *About $3.7 million in funding for provider fee increases went unspent by MCOs in FY07 and FY08, and should revert to the state.*

A Transition To Actual Health Care Outcomes Would Better Inform The Legislature And Public Regarding Health Of The Medicaid Population Under Managed Care. New Mexico, as a state, needs significant improvement in many healthcare quality indicators which can be positively influenced through Medicaid managed care performance. For example, more focus is needed on child and maternal health since Medicaid pays for over half of births in New Mexico.

HSD Has Necessary Oversight Tools To Monitor Quality Of Care, But Could Improve Its Financial Oversight Of MCOs.

- *HSD primarily relies on unaudited financial data for developing managed care rates, putting the state at significant risk for improper payments.*
- *HSD has an internal audit unit, which according to HSD, has not conducted internal audits of Medicaid oversight functions.* Often internal audits can assist organizations experiencing a transforming mission to assess whether changes to functions, organizational structure, staffing patterns and staff qualifications need adjustment.



Work with LFC and DFA to develop a regular reporting format for, at a minimum, up-to-date cohort level data on enrollment and average PMPM spending and to overhaul family of performance measures reported on an annual and quarterly basis.

KEY RECOMMENDATIONS

The Committee may want to consider breaking up Medicaid appropriations into smaller appropriation components, such as physical health managed care, coordinated long-term care services, other fee-for-service, and HSD administration with appropriate performance measures for each part of Medicaid.

HSD should implement the following recommendations.

Amend MCO contracts to recover the estimated $107.4 million in savings through a performance bond and/or reducing FY09 and FY10 rates; cap non-medical expenses, administration and profit at no more than 15 percent of income earned under the contract, and consider further reducing this amount to 14 percent in FY11 and to 13 percent in FY12.

Make available to LFC information on Medicaid managed care contract rates, complete actuarial rate certification letters/reports and amounts paid to MCOs by client type (cohort) as requested. Work with LFC and DFA to develop a regular reporting format for, at a minimum, up-to-date cohort level data on enrollment and average PMPM spending and to overhaul family of performance measures reported on an annual and quarterly basis.

Require MCOs to submit additional data and information on the use of sub-capitation arrangements with primary care providers.

For FY11, reduce the number of MCOs to no more than three, and lock rates for both FY11 and FY12.

Recover and revert general fund portions of unspent provider fee increases from FY07 and FY08 totaling $3,712,945.

Transition to Medicare's payment methodology for outpatient services by no later than the end of FY10, with specific cost savings goals for FY11-FY12 to be reflected in capitation rates.

Amend contracts to increase the amount premiums that must be earned through performance to at least one percent in FY10, and two percent in FY11

Require the Internal Audit Bureau to conduct a staffing and efficiency review of MAD and report the results to LFC by September 1, 2009.

Validate financial data contained in medical spending reports submitted by MCOs that are used for developing rates.

MEDICAID AT A GLANCE

Medicaid is a federal-state funded program for financing health services for low-income groups. Medicaid was created as Title XIX of the Social Security Act in 1965 to provide health insurance for families receiving welfare. Since that time Congress has expanded the program considerably to include other low-income adults and people with disabilities.

Medicaid programs are developed by individual states, but must comply with national guidelines to be eligible for federal funding. Federal matching funds are delivered to states that provide services to the following categorically needy groups:

- Limited-income families with children;
- Children under age 6 whose family income is at or below 133 percent of the Federal poverty level (FPL);
- Pregnant women whose family income is below 133 percent of the FPL;
- Infants born to Medicaid-eligible women, for the first year of life with certain restrictions; and
- All children under age 19, in families with incomes at or below 100 percent of the FPL.

States are given the authority to set their own eligibility criteria, scope of services, and rate of payment. Additionally, the state may offer "State-only" programs that provide medical assistance to groups not qualifying for Medicaid. Regular Medicaid serves children under 185 percent of FPL, but New Mexico has elected to expand eligibility to children between 185 percent of FPL up to 235 percent of FPL using State Children's Health Insurance Program Funding.

FAST FACTS

Population enrolled: As of September 2008, over 450 thousand New Mexicans were enrolled in Medicaid. About 292 thousand of these clients participated in physical health Medicaid managed care. In total, about 21 percent of the population of New Mexico is enrolled in Medicaid.

Funding: The total spending for Medicaid managed care in FY08 was $1.4 billion and is projected to reach $1.6 billion in FY09. The majority of funding from Medicaid comes from federal matching funds. Medicaid general fund appropriations are $697 million and $788 million in FY08 and FY09 respectively.

Providers: There are currently four physical health managed care organizations in New Mexico: Lovelace, Presbyterian, Molina, and Blue Cross Blue Shield (effective FY09).

HISTORY OF MAJOR EVENTS

1965	The United States Congress passed Medicaid Title XVII and Medicare Title XIX as components of the Social Security Act to provide health insurance for families receiving welfare.
1973	New Mexico implements Medicaid with the passage of the 'Public Assistance Act,' later known as Medicaid.
1977	Health Care Financing Administration (HCFA) assumed control over federal Medicaid and Medicare programs.
1988	Requirement established making Medicaid coverage mandatory for uninsured pregnant women.
1990	Medicaid for children age 6-18 phased in.
1994	Legislature requires managed care for most Medicaid recipients.
1997	Federal government encourages expansion of managed care by making waivers more easily accessible. Congress authorizes State Children's Health Insurance Program (SCHIP).
1998	New Mexico implements managed care.
2001	HCFA renamed Centers for Medicare and Medicaid Services (CMS).
2005	Behavioral Health services carved out into a separate managed care contract.
2008	A fourth managed care organization, Blue Cross Blue Shield, is added. Coordinated Long-Term Care Services managed care program begins.

ORGANIZATION

Office of the Secretary. The Secretary of Human Services acts as the department's chief executive and operations officer for financial, food, energy, and health care assistance programs. The appointed secretary serves at the pleasure of the Governor and must be confirmed by the Senate. The Secretary has authority to adopt necessary rules and regulations; appoint, with the governor's consent, division directors; and carries out other duties needed to operate the department.

Medical Assistance Division. The Medical Assistance Division (MAD) is responsible for ensuring the direct administration of Medicaid in accordance with state and federal laws, including managing over 40 Medicaid eligibility categories. MAD is located in Santa Fe and supervised by a Division Director. Three Deputy Directors oversee specific programs and operational activities within MAD. The director's office has 13 FTEs and 1 approved double fill. The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

Program Bureaus. Each Deputy Director supervises several program bureaus and related administration.

Benefits Bureau: (21 FTEs) The Benefits Bureau (BB) is responsible for the development, modification and interpretation of the existing Medicaid benefit package and provider operations for fee-for-service providers. BB is also responsible for ensuring consistency between fee-for-service policy and managed care policies relating to the benefit package.

Client Services Bureau: (35 FTEs, 2 double fills) The primary functions of the Client Services Bureau are to assist clients with enrollment, to develop eligibility policy and to promote Medicaid education and outreach to the public.

Contract Administration Bureau: (17 FTEs) CAB is primarily responsible for the daily oversight and management of the Salud! managed care contracts and the managed care program.

Program Oversight and Support Bureau: (11 FTEs) The role of the Program Oversight and Support Bureau is to manage nursing home and other long-term care fee-for-service programs including home and community based waivers and the Personal Care Option programs.

Program Administration Bureau: (17 FTEs, 1 double fill) PAB manages the financial planning and financial policy affairs of the Division. The focus of the Bureau is programmatic, and its responsibilities include forecasts, projections and analyses of Medicaid expenditures and revenue.

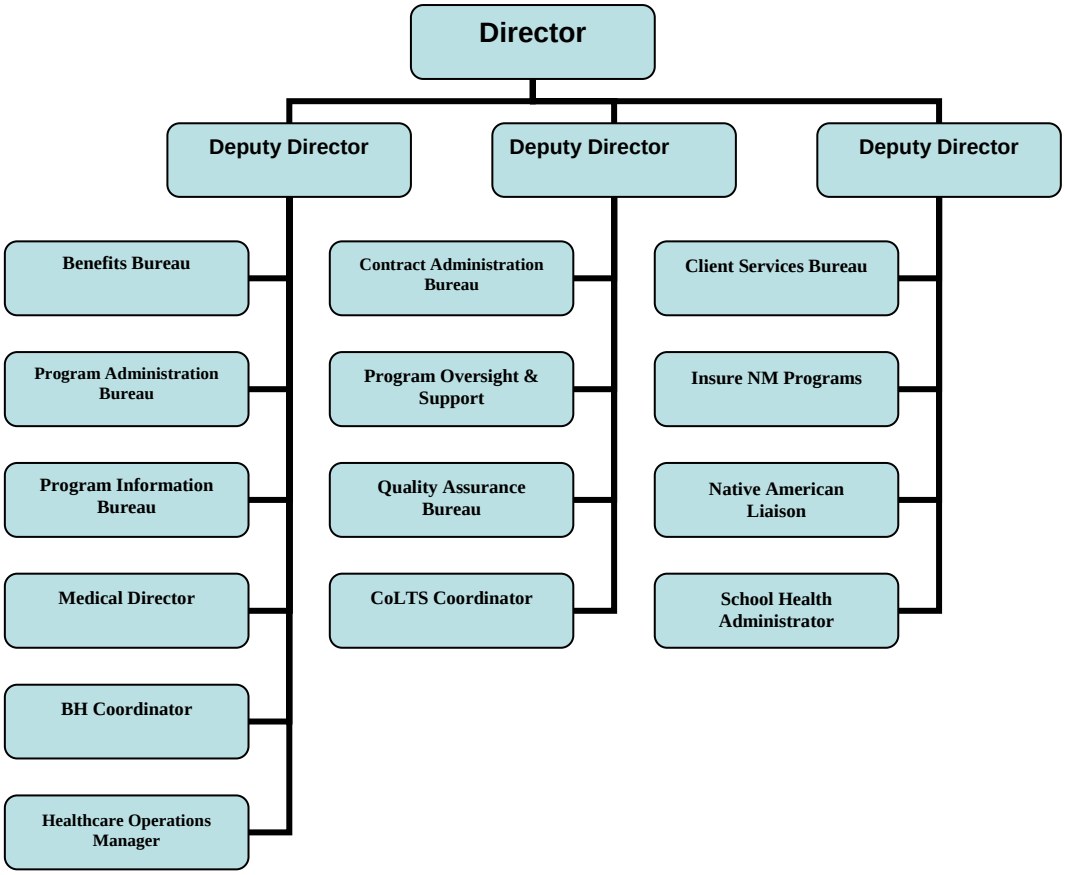
Program Information Bureau: (11 FTE) PIB provides analysis, development, project management and contract oversight of information systems used by the division, including hardware and Medicaid Management Information System related contracts. The goals of the bureau are to provide accurate and timely payments to providers, customer service to providers, and to provide information to administrators for use in programming, evaluation, and fraud detection.

Quality Assurance Bureau: (18 FTEs) The primary objective of QAB is to ensure quality through oversight of all aspects of quality care, fraud and abuse detection, and performance measurement, including monitoring, and tracking of systemic quality indicators and issues.

Behavioral Health Coordination Unit: (3 FTEs) This unit assists the Interagency Behavioral Health Collaborative, which works to improve the access, quality, and accountability of the delivery of behavioral health services to New Mexico residents in need.

Insure New Mexico Programs: (11 FTEs) This bureau assists uninsured populations in New Mexico in procuring healthcare coverage. The programs managed within this bureau include State Coverage Insurance, Premium Assistance Program and Small Employer Insurance Program.

School Health Unit: (4 FTEs) SHU is responsible for management of all Medicaid school health programs, such as Medicaid School-Based Services Program and the School-Based Health Center Program.



Managed Care. The Balanced Budget Act of 1997 (BBA) gave states new authority to require certain Medicaid beneficiaries to enroll in managed care plans and also required the establishment of consumer protections for Medicaid managed care enrollees in areas such as access to quality care (GAO, 2004).

State law authorizes the Human Services Department to provide a statewide managed care system to provide cost-efficient, preventative, primary and acute care for Medicaid recipients (Section 27-12-12.6 NMSA 1978). According to the state law, the managed care system "shall ensure:

- access to medically necessary services, particularly for Medicaid recipients with chronic health problems;
- to the extent practicable, maintenance of the rural primary care delivery infrastructure;
- that the department's approach is consistent with national and state health care reform principles; and
- to the maximum extent possible that Medicaid-eligible individuals are not identified as such except as necessary for billing purposes (Section 27-12-12.6 NMSA 1978)."

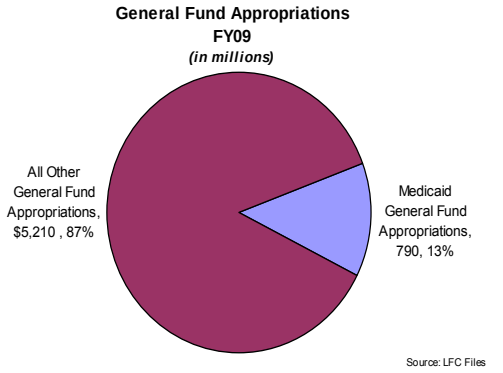
In 1997, New Mexico moved its Medicaid program towards a managed care plan in an effort to improve the health status of recipients and to stabilize and lower costs. New Mexico instituted mandatory managed care for all Medicaid recipients except for those in nursing homes, those also receiving Medicare, and Native Americans (who may choose whether or not to enroll in managed care).

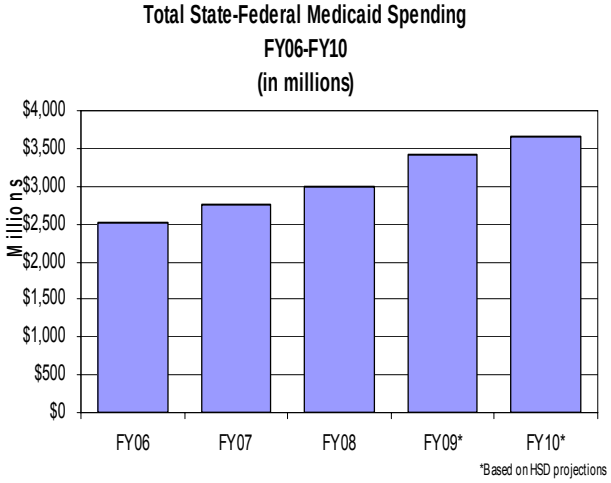
Medicaid managed care attempts to provide appropriate health care services in a cost-efficient manner by paying managed care organizations to provide and arrange for all health care services for enrollees. However, because managed care organizations are paid a fixed amount regardless of the number of services they provide, managed care programs require safeguards against the incentive for some plans to under-serve enrollees, such as limiting enrollees' access to care. Access is also affected by other factors, such as physicians' location and their willingness to participate in managed care plans. Safeguards to ensure enrollees have access to care could include requiring plans to maintain provider networks that provide enrollees with sufficient geographic access to providers or requiring managed care plans to develop and monitor certain quality indicators, such as enrollee satisfaction surveys or grievances.

Managed care delivery structure. Managed care in New Mexico currently operates under three categories, physical health managed care, coordinated long-term services (COLTS) and behavioral health managed care. Salud!, the physical managed care program in New Mexico, enrolls clients in one of four different managed care organizations (MCOs): Lovelace, Presbyterian, Molina, or Blue Cross Blue Shield. Under the managed care system, HSD pays a flat monthly fee, or "capitation rate," per patient to the MCO. Capitation rates vary according to the client: infants and children receive different capitation rates than adults and elderly clients. The MCOs then pay providers, who in return offer health care services. This type of managed care is called 'full risk managed care'—the MCO gets a pre-negotiated dollar amount (per person) to take care of one patient. If the patient is healthy then the MCO saves money, but if the patient is or becomes seriously ill the MCO must cover medical costs by using money from the healthy patients' dollar pool.

FUNDING

The Medicaid program constitutes a major expenditure item for the state and now accounts for about 13 percent of spending from the general fund. Since FY04 general fund appropriations for Medicaid have nearly doubled from $408 million to almost $790 million FY09. However, since FY06 total spending, (both state and federal,) on Medicaid has increased from about $2.5 billion to a projected $3 billion in FY08. Through FY10, HSD projects total spending to increase to over $3.5 billion in combined state and federal spending.





A significant cost driver to the state during this period was a change in the federal medical assistance percentage (FMAP) matching rate. FMAP is used to determine the federal portion of Medicaid matching funds and is based on an annual comparison of the State's average per capita income level with the national income average. As the cost of providing Medicaid increases, the FMAP has decreased. The FMAP in New Mexico for FY08 was 71.04 percent, and in FY09 dropped to 70.88 percent. Nationally, FMAP varies between 50 percent and 77.08 percent. New Mexico's rising per capita average income, relative to the rest of the nation, has resulted in a 3.97 percent decrease since FY04.

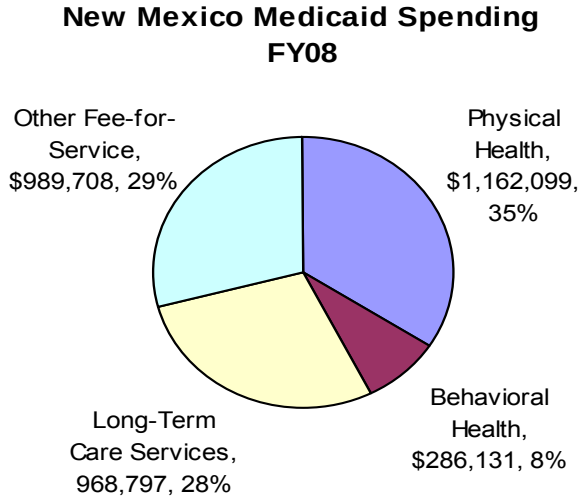
Other cost drivers contributing to the increase in Medicaid costs include the price and amount of services used by clients. Medical cost inflation has increased nationally at approximately 4.5 percent per year. Increase in enrollment is another factor driving the costs of providing Medicaid. New Mexico's total Medicaid enrollment has increased by 66 percent between FY97 and FY06. Enrollment in the state's managed care has increased by 74 percent for the same time period.

Medicaid Enrollment
FY97-FY09

New Mexico	Medicaid Enrollment	Managed Care Enrollment	% Enrolled in Managed Care
FY97	242,445	139,337	57.47%
FY98	243,059	193,818	79.74%
FY99	284,705	208,528	73.24%
FY00	312,360	199,297	63.80%
FY01	331,798	212,456	64.03%
FY02	371,353	243,069	65.45%
FY03	404,497	261,015	64.53%
FY04	420,935	273,018	64.86%
FY05	411,069	248,990	60.57%
FY06	402,152	242,742	60.36%
FY07*	408,948	250,228	61.19%
FY08*	437,836	289,707	66.17%

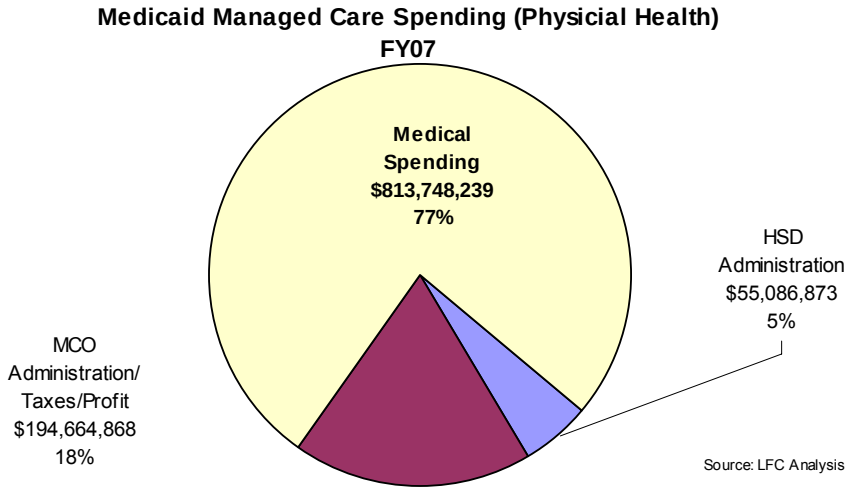
*Projections
Source: CMS and LFC Files
* As of June, 2008

The physical health portion of Medicaid managed care accounts for about 35 percent of all Medicaid spending. In FY09, managed care expanded to include previously excluded groups through the coordinated long-term care services.



Source: HSD
*Long-Term Care Services includes waivers, PACE, personal care options, COLTS, and nursing home

In FY07, about 77 percent, or $813 million, of funding for the physical health portion of Medicaid managed care was spent on medical services. HSD's overhead costs for this program were about five percent, or an estimated $55 million, while the remaining 18 percent or $194 million was left for MCO administration, taxes and profit.



PROJECT INFORMATION

Program Evaluation Objectives.

- Review the costs of the Medicaid managed care program and related performance outcomes.
- Assess the department's oversight of Medicaid managed care organizations to ensure clients' access to cost-effective, high quality services.
- Assess the availability of timely information on performance, quality and cost of Medicaid managed care to clients, the public and policymakers.

Program Evaluation Activities (Scope and Methodology).

- Reviewed state and federal laws, regulations and policies; HSD reports, Medicaid plans, waivers, correspondence with CMS, including CMS audit reports; and MCO contracts, list of required reports and reviewed selected sample;
- Reviewed public (CMS, GAO, other states, etc.) and private research and evaluations of health care quality, managed care, Medicaid managed care and costs of health care in general;
- Reviewed financial, encounter, enrollment, utilization, performance and quality data from HSD, MCOs and PRC-Insurance Division for FY04-09 for Medicaid as a whole and individually by MCO; Reviewed State Coverage Initiative financial data.
- Conducted a web search and structured interviews with selected other states budget offices and Medicaid programs (AZ, AK, CO, FL, LA, MI, MN, MS, OK, NY, NC, TX, UT, WI.)
- Interviewed staff from HSD, MCOs among others.

Review Authority. The Committee has authority under Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political sub-divisions, the effect of laws on the proper functioning of these governing units, and the policies and costs of government. Pursuant to its statutory authority, the Committee may conduct performance reviews and inquiries into specific transactions affecting the operating policies and costs of governmental units and their compliance with state law.

Review Team.

Manu Patel, Deputy Director for Program Evaluation
Charles Sallee, Lead Evaluator
Jordan Maril, Program Evaluator
Pamela Galbraith, Program Evaluator
Amy Boule, LFC Contractor

Exit Conference. The contents of this report were discussed with Pamela Hyde, Secretary, Human Services Department and senior department staff, and LFC staff on January 7, 2009.

Report Distribution. This report is intended for the information of the Office of the Governor, the Human Services Department, the Department of Finance and Administration, the Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report which is a matter of public record.

Manu Patel
Deputy Director for Program Evaluation

MEDICAID MANAGED CARE MEDICAL COSTS WERE ABOUT $107 MILLION LESS THAN ANTICIPATED FOR FY06-FY08, GENERATING SAVINGS THAT SHOULD ACCRUE TO THE STATE.

HSD's actuarial analysis and contracts anticipate that about 85 percent of managed care organizations' premiums are needed to cover standard medical expenses for covered members. HSD has contracted with Mercer to conduct analysis to develop each fiscal year's actuarially sound capitation rate ranges. Actuarially sound rates produce premiums that cover all managed care organizations reasonable and expected medical and administrative costs for a given contract year.

To project future managed care organization (MCO) costs and develop actuarially sound rate ranges Mercer does the following.

- Analyzes historical financial and encounter data submitted by MCOs that include incurred medical costs and use of services by different types of clients based on age and demographic factors.
- Makes necessary adjustments to financial and encounter data, including projected impact of programmatic changes such as available benefits and expected state driven changes to provider fee schedules or prices; prospective trend increases in overall medical costs due to utilization or price; and adjustments for administrative costs, including taxes and profit (about 15 percent is added to projected medical costs).
- Develops a range of total projected Medicaid physical health managed care costs to account for variability in cost experience, population acuity, administration differences and trend projections.
- Divides HSD projected enrollment by cohort into cost ranges to produce per member rate ranges.

While the actuarial sound rates assume an estimated 85 percent of premiums will be spent on medical services, HSD also requires at least this amount be spent on medical services in its managed care contracts. This "medical-loss-ratio" (MLR) requirement is intended to measure efficiency for administration, to prevent excess profit and to ensure a significant portion of premiums are spent on medical care for clients, as projected by the actuary.

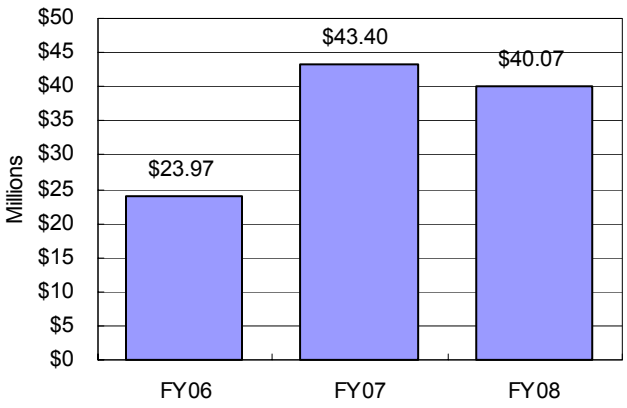
The physical health Medicaid MCOs reported spending about 81 percent of funding on medical services, resulting in an estimated $107.4 million in savings between FY06-FY08. The $107.4 million in savings equal the difference between the projected medical expense, defined as 85 percent of premiums received, and actual medical expense as reported to HSD in medical expense reports. The positive difference between the expected and actual medical costs indicates the MCOs received more funding than was needed to cover anticipated costs according to HSD actuarial and contract assumptions. These savings estimates are conservative for the following reasons.

- The estimates include revenue actually paid to MCOs, which is less than they earn under the contract because HSD routinely reduces premiums to recover past overpayments.

- The estimates do not include other income MCOs generated from the contracts, including interest income, subrogation revenue and pharmacy rebates.
- FY08 spending totals include each plan's projected medical costs for outstanding claims in the fourth quarter, which are typically higher than the final actual costs.

All data used for the savings calculations were provided by HSD or reported by MCOs in data sets used by the state's actuary, and represent services delivered during each contract year. In November, LFC staff testified at a Committee hearing that preliminary estimates for savings were about $100 million and could reach as high as $200 million based on data supplied by HSD. Since that time, HSD discovered errors in the data provided to LFC that was used to calculate the $200 million savings. The savings range was developed using net, or actual, premium revenue paid to MCOs (current $107 million figure) and the gross contract revenue that was earned (number of members multiplied by the contract rates). HSD discovered significant errors in the gross contract revenue figures supplied to LFC and revised them downward. After receiving multiple revised figures, we could no longer rely on this data set. LFC staff was not provided direct access, as discussed later in this report, to raw data, including rates, to develop our own calculations.

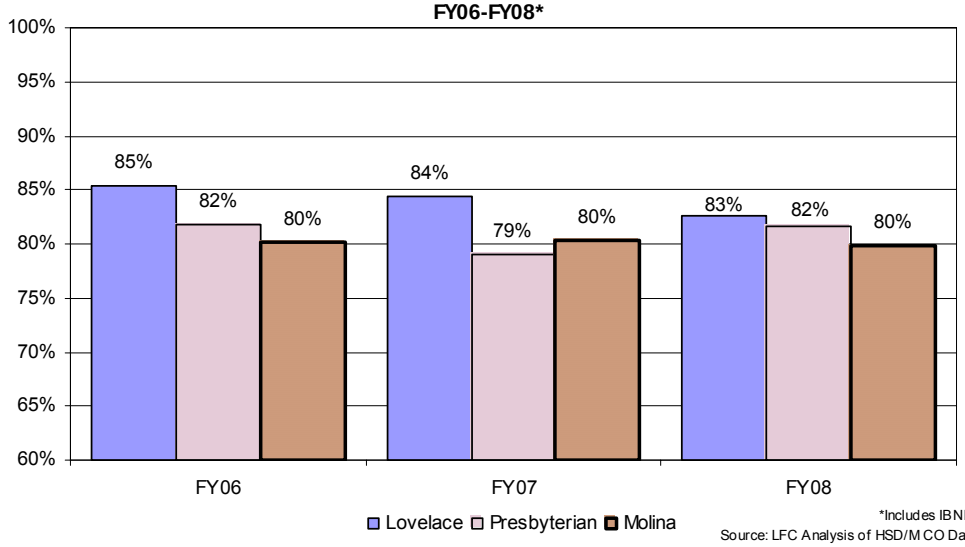
Managed Care Savings FY06-FY08*



Source: LFC estimates based on HSD/MCO Reported Data. *Savings equal projected medical expense defined as 85%of premuim and actual medical expense.

The difference between actual and anticipated medical services costs varied among the three plans, ranging from 80 percent to 85 percent of revenue spent on medical services. While Molina consistently reported spending about 80 percent of premium revenue, Presbyterian generated the largest dollar savings due to the plan's enrollment size.

Percent of Medicaid Funding Spent on Medical Services FY06-FY08*



*Includes IBNR.
Source: LFC Analysis of HSD/MCO Data

Medicaid Managed Care – Revenue, Spending & Savings
FY06-FY08

	Lovelace	Presbyterian	Molina	Total - Medicaid Managed Care
Medical Cost*	$653,701,378	$1,232,647,814	$587,702,291	$2,474,051,482
Revenue	$778,435,326	$1,525,129,731	$733,490,526	$3,037,055,583
Percent Revenue Spent on Medical Cost	84%	81%	80%	81%
Savings (Difference with 85 percent projected medical cost.)	$7,968,649	$63,712,458	$35,764,656	$107,445,763

Sources: LFC Analysis of data reported by HSD and MCOs.
*FY08 includes IBNR

In November 2008, HSD adopted contract amendments as part of cost-containment efforts that it indicates will reduce MCO rates by an estimated three percent and result in savings of about $38.3 million to the Medicaid program for FY09.

HSD has calculated the 85 percent spending requirement in a way not clearly outlined by the contracts and thus does not plan on recovering the estimated savings from MCOs. HSD amended the provisions of contracts outlining the MLR requirements in FY07 and again in FY08. The FY08 amendment requires the MCOs to spend an agreed upon percentage (85 percent) of all income generated under the agreement from capitations on medical services, as required by the contract. HSD is required to determine compliance with this requirement by December 2008 using an average MLR covering FY06-FY08. The contract for FY08 only covers Salud! Medicaid, while the State Coverage Initiative (SCI) and other health insurance plans were covered through separate agreements between HSD and the MCOs. Therefore only that income and expenditures associated directly with Salud! should be included in the calculations to determine contract compliance.

HSD has deviated from what the contract requires in its calculations for contract compliance with the 85 percent MLR. Specifically, HSD calculations include the following that are not clearly contemplated in the contract.

1. *Exclusion of state assessments to the New Mexico Medical Insurance Pool (NMMIP) from revenue paid to MCOs artificially inflates an MCO's MLR.* These assessments are part of the cost of doing business for any health plan and are already accounted for by HSD's actuarial assumptions as an administrative expense, as are all taxes. In addition, the amounts in the calculation do not appear to completely account for the impact of this assessment.

NMMIP Assessment*
FY06-FY08

Plan	Amount
Molina	$8,188,480
Lovelace	$6,900,409
Presbyterian	$18,168,290
Total	$33,257,179

Source: HSD
*As applied to Medicaid

2. *Exclusion of provider fee increases revenue and expenses.* This modification actually hurts the MCOs MLR calculation because, while they did not spend all the revenue, the contract prohibited administrative expenses other than premium taxes. As a result, for the provider fee increase premiums, the MCO percent of revenue for fee increases spent was well over the required 85 percent for FY07 and FY08.

Percent of Provider Fee Increase Premiums Spent on Services FY07-FY08

Plan	Percent Spent on Medical Services (Fee Increase)
Presbyterian	88.0%
Lovelace	90.7%
Molina	105.2%

Source: LFC Analysis of HSD/MCO Data

3. *Inclusion of SCI revenues and net losses.* SCI was not part of the Salud! contract during FY06-FY08, though HSD indicates that it negotiated rates jointly during FY07 and FY08. However, the controlling language in the contract from FY08 does not call for a combined MLR. The MCOs showed very poor results for SCI, posting a collective MLR of 237 percent in FY06 and 117 percent in FY07. While extreme losses for the program overall subsided in FY08, two MCOs still showed higher than anticipated medical costs. Molina, in FY08, brought losses down to a three year low of 81 percent MLR for its own SCI product line. UNM hospital acts as a separate sub-contracted plan under SCI with payments passing through Molina with an administrative fee of 15 percent.

State Coverage Insurance Program FY06-FY08

Plan	Year	Revenue *	Expenditures	Gain (Loss)	MLR
Lovelace SCI	FY 06	$994,210	$2,134,612	($1,140,402)	214.70%
Molina SCI	FY 06	$569,346	$1,591,145	($1,021,799)	279.47%
Molina UNM SCI	FY 06	$0.00	$0.00	$0.00	0
Presbyterian SCI	FY 06	$982,479	$2,316,568	($1,334,089)	235.79%
Grand Total FY 06	**Grand Total**	**$2,546,035**	**$6,042,325**	**($3,496,290)**	**237.32%**
Lovelace SCI	FY 07	$6,158,824	$8,792,289.00	($2,633,465)	142.76%
Molina SCI	FY 07	$3,011,285	$3,725,712.00	($714,427)	123.72%
Molina UNM SCI	FY 07	$6,503,579	$5,531,785.00	$971,794	85.06%
Presbyterian SCI	FY 07	$4,645,314	$5,830,843.00	($1,185,529)	125.52%
Grand Total FY 07	**Grand Total**	**$20,319,002**	**$23,880,629.00**	**($3,561,627)**	**117.53%**
Lovelace SCI	FY 08	$20,641,555	$20,649,781	($8,226)	100.04%
Molina SCI	FY 08	$14,600,015	$11,847,172	$2,752,843	81.14%
Molina UNM SCI	FY 08	$38,188,798	$32,832,039	$5,356,759	85.97%
Presbyterian SCI	FY 08	$24,651,096	$21,659,166	$2,991,930	87.86%
Grand Total FY 08	**Grand Total**	**$98,081,464**	**$86,988,158**	**$11,093,306**	**88.69%**
Total SCI Program FY06-08		***$120,946,501***	***$116,911,112***	***$4,035,38***	***96.66%***

Source: HSD
* Revenue figures include premiums.

According to HSD, the SCI program operates on a similar actuarial soundness basis as Salud!, indicating that expected medical costs should equal about 85 percent of all income and leaving 15 percent for administration. Counting SCI in the overall Salud! MLR allows the MCOs to shift these losses to Salud! rather than return the saved Medicaid dollars to the state. Totaling the actual versus expected medical costs shows the three MCOs had about $14.1 million in higher than expected medical costs, which takes away from available administrative revenue.

SCI – Difference Between Actual and Expected Medical Costs FY06-FY08

Plan	Savings (Losses)
Molina-SCI	($1,710,479)
Molina - SCI (UNM)	($375,303)
Lovelace-SCI	($7,951,281)
Presbyterian-SCI	($4,069,521)
Total	($14,106,586)

Source: LFC Analysis of HSD Data.
*Expected medical losses

4. *Inclusion of some administrative costs for reinsurance as medical expenditures.* MCOs are required to purchase insurance coverage in case of catastrophic medical claims. This reinsurance is not a Medicaid benefit or health service, but rather an administrative cost aimed towards increasing premium coverage. According to the Lewin Group, "reinsurance is insurance bought by insurers, and is used by insurers to limit their risk exposure. [The insurance] limits or caps their claims exposure for any covered individual over a specified period (such as a year)." The contract does not explicitly state reinsurance is classified as an administrative function but HSD's actuary assumes these costs in developing the administrative portion of the capitation rates.
5. *Inclusion of disease management and case management contracts as medical expenses.* According to the American Journal of Managed Care, "disease management refers to a system of coordinated healthcare interventions and communications to help patients address chronic disease and other health conditions."(Mattke, Seid, & Ma; 2007;13:670-676) While the contract does not specifically designate "disease management" as an administrative or medical expense, the components of disease management are listed as administrative functions, including training and education of providers and consumers; reporting data; care coordination; and quality improvement/management functions.
6. *Inclusion of provider incentive payments not otherwise reported in medical expenditure reports.* Provider incentive payments, which may be "bonus" payments or possibly sub-capitation payments, were not included as medical expenses in the FY08 contract, which governs the final calculation for compliance with the 85-15 MLR. HSD has allowed one MCO to include physician incentive payments in its medical expenses. However, the rather large amount, upwards of $38.6 million over FY06-FY08, raises concerns over the amount of spending on providers outside of the normal medical expense reports. Also, it is unclear what controls HSD has in place to ensure that these expenditures were not already reported in the medical expense reports under sub-capitation payments.
7. *Inclusion of member meals and travel not otherwise reported in medical expenditure reports.* The Medicaid benefit includes airfare and lodging for medically necessary services, however it is unclear why this expense is not already reported in the MCOs standard medical expenditure reports that breakdown spending by category of service and is used by its actuary. The total spending amount on this benefit is not significant to the MLR calculation.

HSD medical loss calculations (though not according to the contract) show two of the three MCOs met the 85 percent threshold for contract compliance. HSD will not seek recovery of any funding from the MCOs for FY06-FY08. The calculated results include: Presbyterian at 86 percent; Lovelace at 86 percent and Molina at 84 percent. HSD's complete MCO calculations are included in its response on pages 91-93.

For FY09, HSD has lowered the contract target for medical spending to about 80 percent of premium revenue. Specifically the contract states that MCOs may "spend no more than 15 percent, net of premium taxes and unfunded New Mexico medical insurance pool assessments, on administrative costs." Premium taxes account for about four percent (Section 59A-6-2 NMSA 1978) and NMMIP assessments for about one percent premiums. Removing premium taxes and NMMIP assessment costs increases the amount of premiums that can be used for non-medical administrative costs, where typically taxes were historically included in the 15 percent allowable administrative cost category. Also, the contract is unclear on what "unfunded" NMMIP actually means.

For FY09, HSD set a maximum profit margin of five percent; no cap existed for FY06-FY08. The Medicaid rate setting process seeks to balance capitation rates that are high enough to ensure the financial viability of MCOs, but low enough that MCOs do not make unreasonably large returns. However, up until FY09 there are no clear guidelines or standards for determining how much in net returns were "reasonable." HSD simply allocates about 15 percent of premium revenue for allowable administration and profit. For the current contract covering FY09 through, potentially, FY12, HSD has set a maximum profit margin at five percent across Medicaid Salud! and SCI. However HSD will, in accordance with contract, allow MCOs to retain excess profits and spend those amounts on service-related costs at the direction or approval of the department.

Public Regulation Commission – Division of Insurance (DOI) reports show MCOs are in very good financial condition and have net underwriting gains from their Medicaid/SCI line of business and are sufficiently capitalized. Over the past three full calendar years (2005-2007) the three Medicaid MCOs report net gains on their Medicaid line of business for 2006 and 2007. In 2005, Molina and Lovelace reported losses of 3 percent and 9 percent, respectively. Presbyterian reported net gains of seven percent in 2005 and 2006, while dropping slightly in 2007 to 5 percent. It is important to note that MCOs appear to report Salud! and SCI products as a single Medicaid product in its reporting to the Division of Insurance. Despite losses on SCI, the overall financial health of MCOs does not appear to have suffered.

MCOs have sufficient reserve levels intended to ensure financial solvency. All Medicaid MCOs meet DOI solvency requirements and show sufficient net worth and "risk-based capital" (RBC) levels. DOI requires plans to maintain at least 200 percent of its "authorized control level" of RBC. As of 2007, all plans more than exceeded this requirement as shown in the table below. The plans' RBC levels have increased over the past couple of years to as high as 525 percent for one MCO. Neither DOI nor HSD has benchmarks or limits for the maximum levels of reserves.

MCO Financial Status

Selected Years

MCO	Net Worth – 2007 (millions)	Medicaid Net Underwriting Gain (Loss) - 2007	Risk-Based Capital Ratio – 2005 (200% minimum req.)	Risk-Based Capital Ratio -2007 (200% minimum req.)
Presbyterian	$95.4	5% ($25.5 million)	570%*	417%
Molina	$41.0	7% ($18.6 million)	237%	463%
Lovelace	$125.6	6% ($16.9 million)	275%	528%

Source: PRC, Division of Insurance Reports

*2005 represented an unusually good year for PHP due to $130 million net underwriting gain, the largest during 2003-2007. The 2004 RBC was 353%.

RECOMMENDATIONS

HSD should amend the current MCO contracts as follows.

- Recover the estimated $107.4 million in savings through a performance bond and/or reducing FY09 and FY10 rates.
- Cap non-medical expenses, administration and profit at no more than 15 percent of income earned under the contract, and consider further reducing this amount to 14 percent in FY11 and to 13 percent in FY12.
- Define income as gross premiums from capitations, interest earnings, third-party recoveries, reinsurance recoveries and pharmacy rebates.
- Clarify that costs to purchase reinsurance, NMMIP assessments, disease management services and other contracts where the primary purpose is to coordinate care are counted as administrative expenses.
- Cap the amount of provider incentive bonus payments that an MCO may count as a medical expense at no more than one percent, and require MCOs to explicitly report these payments, in addition to non-medical meals/travel for members as part of their medical expense reports by cohort. HSD should create new spending categories to track these expenditures.

INCREASED MEDICAID MANAGED CARE TRANSPARENCY BY HSD WOULD IMPROVE BUDGETING AND OVERSIGHT RESPONSIBILITIES OF THE LEGISLATURE.

Lack of key information from HSD on Medicaid managed care has hampered LFC staff efforts to carry out Committee functions. The Legislature intended for all government units to cooperate with the LFC so that it may carry out its intended functions. This cooperation is necessary so that the LFC may properly carry out its statutory duties, which include evaluation, oversight and budgeting responsibilities. Specifically, state law provides that LFC shall "examine the laws governing the finances and operation of departments, agencies and institutions of New Mexico and all of its political subdivisions, the effect of laws on the proper functioning of these governmental units, the policies and costs of governmental units as related to the laws" and recommend changes in these laws if any are deemed desirable (Section 2-5-3 NMSA 1978). State law requires the LFC to "annually review budgets and appropriations requests, and the operation and management of selected state agencies, departments and institutions and shall make recommendations with respect thereto to the legislature" (Section 2-5-4 (A) NMSA 1978).

New Mexico Attorney General Opinion 57-118, regarding LFC authority, states, "Whenever the effect of any law is to be determined, there is the necessity for securing information from the parties most concerned with the functioning of such law." As such, Section 2-5-7 NMSA 1978 specifically states that "Each agency or institution of the state and its political subdivisions shall, upon request, furnish and make available to the legislative finance committee such documents, material or information as may be requested by the members of the committee or its director or staff which are not made confidential by law." For LFC appropriations and oversight duties, state law also compels agency cooperation beyond providing an appropriation request, by stating "Each state agency, department or institution shall also furnish to the legislative finance committee and its staff any other supporting information or data deemed necessary to carry out the purposes of this section. (Section-2-5-4 (C)." Unlike LFC's broad cooperation section of statute, there is no limitation on information that should be provided by government units for LFC to carry out its appropriations and oversight duties. Government units may voluntarily cooperate or the Committee may compel information through statutory subpoena powers, which has been historically unnecessary.

These laws provide the framework for LFC to inquire, investigate and obtain necessary information on the costs, effectiveness, and operations of state government so that it may carry out its duties. According to Opinion 57-118, the fact that an "inquiry may also have other far reaching consequences is no justification for a limitation upon the scope of inquiry" by a governmental unit and thus LFC authority.

HSD has failed to provide LFC staff with information requested regarding Medicaid and its operations, citing exceptions related to the Inspection of Public Records Act (IPRA). One objective of this evaluation includes a focus on the costs and outcomes of physical health portion of Medicaid managed care. Central to understanding the costs and effectiveness of the program is for staff to examine contracted capitation rates paid by HSD: how much was paid, the methodology and data used to determine the capitation rates, the actual rates compared to the authorized actuarial rate bands, and the projected versus actual costs of the program compared by different types of clients (cohorts). Another objective of this evaluation involves HSD's oversight functions of Medicaid carried out by the Medical Assistance Division.

HSD initially denied our request for certain information on the grounds that the information is confidential and not subject to disclosure to the LFC or the public. Specifically HSD denied access to the following, **none of which is made confidential by law**:

1. Salud! actuarial [rate certification letters] study reports covering FY04-FY08;
2. Contact information of HSD Actuarial contractor (Mercer);
3. Contractual cohort rates by MCO for FY04-FY08;
4. Aggregate amounts paid by HSD to MCOs for each cohort for FY04-FY08;
5. Cost-effectiveness section of HSD's federal Medicaid waiver for the physical health portion of the Salud! program;
6. Enrollment of clients in each cohort for FY04-FY08;
7. List of internal audit reports on the Medical Assistance Division.

Initially, HSD asserted that the information for items 1-5 above is confidential, citing a long-held assertion by the department and a May 2008 court ruling by the 2nd Judicial District (Cubra Schantz-Vance v. New Mexico Behavioral Health Collaborative) that ruled in favor of HSD's withholding certain information ("budget information submitted to the federal government") for the behavioral health portion of Medicaid from a member of the public. HSD asserted that releasing the information, in light of the pending procurement of a new vendor, would harm the public interest, citing a public policy exception to the Inspection of Public Records Act sometimes recognized by courts. In addition, HSD responded that it could not, without great expense, generate a report showing enrollment of clients by cohort for FY04-FY07 and indicated the Inspection of Public Records Act (IPRA) did not require the agency to create documents. Finally, HSD indicated it would not provide a list of internal audit reports on MAD because that information was exempt under IPRA due to "executive privilege" and "attorney-client privilege." HSD also expressed concerns that if information was provided to LFC, then the information would be subject to disclosure under IPRA.

Requested managed care rates and specific cost information has been historically denied to budget analysts as well. For example, specific rate and cost data was not provided to detail HSD's assumptions over costs to expand Medicaid to more low-income children during the 2nd Special Session of the 48th Legislature in 2008.

In response to an LFC staff request, the Office of the Attorney General (AGO) issued an advisory letter concluding that LFC requests are not subject to the Inspection of Public Records Act (IPRA). In an effort to resolve the differences, and after first trying with HSD staff, the Director of LFC formally requested advice from the AGO on the matter. The AGO advisory letter states, "LFC information requests to agencies are not subject to the requirements and procedures that apply to requests to inspect public records under IPRA." The full letter is included in Appendix A. The letter points out that only in a case where there is a law making the requested information confidential, can an agency deny an LFC request. No such law exists for the information requested from HSD. The AGO letter further explains that under IPRA an agency may deny public inspection of records protected by countervailing public policy exception – which is a judicially created "non-statutory confidentiality exception." However, this exception is unique to IPRA and agencies could not solely rely on this to deny LFC requests. Again, LFC requests are not subject to IPRA. As such, LFC staff expects HSD to make available the requested information.

The AGO advisory letter also addressed how LFC should treat confidential information that an agency elects to provide (though we do not believe any of the requested information from HSD is in fact confidential). Specifically, the letter points out that "An exception that allowed an agency to deny public inspection of a record in its custody could apply once the agency transferred the record to LFC. However, this may not always be the case."

Since initially denying our request, HSD has provided items five and six, portions of item one not containing rate ranges, made Mercer available for questions and indicated it has not conducted any internal audits of MAD. HSD has indicated it still would not provide the remaining requested information, including contract rates, full actuarial rate certification letters that include authorized rate ranges, or aggregate amounts paid by HSD to MCOs for each type of client (cohort). HSD's response to our request after receiving the AGO advisory letter is included in Appendix B.

Other states make more information available publicly, including rates, actuarial studies, sanctions and up-to-date enrollment estimates on Medicaid websites. Transparency provides a foundation for government accountability, public confidence and information which the state policy makers and healthcare consumers can use to make responsible decisions. Numerous states, such as Missouri and Texas, have, through executive order or legislation, implemented transparency initiatives where citizens can easily access how state government is spending their money down to the object of expense and vendor.

Transparency initiatives are expanding in the healthcare field as well. For example, the U.S. Health and Human Services Department is promoting value-based healthcare, with transparency a cornerstone for transformation. Transparency is a broad-scale initiative enabling purchasers (citizens and, by proxy, legislatures) and consumers to compare the quality and price of health care services, so they can make informed choices.

States are one of the country's largest healthcare purchasers through Medicaid and employee benefits. In an effort to provide more information about the operations of government, states are administratively or legislatively directing state agencies to embrace a culture of transparency. Based on web searches and structured interviews with selected other states budget offices and Medicaid programs, including Arizona, Arkansas, Colorado, Florida, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Oklahoma, New York, North Carolina, Texas, Utah and Wisconsin, we found several initiatives to improve the transparency of Medicaid operations. The following measures have been implemented in other states:

- managed care use is reviewed and HEDIS data is posted in order to measure performance outcomes,
- health plans are ranked based on the outcomes of performance monitoring, and are shared with consumers to facilitate plan selection (Florida, Michigan and New York),
- health plan infractions, sanctions and penalty amounts are posted online (Texas),
- prescription costs for consumers are provided online by cost, region and specific pharmacy (Florida and New York),
- state information has been made accessible online, along with information from contactors and insurance companies, including data regarding health care costs, financing and trends in health care prices and costs (Florida),

- the Medicaid Inspector Generals has been separated from the Secretary or Director of Human Services Department reporting structure, with the goal of establishing independence from the monitored agency (New Jersey and Kansas)
- Medicaid program has posted its financial audits online.

Unlike New Mexico, many states reviewed post managed care rates on Medicaid websites, or information is available because its part of a public contract. We did not find any cases where legislative fiscal offices did not have access to Medicaid managed care rate information. In most cases, except for Colorado, rate information is publicly available. For example, Arizona, Texas, Wisconsin and Florida, all publish MCO capitation rates, and Kansas, provided rates since they were part of the public contract. Some states, including Texas and Wisconsin post their actuary's reports detailing the calculation of actuarially sound rate ranges. New York ties MCO rates to the equivalent rates and services within the FFS program. The Legislatures in Arizona and Colorado receive a regular "appropriations status report." Not all states reviewed have managed care.

Many states reviewed post up-to-date enrollment data, unlike New Mexico which has extensive lags in data reporting. For example Arizona, California, Florida, Oklahoma and Texas post current month enrollment estimates, as well as final enrollment figures once all adjustments are completed. Disclaimers do state that numbers will change based upon adjustments for enrollment, but the "point in time" enrollment numbers do serve as trend data for other state agencies to see the direction of enrollment, fund use by category of care, by health plan.

Other state's Medicaid budgets are broken down by key spending categories which adds significant budget transparency for lawmakers. New Mexico appropriates physical health managed care funding as part of a block grant within the overall Medicaid appropriation to HSD. As a result, the Legislature does not make specific appropriations to different parts of Medicaid, such as the physical health managed care, personal care option or disabled and elderly waiver programs administered by HSD (with the exception of behavioral health, which is a new program and the Developmental Disabilities waiver program administered by the Department of Health). Under a Medicaid program largely dominated by fee-for-service this arrangement may have provided a necessary level of flexibility for the agency due to historical difficulties predicting specific medical cost categories. However, under managed care, appropriation needs should be more predictable since there are two easily identifiable cost components: the number of people enrolled and the per member per month capitation rates. Arizona, Texas, and Florida break up their Medicaid budgets by program/eligibility category, adding an additional level of appropriations authority while still providing needed budget adjustment flexibility to their Medicaid agency. Other states provide detail behind managed care spending, including specific enrollment by types of clients and costs for those clients.

In New Mexico, LFC budget staff does not receive detailed figures behind managed care costs, which after FY09 could make up about two-thirds of the entire Medicaid budget (physical health, behavioral health and long-term care).

RECOMMENDATIONS

HSD should make available to LFC information on Medicaid managed care contract rates, complete actuarial rate certification letters/reports and amounts paid to MCOs by client type (cohort) as requested.

Work with LFC and DFA to develop a regular reporting format for, at a minimum, physical health Medicaid managed care as part of regular projection meetings. Reports should provide, at a minimum, up-to-date cohort level data on enrollment and average PMPM spending compared to beginning of the year projections.

The Committee may want to consider breaking up Medicaid appropriations into smaller appropriation components, such as physical health managed care, coordinated long-term care services, other fee-for-service, and HSD administration with appropriate performance measures for each part of Medicaid.

STATE SPENDING ON MEDICAID MANAGED CARE HAS INCREASED ALMOST 30 PERCENT BETWEEN FY06 AND FY08, WHILE ENROLLMENT HAS INCREASED ABOUT 10 PERCENT DURING THE SAME PERIOD.

Managed care rate changes and enrollment drive cost changes to HSD's budget. Each month HSD makes payments to MCOs to cover all medical and administrative costs associated with providing Medicaid benefits called capitation payments. These capitation payments are based on the number of clients enrolled in each plan multiplied by the contracted rate, which varies by type of client.

As a result, during the fiscal year, key variables affecting HSD's managed care spending include overall enrollment growth/decline; enrollment growth/decline by the type of client; and associated contracted rate, which should not change during the fiscal year.

Rates are developed and negotiated based on historical medical spending patterns projected to the current contract year plus administrative costs divided by the projected number and type of clients to be enrolled in managed care. Clients are categorized into 12 different "cohorts" based on age, gender and other demographic factors.

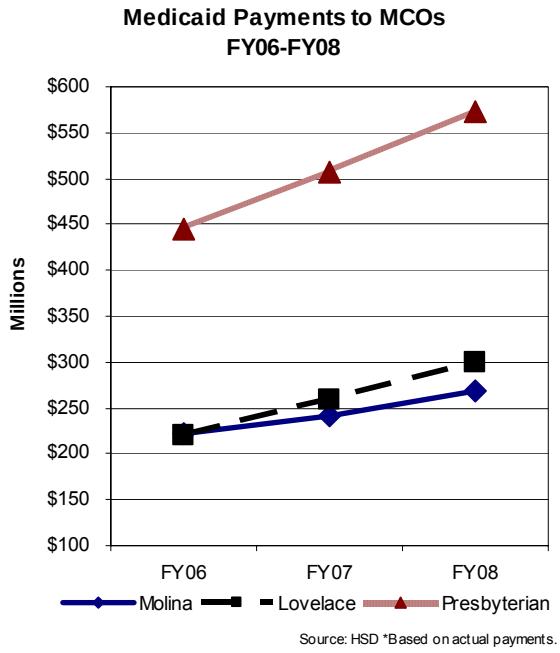
Managed Care Cohorts

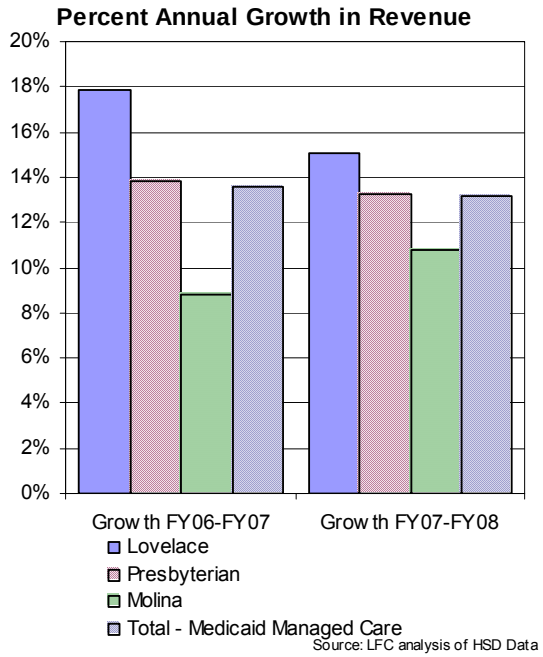
01-TANF/AFDC, MA KIDS, CYFD 0-2 MONTHS
02-TANF/AFDC, MA KIDS 2 MOS THRU 20 YRS
03-TANF/AFDC 21 THRU 49 FEMALE
04-TANF/AFDC 21 THRU 49 MALE
05-TANF/AFDC 50+
06-SSI & WAIVER 2 MOS TO 1 YEAR MALE AND FEMALE
07-SSI & WAIVER 1 YEAR THRU 20 YEARS MALE & FEMALE
08-SSI & WAIVER 21 THRU 39 FEMALE
09-SSI & WAIVER 21 THRU 39 MALE
10-SSI & WAIVER 40+
11-PW/MA 15 THRU 49
12-CYFD 2 MONTHS THRU 20 YEARS

Source: HSD

Overall spending on the physical health portion of Medicaid managed care has increased from about $888 million in FY06 to $1.1 billion in FY08 (about 29 percent). MCO revenue growth has varied across plans between FY06-FY08, with Lovelace experiencing about a 36 percent increase in payments from HSD; Presbyterian about 29 percent; and Molina experiencing a slower rate of growth of about 21 percent.

Medicaid managed care payments, according to data supplied by HSD, experienced an annual rate of growth across of about 14 percent between FY06-FY07 and 13 percent between FY07-08. Again, the year over year changes varied by MCO, with Lovelace outpacing the other plans.





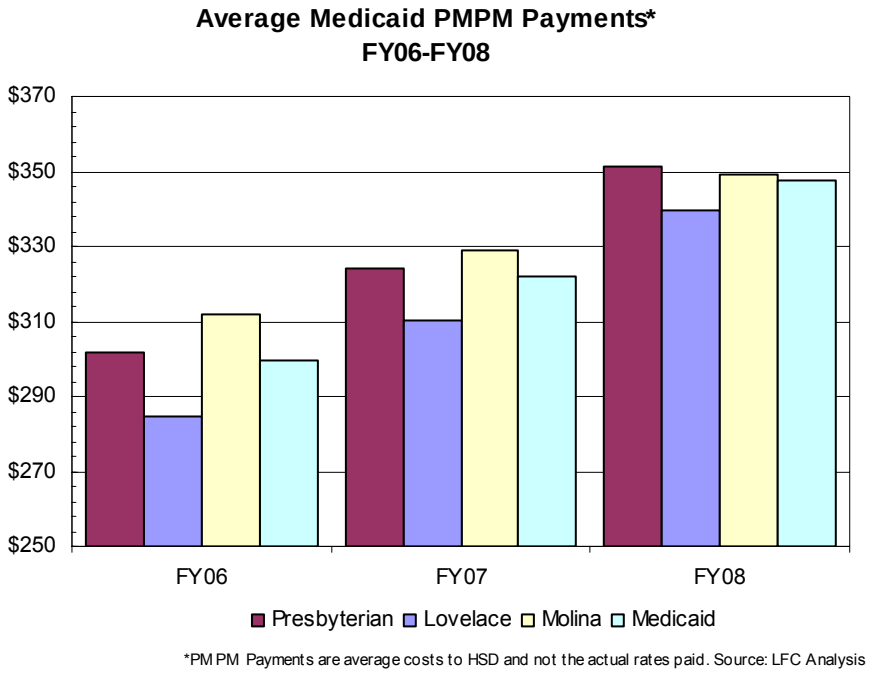
The average per member per month cost (PMPM), weighted by type of client, increased from about $300 in FY06 to $348 in FY08. The weighted average PMPM rate declined about seven percent between FY05 and FY06 when the state separated behavioral health from physical health services into separate programs. Overall PMPM costs rebounded quickly increasing over 15 percent the next two fiscal years. Through August of 2008, HSD reported a significant drop in average PMPM rates as a result of reissuing the MCO contracts and adding a fourth lower cost MCO. Other impacts on the FY09 PMPM rate include carving out some clients from the physical health MCOs and transferring them to the new Coordinated Long-Term Services (CoLTS) managed care program. Without access to specific rate information we cannot verify the changes in rates, or compare New Mexico's rates to other states.

Medicaid Managed Care PMPM Costs
FY04-FY09

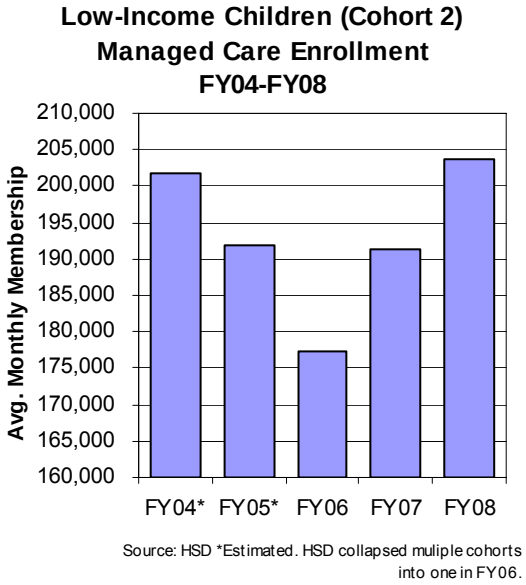
State Fiscal year	PMPM	% Change from Prior FY
FY04	$312.48	-
FY05	$324.39	3.81%
FY06	$300.46	-7.38%
FY07	$323.12	7.54%
FY08	$348.40	7.82%
FY09 (Through August 2008)	$330.38	-5.17%

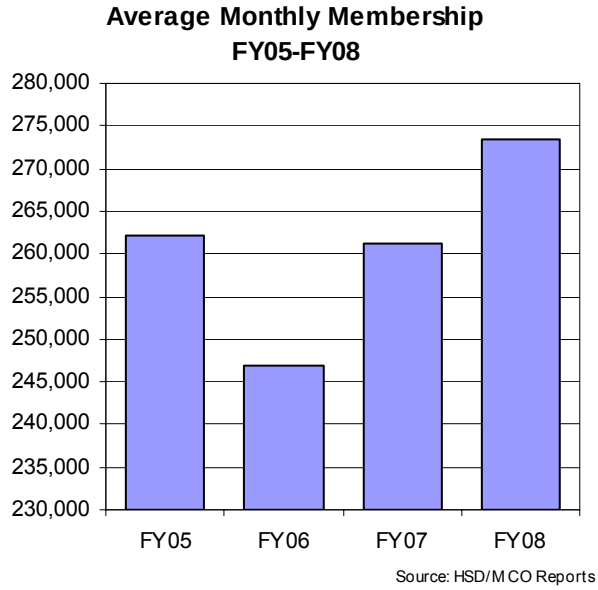
Source: HSD

The average PMPM amount, not weighted by client type, increased about 16 percent from $300 in FY06 to $347 in FY08. PMPM amounts varied by MCO. Lovelace experienced the biggest percentage increase of over 19 percent from $284 in FY06 to $339 in FY08. However, Presbyterian appears to have the most expensive rates as average PMPM payments for FY08 were more than $350.

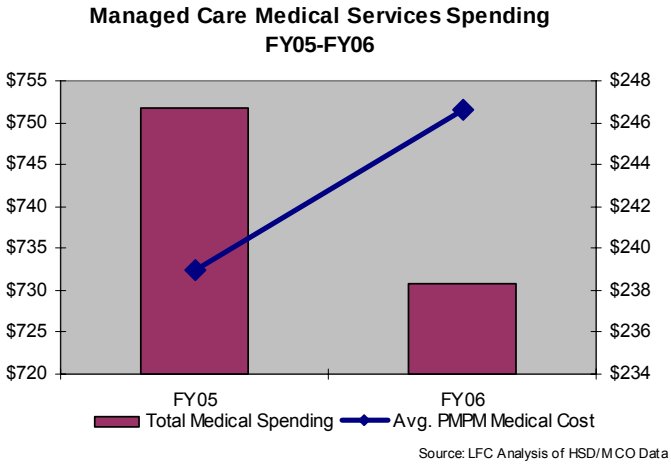


Enrollment appears to have rebounded from sharp declines in FY05, but never met projected levels until FY08. Between FY05 and FY06 average monthly enrollment in managed care decreased almost six percent or about 15,000 clients less each month than the prior year. Average monthly enrollment has increased about 10 percent from about 247 thousand in FY06 to about 273 thousand in FY08 almost entirely driven by increases in cohort 2, children ages 2 months to 20 years (low-income children). Between FY04 and FY06, enrollment of low-income children decreased about 13 percent from about 201 thousand to 177 thousand. Since that time, enrollment of low-income children in managed care has increased about 14 percent and at the end of FY08 exceeded FY04 levels.



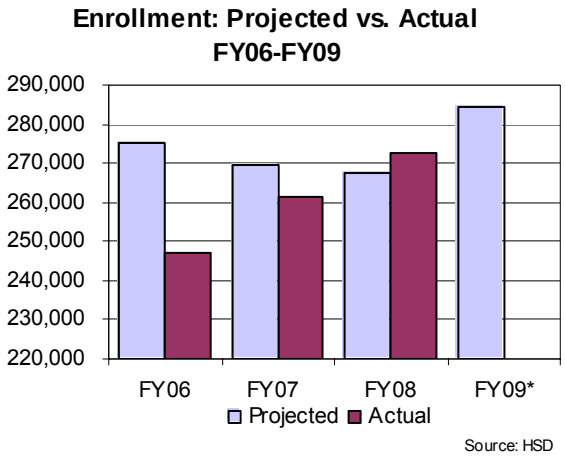


MCOs experienced about a two percent overall decrease in spending on medical services (about $21 million) despite a six percent drop in membership between FY05 and FY06. However, the drop in enrollment resulted in an average PMPM medical cost increase of over seven percent from $239 to $247.



Between FY05 and FY06, spending decreases and increases varied based on categories of services; which may indicate that enrollment changes, cost-containment efforts, and benefit changes by HSD had varying impact on actual expenditures. For example, spending on physicians decreased about 21 percent or $29.5 million; other outpatient hospital spending decreased about 36 percent or $16.6 million; and durable medical equipment spending decreased about 30 percent or about $5.6 million. Other therapies experienced steep declines as did home health spending, but the overall spending on these categories was not as significant. By contrast, other medical spending experienced significant increases between FY05-FY06 offsetting savings from enrollment and cost-containment efforts. For example, spending on ambulatory surgical centers increased about 24 percent or about $9.59 million and offset reductions of about six percent or about $9.65 million for inpatient hospital spending. Spending on urgent care services increased over 240 percent from about $2 million in FY05 to over $8.5 million in FY06. However, emergency room spending also increased about 13 percent from about $59.5 to $67.8 million during the same time period.

Projected enrollment increases did not fully materialize, particularly for low-income children until FY08, resulting in lower than expected costs for managed care. Large balances should have materialized at HSD during FY06 as a result of lower than expected managed care enrollment, and thus costs to Medicaid. HSD indicates that physical health managed care rates were not modified during FY06 and any accumulated balances were shifted to cover shortfalls in other areas of the Medicaid budget.

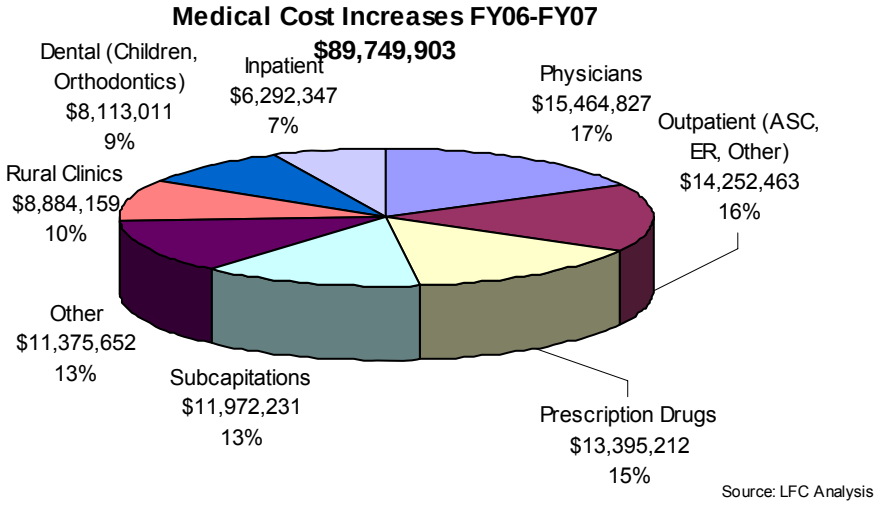


HSD projects enrollment by cohort in order to convert projected medical costs into per member per month rates. Most of the differences between projected versus actual monthly enrollment in managed care are attributable to lower than anticipated enrollment of low-income children. For example, for FY06, HSD expected a monthly average of about 204 thousand low-income children (cohort 2) but had about

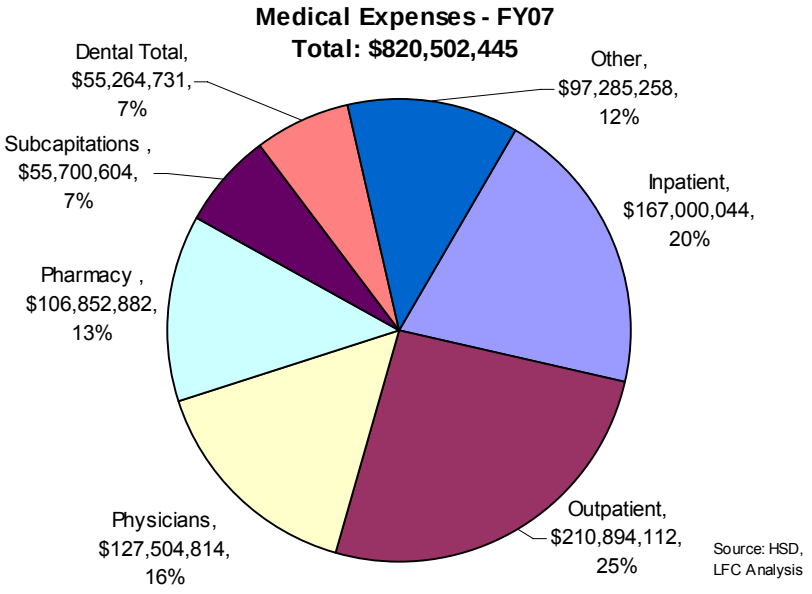
177 thousand enrolled on average; an approximately 27 thousand member difference. The difference narrowed to about seven thousand per month in FY07 and by FY08 average monthly enrollment of low-income children exceeded projections by over four thousand.

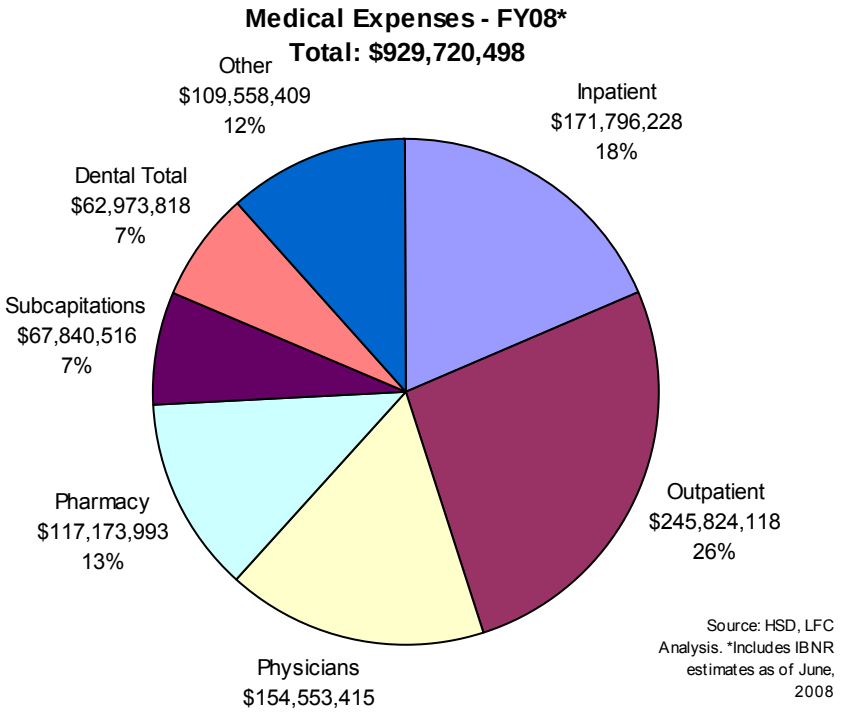
Notably, enrollment of TANF males (cohort 4) never fully materialized either. Though this is a relatively small population in the overall program, in FY06 and FY07 projected monthly enrollment for this population was about 35 percent higher than actual enrollment and about 14 percent higher in FY08.

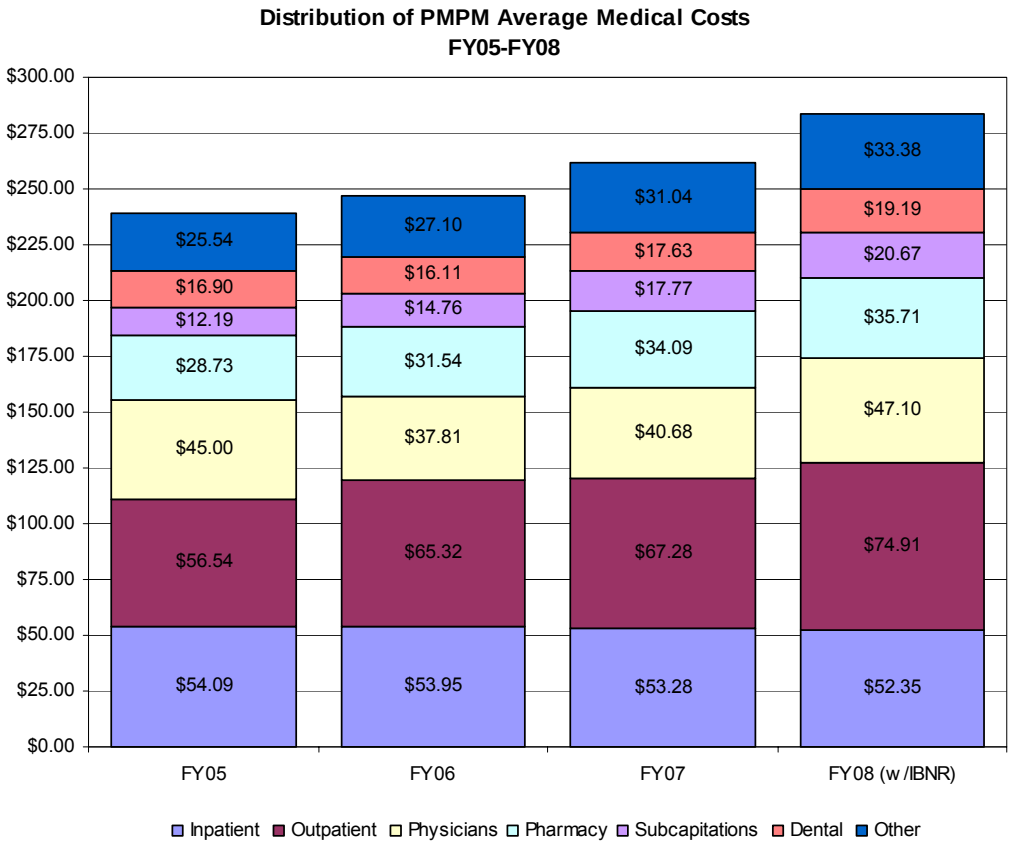
Spending on medical services by MCOs has increased about 27 percent, from $730.7 million in FY06 to an estimated $929.7 million in FY08; driven in part by enrollment and medical price increases. Overall, significant growth has occurred in sub-capitation payments made to providers to manage the care of assigned clients, in outpatient hospital and ambulatory surgical centers, in physicians and in prescription drugs. For example, overall medical costs increased $89.7 million or about 12 percent between FY06-FY07 from about $730.7 million to $820.5 million. Major spending increases are shown below.



MCOs report medical expenditures in 48 different categories by type of client for each month of the fiscal year. For purposes of this report, these categories were collapsed into seven categories: inpatient hospital, outpatient (which includes ambulatory surgical centers, emergency room, urgent care, outpatient hospital other, and lab and x-ray services done on an outpatient basis), physicians, pharmacy prescription drugs, dental, other (which includes transportation, therapies, vision, and clinics), and sub-capitation payments (which are per member per month payments made to providers to cover the full costs of caring for assigned clients). The charts below show the breakdown of total spending by category across the three MCOs for FY07 and FY08, and a breakdown of costs on a per member per month basis for FY05-FY08.


Medical Expenses - FY07
Total: $820,502,445
Dental Total, $55,264,731, 7%
Other, $97,285,258, 12%
Subcapitations , $55,700,604, 7%
Inpatient, $167,000,044, 20%
Pharmacy , $106,852,882, 13%
Physicians, $127,504,814, 16%
Outpatient, $210,894,112, 25%
Source: HSD, LFC Analysis


Medical Expenses - FY08*
Total: $929,720,498
Other $109,558,409 12%
Inpatient $171,796,228 18%
Dental Total $62,973,818 7%
Subcapitations $67,840,516 7%
Pharmacy $117,173,993 13%
Outpatient $245,824,118 26%
Physicians $154,553,415
Source: HSD, LFC Analysis. *Includes IBNR estimates as of June, 2008



Sub-capitation payments have increased 77 percent since FY05 to about $67.8 million in FY08; more information is needed to determine the cost-effectiveness of this payment approach. HSD contracts and federal regulations provide the framework for how MCOs may use sub-capitation arrangements with individual or group providers. However, HSD does not appear to receive sufficient data or other information on the use of these arrangements, which have an increasingly significant impact on Medicaid managed care costs. For example, HSD lacks information showing the utilization patterns of clients assigned to providers receiving these per-member-per-month payments; notably whether client's receive similar levels of preventative care as those without sub-capitations, have better health outcomes such as lower emergency room usage, etc. HSD also lacks data to better understand whether the payment arrangements are reasonable – not too high or low.

Despite declines in overall enrollment in FY06 these payments continued to increase as shown in the table below.

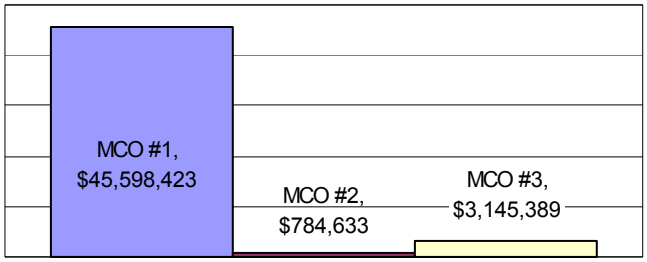
Sub-capitation Spending
FY05-FY08

Fiscal Year	Avg Enrollment	Subcapitations
FY05	262,143	$38,337,002
FY06	246,955	$43,728,373
FY07	261,209	$55,700,604
FY08 (w/IBNR)	273,477	$67,840,516

Source: LFC Analysis of HSD/MCO Data

About 89 percent of sub-capitation payments are made to manage the care of low-income children (cohort 2). For example, in FY07 low-income children accounted for $49.5 million of the $55.7 million in reported spending on sub-capitations. MCO use of sub-capitation payments varies significantly with one MCO accounting for almost 90 percent of all cohort 2 spending on sub-capitations as shown in the chart below.

Sub-capitation Spending on Low-Income Children FY07



Source: HSD/MCO

The use of sub-capitation payments for low-income children results in one MCO having the most expensive medical costs for an otherwise relatively inexpensive client group to cover. Without sub-capitation payments, MCO #1 has the lowest medical costs for low-income children, yet including the payments makes this same plan the most expensive. As a result of these differences, MCO #1 drives the overall average medical costs for this client group, which may distort the actuarial analysis towards higher rates this plan as well as all other plans.

Sub-capitation PMPM Costs for Low-Income Children FY07

	PMPM Cost/Without Sub-capitations	PMPM for Sub-capitations	Total PMPM Medical Cost
MCO #3	$119.90	$5.83	$125.73
MCO #2	$142.55	$1.28	$143.82
MCO #1	$113.61	$39.90	$153.50

Source: LFC Analysis of HSD/MCO Data

In addition, for FY08 about 84 percent of MCO #1's total sub-capitation costs were payments made to an affiliate provider group, another four percent to individual primary care providers/clinics and the balance for miscellaneous services (such as dental premiums and durable medical equipment).

Outpatient costs have increased almost 40 percent ($178 to $246 million) since FY05 and are now more expensive than inpatient services ($171 million). Outpatient costs have increased across service categories and appear to be driven by price, since utilization has remained relatively stable. Estimated per member per month spending on outpatient services was $74.91 for FY08, now more than PMPM spending for inpatient services, which was $52.35.

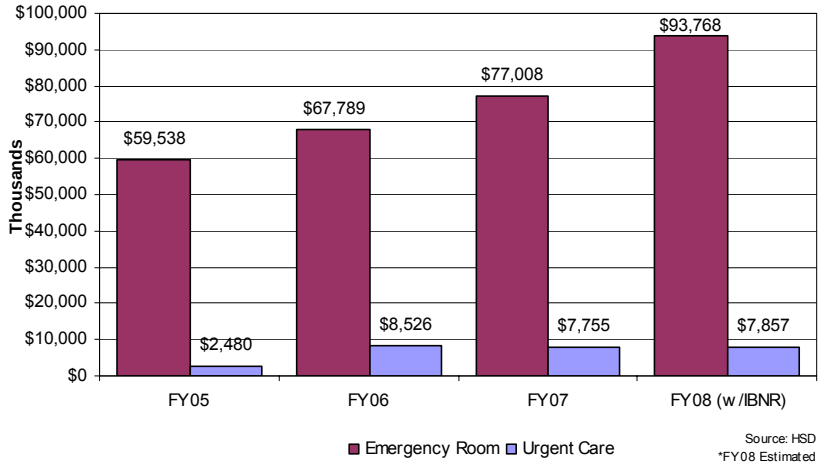
Outpatient Services
FY05-FY08

Fiscal Year	Outpatient	Percent of Total	PMPM
FY05	$177,847,677	23.66%	$56.54
FY06	$193,572,086	26.49%	$65.32
FY07	$210,894,112	25.70%	$67.28
FY08 (w/IBNR)	$245,824,118	26.44%	$74.91

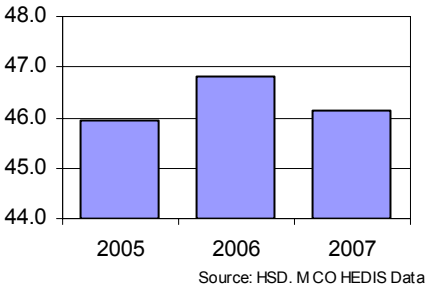
Source: LFC Analysis of HSD/MCO Data

Emergency room spending has increased 57 percent from $59.5 million in FY05 to an estimated $93.7 million in FY08— far outpacing spending on urgent care services. Upon closer examination however, ER visits have increased about five percent between CY05-CY07, whereas costs increased almost 28 percent. When adjusting for plan enrollment, ER utilization has remained flat during the same period.

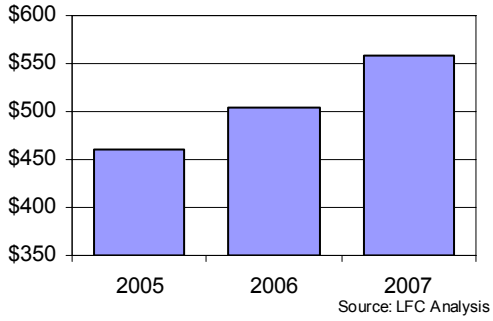
ER & Urgent Care Spending
FY05-FY08



Emergency Department Visits/1,000 Member Months
CY05-CY7



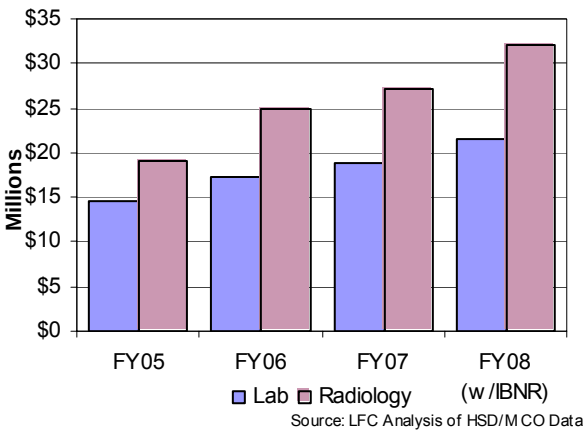
Average ED Cost Per Visit
CY05-CY07



Ambulatory surgical (ASC) procedures and outpatient visits have actually decreased during the same time period, but costs continue to rise. Between FY05 and FY08 ASC costs increased almost 50 percent from $36.3 million to $54 million.

Spending on outpatient lab and radiology services has increased 47 and 69 percent respectively between FY05 and FY08. MCOs experienced a one year 30 percent increase in radiology between FY05 and FY06, despite significant drops in enrollment.

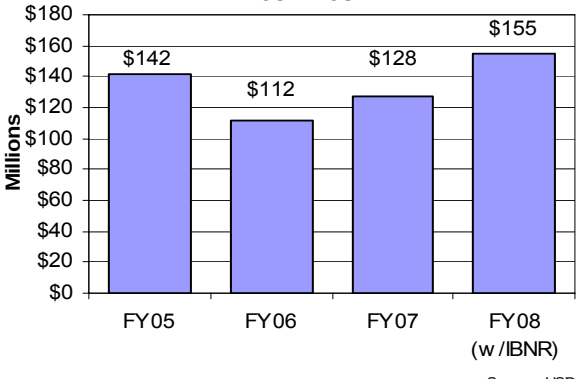
Outpatient Lab and Radiology Spending FY05-FY08



Source: LFC Analysis of HSD/MCO Data

Payments to physicians have rebounded significantly since dropping in FY06 and are driven by utilization and price increases. According to HSD analysis, New Mexico Medicaid rates for physicians compare favorably to neighboring states' Medicaid programs and to local commercial rates. As of September 2008, Medicaid paid the highest rates for professional visits among neighboring states (AZ, CO, TX), commercial (Lovelace & Presbyterian) and Medicare. Rates for some procedures have increased almost 30 percent since FY07.

Physicians FY05-FY08*



Since FY06, spending on physicians has increased about 38 percent from $112 million to $155 million. PMPM spending has increased about 25 percent, from $37.81 to $47.10 in FY08. The slower growth in average costs indicates increases in utilization, which are consistent with other HSD data showing increasing numbers of clients using physician services and the number of visits per client increasing.

Prescription drug costs have increased about 30 percent over the past four fiscal years, from $90.3 million in FY05 to $117 million in FY08. Beginning in FY08 MCOs began reporting prescription drug spending for behavioral health conditions in a separate category. MCOs reported spending about $8.8 million on behavioral health prescription drugs for FY08.

Prescribed Drugs Spending FY05-FY08*

Year	Amount	Percent Increase
FY05	$90,387,289	
FY06	$93,457,626	3.40%
FY07	$106,852,882	14.33%
FY08*	$117,173,993	9.66%

Source: LFC Analysis of HSD/MCO Data
*Includes IBNR

Spending on inpatient services has remained relatively flat, however it appears cost increases have eliminated potential savings from decreased utilization. Since FY05, MCOs have relied less on inpatient services, which is one goal of managed care. As a percent of total medical spending, inpatient services have decreased from over 22 percent in FY05 to an estimated 18 percent in FY08. PMPM costs have decreased as well.

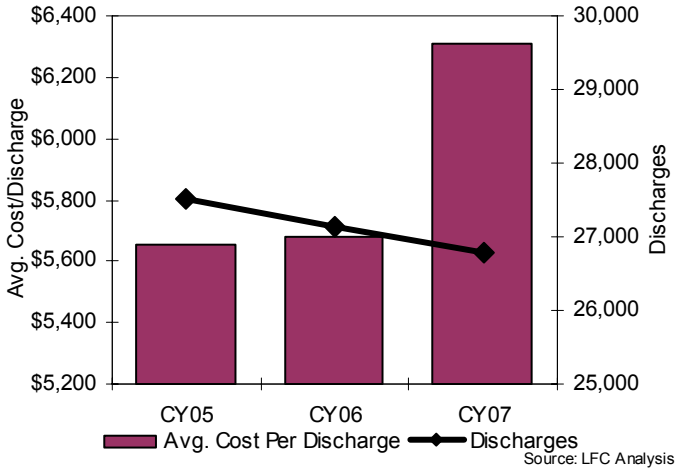
Inpatient Spending
FY05-FY08

Fiscal Year	Avg Enrollment	Inpatient	Percent of Total	PMPM
FY05	262,143	$170,143,069	22.63%	$54.09
FY06	246,955	$159,877,872	21.88%	$53.95
FY07	261,209	$167,000,044	20.35%	$53.28
FY08 (w/IBNR)	273,477	$171,796,228	18.48%	$52.35

Source: LFC Analysis of HSD/MCO Data

However, additional analysis of utilization patterns and average cost per client using the services shows different trends. Utilization and cost data provided by MCOs shows a decreasing rate of inpatient discharges of about 2.6 percent between CY05-CY07 and an increasing average cost per discharge during the same time period of almost 12 percent. Utilization and spending varied widely among the three MCOs. One MCO's average inpatient costs increased 42 percent during this period despite a modest 2.5 percent increase in discharges. Another had modest spending increases of about five percent with flat discharge rates (.85 percent increase). The third MCO had the greatest success at controlling inpatient costs and actually decreased spending by 13 percent and decreased discharges by 12 percent, while keeping overall average costs remaining about the same.

Inpatient Spending & Utilization
2005-2007



Source: LFC Analysis

Low-income children (cohort 2) make up about 73 percent of all clients in managed care and account for about 40 percent of medical spending. This client group had an average medical cost of about $144 per member per month in FY07, up 12 percent from the FY06 PMPM medical cost of $128. Medical costs for low-income children were about $331.6 million in FY07, up 21 percent (or $57.4 million) from FY06 spending levels. Given the size of this group of clients, we analyzed spending patterns to determine cost drivers and the impact on overall program medical costs for FY06-FY07. MCOs spent about 24 percent of all inpatient spending ($160 million) on low-income children ($38 million) in FY07. Low-income children account for about 44 percent of all emergency room spending and less than a third of spending on prescription drugs. Adults on Social Security Income or a waiver program make up about 7.5 percent of enrollment but account for about 25 percent of medical spending.

Major cost drivers are listed in the table below, and include significant increases in inpatient, emergency room, dental orthodontics and, as previously reported, sub-capitation payments. Also of note, spending on low-income children for urgent care services decreased about four percent or about $135 thousand between FY06-FY07 from about $3 million to $2.9 million.

Selected Medical Spending for Low Income Children* FY06-FY07
(in millions)

Expense Category	FY06	FY07	% Change
Inpatient	$29.9	$38.0	27% ↑
ER	$29.4	$33.8	15% ↑
Outpatient/Other	$7.0	$9.0	31% ↑
Prescription Drugs	$26.3	$30.5	14% ↑
Physician	$45.9	$56.7	24% ↑
Dental/General	$32.4	$36.6	13% ↑
Dental Orthodontics	$3.4	$6.5	90% ↑
Subcapitation Payments	$43.7	$49.5	28% ↑
Outpatient Radiology	$6.8	$7.8	15% ↑

Source: LFC Analysis of HSD/MCO Data
*Cohort 2. Figures are rounded.

RECOMMENDATIONS

Require MCOs to submit additional data and information on the use of sub-capitation arrangements with primary care providers. HSD should:

- assure that sub-capitation payments meet federal requirements, have a reasonable basis for cost and risk, and do not present a conflict of interest;
- assess whether practice and utilization patterns are better than average for clients assigned to PCPs receiving sub-capitation payments than for those not receiving payments both in-network and across the entire Medicaid managed care program;
- require MCOs to submit regular utilization reports for PCPs receiving sub-capitation payments using a similar format as the overall manage care program utilization reports;
- consider capping or eliminating the use of sub-capitation payments given the results of HSD analysis of the above information; and
- report the results of HSD analysis and activities taken to LFC no later than June 1, 2009.

Provide LFC with quarterly and annual reports on MCO medical expenditures broken down by cohort and medical cost category. Include annualized medical spending data for managed care in HSD's overall annual report to the Legislature and public, and post on the web.

Provide LFC with a report no later than February 1, 2009 with a breakdown of how HSD spent Medicaid funding that accumulated due to lower than expected enrollment in physical health managed care during FY06.

REALIGNING INCENTIVES AND IMPROVING EFFICIENCY WOULD SAVE MONEY AND CREATE BETTER VALUE FOR TAXPAYERS PURCHASING HEALTHCARE FOR LOW-INCOME NEW MEXICANS.

States, including New Mexico, have increasingly turned to managed care to control costs, to save money and to improve access and quality for their Medicaid programs. Managed care (health maintenance organizations or primary care case management) has become the most common delivery system for health benefits to Medicaid clients. Nationally, the use of Medicaid managed care grew rapidly during the 1990s with the number of clients enrolled in some form increasing from about 2.1 million in 1991 to over 27 million in 1997, according to CMS. In 2007, CMS reports show that about 64 percent of all Medicaid clients nationally are now enrolled in some form of managed care, with only Alaska and Wyoming yet to implement this delivery model. The use of primary care case management is growing in many populations, with some states even shifting away from traditional HMOs.

Concentrating both the financing and management of health care into single managed care organizations is intended to create strong cost-containment incentives, while also improving coordination of care. Originally Medicaid was designed to mimic the private health care sector which, largely due to political constraints, was based on "freedom of choice of provider," did not interfere in the "practice of medicine" and was based on open-ended fee-for service payments. As state's Medicaid budgets grew, competing with other traditional state expenditures, it became more of a target for cost-control measures. Managed care in Medicaid largely grew out of reactionary concerns over rapid cost increases in the 1980s, problems with finding sufficient numbers of providers due to low unit prices paid by Medicaid and bureaucratic billing processes, inappropriate use of high cost services such as emergency departments, and doctor shopping and self-referrals. Partially as a result of state demonstration projects in California and Arizona and changing national philosophy, alternative delivery systems to fee-for-service emerged that began to shift service delivery patterns and create competition as a means of controlling costs and improving quality.

According to Lewin, managed care offers savings opportunities for Medicaid by moving away from the traditional fee-for-service program which "is an unstructured system of care that creates incentives to provide as many services as possible, while doing little to encourage providers to manage the mix and volume of services effectively." Managed care models emphasize lower cost preventative care through the use of a primary care provider, which acts as a "gatekeeper" to services. MCOs also use care coordination functions intended to help clients access medically appropriate and only the most cost-effective care. Managed care limits choice of provider and helps direct clients to certain providers in their health care networks. This is intended to infuse competition on provider pricing and thus contain unit costs through pricing and other volume discounts. Using more market-based approaches for network development is intended to expand the range of quality service providers.

Some factors work against managed care achieving savings in Medicaid. According to research by the Lewin Group, state Medicaid managed care programs face unique structural challenges of achieving savings or containing costs that private sector managed care or even Medicaid fee-for-service may not.

- Populations Covered and Changes in Enrollment. Most of New Mexico's Medicaid population covered by the physical health MCOs are relatively inexpensive and include

children and working age low-income adults eligible for Temporary Assistance to Needy Families (TANF). According to Lewin, this group of clients "may be the population whose costs can be least easily impacted by managed care." In addition, most TANF population's health needs are concentrated in maternity/delivery-related services, well-child care and minor episodic needs, according to Lewin. As a result, health care costs actually increase if managed properly. For example, standard performance measures for managed care seek to increase use (and thus overall program cost) of key preventative services, such as dental and well-child visits, as well as other screenings.

However, enrollment volatility of this population generally and in New Mexico over the past four years decreases the potential benefits of managed care. Unstable enrollment undermines the central premise of managed care; that care coordination/management will improve long-term health and lower use of high-cost services. New Mexico continuously enrolls this population in managed care for 12 months, enough time to increase use of services. However, assuming these clients leave-return-leave-return then the savings from better care coordination by manage care will be lost. In addition, continual changes in enrollment increase MCO administrative costs, including marketing.

- Impact of Poverty. Medicaid managed care faces challenges of coordinating medical care for populations who lack adequate resources, whether income, housing or even education, and have low literacy levels or language barriers. These challenges can increase administrative costs for MCOs, including continuously updating records of where clients live, how to contact them for services, and ensuring appropriate oral and written communication.

- Prescription Drug Rebates. The Medicaid Drug Rebate Program created in 1990 was designed to maximize purchasing power of the program to extract "best prices" on prescription drugs, which are among the best of all public purchasers. Private managed care companies do not qualify for the same best prices under Medicaid, and since these prices are already so low, managed care cannot typically negotiate better prices on prescription drugs than Medicaid.

- Rural Barriers. The scarcity of providers in rural areas limits MCOs ability to selectively contract and channel patients to lower cost, efficient providers. In New Mexico, MCO networks have high overlap among primary care providers in rural and frontier counties, meaning there are multiple plans using almost the same exact network of providers. This scarcity also creates lack of competition for some high cost services, such as hospitals, that may drive up some unit costs. However, overall cost of care in rural areas is such that achieving scale efficiencies is not always possible, thus savings opportunities are limited, according to Lewin.

- Capitation Rate-Setting. Federal regulations require states to pay "actuarially sound" capitation rates which are supposed to cover all medical and administrative expenses, which makes extracting savings out of the rates themselves challenging, though not insurmountable.

Limited incentives exist for managed care to lower costs or save money for the state Medicaid program. Medicaid operates in a complex regulatory and political environment that often produces conflicting objectives that unintentionally limit the cost-effectiveness of it's managed care program in New Mexico. For example, average costs may be justifiable at higher than needed levels to the extent that Medicaid is viewed as an economic development engine for the healthcare industry, such as increasing upper payment limits to maximize the amount of federal Medicaid funding. However, the higher average costs; some may say subsidies, makes efforts to expand enrollment and coverage to the thousands of New Mexicans who qualify for Medicaid cost prohibitive. A 2001 study indicated that New Mexico managed care rates were some of the highest in the country. Other regulations or policy decisions have a more direct impact on limiting the savings or cost containment potential for Medicaid managed care.

Federal rate making regulations no longer require Medicaid managed care to cost the same or less than if client were in the fee-for-service program, and instead now require a form of cost-plus contracting. The federal government moved away from this requirement, in part, because with the massive expansion of managed care comparable fee-for-service data had diminished, particularly in states like New Mexico. Another perceived problem was that while the regulation created an upper-payment limit, there was no floor. This was particularly problematic for MCOs in states that had already low provider rates because managed care was expected to carve out administrative fees from an already low starting point. These problems were solved by creating a new regulation that eliminated an upper payment limit and required payments to be "actuarially sound," which in practice means rates that are neither too excessive or inadequate.

Even though the federal regulation requires states' actuaries to use standards adopted by the Academy of Actuaries, there are in fact no such standards. Instead, the system has operated under the nonbinding guidance issued as a practice note by a workgroup set up by the Academy of Actuaries. The workgroup's proposed definition is as follows:

"Actuarial Soundness—Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stoploss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital."

This actuarial soundness requirement presents several challenges, though not insurmountable, for appropriators and administrators.

- The actuarial soundness regulation attempts to de-link rates from budget considerations, according to the Centers for Medicare and Medicaid Services (CMS) responses to the regulation. Specifically, CMS indicates that "rates or ranges of rates depend on the benefits provided and the population covered. These rates are normally independent of budget issues unless benefits or populations change." However, states do have flexibility to set rates within the developed actuarial sound "rate ranges" which can make a significant budget impact. States are not required to ensure rates are actuarially sound for a particular MCO.

LFC staff was denied access to these rate ranges by HSD, which makes determining whether New Mexico has historically paid at the high, mid or low end of the actuarial rate bands impossible. However, given the difference between actual versus projected medical costs discussed elsewhere in this report, the state may be paying at the upper end of the rate ranges.

- MCO administrative funding has been growing at or about the same rate as projected medical costs, which discourages administrative efficiencies. The methodology of developing actuarially sound rate ranges involves projecting future costs based on historical spending, plus administrative costs. State policies requiring plans to spend 85 percent of revenue on medical costs may unintentionally encourage unnecessary spending on medical care.

- Using a 15 percent cap on administration does not take into account administrative scale efficiencies achieved by larger plans. Plans with bigger premium income are rewarded with larger administrative allocation and potential profit simply because they are larger, not because they are better value (lower cost-high quality) or have better performance. For example, Presbyterian's Salud! line of business is twice that of its competitors and operates multiple product lines. As a result, the plan should be able to achieve a different level of administrative efficiency. A similar situation exists for Molina, which relies on its out-of-state parent company to provide claims processing and other services. One would assume this outsourcing is done to lower administrative costs; however it is unclear how New Mexico Medicaid benefits from these administrative efficiencies in the rates it pays. HSD appears to have recognized this problem and put a five percent cap, though rather large, on profit margin for the current contract in FY09.

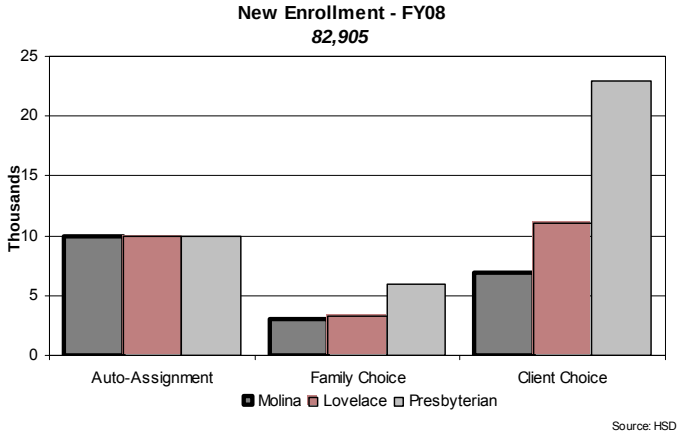
Historically, New Mexico has not fully exercised its authority to increase price competition and has limitations placed on it to assure the benefits of competitive procurement. Clients have been choosing to enroll in the plan with the highest medical costs, and presumably rates, and when the state has the choice (auto-assign) it does not give preference to lower cost either. No significant differences exist in quality among the three plans, with all accredited as excellent.

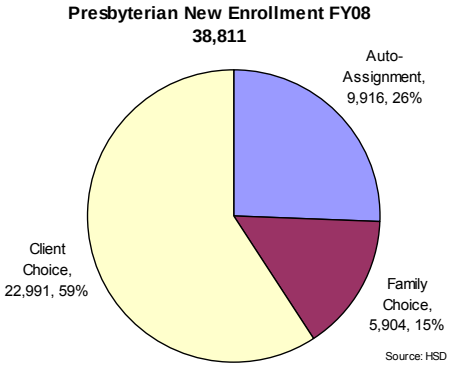
A fundamental aspect of HSD's Medicaid waiver is client's freedom to choose among at least two MCOs, however clients have no price sensitivity when choosing "free health care." Presbyterian historically has dominated the market with almost 57 percent of clients making a choice actually choose to enroll in this MCO. HSD appears to have limited authority over which MCO clients make a choice in which to enroll and instead has to control for this limitation through the rate setting/negotiation process. As a result, Medicaid expenditures increase at a faster rate than if clients had any price sensitivity. HSD has not provided comparable cost information for clients during their selection period because it considers that information confidential from the public.

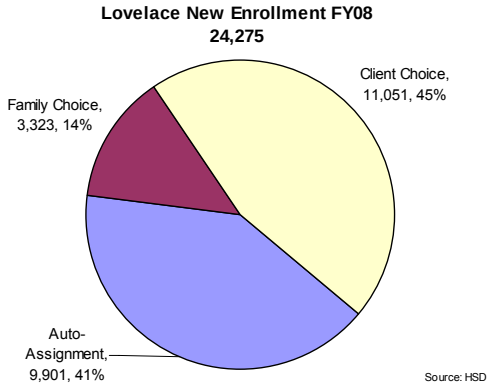
New Mexico has not implemented cost-sharing requirements, such as premiums or co-pays, on clients that could offset higher than average capitation rates. According to HSD, federal regulations may limit the state's ability to selectively use cost-sharing requirements for higher cost plans unlike Medicare. This issue may require further research.

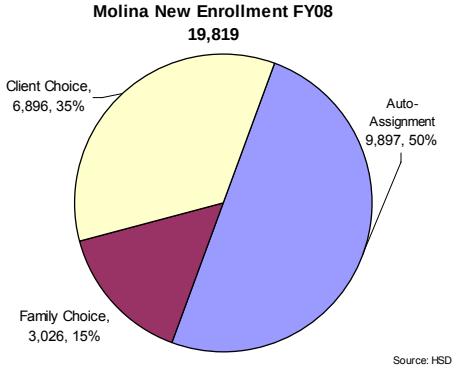
Historically, HSD has not steered clients who do not make their own choice of plan to lower cost MCOs, a process called "auto-assignment." About 35 percent of clients are automatically assigned to a plan. HSD has assigned these clients equally among the plans, giving no

preference to cost. Molina relies heavily on auto-assignment to keep afloat with enrollment. During the course of this evaluation, HSD did modify its assignment algorithm to steer more clients to MCOs with lower rates.









HSD has not limited the number of plans that may offer Medicaid managed care during the procurement process. As a result, MCOs bidding on the contracts cannot be assured the awarding of large blocks of clients for price, in addition to quality. For the FY09-FY012 procurement HSD awarded contracts to all four bidders that in practice served as an "any willing provider" procurement. These procurement arrangements limit the effectiveness of competition because HSD did not exclude higher priced bidders from being awarded a contract.

Using four MCOs to manage care for the lowest cost population in Medicaid creates additional inefficiencies in administration. More state resources are tied up in four companies performing the exact same functions, including four executive, finance and medical offices, four government relations and lobbying functions, four cost centers for claims/billing, network development and monitoring, care coordination, utilization review, etc. Additional MCOs also add to HSD administrative workload and cost including direct cost increases in contracts for additional external quality audits.

Most providers, particularly outside Albuquerque, must deal with multiple payers and separate and lengthy administrative process of being credentialed by multiple companies before being eligible to bill for services. As of June 2008, an estimated fifty seven percent of primary care providers contracted with more than one of the three MCOs. In rural and frontier counties there is about 60 percent overlap indicating that New Mexico has used three separate MCOs to contract with what is in essence a single provider network outside of urban counties. Given that many providers will also participate with other Medicaid managed care programs such as in Coordinated Long-term Care Services (CoLTS) and possibly behavioral health, then the total number could rise as high as seven, plus Medicaid fee-for-service program.

State law requires HSD to ensure credentialing processes are coordinated among MCOs with legislative findings that stated, "licensed professionals in New Mexico, particularly those in the health care field are severely burdened by multiple layers of mandatory credentialing obligations, costing them, their patients and third-party payers needless expense and wasted time" (Section 27-2-12.12). Yet each MCO has a separate credentialing function. Credentialing is the process used by insurers to review and approve the paneling of providers in their network, and involves ensuring providers are properly licensed to perform a given function.

In addition, HSD regulations allow MCOs to complete the credentialing process in 180 days. However, draft Division of Insurance (DOI) regulations require all insures, except for Medicaid, to complete this process within 45 days. Long credentialing time frames can make recruiting providers to the state difficult because they cannot bill for services until paneled by an insurer. Given that many providers hire individual practitioners on salary, those providers could be subject to cash flow problems due to the long time frame for approving the new employees to bill Medicaid. It is unclear why insurers' Medicaid lines of business should be subject to a different standard from the rest of the industry.

Additional provider fee increases do not appear warranted at this time; not all of fee increases in FY07 or FY08 were needed and should be recouped by HSD. The Legislature pumped more than $101 million in state and federal Medicaid funding for provider fee increases in FY07 and FY08 across the entire program. The table below provides a breakdown of each year's provider fee increase funding and the mix of funds. For FY07, the Legislature specifically allocated increases across providers, with physicians accounting for $33.9 million (state/federal) or 61 percent, dentists at about $3.4 million (6 percent) and general providers at about $18.6 million (33 percent).

In FY08, the Legislature delegated the task of dividing up rate increases among provider types to HSD and only included language appropriating funding for generic provider rate increases.

Provider Fee Increase Appropriations
FY07 & FY08

	FY07			FY08		
	GF	Federal	Total	GF	Federal	Total
Physician	$9,450,000	$24,445,265	$33,895,265	$ -	$ -	$ -
Provider	$5,200,000	$13,451,363	$18,651,363	$13,000,000	$32,855,379	$45,855,379
Dentist	$950,000	$ 2,457,461	$3,407,461	$ -	$ -	$ -
Total	$15,600,000	$40,354,089	$55,954,089	$13,000,000	$32,855,379	$45,855,379

Source: HSD

The physical health MCOs received about 49 percent of the total provider fee increase funding for FY07, and about 40 percent in FY08 and were required to pass all funding through to providers, less premium taxes. While not required by the General Appropriations Act, HSD did mandate a separate accounting of all provider fee increase revenue and expenditures to ensure available funding was spent as intended by the Legislature. The administrative process of determining how to allocate fee increases to specific provider types was burdensome for HSD and resulted in delays in allocating the funding to the MCOs.

Provider Fee Increase Funding –
All Medicaid vs. Physical Health MCOs
FY07-FY08

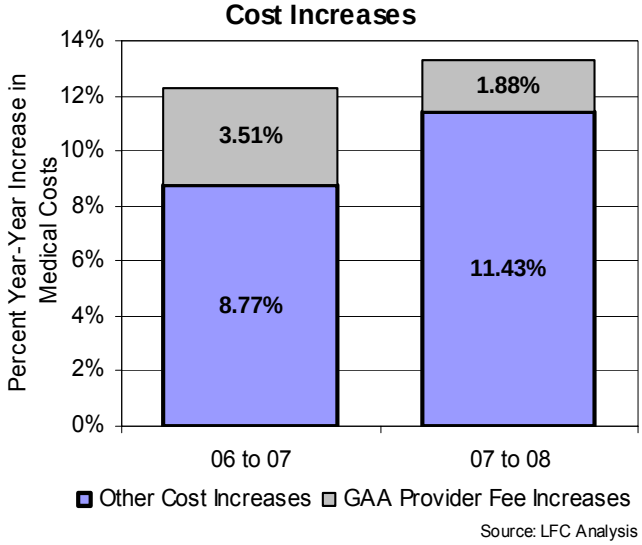
Year	Total for All Medicaid	Physical Health MCO-Total	Percent MCO
FY07	$55,954,089	$27,427,185	49.0%
FY08	$45,855,379	$18,520,452	40.4%

Source: HSD

The increases in provider fees increased overall medical costs by an estimated 3.5 percent between FY06 and FY07 and less than two percent between FY07 and FY08. While funding for provider fee increases through MCOs was significant in FY07 and FY08, they were not the only cost driver.

The managed care rate development process already accounts for trends in medical prices that potentially make additional fee increase appropriations unnecessary. MCOs are required to meet network access requirements regardless of additional specific funding for provider rates. In addition, while contracts do use the Medicaid fee-for-service rates as the default benchmark, MCOs and providers are free to negotiate other fee levels. Actual fees schedules paid to providers will vary to the

Impact of Legislative Provider Fee Increases on Overall Managed Care Cost Increases



Source: LFC Analysis

extent that the market requires higher fees for MCOs to meet network requirements or can extract volume discounts. Additional specified fee increases can distort this market and undermine a key function the state has hired MCOs to perform – develop a network of providers within a set funding amount.

New Mexico's Medicaid fee schedule for many common provider procedures appears adequate compared to neighboring states, Medicare and commercial lines. To the extent that providers and MCOs do not agree on contracted rates the default Medicaid fee-for-services rates provide an attractive alternative, based on analysis conducted by HSD. Neighboring states include Arizona, Texas and Colorado and commercial benchmarks analyzed were from Lovelace and Presbyterian.

Relatively few primary care providers (PCPs) may have received a significant portion of fee increases since about 15 percent (about 300) of primary care providers serve over 70 percent of Medicaid managed care clients. Less than three percent of PCPs (47) have almost 25 percent of Medicaid clients assigned to their care as of June 2008. These PCPs each have over 1,000 Medicaid managed care clients assigned to their care. In FY07, MCOs reported spending about $14.9 million on fee increases for physicians and another $3.8 million in FY08. Because these PCPs serve such a large portion of Medicaid managed care clients it appears, just based on shear volume, that much of the increased fees would benefit primarily those PCPs serving the vast majority of clients. Conceivably some of the remaining fee increase expenditures could have benefited the small number primary care providers who are not physicians.

Clients Assigned to Primary Care Providers (PCP)
June 2008

Number of Clients Assigned Per PCP	PCPs	Percent of Total PCPs	Clients	Percent of Total Clients
1,000 -1,500	47	2.8%	67,623	24.9%
750 to 999	32	1.9%	28,109	10.3%
250 to 749	223	13.2%	95,398	35.1%
50 to 249	551	32.5%	67,167	24.7%
10 to 49	464	27.4%	12,401	4.6%
Less than 10	378	22.3%	1,318	0.5%
Total	1,695	100.0%	272,016	100.0%

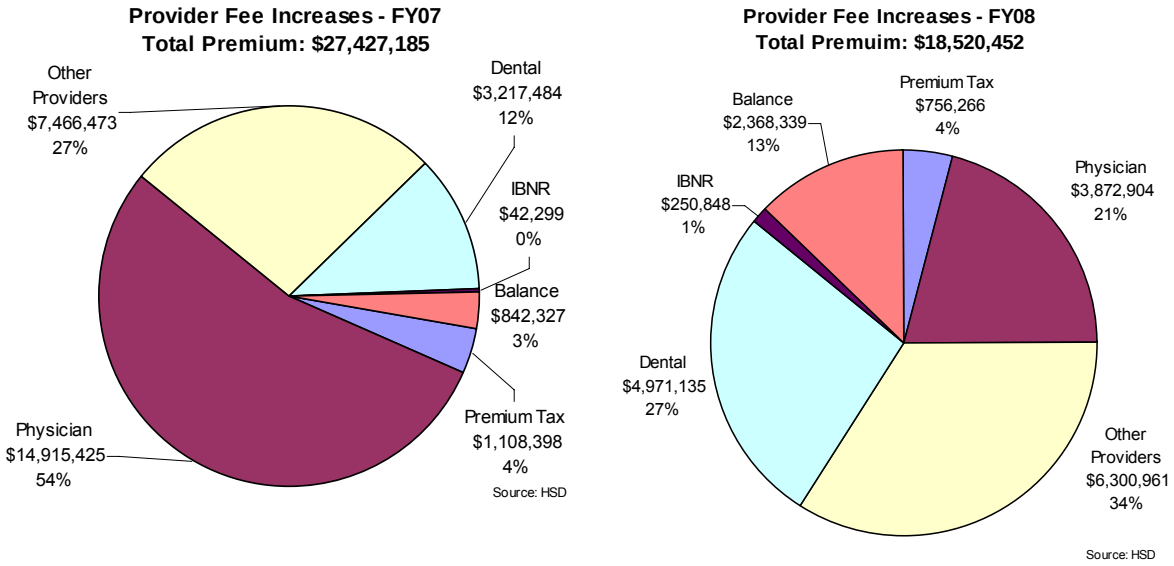
Source: LFC Analysis of HSD Data

About $3.7 million in funding for provider fee increases went unspent by MCOs in FY07 and FY08, and should revert to the state. The MCOs reported spending about 94 percent of the funding for FY07 and 83 percent in FY08, leaving large balances in unspent funding that the Legislature specifically appropriated for provider fee increases. The fee increase appropriations are subject to requirements in the General Appropriations Acts for 2006 and 2007 requiring unspent funding to revert to the state. The following table shows unspent totals by plan and graphs show the breakdown of expenditures of the provider fee increase funding. The difference between premium balances in the table and graphs are due to some MCOs reporting spending more on fee increases than they received in premiums.

Provider Fee Increase Unspent Premium Balances* FY07-FY08

MCO	FY07	FY08
Presbyterian	$0	$1,647,118
Molina	$0	$1,060,989
Lovelace	$1,004,837	$0
Total	$1,004,837	$2,708,108

Source: MCO reports to HSD.



Enhanced oversight into the reasonableness of MCOs reported network costs is warranted to ensure efficient purchasing of health care services. Rate development procedures do not require or contemplate adjustments of reported cost data, unless there is an absence of data. The state uses actual reported costs as the basis for determining future actuarially sound rates. MCOs have been reporting incomplete encounter data for some services that require HSD's actuary to assume the procedures were paid at the standard FFS rates. To the extent that MCOs actually paid discounted rates for those procedures, the state could be building in unnecessarily high costs. Medicaid FFS rates serve as default benchmarks should MCOs and providers not agree on a different rate. However, MCOs and providers may agree to higher rates than FFS or lower rates due to volume discounts. For example, in some cases the state should expect MCOs to achieve negotiated rates below Medicaid FFS levels, particularly in urban counties where an MCO can steer large a volume of clients to a limited number of providers. In other cases an MCO may need to pay above Medicaid FFS levels in order to attract high quality or specialty providers or to meet access standards in remote areas of the state.

Given that two MCOs have affiliated companies that provide direct services, additional price scrutiny may be necessary to ensure a well functioning market for certain types of provider fees. If MCOs are paying above market rates, particularly to an affiliated provider, HSD should assure itself these amounts are necessary for a well functioning network. It is extremely important that HSD ensure unit costs to companies affiliated with MCOs are reasonable and that the state is not, in effect, being overcharged. HSD indicated that for FY09 it had started this level of

examination. Depending on the results of its analysis, HSD may want to assume managed care produces discounted rates based on volume and take credit for these savings during rate development.

Modernizing payment methodology for some outpatient services and requiring electronic billing could save millions and improve predictability of medical costs. Medicaid regulations require MCOs to pay for outpatient services on a "percentage of billed charges", whatever those charges may be. Wide variation of costs for the same or similar procedures exists among different providers and regions in the state. In some cases costs vary between 100 to almost 300 percent for the same services. In addition, the system has experienced rapid and uneven price increases (12-18 percent within a year), far outpacing other medical spending categories. As demonstrated in other areas of this report aggregate outpatient services are a major cost driver in Medicaid managed care and now cost more on a per member basis than inpatient services.

Medicare and commercial markets have moved away from paying a percent of bill charges to a fixed payment structure similar to those used for inpatient hospitals. Moving towards Medicare's payment methodology could yield significant savings and improve the predictability of future costs, according to HSD and MCOs. Savings would be achieved through reductions in excessive prices and/or slowing the annual growth rate of costs.

Given the unusual pricing practices across the state, providers may be using these services as subsidies for losses in other operational areas or as profit centers. In other cases, high prices may be required to compensate for low-volume of business in certain non-urban areas around the state. As a result, care should be taken to understand the industry's business dynamics, particularly for rural and true safety net hospitals, as changes are made to payment methodology to ensure a smooth transition of billing practices. However, changing payment methodology should still result in savings to the state in the form of lower and then slower growth in capitation rates paid to MCOs.

Medicaid regulations require electronic billing for the fee-for-service portion of the program, but not for services billed through MCOs. Less than 80 percent of claims are submitted to MCOs electronically, though the trend has been improving from previously lower levels of about 50-60 percent during the beginning of FY07. Paper-based claims increase administrative workload, and thus cost, and result in longer allowable payment time periods. These increased lag times make monitoring of MCO costs more complicated and requires additional costly analytical work for rate negotiations.

HSD can build on its best practice of requiring MCOs to earn a portion of their premiums by increasing financial ramifications of poor performance. MCOs are required to set aside 0.5 percent of their premiums which must be earned by meeting contract performance measures This form of pay for performance is nationally recognized as a best practice for Medicaid managed care; becoming almost commonplace.

Penalties for poor performance on individual performance measures are relatively low, particularly in relation to publicly reported profit margins earned outside of this pay for performance process. In FY07, MCOs were required to earn about $4.7 million through performance. MCOs earned about 61 percent, or $2.9 million by meeting performance targets. However, during CY07 MCOs reported combined net underwriting gains on Medicaid totaling over $61 million. In addition, for FY09, HSD has set a cap on profit at five percent, which

could total upwards of $70 million. By contrast, MCOs could earn a maximum of about $7 million through this performance program.

Each of the 10 designated performance measures, which are weighted equally, have diluted value because of the low withhold amount. The performance measures cover quality, access and administration, including paying providers timely.

HSD allows MCOs to keep penalty amounts, but directs how they are spent. Historically, HSD has directed MCOs to spend the penalty amounts to improve performance on those areas where MCOs did not meet expectations. For example, for FY07 one MCO that did not meet its administrative reporting measures proposed to spend a portion of the penalty amounts on improving administrative systems and process. One MCO proposed to spend penalties on incentives to get members to have certain health screenings, to conduct education outreach for asthma management and to provide baby showers for new mothers. Another MCO implemented a provider pay for performance program that used penalty amounts to give providers bonus payments for meeting certain performance targets– this approach has been expanded to all MCOs and is one of the main uses of penalty funds for FY09. It is unclear how penalties act as a deterrent if MCOs are allowed to spend the penalty amounts on initiatives presumably they are already contracted or have the flexibility to already perform. In addition, for FY09 all penalty expenditures will benefit MCOs in calculating their medical spending requirements.

RECOMMENDATIONS

Modify the auto-assignment algorithm to steer more Medicaid members not choosing a plan to the lowest priced plans. Do not assign any members through this process to higher priced plans with rates at or above 60 percent of the maximum end of the actuarially sound rate range. Consider capping enrollment of any plan with rates that exceed 60 percent of the maximum end of the actuarially sound rate range.

For FY11, reduce the number of MCOs to no more than three, and lock rates for both FY11 and FY12. Currently, the four MCOs have contracts for FY09 and FY10 with options for FY11 and FY12. This recommendation would reintroduce price competition for FY11 and extend it into FY12. Assuming quality levels remain about equal, price should be the primary consideration for awarding contract extensions. Locking in rates for two year will improve predictability of costs for the state.

Explore options to introduce price sensitivity into client's choice of MCOs, including providing clients with comparative cost information or a "cost rating," in addition to quality ratings; and identifying waiver options to require higher priced MCOs to charge premiums or co-pays. Premium or co-pay revenue would reduce state payments to higher cost MCOs. HSD should seek input from interested parties and report findings to LFC no later than June 2009.

Align requirements for maximum time frame, from 180 days to 45 days, which an MCO may take to complete a provider's credentialing application to Division of Insurance regulations. Require a consolidated provider credentialing agency for all Medicaid managed care plans by FY11.

Recover and revert general fund portions of unspent provider fee increases from FY07 and FY08 totaling $3,712,945.

Continue monitoring rates paid by MCOs on a risk basis using, at a minimum, affiliation with MCO, provider type and region as risk criteria. Make adjustments to MCO rates as necessary. For example, HSD may want to assume a certain amount in discount rates for high-volume providers if MCOs are not achieving desired efficient purchasing.

Transition to Medicare's payment methodology for outpatient services no later than the end of FY10, with specific cost savings goals for FY11-FY12 to be reflected in capitation rates. Before issuance of any proposed rule or managed care contract changes, solicit from stakeholder groups input on the most cost-effective approach to transition into the new payment methodology, including whether to phase in the rate level and structure, what amount of pricing flexibility should be allowed between MCO and providers, whether differential rates should be allowed for some true safety net hospitals and whether adjustments of inpatient rates are necessary.

Extend Medicaid regulations requiring providers to submit claims electronically to providers participating in managed care, unless the provider has been granted a hardship exemption by HSD. Implementation date should be the same for managed care as fee-for-service.

Amend contracts to increase the amount premiums that must be earned through performance from 0.5 percent to at least one percent in FY10, and two percent in FY11. To ensure a true penalty for non-performance, do not allow directed spending of penalties to count as a medical expense and take credit for penalties as income when calculating the following year's capitation rates.

A TRANSITION TO ACTUAL HEALTH CARE OUTCOMES WOULD BETTER INFORM THE LEGISLATURE AND PUBLIC REGARDING HEALTH OF THE MEDICAID POPULATION UNDER MANAGED CARE

HSD requires physical health MCOs to collect a significant amount of data and information on quality, performance and outcomes. The primary source for quality data is the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA). NCQA develops accreditation standards and performance measures as a means to inform purchasers of the quality of healthcare delivered through health plans. Each of the three physical health MCOs is accredited by NCQA and reports a significant amount of data on health care processes, utilization of services and outcomes through HEDIS to HSD. The data set includes reporting on about 59 different categories (excluding plan enrollment and practitioner information). Many of the measures are broken down by age and type of client.

Over 100 million Americans are enrolled in health plans that consistently measure performance and reports independently audited data to NCQA for public release. This is an increase of 29 percent over 2006 and an increase of over 100 percent since 2000. This number does not include the 150 million in private programs that do not publicly report or who have coverage through Medicare or Medicaid.

In addition, HSD requires MCOs to evaluate implementation of quality initiatives, including disease management programs. All of the data and other reporting are intended to foster a cycle of continuous quality improvement to ensure Medicaid clients receive high quality and effective care through the MCOs network of providers.

The legislature requires HSD to report on the performance of Medicaid through the Accountability in Government Act (AGA) and annual General Appropriations Acts (GAA). Likewise as a major purchaser of health care services, the Legislature requires HSD to submit performance information on Medicaid. The purpose of these laws is "to provide for more cost-effective and responsive government services by using the state budget process and defined outputs, outcomes and performance measures to annually evaluate the performance of state government programs. (Section 6-3A-2 (B) NMSA 1978)." HSD reports performance information contained in the GAA, and a broader set of performance measures as part of its quarterly reports to the legislature and Committee.

Medicaid General Appropriations Act
Performance Measures-FY09

Measure	FY09 Target
Children are in the Medicaid school-based services program.*	17,500
Employers participate in state coverage insurance.*	375
Children in Medicaid managed care receive early and periodic screening, diagnosis and treatment services as measured by health care effectiveness data and information set.	70%
Eligible children under age twenty-one get healthcare coverage through medical assistance programs.*	2%
Eligible adults, with incomes below one hundred percent of federal poverty level, get healthcare coverage through medical assistance programs.*	2%
Eligible children under age five get healthcare coverage through medical assistance programs.*	2%
Eligible children enrolled in Medicaid managed care have a dental exam as measured by HEDIS.	50%
Age-appropriate women enrolled in Medicaid managed care receive breast cancer screenings as measured by HEDIS.	53%
Age-appropriate women enrolled in Medicaid managed care receive cervical cancer screenings as measured by HEDIS.	69%

Source: General Appropriates Act, Laws 2008, page 129.
*Not directly related to physical health Medicaid managed care program.

HSD requires a broader, and in some cases more specific, set of performance measures than the GAA in its contracts with the MCOs. For example, HSD has set specific performance targets for well-child visits, primary care provider visits and appropriate use of asthma medication depending on different age groups of young children.

Performance Measures as Stated in the 2009 HSD/MCO Contract

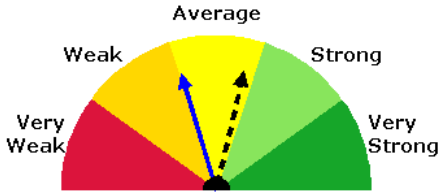
	Measures	Target
1.)	**Annual Children's Dental Visit**	52%
2.)	**Well Child Visits**	
	Percentage of children who had six (6) or more Well Child visits with a primary care practitioner during the first fifteen (15) months of life.	47%
	Percentage of children ages 3-6 who received on or more well-child visits.	64%
3.)	**Children and Adolescent Access to Primary Care Practitioners (PCPs)**	
	Percentage of children ages 1-2 who had a visit of a primary care provider	92%
	Percentage of children ages 25 months through 6 years old who had a visit of a primary care provider	84%
	Percentage of children ages 7 -11 years old who had a visit of a primary care provider	83%
	Percentage of children ages 12-19 years old who had a visit of a primary care provider	81%
4.)	**Childhood Immunizations (Combo 2)**	
	Percentage of children receiving combo 2 immunization on or before their 2nd birthday	76%
5.)	**Use of Appropriate Medications for People with Asthma**	
	Percentage of children ages 5 - 9 who were appropriately prescribed asthma medication	88%
	Percentage of children ages 10-17 who were appropriately prescribed asthma medication	88%
6.)	**Breast Cancer Screening**	
	The percentage women 40 – 69 who had a mammogram to screen for breast cancer	55%
7.)	**Diabetes Care (HbA1c Testing)**	
	Percentage of members ages 18 – 75 who had an HbA1c Test	84%
8.)	**Provider Payment Timeliness**	90%
	Percent of all clean claims paid within 30 days.	99%
9.)	**Encounter Data Reporting**	
	Percent of all encounter data submitted on a timely basis	99%
	Maximum encounter data error rate for at least 90 percent of files.	3%
10.)	**Timely Submission, Accuracy and Analysis of HSD/MAD Required Reports**	
	Compliance rate with all due dates, content and format requirements.	95%

Source: HSD - FY09 MCO contracts,

New Mexico, as a state, needs significant improvement in many healthcare quality indicators, some of which can be positively influenced through Medicaid managed care performance. The U.S. Agency for Healthcare Quality and Research (AHRQ) annually produces state snapshots on the status of the healthcare delivery system which demonstrates strengths, weaknesses, and opportunities for improvement in health care. The goal is to help State officials and their public- and private-sector partners better understand health care quality and disparities in their State.

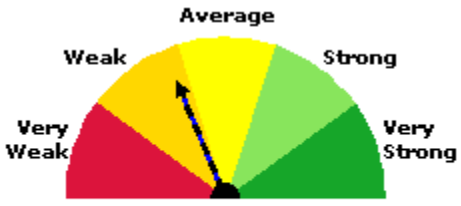
Overall, New Mexico shows average, though declining, performance on AHRQ (Agency for Healthcare Research and Quality)'s composite health care quality rating. The meter below is a summary of over 100 measures reported at the State level, while the four other meters below describe specific care in clinical areas, where New Mexico has weak performance.

New Mexico Health Care Quality
As Compared to Other States – 2007
(Not Medicaid Specific)
Overall Health Care Quality

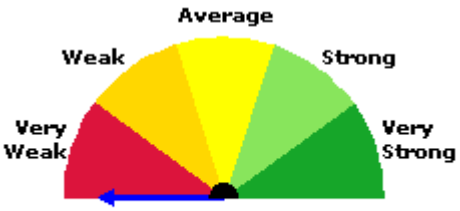


Performance Meter: All Measures

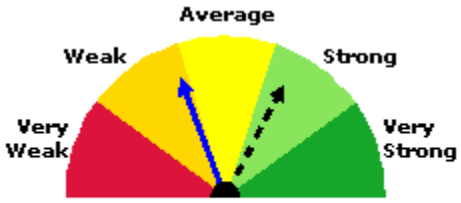
Care by Clinical Area



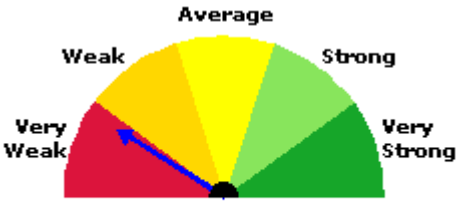
Performance Meter: Diabetes Measures



Performance Meter: Heart Disease Measures



Performance Meter: Maternal and Child Health Measures



Performance Meter: Respiratory Diseases Measures

= Most Recent Data Year
= Baseline Year

(Baseline year may vary across measures)

Source: Agency for Healthcare Quality and Research.
Online: http://statesnapshots.ahrq.gov/

Performance measures focus on process, not outcomes, of care and are not sufficiently aligned with populations served or costs to the system. The measures required by the GAA and HSD's contracts measure the process of health care, and not outcomes. For example, neither requires performance standards for consumer satisfaction, though HSD collects this information. Generally, clients are satisfied overall with Salud! Other outcome measures could help show whether preventative screenings and care are producing desired outcomes. For example, HSD in its contracts requires MCOs to ensure people with diabetes receive recommended screening of

hemoglobin levels (Hb1AC) but not whether the results showed good or poor control of clients' diabetes.

Examples of Health Outcome Measures

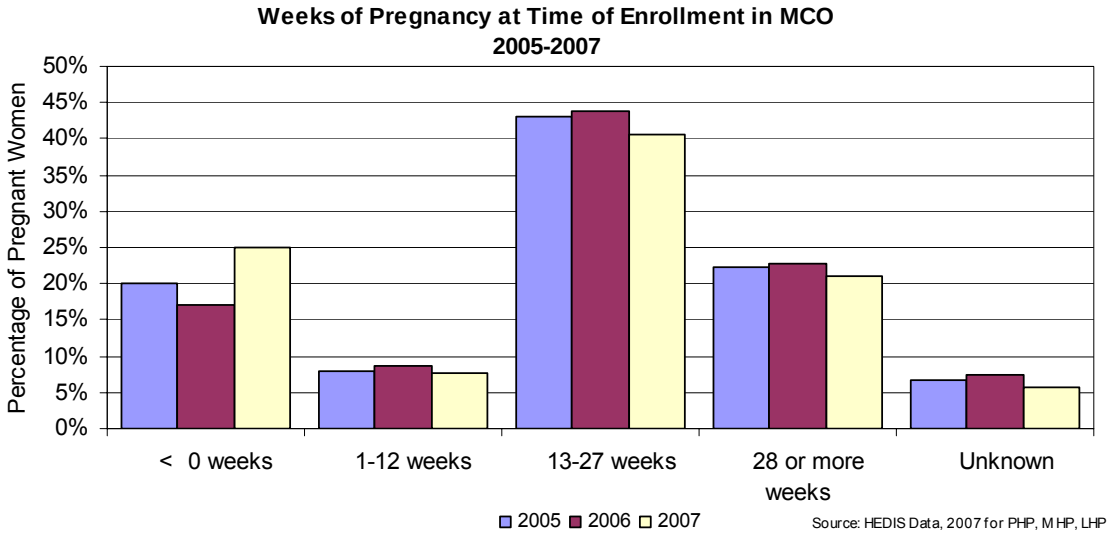
Measure	Example
Mortality	Infant death rate
Physiologic measures	Blood pressure
Clinical events	Stroke
Symptoms	Difficulty breathing
Functional measures	Medicare's SF-36, a 36-item health survey on the functional status of clients
Patients' experiences with care	Consumer Assessment of Health Plans survey

Source: ARQH, Outcomes Research Fact Sheet

More focus is needed on child and maternal health. Medicaid pays for over half of births in New Mexico, yet GAA lacks any related measures. According to the Department of Health (DOH), between 1999 and 2005 Medicaid paid for about 55 percent of births in the state. As a result, Medicaid performance related to prenatal and other child and maternal health indicators should be expected to have a significant impact on the state's overall health care quality in this area. About 10 percent of medical spending in FY07 was for newborns and pregnant women ($84 million).

Nationally, New Mexico ranks worse than average for prenatal care during the first trimester. According to AHRQ, about 69 percent of women received prenatal care during their first trimester in New Mexico versus a national average of 83 percent and a regional average of 77 percent, according to 2004 data. Comprehensive prenatal care can help reduce preterm births and infant low-birth weight rates, and thus risk for neurodevelopmental handicaps, congenital anomalies and respiratory illness, and infant mortality according to NCQA.

In CY07, only 25 percent of Salud! women were enrolled in managed care for their full pregnancy, according to HEDIS data. It is clearly possible some of the other 75 percent of these women receive some prenatal care, just not coordinated through Salud! MCOs. Early enrollment of women in Salud! creates better opportunities for an MCO to ensure women have a full complement of prenatal services throughout their entire pregnancy and improve child birth outcomes. However, about 22 percent (between 2,300 and 2,500) of women are not enrolled until 28 or more weeks into pregnancy reducing the opportunities for a full complement of prenatal services. Overall the number of pregnant women enrolled increased about 6 percent, from 10,349 in CY06 to 11,914 in CY07.



From time of enrollment, between 76 and 87 percent of women receive a timely prenatal visit in Salud!. The CY07 Medicaid national average was 81 percent, with commercial plans achieving an average of about 91 percent. For Salud! between 45 and 68 percent receive the recommended frequency of prenatal care during their pregnancy while enrolled, based on CY07 data.

Medicaid does not track or report birth outcomes such as low-birth weight, mortality, or newborns needing intensive care. Lower rates are better and are indicative of quality outpatient and other healthcare services, particularly when combined with a family of measures.

New Mexico's overall low-birth weight rates are about average with the rest of the country, however trends have not shown strong improvement, and in some measures have worsened based on 2004 data as reported by AHRQ. The state has a disturbing trend of significantly higher infant mortality rates for children without low-birth weight. Use of neonatal intensive care is an important indicator of high cost adverse birth outcomes that can be easily collected and reported by MCOs. The other measures are generally considered public health oriented, similar to child immunization rates. However, it is important to regularly track whether clients in Medicaid managed care and/or fee-for-service have as good or better health outcomes than the general population in this key area given the size of Medicaid managed care and the potential for this program to have significant positive impact on the state's overall rates. This information disaggregated by MCO would be useful for general monitoring purposes, but would not be appropriate for as contractual performance measures subject to penalties.

New Mexico Infant Health Outcomes

Short Measure Name	New Mexico Performance	Most Recent Data Year	State Rate	All-State Average	Regional Average	Baseline Year	Average Annual Change	Direction of Change	Full NHQR Measure Title
Infant death-without low birth weight	Worse than Average	2004	2.9	2.2	2.1	2002	9.9%	Worsened	Infant deaths per 1,000 live births, birthweight > 2,499 grams
Low-weight births	Average	2004	8.1	8.2	7.7	1998	1.1%	Worsened	Percent of liveborn infants with low birth weight (less than 2,500 grams)
Very low-weight births	Average	2004	1.3	1.5	1.3	1998	2.8%	Worsened	Percent of live-born infants with very low birth weight (less than 1,500 grams)
Infant deaths-all births	Average	2004	6.5	6.6	6.1	1998	-1.7%	Improved	Infant deaths per 1,000 live births
Infant deaths-very low birth weight	Average	2004	225	240.7	255.3	2002	3.3%	Worsened	Infant deaths per 1,000 live births, birthweight < 1,500 grams

Source: Agency for Healthcare Quality and Research, State Snapshots 2007. Online: http://statesnapshots.ahrq.gov/

Asthma is leading chronic condition for children, but lacks measures of improved outcomes in the GAA. Poor control of asthma symptoms can lead to expensive emergency room and hospital costs. In 2006, nearly 10 percent of children had a current diagnosis of asthma and 14 percent had a diagnosis at some point in their lives, reaching these levels after significant rate of growth during the 1980s and early 1990s, according to AHRQ. Many asthma related hospital stays, emergency room visits and missed school can be avoided through effective medication management and primary care services, according to NCQA. Nationally, asthma was the primary cause of over 13 percent of all pediatric (other than newborn) hospitalizations in 2006, with over 64 percent originating through the emergency department, based on research by AHRQ.

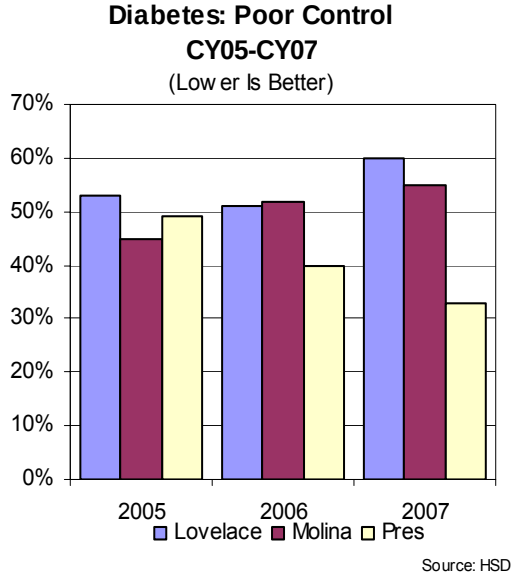
Asthma disproportionately affects low-income children, who also experience higher rates of asthma morbidity and mortality due in part to disparities in treatment. National regional differences in the prevalence and use of high cost services also exists.

Similarly disparities exist in New Mexico. According to DOH, about 14 percent of children in northwest New Mexico have asthma and almost 12 percent in southeast (SE NM) counties. These rates are significantly higher than the rest of the state. However, SE-NM has far higher emergency room visits and inpatient hospital rates than any other part of the state, including NW-NM. For example, average discharge rates per 10,000 children under age 15 for 2003-2005 were 70.8, far above state average of 22.4. Hispanic children experienced higher rates than their Anglo peers as well. Medicaid was a primary payer for most of these high cost services.

HSD correctly has made child asthma a focus of the Medicaid managed care program. MCO contracts contain performance measures related to the appropriate use of asthma medication for children and have made this a focus area for disease management. Given the importance, relative resource use and cost information should also be monitored by HSD to ensure MCOs

can cost-effectively reduce emergency department visits and hospitalizations. This data is already reported by MCOs.

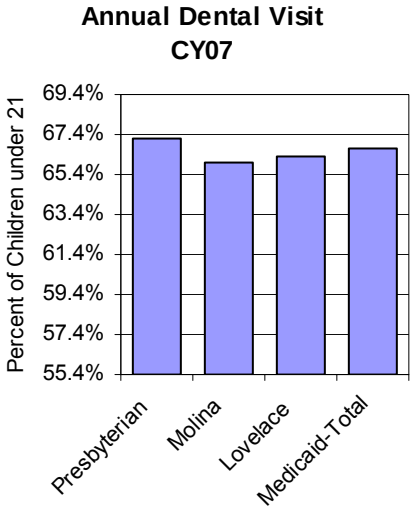
Diabetes is a costly chronic condition for adults, but lacks performance measures in the GAA. HSD has appropriately focused disease management and other process measures of care on this condition; however outcome information (poor/good control) is available and should be included in GAA. MCOs regularly collect and report whether clients with diabetes have their conditions under control or not, and whether providers are effectively implementing recommended practices, such as eye and foot exams. Two of the three MCOs compared poorly when examining whether clients have their diabetes under control, compared to plans nationally. In 2007, about 48 percent of client's had poor control of their diabetes in Medicaid, and about 29 percent in commercial plans. Presbyterian has made significant improvements on this measure, while the other two plans have continued to struggle.



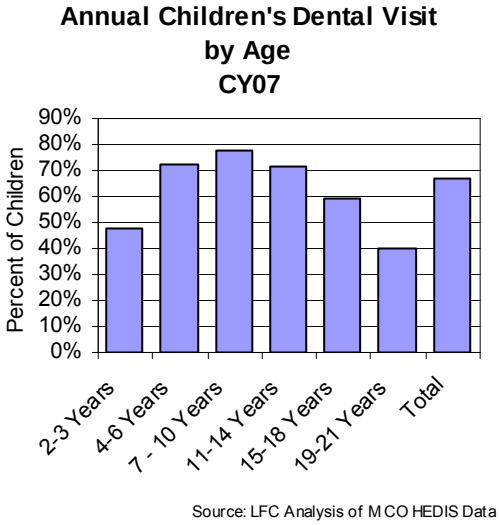
The rationale for a diabetes management program and associated reporting is compelling, based on research compiled by NCQA.

- People with diabetes are 2 to 4 times more likely than others to die as a result of heart disease. Diabetes accounts for almost 45 percent of new cases of kidney failure.
- About 60 to 70 percent of people with diabetes have mild to severe forms of nervous system damage, including impaired sensation in the feet and hands and carpal tunnel syndrome.
- Diabetic retinopathy, the damage of blood vessels in the retina, is the most common diabetic eye disease and a leading cause of blindness, causing 12,000 to 24,000 new cases of blindness annually. Improved control of cholesterol can reduce cardiovascular complications by 20 to 50 percent.
- Patients with diabetes who maintain near- normal HbA1c levels gain, on average, an extra five years of life, eight years of eye sight and six years of freedom from kidney disease.
- The cost of diabetes totaled $174 billion in 2002, including $58 billion in indirect costs, such as work loss, mortality and disability.
- Medical costs for people with diabetes are more than double the medical costs of others.

Adjustments to performance measures and targets for children's use of dental services may be needed in the GAA. MCOs have made improvements in the percentage of children receiving an annual dental exam which has been a significant focus of the program. However, historical targets set through the GAA may have been too ambitious. HSD has struggled to set appropriate targets through its contracts as well. Currently, New Mexico's performance on this target is near the top nationally compared to other Medicaid programs. Further examination of data shows, the program achieves high access rates for children ages 4 to 14, but has lower rates for other age groups. More targeted focus on certain age groups may help the state achieve top marks for children's dental access.



Source: MCO HEDIS Reports



Source: LFC Analysis of MCO HEDIS Data

Other administrative data could be more appropriate for monitoring Medicaid managed care on a quarterly basis. For FY09, the state began to report some enrollment data in its quarterly reports, but that information is not specific to the significant cost center of the physical health managed care program. Typically, to have a complete "family" of performances measures programs should augment outcome measures, with measures showing other activity, such as outputs, and how efficient the program operates. The following measures could be easily reported on a quarterly basis. While other appropriate measures exist for regular reporting, the following table includes examples of output and efficiency.

Potential General Appropriations Act
Output and Efficient Measures for Medicaid Managed Care (physical health)

Output Measures	Explanation/Benefit of Measure
Average Monthly Enrollment in physical health Medicaid managed care.	Enrollment is a major cost driver in what the state pays for managed care and should be monitored on a regular basis. This data can then be compared against the projected target enrollment to determine whether the program is exceeding expected levels (which may result in a shortfall) or is lower than expected (accumulating balances).
Average Monthly Enrollment of low-income children in physical health Medicaid managed care.	Given the state's interest in maximizing enrollment of low-income children (cohort 2) in Medicaid, additional focused monitoring is warranted. For example, during the recent specifically session in August 2008, the Legislature appropriated additional funding for anticipated increased enrollment in this category of children. As such, addition and constant monitoring of enrollment patterns is necessary to assess whether the state achieved its goals for enrolling 19,000 children with the funding.
Emergency Room Visits per 1,000 member months	One goal of managed care is to replace high cost services with preventative health care. Measuring, with a goal of reducing, emergency room visits is one measure that can be used to monitor the use of this high cost service.
Inpatient Hospital Discharges per 1,000 member months	One goal of managed care is to replace high cost services with preventative health care. Measuring, with a goal of reducing or maintaining flat levels, inpatient hospital discharges is one measure that can be used to monitor the use of this high cost service.
Percentage of clean claims received by physical health MCOs paid within 90 days	MCOs process almost $900 million in payments to providers. Payment timeliness is a key monitoring measure for HSD that could be reported to the Legislature on a quarterly basis as well.
Efficiency Measures	
Avg. Medical Cost Per Member Per Month	Average medical costs per member can be used to monitor the efficiency of care and changes in spending patterns. Average costs can be kept in check through greater use of preventative care, controls over unnecessary care, and better pricing.
Avg. Medical Cost of low-income children Per Member Per Month	This measure would more specifically show the average cost of the for the largest group of clients in the program.
Avg. Per Member Per Month Cost to HSD	The average cost to HSD, and thus the state, would reflect the average rates paid.
Avg. low-income children Per Member Per Month Cost to HSD	The average cost to HSD, and thus the state, would reflect the average rates paid for the largest group of clients in the program.

While all New Mexico MCOs are rated as "excellent" by NCQA, improvement is still needed in key performance areas; also, like Medicaid nationally, significant disparities exist between performance of Medicaid and commercial plans. MCOs continue the positive trend of excellent ratings by NCQA for their Medicaid line of business and should be commended for this accomplishment. The ratings indicate positive baseline performance. The HEDIS data can be used to compare each New Mexico plan to other publicly reported plans and to compare performance with other states and national average performance. However, only one in four Medicaid beneficiaries are enrolled in plans that consistently measure and report on performance. HSD regularly compares MCOs annual performance on HEDIS measures to national averages and reports this information on its website.

The *State of Health Care Quality* report is produced annually by the National Committee for Quality Assurance (NCQA) to monitor and report on performance trends over time, track variations in patterns of care and provide recommendations for future quality improvement. In every aspect of care reported, Medicaid members had worse results than commercial members, including Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures of member satisfaction with plans. According to the 2007 report,

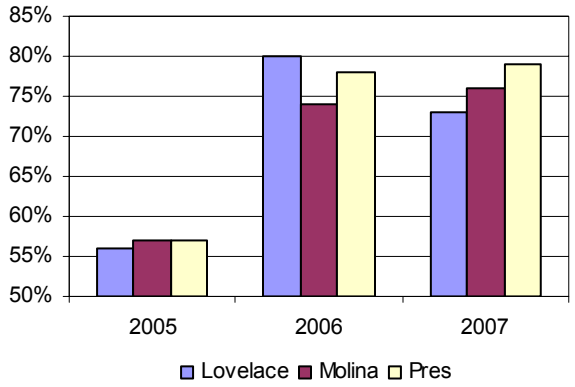
- less than half (49 percent) of appropriate Medicaid members received a screening mammogram within the past two years, compared to 69 percent of commercial plan members;
- almost 65 percent of Medicaid members received cervical cancer screening compared to almost 82 percent of members in commercial plans;

- childhood immunization rates were 3-10 percent lower for Medicaid members than for commercial members;
- cholesterol control was 38 percent for Medicaid compared to almost 59 percent for commercial;
- poor HbA1c control (lower is better) was 47.9 percent for Medicaid compared to 29.4 percent for commercial; and
- timeliness of prenatal care was 81.4 percent compared to 92 percent for commercial.

While Salud! members are showing similar to or better results than national Medicaid results, they still fare much worse than commercial members. Some areas of concern include:

- Childhood immunizations, a focus area for the state, has shown significant improvements but continue to lag behind national commercial rates. Immunizations are the safest, most effective way to protect children from a variety of potentially serious childhood diseases. In New Mexico in 2007, between 21-27 percent of Salud! children lacked one or more recommended vaccinations.

Childhood Immunization Rates (Combo 2) CY05-CY07



Source: HSD

- Salud! has significantly worse rates than both national Medicaid and commercial members for breast cancer screening. While breast cancer screening is clearly important, few female clients meet the age criteria for effective use of this screening (AFDC Over 50 cohort). Mammography screening for women 50 to 69 years of age can reduce breast cancer mortality by up to 35 percent through early detection. A mammogram can detect breast cancer one to four years before a woman can feel the lump.
- Cervical cancer screening: Significantly worse rates than for national commercial members. Cervical cancer has a five-year survival rate of more than 90 percent when the cancer is localized, but only 13 percent once the cancer has spread throughout the body.
- Diabetes care: While New Mexico's HbA1c testing rate is comparable or slightly better than national Medicaid averages, the poor A1c and LDL-C, true health outcomes, are worse than national Medicaid (Lovelace and Molina) and national commercial (all MCOs).
- Cholesterol control for patients with cardiovascular condition: all MCOs report significantly worse rates for this measure compared to commercial members. Coronary heart disease is the number one killer in the United States, claiming as many as 450,000 lives annually.

Improved reporting on MCO performance and outcomes could aid informed decision-making by clients and policy makers. An educated consumer, either someone using services or a purchaser, can be a powerful force for driving improvements in health care quality, according to NCQA.

Medicaid clients do not receive comparative information from HSD on the quality of health plans when choosing an MCO. HSD provides basic information to clients when they enroll in Medicaid about available plans and the selection process. However, clients do not receive impartial information giving tips on how to effectively choose a plan that meets their needs or comparative performance information. Other states provide more user friendly performance information or "report cards" to clients to aid in decision-making. For example, New York and Michigan (among other states) provide a rating system that compares MCOs across multiple aspects of care; such as maternal and women's preventative care, asthma and diabetes care and customer satisfaction rating. As mentioned in previous pages, clients are not provided with comparative cost information.

The nature of data collected and reported through HEDIS and for quarterly HSD performance reports are not compatible and may lead to unnecessary confusion over performance of managed care. HSD relies on HEDIS data, which has extensive controls for the accuracy and reliability of data, for assessing contractual performance and public reporting. HEDIS performance measures are based on calendar year and have a significant lag time of six months for final reporting. For example, HEDIS 2008 represents calendar year 2007 and is not reported until the late summer of 2008. Using data from HEDIS on true outcome and effectiveness measures appears most appropriate for tracking long-term performance of the program.

HSD, to meet requirements of the AGA and GAA, reports some performance measures normally collected through HEDIS on a quarterly basis. HSD extracts this data from encounter data submitted by the MCOs, but it is not plan specific. The quarterly data represents a cumulative measure, which makes the reports somewhat confusing. For example, during the first quarter Medicaid performance data will be far below the expected target, requiring further analysis on the part of the reader to compare performance to the prior year's quarter. As such, requiring HSD to report certain outcome data on an annual basis may prove less confusing.

RECOMMENDATIONS

Work with LFC and DFA to overhaul family of performance measures reported on an annual and quarterly basis. Annual measures should, at a minimum, focus on child and maternal health and outcomes associated with higher cost clients. For measures where MCOs are above national averages, use the 90^{th} percentile and/or national commercial averages for appropriate benchmarks for target setting. Output and efficiency measures listed on previous pages should be reported, at a minimum, for quarterly measure reporting.

Provide Medicaid clients at the time of enrollment with comparative information on the cost (to the state, and possibly them) and quality of each MCO. Consider creating a rating system for cost and quality that allows sufficient differentiation between the plans.

HSD HAS NECESSARY OVERSIGHT TOOLS TO MONITOR QUALITY OF CARE, BUT COULD IMPROVE ITS FINANCIAL OVERSIGHT OF MCOS.

HSD uses a variety of oversight tools to ensure MCOs provide access to quality care for Medicaid managed care clients. The federal government has extensive requirements for state's managed care oversight of quality of care issues, some of which require additional contract costs. For example, states are required to contract with an approved external quality review organization (EQRO) to perform a minimum set of audits of MCOs compliance with certain quality requirements. At a minimum, states must have an EQRO perform a compliance audit, performance measure audit and performance improvement audit (CFR 438.358 (b)). Other optional projects include audits to validate encounter data submitted by MCOs, administration or validation of consumer satisfaction surveys, calculate additional performance measures, conduct performance improvement projects, or any other studies on quality of care. The federal government pays for 75 percent of EQRO activities (CFR 438.370). HSD contracts with the New Mexico Medical Review Association to conduct EQRO activities, with physical health MCOs totaling an estimated $921 thousand, of which about $230 thousand is state funding. Additional contract funding is set aside for behavioral health and other special optional projects should funding be available.

HSD also collects a massive amount of information from MCOs through about 69 contractually required reports. The two main users of these reports within MAD include the contract management bureau and quality assurance bureau. The reports vary in timing of submission, from monthly, to quarterly and annual and cover everything from financial reporting, such as solvency information and medical spending, to access to care through geo-access reports. Geo-access reports are used to determine whether MCOs have a sufficient number of providers in all geographic areas of the state. Other reports include required quality improvement plans and annual self-evaluations, member grievances, reports on fraud and abuse plans and results and performance measure data from HEDIS. HSD also collects information on MCOs disease management programs, including self-evaluations of their effectiveness.

Expansion of managed care to other Medicaid populations may divert resources for effective oversight of physical health MCOs. Throughout this evaluation project, it was apparent that the expansion of Medicaid managed care was increasing resource competition within MAD that was having a direct impact on oversight of the physical health MCOs. For example, the addition of a behavioral health MCO, two coordinated long-term services (CoLTS) MCOs and a fourth physical health MCO will require additional federally required EQRO audits. The increased number of required audits will force HSD to decide whether to limit the number of optional EQRO activities in order to keep down NMMRA contract costs, divert funding from other MAD functions to increase the NMMRA contract or receive additional appropriations to increase MAD overhead costs for a contract expansion. The additional MCOs put upward pressure on contract costs for HSD's actuary, Mercer. HSD cannot fully utilize Mercer's services for only physical health. Without a full evaluation of MAD's efficiency and current use of total resources, contract expansions may not be warranted.

Likewise, HSD now has additional oversight duties in contract management and quality assurance, among others, with the expansion of the number of managed care contractors. The additional MCOs, without increased dedicated staff, increase the workload of existing staff and

may hamper effective oversight. For example, the decreased use of Medicaid fee-for-service should conceivably free up resources for reallocation to managed care oversight. However, without a full evaluation of MAD's efficiency and current use of total resources, staff expansions may not be warranted.

Some EQRO activities appear redundant or unnecessary, limiting HSD's flexibility to fully use existing contract funding for other important oversight activities of MCOs and resulting in a possible waste of resources. For example, federal regulations require audits of performance measure data submitted by MCOs. However, HSD requires MCOs to use NCQA developed HEDIS performance measures, which have extensive specifications and audit requirements already. HSD dedicates staff internally to monitor and review MCOs performance improvement projects, but then must pay its EQRO, per federal requirements, to also conduct audits of MCOs' performance improvement audits. Finally, given that physical health MCOs have been rated as "full compliance" on past comprehensive evaluations of performance against MAD regulations, it is unclear the purpose of continuing these annual audits in the near term. Other states have complained about the redundancy of these EQRO activities given that NCQA has extensive accreditation requirements, which all of New Mexico's MCOs meet.

Federal regulations appear to allow some flexibility on whether state's must conduct all mandatory EQRO activities. To avoid duplication of efforts a state, according to CFR 438.360, may use information obtained about the MCO from a Medicare EQRO review or private accreditation review in place of its Medicaid review. HSD requires all of its physical health MCOs to be accredited by NCQA. Because most of NCQA standards are similar to federal Medicaid requirements, MAD may be able streamline managed care oversight. The state would need to ensure alignment of its plan for quality, and possibly regulations, with NCQA accreditation standards. Another option would be to use the results of any MCOs EQRO reviews for Medicare's managed care programs, which is authorized under federal regulations. Two MCOs, Presbyterian and Blue Cross Blue Shield may qualify under this scenario.

HSD has an internal audit unit, which according to HSD, has not conducted internal audits of MAD and its oversight functions. Often internal audits can assist organizations experiencing a transforming mission to assess whether changes to functions, organizational structure, staffing patterns and staff qualifications need adjustment.

HSD primarily relies on unaudited financial data for developing managed care rates, putting the state at significant risk for improper payments. HSD's actuary relies on two main sources of financial data for developing federally required actuarially sound rates. The data sources include regular spending reports submitted by MCOs, breaking down monthly expenditures by cohort and medical category; and encounter data (data on the distinct health care services provided to each Medicaid managed care enrollee). MCOs submit encounter data to HSD's claims administrator, ACS.

MCOs have submitted incomplete and inconsistent financial data that requires additional adjustments for rate setting. Mercer does not audit the financial data it receives, but does assess the reasonableness and completeness of the data. According to Mercer, some financial data submitted by MCOs has shown inconsistencies or been incomplete and required adjustments. The extent of these inconsistencies, incompleteness and needed adjustments is unclear.

Similarly, problems have existed with encounter data submitted by MCOs. For example, facility costs were not included in some encounters, resulting in incomplete cost data. In other cases, Mercer observed over reporting.

HSD does not audit financial reports submitted by MCOs, and has conducted very limited validation of encounter data. MAD does not contract or use state staff to validate financial reports submitted by MCOs that are used not only for general oversight but as the basis for determining future MCOs rates. To the extent these reports contain inaccuracies, the state would be basing MCO rates on erroneous cost data that could result in overpayments, or even underpayments. HSD has used its EQRO to conduct a validation of some MCO encounter data. However, the report tested data from FY06 and only focused on primary care, dental and transportation data. Other higher risk services were not validated even though Mercer has noted problems with facility cost data and the state has experienced large increases in outpatient hospital costs. Previous LFC program evaluations have found problems with HSD's use and validation of encounter data.

MCOs do not consistently report other income generated under the contract, such as pharmacy rebates, third-party liability recoveries or interest income. In developing rates, HSD is required to take into account other income besides capitation payments to determine "actuarial soundness." However, MCOs are not consistent in reporting this income and HSD does not have a process in place to audit what information is reported. Using DOI and other audit reports submitted by MCOs is made difficult because information is based on calendar year and income, other than premiums, is not separated by product line or in some cases easily identifiable. HSD indicates that Mercer does account for this income, however to the extent that Mercer uses MCOs reports this income could be underrepresented. For purposes of this report we could not verify that Mercer takes this income or amounts into account. In developing the rates, Texas' actuary assumes a certain level of income based on industry experience for items such as third-party liability recoveries.

A comprehensive program evaluation of the effectiveness of Medicaid provider fraud and abuse programs may be needed. Provider fraud and abusive billing practices divert Medicaid resources that could otherwise be used to serve vulnerable and low-income New Mexicans. Fraud and abuse practices can take a variety of forms, from providers charging for inappropriate cost or non-existent services to MCOs engaging in procurement fraud and marketing fraud. State and federal statutes and regulations create a significant, and somewhat complicated, framework for combating fraudulent and abusive billing and other practices by Medicaid providers. A number of organizations play a role in detecting and prosecuting provider fraud and abuse, including HSD, the Medicaid Fraud Control Unit (MFCU) in the Office of the New Mexico Attorney General, and individual MCOs in addition to federal authorities. Physical health MCOs, as are all Medicaid MCOs, must meet standards for deterring, detecting and referring suspected fraud or abusive provider billing practices. Oversight is generally focused on whether states and MCOs are in compliance with standards; i.e. do the organizations have the programs and policies in place to deal with fraud and abuse. New Mexico, including HSD and physical health MCOs, appear to have the organizational policies, functions and systems in place for dealing with provider fraud and abuse. However, an evaluation of how effective all the organizations in New Mexico, across Medicaid, combat fraud and abuse and the results of their efforts compared to other states has not been done.

RECOMMENDATIONS

Review and determine whether any of the required MCOs reports can be eliminated or streamlined, including combining of financial reports to account for all income and medical and administrative spending. HSD may also consider reducing other reporting requirements for MCOs in good standing for a particular aspect of program requirements.

HSD Internal Audit Bureau should conduct a staffing and efficiency review of MAD to determine whether staffing levels, organization, and expertise need modification to effectively oversee a changed Medicaid delivery system that relies almost entirely on managed care. Submit a copy of the report with the results to LFC and DFA no later than September 1, 2009.

Eliminate EQRO activities where NCQA accreditation or standards can be used to meet federal requirements. Adjust HSD requirements as needed to reduce duplication of effort for these activities.

Validate financial data contained in medical spending reports submitted by MCOs that are used for developing rates. Ensure definitions for reporting expenses are well defined.

Validate encounter data, particularly facility and other services with high unit costs, submitted by MCOs.

Require uniform reporting of income, including pharmacy rebates, third-party liability recoveries, collections from overpayments and all interest income. If necessary, HSD should implement a reporting definition for interest income for MCOs with multiple product lines to ensure sufficient allocation of interest income to the Medicaid program. Validate reported income.

New Mexico Human Services Department

Office of the Secretary
PO Box 2348
Santa Fe, NM 87504-2348
Phone: (505) 827-7750; Fax: (505) 827-6286

Bill Richardson, Governor
Pamela S. Hyde, J.D., Secretary

January 9, 2009

Mr. David Abbey, Director
Legislative Finance Committee
325 Don Gaspar Avenue, Suite 101
Santa Fe, NM 87501

RE: HSD Management Response to LFC Program Evaluation Report on Medicaid Managed Care

Dear Mr. Abbey:

Attached please find the Human Services Department's (HSD's) response to the LFC staff's draft evaluation report. We have learned a lot in this process and believe you and your staff have as well. We agree with a number of the recommendations in your draft report and will try to implement them. We agree with many others but do not have the resources to implement these recommendations. Still others appear to be something we could consider. A few are areas we simply disagree with the information presented, the interpretation of that information, or the conclusions and recommendations LFC staff have come to from that information. These agreements and differences of opinion are presented in both our narrative response and in the attached matrix summarizing your staff's conclusions and our responses.

Despite the current national and state economic crises, past cost containment requirements, and a continuing environment of human and financial resource limitations, the Human Services Department is proud to have provided the best service possible for New Mexicans within available appropriations. HSD has done this through three core values: access, quality, and accountability. The Medicaid program serves individuals from every county in New Mexico. As of September 2008, close to 500,000 persons are enrolled in Medicaid in New Mexico and approximately 292,000 of those individuals participate in Medicaid physical health managed care programs.

As mentioned in your Medicaid managed care program report, "Through August of 2008, HSD reported a significant drop in average PMPM rates as a result of reissuing the MCO contracts and adding a fourth lower cost MCO." In fact, HSD managed to secure a PMPM (per member per month) average weight for Salud! of $292.12 in December 2008. This is the first time in several years that this figure dropped below the $300 threshold. This provides a savings, against the original budgeted amount for FY09, exceeding $100 million. Considerable staff expertise and effort led to this positive outcome for the State of New Mexico and typifies HSD's commitment to our core values and service to our most vulnerable populations.

Over the past two years, HSD's Medical Assistance Division (MAD) has not had sufficient staffing or certain skill sets to undertake all desired endeavors to fulfill our core mission.

Access • Quality • Accountability

Historically for the Medical Assistance Division, the Executive budget requested an expansion of full time employees (FTE). Few of the requested FTE have been supported in the LFC budget or in the final appropriations for the last few years. This staffing shortage results in a focus on critical needs at the expense of nonessential desires. Mission expectations for MAD continue to expand while staffing resources remain constrained and therefore, even when we agree with a recommendation or suggestion by a stakeholder group, a legislative committee, or a federal auditor, it may be beyond our ability to implement that recommendation.

We applaud LFC staff for their willingness to assist us with our continuous improvement. Prioritization and implementation of recommendations will occur as current and future resources allow. HSD management remains focused on meeting challenges while strengthening healthcare programs by improving quality, building system capacity and partnering to invest in the state's infrastructure for health care. We are committed to continuing our efforts to ensure that New Mexico's citizens receive high quality services, and we appreciate your interest in Medicaid managed care.

Sincerely,

Pamela S. Hyde, J.D.
Secretary

HSD Summary Response Matrix to LFC Recommendations re Medicaid Physical Health Managed Care (Salud!)
January 9, 2009

I. Amend MCO Contracts

RECOMMENDATION	RESPONSE	COMMENT
1. Recover $107.4 in "savings" from MCOs.	Disagree	No such "savings" exist; years not complete
2. Reduce allowed non-medical expenses from 15% to 14% in FY11 and 13% in FY 12.	Agree	Will consider in FY10 contract negotiations
3. Define income of MCOs more broadly.	Disagree	Not consistent with industry standards
4. Clarify definition of administrative expenses.	Agree	Will include in FY10 contract
5. Cap and track amount of provider incentive bonus payments MCOs count as medical expense.	Disagree	Pay for performance payments are increasingly used as method to increase quality

II. Provide Reports and Information to LFC

RECOMMENDATION	RESPONSE	COMMENT
1. Make available to LFC MCO rate and payment information by cohorts.	Disagree (currently)	Info is confidential by law; will seek legislation to allow disclosure to LFC only
2. Develop regular reporting format for up-to-date cohort level data on enrollment and PMPM rates.	Agree	Except those items made confidential by law
3. Legislature should consider appropriating Medicaid funding in smaller components.	Disagree	Will increase administrative costs for HSD, DFA and LFC without an increase in accountability

III. MCO Reporting

RECOMMENDATION	RESPONSE	COMMENT
1. Require MCOs to submit and HSD analyze data and information on MCO sub-capitation arrangements, by 6-1-09.	Agree	Will begin during FY10; timeline cannot be met; currently insufficient resources to analyze data
2. Provide LFC with quarterly and annual reports on MCO medical expenditures, by cohort and medical cost category.	Agree	Within resources available to produce information
3. Report how HSD spent FY06 funds that accumulated due to lower than expected Salud! enrollment, by 2-1-09.	Disagree	Staff resources not available for this activity

IV. Realign Incentives

RECOMMENDATION	RESPONSE	COMMENT
1. Modify the auto-assignment algorithm to steer more Medicaid members to lowest priced plans.	Agree	In process
2. Reduce the number of MCOs to no more than three in FY11, and lock rates for both FY11 and FY12.	Disagree	Best number of MCOs and whether to lock in rates for multiple years will be determined each procurement and contracting cycle
3. Explore options to introduce price sensitivity into client's choice of MCOs, including providing comparative cost information and considering variable premiums or co-pays; report by 6-09.	Agree to consider	Whether this will increase or decrease costs and access needs to be determined; depends on staffing availability
4. Reduce maximum time frame for credentialing from 180 days to 45 days (consistent with DOI regulations); and require a common provider credentialing agency for all MCOs, by FY11.	Agree	Will begin with FY10 contract

IV. Realign Incentives (Continued)

5.	Recover and revert GF portions of unspent provider fee increases from FY07 and FY08 ($3,712,945).	Disagree	FY07 provider increases are all spent; FY08 increases are in process
6.	Continue monitoring and adjusting risk-based rates paid to providers by MCOs, using affiliation with MCO, provider type and region as risk criteria.	Agree	Will continue current activities and increase as resources are available
7.	Transition to Medicare's payment methodology for outpatient services, by end of FY10, with specific cost savings goals for FY11-FY12 reflected in capitation rates, after input from impacted stakeholder groups.	Agree	May not meet timeline, due to staffing resources and need to consider impact on providers (especially small rural hospitals)
8.	Extend Medicaid regulations requiring providers to submit claims electronically to providers participating in managed care.	Agree	Will implement with FY10 contract
9.	Amend contracts to increase the amount of premiums that must be earned through performance from 0.5% to 1% in FY10 and 2% in FY11, with penalties not counted as a medical expense in current year or income in following year's capitation rates.	Agree	Will negotiate some increased amounts as part of FY10 contract

V. Overhaul Performance Measures

	RECOMMENDATION	RESPONSE	COMMENT
1.	Overhaul reported performance measures focusing on child and maternal health and outcomes associated with higher cost clients, using 90th percentile and/or national commercial averages for benchmarks where MCOs already exceed national Medicaid averages.	Agree	Will work with DFA and LFC on appropriate measures and targets
2.	Provide clients at the time of enrollment with comparative information on cost and quality of each MCO.	Agree	Currently no resources to accomplish this

VI. Financial Oversight

	RECOMMENDATION	RESPONSE	COMMENT
1.	Determine whether any required MCOs reports can be eliminated or streamlined, including eliminating some reporting requirements for MCOs in good standing in program requirements.	Agree	In process
2.	HSD conduct a staffing and efficiency review of MAD staffing levels, organization, and expertise needed to effectively oversee the changed Medicaid delivery system that relies almost entirely on managed care, by 9-1-09.	Agree	Will attempt to identify internal resources to accomplish
3.	Eliminate EQRO activities where NCQA accreditation or standards can be used to meet federal requirements.	Agree	In process
4.	Validate financial data contained in MCO medical spending reports that are used for developing rates, with clear definitions for reporting expenses.	Agree	Will do as much as resources allow
5.	Validate encounter data, particularly facility and other services with high unit costs, submitted by MCOs.	Agree	Currently no resources to accomplish
6.	Require uniform reporting of MCO income, including appropriate allocation of interest income to Medicaid program, and validate data.	Agree	Will clarify reporting requirements; currently no resources to validate data

I. MEDICAID MANAGED CARE MEDICAL COSTS WERE ABOUT $107 MILION LESS THAN ANTICIPATED FOR FY06-08; GENERATING SAVINGS THAT SHOULD ACCRUE TO THE STATE

HSD disagrees with this report finding and the associated recommendation that $107 million should accrue to the State.

The LFC staff determined that the physical health Medicaid managed care organizations (MCOs) reported spending approximately 81% of spending on medical services, resulting in an estimated $107.4 million in savings for FY06-08. HSD disputes the staff's calculations as it fails to consider **all** revenue/expenditures by the three physical health MCOs: Presbyterian Health Plan, Lovelace Health Plan, and Molina Healthcare of New Mexico, Inc. The final evaluations for each of the years examined by LFC will not be complete until all medical claims and expenses have been paid by the MCOs. HSD staff met with the LFC staff on several occasions to explain these differences such as classifications of expenses (i.e., disease management), but was unable to come to an agreement with the staff auditors. For example, in the preliminary report the LFC staff calculated gross revenues as all money received by an MCO regardless of the services performed by that organization. For Presbyterian, the LFC staff included in their gross revenue calculations income received for NMRx, an administrative services agreement between HSD and Presbyterian to coordinate prescription drug benefits for Medicaid fee-for-service recipients. This program is not tied to Salud! and should not be involved in the calculations.

The following table supports HSD's position that the physical health MCOs have performed due diligence in spending on medical expenditures:

PRESBYTERIAN	FY06	FY07	FY08	TOTAL
Total Revenue Less PFI & NMMIP	$441,911,082	$491,691,639	$581,052,100	$1,514,654,821
Adjusted Medical Expenses	$378,775,856	$416,251,074	$507,156,788	$1,302,183,718
LOVELACE	**FY06**	**FY07**	**FY08**	**TOTAL**
Total Revenue Less PFI & NMMIP	$219,943,846	$255,131,091	$311,000,118	$786,075,055
Adjusted Medical Expenses	$191,849,036	$221,336,960	$262,637,134	$676,823,130
MOLINA	**FY06**	**FY07**	**FY08**	**TOTAL**
Total Revenue Less PFI & NMMIP	$221,094,535	$243,672,411	$312,578,606	$777,345,552
Adjusted Medical Expenses	$185,413,908	$201,524,839	$264,656,338	$651,595,085

A complete list of each respective MCO's revenue and expenditures is attached as Exhibit A. HSD continues to work with the MCOs to finalize these expenditures as they are prepared including IBNR (incurred but not reported expenses) and other expenditure items, such as Provider Incentive Plans and subcapitations. This process will not be finalized until all expenses

have been incurred. Therefore, any calculations by LFC of the medical expenditures should be considered preliminary and not complete. In November 2008, HSD renegotiated FY09 rates with the MCOs. The new rates were significantly lowered and savings have been incorporated into FY09 projections. The LFC did not take this into account.

In the report, the LFC staff claim that they were not provided with "raw" data to draw their conclusions. However, LFC staff were provided with sufficient information in the form of reports, projections, and letters from HSD's actuaries and had access to waiver calculations in order to develop their report and to conduct their audit. Repeatedly, LFC staff were reminded that total program dollars for Salud! had to be within expenditures submitted to the Centers for Medicare and Medicaid Services (CMS) pursuant to the State's 1915(b) waiver, aligned with the budget provided by the Legislature and matched with federal dollars, and within actuarially sound rate ranges within each specific cohort. HSD has achieved all of these goals for each specific fiscal year.

It is important to remember that development of a capitation rate range for each cohort follows a comprehensive methodology based on actual program historical expenditures rather than utilizing a loss ratio approach. The base data typically consists of historical financial and encounter information. The base data is then verified by the State's independent actuaries, reviewed for reasonableness, and comparisons to audited information are performed. The base data, separated by rate cohort is then adjusted for items including:

A. impact of reporting irregularities, inaccuracies, and/or revisions to financial experience;
B. impact of rebates and other reductions to medical expenses;
C. impact of programmatic changes including fee schedule (pricing) or benefit changes;
D. prospective trend based on analysis of historical data and reviewed for reasonableness and comparison to other similar Medicaid state trends; and
E. other adjustments that could include additional managed care savings adjustments.

These steps develop a range of expected medical costs, on a per member per month (PMPM) basis for each cohort. Similarly, ranges are developed separately for administration and profits/risks and contingencies. Taxes are then applied as a separate calculation.

A. Administration is developed based on analysis of administrative cost, profits and other costs reported by the Salud! plans in annual Department of Insurance filings. Administration loading includes a range of administrative percentages. A flat target of 15 percent is not utilized in the Salud! rate development.

B. Premium tax is applied to the total rate on a cohort basis; currently the State premium tax is approximately 4 percent.

The administration and taxes loaded to the medical PMPM result in a range of lower and upper bound PMPMs. These are the actuarially sound rate ranges. These rate ranges are developed to assist the State during negotiations with the MCOs. These ranges are certified to CMS as being actuarially sound. The State negotiates rates with the Salud! MCOs within the rate ranges for each cohort.

The LFC staff noted that HSD "deviated from what the contract requires in its calculations for contract compliance with the 85 percent MLR." HSD does not agree with this statement and the following section discusses these claims. However, HSD does agree that the contract should be clarified in these areas and will take steps to implement these changes.

1. Exclusion of the gross assessment to the New Mexico Medical Insurance Pool (NMMIP).

NMMIP assessments have greatly increased in the past few years, with Medicaid bearing a large amount of these medical expenditures. On December 8, 2008, new projections for 2010 were presented to the NMMIP Board of Directors. For 2010, the assessments totals are estimated at $91 million, an increase of over $20 million from the prior calendar year. These assessments cover the medical expenses of very high risk individuals. Because these assessments pay for direct medical services, HSD removed them from the 85/15 calculation and determined that these assessments be considered a "pass through", accurately reflecting HSD's belief that this was an actual cost of doing business, but one related to the payment of **medical expenditures** for this population. A copy of the NMMIP proposed budget is attached as Exhibit B. HSD does agree to clarify these sections of the contract.

2. Exclusion of provider fee increase revenues and expenses.

In excluding provider fee increases from the 85/15 calculation, HSD believed that it was accurately interpreting the Legislature's intent of giving more money to provider groups and specific providers, exclusive of any MCO administrative charge. As such, with the exception of premium tax, all money was paid out to providers. With regard to FY08, Presbyterian has paid the remaining amount shown and HSD has approved Molina's spending plan to ensure that all money passes through to the providers as was directed. Therefore, since payments to providers are considered direct services, all these funds are counted in the 85 percent direct services expenditure requirement.

3. Inclusion of SCI revenues and net losses.

In managing the Medicaid program the State must utilize its buying power across all product lines in order to gain efficiency and to lower costs to the State. To that end, State Coverage Insurance (SCI) revenues and net losses were legally taken into account against the MCOs' physical health 85/15 calculation. During the years at issue, FY06-08, all three Salud! MCOs also operated SCI. As noted in the LFC report, the MCOs operated SCI with high MLRs. In order to achieve coverage for the adult population, HSD leveraged its Salud! product (each year in excess of $1 billion), against its SCI product (each year in excess of $100 million), in order to obtain cost-efficiencies and provide the best overall dollar on a PMPM basis for both programs. The rates for SCI have also continued to be "actuarially" sound during this process. HSD will change the contract to clarify this section.

4. Inclusion of some administrative costs for reinsurance as medical expenditures.

Reinsurance is required per the contract between the State and the Salud! MCOs. That expense offsets medical expenses and therefore should be treated as medical expense. HSD does include reinsurance as a medical expense that provides protection for medical expenses above a pre-determined amount or threshold. Reinsurance may be sought for a certain service or may be

inclusive for a health plan. Reinsurance expense is generally offset by reinsurance claims. For purposes of rate setting, the State's actuary assessed the net reinsurance expense as reported by the Salud! plans, that is the total reinsurance premium less reinsurance recoveries. In many cases the net reinsurance expense is positive, thus the plan has not received reinsurance recoupments in excess of the premium paid. In the rate development, the State's actuary regards the reinsurance expense as an offset to medical expenses and not as an administrative cost. Regardless, the reinsurance expense is minimal when reviewed as a percentage of total capitation revenue.

5. Inclusion of disease management and case management contracts as medical expenses.

There is inclusion of some administrative expenses for disease management, case management services, provider incentive payments, and meals and travel as medical expenses under the contract. Each respective Salud! contract has an exhaustive list of what HSD considers an administrative expense. These include such items as: network development and contracting, licenses, taxes, profit, etc.[1] Because HSD defined this list, all other items must be considered non-administrative, i.e., medical costs. This includes disease management, case management, provider incentive payments, and reinsurance.[2] Based on the LFC report, HSD will revisit this list to provide clarification to the plans regarding what may be calculated and included as medical expenses.

The LFC staff made the following recommendations:

HSD should amend the current MCO contracts as follows:

1. Recover the estimated $107.4 in savings through a performance bond and/or reducing FY09 and FY10 rates.

HSD Response: HSD disagrees with the characterization that it overpaid the MCOs by $107.4 million as indicated above. Therefore, there has not been any overpayment that can be recovered. The final process of calculating MLRs will not be completed until all expenditures have occurred. Therefore, LFC's calculation should only be considered

[1] Section 5.9 states, "The following are HSD/MAD's designated administrative expense functions: (1) network development and contracting; (2) direct provider contracting; (3) credentialing/re-credentialing; (4) information systems; (5) encounter data collection and submission; (6) claims processing; (7) Consumer Advisory Board; (8) Member Services; (9) training and education for providers and consumers; (10) financial reporting; (11) licenses; (12) taxes; (13) plant expenses; (14) staff travel; (15) legal and risk management; (16) recruiting and staff training; (17) salaries and benefits; (18) supplies, non-medical; (19) purchased service, non-medical; (20) depreciation and amortization; (21) audits; (22) grievances and appeals; (23) capital outlay; (24) reporting and data requirements; (25) compliance; (26) profit; (27) care coordination; (28) surveys; (29) quality assurance; (30) quality improvement/quality management; and (31) marketing.

See, Section 5.9, Managed Care Agreement.

[2] With regard to reinsurance, HSD takes reinsurance expenses into account when using the data to set proposed rates.

preliminary. In addition, LFC's calculation is based on an interpretation of what is calculated as the numerator and denominator and HSD disagrees with this methodology. Also, as part of cost containment initiatives, HSD recently renegotiated MCO contracts in November 2008, lowering the average PMPM and saving approximately $100 million against the original budget amount for FY09.

2. **Cap non-medical expenses, administration and profit at no more than 15 percent of income earned under the contract, and consider further reducing this amount to 14 percent in FY11 and to 13 percent in FY 12.**

HSD Response: HSD agrees that administration and profit should be capped at no more that 15 percent as stated in its RFP released in December 2007 for Salud!/ SCI. HSD will consider further reducing this amount as additional contract negotiations occur over the next couple of years. It should be remembered that over four percent of the 15 percent allowed for non-medical expenses is funding that comes back to the State as general fund revenue in the form of premium taxes.

3. **Define income as gross premiums from capitations, interest income, third-party recoveries, reinsurance recoveries, and pharmacy rebates.**

HSD Response: HSD disagrees with this approach. For purposes of calculating medical loss ratios (MLR), the only revenues that are taken into consideration are premium revenues, i.e., capitation payments after adjustments. The LFC staff recommendation to define income broadly deviates from national industry practices and definitions of MLR.

4. **Clarify that costs to purchase reinsurance, net NMMIP assessments (after any offsets), disease management services and other contracts where the primary purpose is to coordinate care are counted as administrative expenses.**

HSD Response: HSD agrees that it is important to define the specific components of administrative expenses and will revisit this definition in its managed care contracts.

5. **Cap the amount of provider incentive bonus payments that an MCO may count as a medical expense at no more than one percent, and require MCOs to explicitly report these payments, in addition to non-medical meals/travel for members as part of their medical expense reports by cohort. HSD should create new spending categories to track these expenditures.**

HSD Response: HSD disagrees with the LFC staff recommendation to cap provider incentive bonus payments at one percent. In researching this point HSD found that an incentive this small has had no effect on provider behavior. In order to influence provider behavior via pay-for-performance models, the incentive has to be sufficient to motivate behavioral changes by providers. HSD agrees with the LFC staff that MCOs should obtain necessary approvals prior to implementation of any provider incentive bonus payment and should report such expenditures to HSD.

II. INCREASED MEDICAID MANAGED CARE TRANSPARENCY BY HSD WOULD IMPROVE BUDGETING AND OVERSIGHT RESPONSIBILITIES OF THE LEGISLATURE

LFC's audit report is misleading in this area. HSD has provided the LFC staff with reams of specific information that was requested. HSD's criteria for providing information has been whether it was available and whether it was "made confidential by law". The only information HSD has withheld is information about specific rate ranges by cohorts, which is confidential by law and would result in additional expense to the State if this information were to become available to MCOs. The Attorney General's advisory opinion makes clear that "an agency is not obligated to provide information to LFC…if the information is "made confidential by law" and that if "an agency nevertheless choose to provide LFC with confidential information, LFC might not be able to keep the information confidential if a person made an IPRA request to inspect records containing information."

While we appreciate LFC's promise to try to keep these records from disclosure should an IPRA request be made, the idea, in that respect, would be in and of itself a violation of IPRA. Basically, once HSD provides LFC with the documents we have waived our confidentially arguments, even if LFC returned the documents to us and retained no copies. We would direct LFC to the portion of the Attorney General's advisory letter that reads, "absent a statutory amendment, LFC cannot guarantee protection for confidential information it obtains from other agencies." HSD proposes that legislation be introduced to address this issue so that agencies may release information to the LFC for evaluation purposes and have it be protected from further disclosure by law.

The LFC staff made the following recommendations:

1. **HSD should make available to LFC information on Medicaid managed care contract rates, complete actuarial rate certification letters/reports and amounts paid to MCOs by client type (cohort) as requested**.

   HSD Response: HSD provided every document to the LFC staff that was available and not deemed confidential by law. In fact, the LFC staff were provided with every item requested in the recommendation with the exception of the rates paid by cohort.

2. **Work with LFC and DFA to develop a regular reporting format for, at a minimum, physical health Medicaid managed care as part of regular projection meetings. Reports should provide, at a minimum, up-to-date cohort level data on enrollment and average PMPM spending compared to beginning of the year projections.**

   HSD Response: HSD agrees that certain information could be provided to LFC and DFA regarding information on physical health Medicaid managed care. This information has already been provided to HSD's Medicaid Advisory Committee (MAC). HSD will continue to provide this information at intervals that are possible based on the resources it has available. However, providing certain information on a cohort level, such as an appropriate

PMPM or rate ranges by cohort, would put HSD and hence the State at a disadvantage during contract rate negotiations with the MCOs. These documents have been deemed confidential and cannot be released without a legislative change allowing and requiring LFC to maintain the confidentiality of this data once provided to it.

3. The Committee may want to consider breaking up Medicaid appropriations into smaller appropriation components, such as physical health managed care, coordinated long-term care services, other fee-for-service, and HSD administration with appropriate performance measures for each part of Medicaid.

HSD Response: HSD strongly disagrees with this recommendation. Within Medicaid's programs, individuals may move from one program to another, and have multiple service types, depending on the individual's revised category of eligibility and his/her needs. To split appropriations into each specific program would not encompass these changes and may cause inaccurate projections/appropriations. In addition, these changes would increase the administrative efforts by DFA, LFC and HSD to run the program resulting in a waste of limited resources. Making this change would not achieve LFC's goals of having greater accountability over managed care. Rather limited executive and legislative staff would spend time trying to determine what amounts might be spent in which "buckets" and juggling budget adjustment request documents.

The Department should not try to manage each line in its projection model in isolation. We are aware of our annual revenues and make every attempt to keep expenditures within the limits of that revenue. If any one line of projected expenditures looks like it may be lower than originally projected (e.g., the physical health managed care line in the projection model), HSD does not see this as a cost savings that will need to be reverted but rather as a change that has to be taken into account in our efforts to live within the revenues available for the entire Medicaid program. Undoubtedly there will be another line in that projection where actual expenditures are projected to be higher than originally thought. Reverting potential "savings" in any given line of the dynamic and changing projection only to rely on supplemental appropriations or budget shortfalls that must carry-over to the next fiscal year is not the most prudent or administratively efficient way to operate and manage the Medicaid program.

Furthermore, managing the program in this manner would likely necessitate either curtailing certain services or enrollment outreach for the program at the end of the year or ramping up of certain parts of the program hastily in order to spend the appropriation provided. Both of these can cause undue burden on affected State Agencies (HSD and those agencies we fund) and confusion or hardship for consumers. We do not believe that this kind of line by line appropriation and budgeting would be more cost efficient and do believe that it could lead to poorer access and health outcomes for consumers.

III. STATE SPENDING ON MEDICAID MANAGED CARE HAS INCREASED ALMOST 30 PERCENT BETWEEN FY06 AND FY08, WHILE ENROLLMENT HAS INCREASED ABOUT 10 PERCENT DURING THE SAME PERIOD.

While the Department does not dispute this claim, it believes that the LFC audit omits some of the context needed to fully evaluate this situation. There is an implication that increased cost can be viewed only in the context of increased enrollment. Instead, there are many factors that account for increasing program costs, including utilization shifts, medical price increases, and other inflationary factors.

Health care costs increase each year due to a combination of enrollment, utilization, and medical costs. Costs in the Medicaid program, as any health care program, would increase a significant percentage each year without adding one new individual to the program. Average annual medical cost increases are about 7-8 percent nationally. Additionally, in New Mexico, during the time period studied, Medicaid provider rates were increased at legislative direction, thereby increasing costs to the program without any additional persons being served. While provider rate increases were needed, this cost increase is a significant reason why New Mexico's program costs increased much faster than enrollment. So, even with drops in or stability of enrollment, costs will continue to rise due to greater utilization and/or rising medical costs.

The LFC report states that HSD lacks information showing the utilization patterns of clients assigned to providers receiving these per-member-per-month payments; notably whether client's receive similar levels of preventative care as those without subcapitations or have better health outcomes such as lower emergency room usage. The report contends that HSD also lacks data to better understand whether the payment arrangements are reasonable - not too high or low. In the past, subcapitations have occurred in such areas as transportation and vision services; managed care organizations frequently use subcontractors to provide glasses, dental services, durable medical equipment and transportation. Within the last few years some of the areas of subcapitation have increased. HSD is working with the MCOs to identify these agreements and develop additional reports so that utilization and expenditure information can be properly tracked. However, HSD does not have the resources to track health outcomes of members who see subcapitated providers versus those who see non-subcapitated providers.

The LFC report states that outpatient costs have increased almost 40 percent ($178 to $246 million) since FY05 and are now more expensive than inpatient services ($171 million). In general, outpatient increases are a positive outcome and a goal of managed care. It does not suggest the need to alter reimbursement methods; rather it suggests the program is doing what it was intended to do. Overall, HSD does have some concern that hospital outpatient costs continue to grow faster than medical trend. This is primarily due to the hospital provider's ability to change the charge master or amount they charge for services without regard to actual costs or medical expense trends.

In regard to this issue, HSD/MAD has released emergency regulations effective January 1, 2009 that will allow the MCOs to negotiate with hospitals regarding outpatient payments. HSD will examine moving gradually to a different payment methodology for

outpatient hospital services. These changes will be done very carefully to ensure that New Mexico's hospital safety net is protected.

The LFC report states that prescription drug costs have increased about 30 percent over the past four fiscal years, from $90.3 million in FY05 to $117 million in FY08. An increase in the cost of prescription drugs in the amount of 30 percent in four years is in line with national trends.

The LFC staff made the following recommendations:

1. **Require MCOs to submit additional data and information on the use of sub-capitation arrangements with primary care providers. HSD should:**
   - **assure that sub-capitation payments meet federal requirements, have a reasonable basis for cost and risk, and do not present a conflict of interest;**
   - **assess whether practice and utilization patterns are better than average for clients assigned to PCPs receiving sub-capitation payments than for those not receiving payments both in-network and across the entire Medicaid managed care program;**
   - **require MCOs to submit regular utilization reports for PCPs receiving sub-capitation payments using a similar format as the overall manage care program utilization reports;**
   - **consider capping or eliminating the use of sub-capitation payments given the results of HSD analysis of the above information; and**
   - **report the results of HSD analysis and activities taken to LFC no later than June 1, 2009**.

   HSD Response: Overall HSD concurs with the concepts expressed in this recommendation, but will require additional staff to achieve these additional expectations. The Department is implementing cost containment initiatives including decreasing funds for contracts and a hiring freeze that significantly impacts MAD's ability to expand duties beyond those that are required. HSD is not able to meet the recommended timeframes outlined in the LFC recommendations with the current staffing levels.

   HSD agrees with this recommendation and in fact HSD already assures that sub-capitation payments meet federal requirements. HSD agrees to collect and analyze sub-capitation data and information in keeping with the principles of managed care.

2. **Provide LFC with quarterly and annual reports on MCO medical expenditures broken down by cohort and medical cost category. Include annualized medical spending data for managed care in HSD's overall annual report to the Legislature and public, and post on the web.**

   HSD Response: The Department has provided medical cost data by expense category to the LFC, as well as to the MAC. We have provided reports that show more detail in this area. During the audit period, the Department did provide all available reports regarding cost by expense category under Salud! and we can continue to provide that information in

the future, including as part of our annual report within the resources we have available. HSD has not yet provided medical cost data by cohort. We have not received information from the MCOs broken down in this manner nor have we set up the programming necessary in the Omnicaid system to produce such a report. The Department is amenable to working with the LFC on a report format that would provide needed information regarding medical cost data and that would be feasible for us to produce within the resources we have available.

3. Provide LFC with a report no later than February 1, 2009 with a breakdown of how HSD spent Medicaid funding that accumulated due to lower than expected enrollment in physical health managed care during FY06.

HSD Response: As HSD has responded above, we disagree that there has been an accumulation of funding and do provide monthly information that provides detail about how all Medicaid dollars are spent In budgeting for a fiscal year, HSD's primary concern is to focus on living within the budget appropriated by the Legislature for the Medicaid program as a whole. The Department makes projections, forecasts, and estimates for various programmatic and service areas and then tracks each of those line items throughout the year. For example, the Department tracks expenditures for the Home and Community-Based Waiver programs, Behavioral Health, as well as Salud! and SCI. The LFC and interested stakeholders such as the Medicaid Advisory Committee members are well aware of this process as the Department shares and reviews the projection and the budget on a regular basis with these stakeholders.

The Department does not, however, look at each line item in isolation therefore there was no accumulation of funding in physical health or any other line item due to enrollment changes. HSD is aware of annual revenues (some of which are also estimated and projected, rather than fixed as the appropriation) and makes every attempt to keep expenditures within the limits of that revenue. If actual line item expenditures are projected at any point in time lower than originally projected, this is not a general fund cost savings to be reverted because undoubtedly there will be another line item where actual expenditures are projected to be higher than originally projected for that year. HSD believes that reverting funds from an individual line where projections at any given point in time might appear to show a decrease in possible expenditures compared to an earlier projection, only to rely on supplemental appropriations or budget shortfalls that must carry-over to the next fiscal year in another projection line is not the most prudent or efficient way to operate and manage the Medicaid program.

For programs and services where there is a specific line item appropriation it would be necessary to either curtail services or program entry at the end of the year or to ramp up the program hastily in order to best manage the appropriation provided. Both of these can cause undue burden on State Agencies and confusion or hardship for consumers. HSD does not believe that this kind of line item appropriation and budgeting would be more cost efficient and do believe that it could lead to poorer access and health outcomes for consumers.

IV. REALIGNING INCENTIVES AND IMPROVING EFFICIENCY WOULD SAVE MONEY AND CREATE BETTER VALUE FOR TAXPAYERS PURCHASING HEALTHCARE FOR LOW-INCOME NEW MEXICANS.

The LFC staff made the following recommendations:

1. **Modify the auto-assignment algorithm to steer more Medicaid members not choosing a plan to the lowest priced plans. Do not assign any members through this process to higher priced plans with rates at or above 60 percent of the maximum end of the actuarially sound rate range. Consider capping enrollment of any plan with rates that exceed 60 percent of the maximum end of the actuarially sound rate range.**

   HSD Response: HSD agrees and began the process of steering recipients to lower cost plans in the Fall of 2008 through the auto assignment process. HSD will continue to do this to the extent that is consistent with CMS' requirements about choice of plans and our commitment to seeking the highest quality of care possible within available resources.

2. **For FY11, reduce the number of MCOs to no more than three, and lock rates for both FY11 and FY12. Currently, the four MCOs have contracts for FY09 and FY10 with options for FY11 and FY12. This recommendation would reintroduce price competition for FY11 and extend it into FY12. Assuming quality levels remain about equal, price should be the primary consideration for awarding contract extensions. Locking in rates for two year will improve predictability of costs for the state.**

   HSD Response: HSD disagrees with this recommendation. The number of MCOs in New Mexico is not excessive for the size of the managed care enrollment and the number of MCOs in any given time period might vary to get the State the best overall price and quality of plans. Moreover, since changing the number of MCOs could lead to disruption for members and might deny access to (and choice of) providers only affiliated with one MCO, we only consider such a change during the 3-4 year procurement cycle and/or when are unable to secure the price we need to obtain for the State or the quality we are seeking for the service recipients of the program. We offer the following comments to explain our assertions:

   - Adding a fourth MCO recently has allowed HSD to shift clients to less expensive MCOs.

   - Managed care plans differ on how they administer their programs including the services for which they offer case management; how they assist pregnant women with educational programs; the pharmacy items available; the availability of transportation services; the accompanying dental and other provider type networks; the available pharmacy network; prior authorization requirements; how referrals to specialists are handled; the quality of services and the extent to which value added services (those beyond the routine benefit package) are available.

- Access to specialists may also vary from MCO to MCO. For example, in a small community like Tucumcari the primary care physicians may all contract with all the MCOs but the recipient may perceive that they are best served by the specialists of one MCO rather than another. An individual with cancer can choose a particular MCO while another recipient chooses a different MCO because of their HIV specialists.

- Reducing the number of MCOs may be a problem when you consider the infrastructure shortages in the State. For example, when one health plan under Salud! maintains approximately 53 percent of the network in the greater Albuquerque area. It would be key in maintaining access to care for our clients to ensure that this network is available. If that plan were to be excluded from the Salud! program the other plans may not be able to provide that network access at the same rate. It may appear easy, as the report suggests, to eliminate one MCO because they are perceived to cost too much, but by doing that we will drive up costs (through their negotiations with remaining plans); and, if we eliminate one MCO, the inability to use that MCO's network, could reduce needed access.

- Using 2006 data from the Centers for Medicare and Medicaid Services, New Mexico's use of four MCOs appears reasonable and valid. Using the 2006 data, NM enrolled about 244,000 members in three MCOs, for an average of about 81,400 members per MCO. Of the 35 states that enrolled at least a portion of its Medicaid population in managed care, 23 states had lower averages (meaning relatively higher numbers of MCOs per total enrollment).

- States with comparable enrollment size to New Mexico mostly used more, rather than fewer, MCOs. For example, Massachusetts uses four MCOs; Connecticut uses four; Virginia and Missouri use seven; Minnesota uses nine; and Oregon uses thirteen.

- Our neighboring states of Colorado and Texas have similar averages (CO with two MCOs and approximately 74,000 in each; TX with 10 MCOs and approximately 84,000 per MCO). Arizona, uses 25 MCOs and roughly 32,000 per MCO.

HSD is not be opposed to considering rates covering a two-year period. In fact we have used a two-year negotiated rate in the past and have considered it even during the last series of contract negotiations. However, this approach may also harm the State if budgetary and/or provider reimbursement changes occur that would have an impact on year two. HSD will consider this in a more stable economic and revenue situation and will make its best decision at any given contract negotiation whether locking in a two-year rate is likely to be more or less favorable for the State.

3. Explore options to introduce price sensitivity into clients' choice of MCOs, including providing comparative cost information or a "cost rating," in addition to quality ratings; and identifying waiver options to require higher priced MCOs to charge premiums or co-pays. Premium or co-pay revenue would reduce state payments to higher cost MCOs. HSD should seek input from interested parties and report findings to LFC not later than June 2009.

HSD Response: HSD agrees that it could explore options to introduce price sensitivity into a client's choice of MCOs. However, feedback from stakeholders concerned with this type of program would need to be evaluated prior to any changes. It might actually influence some individuals to select higher cost plans and services if they believe the State paying more suggests higher quality, when in fact it may have more to do with a higher proportion of higher risk individuals being in the higher cost plan.

Also, implementing this recommendation is not feasible under current waiver parameters, and HSD does not have the staff resources at the current time to seek such an additional waiver. This recommendation also presupposes that the MCOs are paid different amounts *for the same rate cohort.* That is, it presupposes that one MCO would be paid $100 PMPM for person A, and another MCO would be paid $110 PMPM for the same type of person, and that HSD should create a mechanism to influence such persons to select the first (less expensive) MCO. This may not actually be the case and may make implementation difficult.

4. **Align requirements for maximum time frame, from 180 days to 45 days, which an MCO may take to complete a provider's credentialing application to Division of Insurance regulations. Require a consolidated provider credentialing agency for all Medicaid managed care plans by FY11.**

HSD Response: HSD agrees to consider alignment of credentialing timelines with the Division of Insurance's regulations where possible and feasible within resource limitations.

5. **Recover and revert general fund portions of unspent provider fee increases from FY07 and FY08 totaling $3,712,945.**

HSD Response: All of the FY07 provider fee increase monies have been expended. FY08 funding has been approved for plans to ensure the money goes to providers for services. HSD will continue to monitor this spending to ensure all money has been distributed to providers for services.

6. **Continue monitoring rates paid by MCOs on a risk basis; using, at a minimum, affiliation with MCO, provider type and region as risk criteria. Make adjustments to MCO rates as necessary. For example, HSD may want to assume a certain amount in discount rates for high-volume providers if MCOs are not achieving desired efficient purchasing.**

HSD Response: HSD agrees to continue monitoring MCO rates paid on a risk basis, and make adjustments as necessary, but does not have staff resources to devote to implementation of other portions of this recommendation given other required priorities at this time.

7. **Transition to Medicare's payment methodology for outpatient services no later than the end of FY10, with specific cost savings goals for FY11-FY12 to be reflected in capitation rates. Before issuance of any proposed rule or managed care contract changes, solicit from stakeholder groups input on the most cost-effective approach**

to transition into the new payment methodology, including whether to phase in the rate level and structure, what amount of pricing flexibility should be allowed between MCO and providers, whether differential rates should be allowed for some true safety net hospitals and whether realignment of inpatient rates is necessary.

HSD Response: Overall, HSD agrees with LFC on this recommendation. HSD will be exploring moving to a different rate methodology. HSD will proceed carefully with the implementation of this requirement to ensure that small rural hospitals remain viable as they are the safety net providers in those communities.

8. **Extend Medicaid regulations requiring providers to submit claims electronically to providers participating in managed care, unless the provider has been granted a hardship exemption by HSD. Implementation date should be the same for managed care as fee-for-service.**

HSD Response: HSD agrees and has implemented this function for fee-for-service and agrees to extend the electronic submission requirement to Salud!.

9. **Amend contracts to increase the amount premiums that must be earned through performance from 0.5 percent to at least one percent in FY10, and two percent in FY11. To ensure a true penalty for non-performance, do not allow directed spending of penalties to count as a medical expense and take credit for penalties as income when calculating the following year's capitation rates.**

HSD Response: HSD agrees to consider this recommendation for FY10 and FY11 and to determine if it would be allowable under federal regulations. However, it should be noted that HSD does currently assess penalties on the MCOs for non-performance and will continue to do so.

V. A TRANSITION TO ACTUAL HEALTH CARE OUTCOMES WOULD BETTER ENABLE THE LEGISLATURE AND PUBLIC TO VISUALIZE IMPROVED HEALTH OF THE MEDICAID POPULATION UNDER MANAGED CARE.

HSD offers the following comments in reference to this section of the report.

For the last several years, interest in collecting and publicly reporting information about the cost and quality of health care has been growing. Yet such activities are controversial. While healthcare providers and payers face demands to conduct their business more transparently, questions remain about the accuracy of the reported price, process and outcome information; and whether and how patients and others use the information in making decisions. The cost of collecting such data also adds to cost of administering the Medicaid program as well. Therefore, we must be clear about the accuracy, use and necessity of such data before we require it.

In a part of it's report, the LFC staff used AHRQ's indicators as a measure of health outcomes in New Mexico. One should note that the AHRQ discussion is irrelevant to this Medicaid population (Salud!), as the data presented are about a state's entire health care system, not just about the Medicaid program. The *National Healthcare Quality Report* (NHQR) presents data at

the national level and at the state level **where state level data are available**. Data sources include provider/facility surveys, population sample surveys, vital statistics and organizational data systems such as AHRQ-Healthcare Cost and Utilization Project (HCUP), CMS QIO, CMS Medicare Patient Safety Monitoring System, CMS Nursing Home Minimum Data Set, and other CMS data systems and includes Medicaid, Medicare and commercial health care reporting data.

Moreover, this data is not validated and may be incomplete. HSD/MAD is aware of the AHRQ state rankings for the individual measures and New Mexico's rankings within this report. Our research and collaboration with AHRQ has identified significant issues and gaps in the available data elements/sources utilized by AHRQ to compile the state level data for New Mexico. Therefore, HSD/MAD has collaborated with the NM Health Policy Commission to identify the root cause of the gaps in data and is currently working to help remedy these issues. Until these issues are resolved, AHRQ data should not be relied on solely and should definitely not be data used to comment on New Mexico's Medicaid program or its role within the larger health care system.

The current methodology of collecting quality auditable data through HEDIS®, measures Medicaid specific data for comparison with other Medicaid specific programs. HSD uses HEDIS® measures and believes them to be more accurate and helpful in assessing the outcomes of the Medicaid managed care program.

The LFC report claims that HSD measures the process of health care and not outcomes. This statement in not accurate. All of the physical health MCOs report a significant amount of data on health care processes, utilization of services and outcomes through HEDIS®. HSD/MAD recommends focusing on HEDIS® measures that will align with the populations served (women and children) and outcomes of those HEDIS® measures.

LFC also states in their report that Medicaid does not track or report birth outcomes. This statement in not accurate. Medicaid does currently monitor MCO performance specific to teen maternal care which is recognized as a high risk population. MCOs report monthly for the age groups of 10-14 years and 15-19 years, on number of births, number of births with low birth weight (LBW) and number of stillbirths. MCO performance is much better than the state-wide rates reported by AHRQ. The Department of Health measures birth outcomes in New Mexico. HSD does supply DOH with Medicaid data and DOH produces reports that provide Medicaid birth outcome results. In order to effectively use our limited resources, HSD does not duplicate efforts of other state agencies.

The LFC audit states that while Salud! members are showing similar to or better results than national Medicaid results they still fare much worse than commercial members. This statement is an unfair comparison and not supported in literature or by national quality standards. With the exception of health children, Medicaid clients have different needs and often different or more severe health care issues compared to commercial members. Therefore, HSD focuses on improving quality of care for the Medicaid population in areas where we need to improve for that population, not on meeting a commercial standard that is not likely to be relevant for the populations served by this public sector program.

The LFC staff made the following recommendations:

1. **Work with LFC and DFA to overhaul family of performance measures reported on an annual and quarterly basis. Annual measures should, at a minimum, focus on child and maternal health and outcomes associated with higher cost clients. For measures where MCOs are above national averages, use the 90th percentile and/or national commercial averages for appropriate benchmarks for target setting. Output and efficiency measures listed on previous pages should be reported, at a minimum, for quarterly measure reporting.**

   HSD Response: HSD will continue to work with the LFC and DFA to align the performance measures reported on an annual and quarterly basis. Annual measures might focus on child and maternal health if we can utilize HEDIS® to report data to ensure comparability to other Medicaid programs nationally and to prevent additional administrative cost in the collection and reporting of data for these measures.

2. **Provide Medicaid clients at the time of enrollment with comparative information on the cost (to the state, and possibly them) and quality of each MCO. Consider creating a rating system for cost and quality that allows sufficient differentiation between the plans.**

   HSD Response: HSD agrees to consider implementation of this recommendation within the limited resources that are available. It is important to note that providing cost information to consumers may not result in changing the consumers' selection behavior. In fact, consumers may be more likely to choose a high priced MCO for care where the consumer is not paying the reported price, but rather may see a higher price to the State as indicative of higher quality without understanding the case mix impact on MCO cost.

VI. HSD HAS NECESSARY OVERSIGHT TOOLS TO MONITOR QUALITY OF CARE, BUT COULD IMPROVE ITS FINANCIAL OVERSIGHT OF MCOS.

HSD provides the following comments to this section of the report.

Generally, HSD agrees with this overall finding. Staff and contract resource limitations prevents HSD from doing many of the oversight functions it would like to do. The LFC report suggests that staff within MAD could be reassigned. In fact, HSD has shifted the duties of the staff where possible. As more recipients go into managed care, HSD has been adjusting staff responsibilities. For example, coinciding with the implementation of CoLTS, we have devoted more resources from the Benefits Bureau to overseeing dental and pharmacy services in those programs and are currently working on better ways to review and analyze MCO encounter data. We also are working on a plan to provide more assistance and enforcement for MCOs to accurately code provider types and specialties on their encounter data claims because that is currently the most significant weakness in their encounter data. This is particularly necessary because the MCO implementation of National Provider Identifiers (NPI) has created new issues in the MCO encounter data. This effort is led by the Benefits Bureau.

As Managed Care grows with CoLTS, we have been assigning more responsibilities to those familiar with FFS claims to now review encounter data accuracy, because that staff is the most familiar with claims data elements and can evaluate the correctness and consistency of Managed Care encounter claims.

It is important to note that the Benefits Bureau has to do much more than just develop benefits for a smaller and smaller population. In this Bureau there are three staff members who work predominantly on the fee-for-service (FFS) program and ½ FTE is devoted to the family planning waiver which is FFS. This work involves (1) assisting recipients and providers with processing fee-for-service claims when MCOs recoup payments from providers because of retro-disenrollment from Managed Care – usually because of retro Medicare enrollment; (2) assisting recipients and providers with issues during a transition to managed care such as the recipient was in the hospital at the time of managed care enrollment; (3) participation in fair hearings regarding program benefits even for MC recipients; and (4) assistance to the MCOs in understanding FFS reimbursement methodology and levels when MCOs seek to parallel FFS rates. Additionally, this Bureau leads the efforts to adjust rates, rate methodologies, regulations and service definitions that affect the entire Medicaid program, not just FFS.

The LFC report suggests that an evaluation of how effective Medicaid is at combating fraud and abuse needs to be performed. We agree, and in the past have contracted with outside entities to help improve our process. HSD is continually monitor the program as well as being monitored for fraud and abuse activities by outside entities. For example, CMS' Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the New Mexico Medicaid program in 2008. Objectives of the review included: determining compliance with Federal laws and regulations; identifying program vulnerabilities and effective practices; helping New Mexico improve its overall program integrity efforts; and considering opportunities for future technical assistance.

In addition, CMS' MIG, has contracted with Health Management Systems (HMS) as the Audit Medicaid Integrity Contractors (MIC) for New Mexico. The purpose of the Audit MIC is to audit claims for payment of items or services furnished, or administrative services rendered under a State Plan, and to identify overpayments to individuals or entities receiving federal Medicaid funds. HMS will be performing desk, field, comprehensive, and cost report audits of providers in NM beginning 2009.

The LFC staff made the following recommendations:

1. **Review and determine whether any of the required MCOs reports can be eliminated or streamlined, including combining of financial reports to account for all income and medical and administrative spending. HSD may also consider reducing other reporting requirements for MCOs in good standing for a particular aspect of program requirements.**

   HSD Response: HSD agrees to review all reports for the possibility of elimination where the costs associated with producing the reports exceed the oversight value gained by HSD from the reports. It is important to note that HSD does this currently on a regular basis.

2. **HSD Internal Audit Bureau should conduct a staffing and efficiency review of MAD to determine whether staffing levels, organization, and expertise need modification to effectively oversee a changed Medicaid delivery system that relies almost entirely on managed care. Submit a copy of the report with the results to LFC and DFA no later than September 1, 2009.**

   HSD Response: HSD will make every effort to identify resources with its internal audit bureau to proceed with this recommendation. On an annual basis, HSD does review its staffing needs and, if needed, submits a request for additional staff for Medicaid through the executive budget recommendation. The LFC has not recently funded this request.

3. **Eliminate EQRO activities where NCQA accreditation or standards can be used to meet federal requirements. Adjust HSD requirements as needed to reduce duplication of effort for these activities.**

   HSD Response: HSD agrees and in fact the current External Quality Review Organization (EQRO) contractor works to prevent duplication of the CMS-mandatory activity of validating performance measures if an MCO has NCQA accreditation. The results of the most recent MCO HEDIS® audit are incorporated in the performance measure report for HSD. MCOs that are not NCQA accredited do receive a HEDIS®-like audit to validate performance measures.

   The EQRO contractor conducts an extensive audit of MAD regulations that are not covered by NCQA. The contractor works collaboratively with the State regarding outcome measures, process improvement and targeting areas of concern located in an MCO.

4. **Validate financial data contained in medical spending reports submitted by MCOs that are used for developing rates. Ensure definitions for reporting expenses are well defined.**

   HSD Response: HSD agrees with this recommendation and currently uses available limited resources to review financial information. Unfortunately, recent cost containment measures caused reductions in contracts that were being used to develop templates for this type of activity. HSD will continue to move forward with this recommendation within the resources it has available.

5. **Validate encounter data, particularly facility and other services with high unit costs, submitted by MCOs.**

   HSD Response: HSD agrees and currently uses available limited resources to validate encounter data to the extent possible. HSD will continue to do so within the resources available.

6. **Require uniform reporting of income, including pharmacy rebates, third-party liability recoveries, collections from overpayments and all interest income. If necessary, HSD should implement a reporting definition for interest income for MCOs with multiple product lines to ensure sufficient allocation of interest income to the Medicaid program. Validate reported income.**

HSD Response: HSD agrees that uniform reporting is beneficial and will continue to develop uniform financial reporting within the resources that are currently available. Unfortunately, the Department has implemented cost containment initiatives including the decreasing of contracts and a hiring freeze that significantly impacts the ability to expand activities beyond those that are federally required.

EXHIBIT A

LOVELACE COMMUNITY HEALTH PLAN

	SFY 2006	SFY 2007	SFY 2008	Contract Total
PH Payments with Adjustments by DOS	$ 220,186,386.00	$ 259,595,566.00	$ 298,653,374.00	$ 778,435,326.00
SCI Payments by DOS	$ 994,210.00	$ 6,158,824.00	$ 20,641,555.00	$ 27,794,589.00
Total Revenue	**$ 221,180,596.00**	**$ 265,754,390.00**	**$ 319,294,929.00**	**$ 806,229,915.00**
Less PFI Revenue (Physical Health)	$ -	$ 8,172,533.00	$ 4,405,262.00	$ 12,577,795.00
Less PFI Revenue (SCI)	$ -	$ 250,533.00	$ 426,123.00	$ 676,656.00
Less NMMIP	$ 1,236,750.00	$ 2,200,233.00	$ 3,463,426.00	$ 6,900,409.00
Total PFI and NMMIP	**$ 1,236,750.00**	**$ 10,623,299.00**	**$ 8,294,811.00**	**$ 20,154,860.00**
Revenue less PFI & NMMIP	**$ 219,943,846.00**	**$ 255,131,091.00**	**$ 311,000,118.00**	**$ 786,075,055.00**
Physical Health Expenditures Report 30 (DOS)	$ 188,049,248.00	$ 219,639,855.00	$ 247,588,412.00	$ 655,277,515.00
Physical Health Expenditures Report 31 (DOS)	$ 1,665,176.00	$ 26,901.00	$ -	
Less Physical Health PFI Expenditures	$ -	$ (6,906,688.00)	$ (4,445,079.00)	$ (11,351,767.00)
SCI Expenditures Report 30 (DOS)	$ 2,134,612.00	$ 8,778,333.00	$ 20,224,213.00	$ 31,137,158.00
SCI Expenditures Report 31 (DOS)	$ -	$ 13,954.00	$ 425,566.00	$ 439,520.00
Less SCI PFI Expenditures	$ -	$ (215,395.00)	$ (155,978.00)	$ (371,373.00)
Total Medical Expenditures	**$ 191,849,036.00**	**$ 221,336,960.00**	**$ 263,637,134.00**	**$ 676,823,130.00**

Created by CAB/FIN on 12/04/2008

MOLINA HEALTH PLAN

	SFY 2006	SFY 2007	SFY 2008	Contract Total
Revenue				
PH Payments with Adjustments by DOS	$ 222,657,995.00	$ 242,335,568.00	$ 268,496,962.00	$ 733,490,525.00
SCI Payments by DOS	$ 569,346.00	$ 3,011,285.00	$ 14,600,015.00	$ 18,180,646.00
UNM SCI Payments by DOS	$ -	$ 6,503,579.00	$ 38,188,798.00	$ 44,692,377.00
Interest Earned on Cash Reserve Account	$ 199,267.00	$ 303,430.00	$ 307,633.00	$ 810,330.00
Total Revenue	**$ 223,426,608.00**	**$ 252,153,862.00**	**$ 321,593,408.00**	**$ 797,173,878.00**
Less PFI Revenue (Physical Health)	$ -	$ 5,995,477.00	$ 5,219,941.00	$ 11,215,418.00
Less PFI Revenue (SCI)	$ -	$ 111,955.00	$ 312,473.00	$ 424,428.00
Less NMMIP	$ 2,332,073.00	$ 2,374,019.00	$ 3,482,388.00	$ 8,188,480.00
Total PFI and NMMIP	**$ 2,332,073.00**	**$ 8,481,451.00**	**$ 9,014,802.00**	**$ 19,828,326.00**
Revenue less PFI & NMMIP	**$ 221,094,535.00**	**$ 243,672,411.00**	**$ 312,578,606.00**	**$ 777,345,552.00**
Medical Expenditures				
Physical Health Expenditures Report 30 (DOS)	$ 179,628,728.00	$ 194,794,896.00	$ 218,610,947.00	$ 593,034,571.00
Less Physical Health PFI Expenditures	$ -	$ (5,881,470.00)	$ (3,829,798.00)	$ (9,711,268.00)
SCI Expenditures Report 30 (DOS)	$ 1,530,681.00	$ 3,626,283.00	$ 11,562,772.00	$ 16,719,736.00
SCI Expenditures Report 31 (DOS)	$ 60,464.00	$ 99,429.00	$ 284,400.00	$ 444,293.00
Less SCI PFI Expenditures	$ -	$ (103,432.00)	$ (110,802.00)	$ (214,234.00)
UNM SCI Expenditures Report 30A (DOS)	$ -	$ 5,531,785.00	$ 32,832,039.00	$ 38,363,824.00
Total Medical Expenditures	**$ 181,219,873.00**	**$ 198,067,491.00**	**$ 259,349,558.00**	**$ 638,636,922.00**
Additional Medical Expenditures				
Air Ambulance pd via invoice (Salud)	$ 948,159.00	$ 819,531.00	$ 1,416,817.00	$ 3,184,507.00
Transportation Adjustment (SCI) [1]	$ -	$ 33,965.00	$ 26,476.00	$ 60,441.00
Incentives, Smoke Cess, Trad Med (Salud)	$ 17,686.00	$ 16,349.00	$ 2,033,427.00 [2]	$ 2,067,464.00
Incentives, Smoke Cess, Trad Med (SCI) [1]	$ -	$ -	$ 215.00	$ 215.00
Healthcare Recovery Fees [1]	$ 394,896.00	$ 472,173.00	$ 486,328.00	$ 1,353,397.00
Net Reinsurance [3]	$ 586,313.00	$ (74,470.00)	$ (772,791.00)	$ (260,948.00)
*IBNR (Salud)	$ 2,246,981.00	$ 2,189,800.00	$ 2,116,308.00	$ 6,553,089.00
IBNR (SCI)	$ -	$ -	$ -	$ -
Total Additional Medical Expenses	**$ 4,194,035.00**	**$ 3,457,348.00**	**$ 5,306,780.00**	**$ 12,958,163.00**
Adjusted Medical Expense	**$ 185,413,908.00**	**$ 201,524,839.00**	**$ 264,656,338.00**	**$ 651,595,085.00**

[1] Reported by Health Plan, still being discussed with MCO.
[2] Amount taken from #30 Reconciliation Worksheets
[3] Net Reinsurance (reinsurance premiums - reinsurance recoveries) Report #26A
* IBNR as reported by MCO

Created by CAB/FIN
Updated on 12/19/2008

PRESBYTERIAN HEALTH PLAN RECONCILIATION WITH HSD

	SFY 2006	SFY 2007	SFY 2008	Contract Total
Revenue				
PH Payments with Adjustments by DOS	$ 444,868,380.00	$ 506,481,974.00	$ 573,779,378.00	$ 1,525,129,732.00
SCI Payments by DOS	$ 982,479.00	$ 4,645,314.00	$ 24,651,096.00	$ 30,278,889.00
Total Revenue	**$ 445,850,859.00**	**$ 511,127,288.00**	**$ 598,430,474.00**	**$ 1,555,408,621.00**
Less PFI Revenue (Physical Health)	$ -	$ 13,259,175.00	$ 8,894,049.00	$ 22,153,224.00
Less PFI Revenue (SCI)	$ -	$ 188,621.00	$ 243,665.00	$ 432,286.00
Less NMMIP	$ 3,939,777.00	$ 5,987,853.00	$ 8,240,660.00	$ 18,168,290.00
Total PFI and NMMIP	**$ 3,939,777.00**	**$ 19,435,649.00**	**$ 17,378,374.00**	**$ 40,753,800.00**
Revenue less PFI & NMMIP	**$ 441,911,082.00**	**$ 491,691,639.00**	**$ 581,052,100.00**	**$ 1,514,654,821.00**
Medical Expenditures				
Physical Health Expenditures Report 30 (DOS)	$ 364,076,387.00	$ 406,951,492.00	$ 466,047,026.00	$ 1,237,074,905.00
Less Physical Health PFI Expenditures	$ -	$ (12,883,224.00)	$ (6,813,118.00)	$ (19,696,342.00)
SCI Expenditures Report 30 (DOS)	$ 2,292,474.00	$ 5,739,676.00	$ 21,243,624.00	$ 29,275,774.00
SCI Expenditures Report 31 (DOS)	$ 24,093.00	$ 91,168.00	$ 415,543.00	$ 530,804.00
Less SCI PFI Expenditures	$ -	$ (125,376.00)	$ (150,463.00)	$ (275,839.00)
Total Medical Expenditures	**$ 366,392,954.00**	**$ 399,773,736.00**	**$ 480,742,612.00**	**$ 1,246,909,302.00**
Additional Medical Expenditures				
Subrogation Revenue	$ (475,199.00)	$ (611,129.00)	$ (890,771.00)	$ (1,977,099.00)
Pharmacy Rebates	$ (1,616,769.00)	$ (2,073,147.00)	$ (1,431,358.00)	$ (5,121,274.00)
Meals and Travel for members	$ 438,894.00	$ 527,492.00	$ 625,124.00	$ 1,591,510.00
Net Reinsurance Expense	$ (914,359.00)	$ 2,138,141.00	$ 1,150,232.00	$ 2,374,014.00
* Reclass CM, Misc Exp, Panidigm, Adv Dev	$ 14,950,335.00	$ 16,495,981.00	$ 21,722,446.00	$ 53,168,762.00
Remaining IBNR	$ -	$ -	$ 5,238,503.00	$ 5,238,503.00
Total Additional Medical Expenses	**$ 12,382,902.00**	**$ 16,477,338.00**	**$ 26,414,176.00**	**$ 55,274,416.00**
Adjusted Medical Expense	**$ 378,775,856.00**	**$ 416,251,074.00**	**$ 507,156,788.00**	**$ 1,302,183,718.00**

* Disputed continue to discuss and review with PHP

Created by CAB/FIN
Updated on 12/05/2008

EXHIBIT B

LEIF ASSOCIATES, INC.

1515 Arapahoe Street
Tower 1, Suite 410
Denver, Colorado 80202
Phone 303.294.0994
Fax 303.294.0979
Email ejleif@leif.net

MEMORANDUM

Date:	November 17, 2008
To:	Finance Committee
RE:	Proposed 2010 Budget - Version 2
From:	Liz Leif, FSA

Highlights of Proposed 2010 Budget (v2):

Income:	No change in premiums from 2009, except some LIPP Members increase every 6 months CMS grants assumed to be quarterly payments of $240k Assessments total $91,755,000
Membership:	Membership growth is assumed to continue at 144 per month Year end membership assumed at 9,668 members, a growth rate of 21.8%
Claims Expense:	Medical and pharmacy trends assumed to be as follows: Medical trend of 15% for regular plans, 5% for Medicare plans, except all LIPP at -5% Rx trend of 3.6% for all plans, except Publicly Sponsored plans at 15% Disease Management assumed at $2.25 pmpm
Operating Expense:	BCBSNM admin of $40.50 pmpm LAE increases based on growth in BCBSNM admin fees 5% increase for actuarial and legal Contractor fees at $450,000 per year including expenses ($20k increase from 2009) 0% increase in total budget for advertising, outreach, meetings, board reimbursement 0% increase in pmpm for broker fees 0% increase in total budget for insurance, dues, line of credit Audit of $35,000 for year (+$5,000 from 2009) Miscellaneous at $0.05 pmpm (same as 2009) Printing & Office Supplies at $0.37 pmpm (same as 2009) Operating Expenses assumed at 4.9% of total revenue, or $52.88 pmpm
Policy Changes:	None

David Abbey, Director
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87501

Re: Opinion Request - Information Requests to Agencies

Dear Mr. Abbey:

You have requested our advice regarding the authority of the Legislative Finance Committee ("LFC") to request and obtain information from state agencies. In particular, you ask:

1. Should a LFC request to an agency for information under LFC's statutory authority to examine the costs and effectiveness of state government be treated the same as a request to inspect public records made by a member of the public under the Inspection of Public Records Act, NMSA 1978, §§ 14-2-1 to -12 (as amended through 2005) ("IPRA")?

2. Are there any procedures LFC might use to protect confidential information it requests from an agency?

As discussed below, based on the information available to us at this time and applicable law, we conclude that (1) LFC's information requests to agencies are not subject to the requirements and procedures that apply to requests to inspect public records under IPRA; and (2) no mechanism or process exists that generally allows LFC to protect confidential information provided by state agencies. As in any case involving the non-disclosure of information maintained by a public body, LFC's authority to protect that information will depend on the particular characteristics of the requested information and the law that allows the providing agency to keep the information confidential.

1. Applicability of IPRA to LFC Requests for Information

IPRA generally gives "[e]very person ... a right to inspect any public records of this state," with certain exceptions. NMSA 1978, § 14-2-1(A). Although it could, LFC does not have to rely on IPRA when it requests information from state agencies because it has independent statutory authority to make those requests.

Specifically, LFC is required by statute to "annually review budgets and appropriations requests, and the operation and management of selected state agencies, departments and institutions and ... make recommendations with respect thereto to the legislature." NMSA 1978, § 2-5-4(A) (1967). A state agency must furnish LFC with "a copy of its appropriation request made to the department of finance and administration," and "shall also furnish to the legislative finance committee and its staff any other supporting information or data deemed necessary to carry out the purposes of this section." Id. § 2-5-4(C).

Each state agency has a statutory duty to cooperate with LFC. An agency shall, "upon request, furnish and make available to the legislative finance committee such documents, material or information as may be requested by members of the committee or its director or staff which are not made confidential by law." Id. § 2-5-7 (1965). If necessary, LFC may obtain information it deems necessary by subpoena, which may be enforced in the appropriate district court. Id. § 2-5-5 (1957).

Although not subject to IPRA, LFC's authority to request information and documents from state agencies is not unqualified. As quoted above, Section 2-5-7 requires an agency to provide "such documents, material or information" requested by LFC "which are not made confidential by law." Consequently, an agency may deny LFC access to information if the agency can identify a law that makes the information confidential.

The term "law" as used in Section 2-5-7 is not defined. Under the rules of statutory construction, when the legislature fails to define a term in a statute, other statutory provisions addressing the same subject matter ("in pari materia") may be used to determine the legislative intent. See New Mexico Bd. of Veterinary Medicine v. Riegger, 2007-NMSC-044, ¶ 13, 164 P.3d 947, 952.

As noted above, IPRA creates a right to inspect public records, subject to certain exceptions. The last exception is "as otherwise provided by law." NMSA 1978, § 14-2-1(A)(12). Although the quoted phrase is used in a different context than that covered by Section 2-5-7, the statutory provisions are in pari materia. Both statutes deal with requests for agency records and neither requires disclosure if the records are protected "by law." Accordingly, it is appropriate to interpret the term "law" in Section 2-5-7 similarly to same term used in Section 14-2-1(A)(12) of IPRA.

This office has long interpreted the phrase "otherwise provided by law" in Section 14-2-1(A)(12) to refer to a federal or state statute or a court rule prohibiting or limiting the disclosure of agency records. See Attorney General's IPRA Compliance Guide, pp. 17-24 (5th ed. 2008). See also City of Las Cruces v. Public Employee Labor Relations Bd., 1996-NMSC-024, 917 P.2d 451, 453 (IPRA's "otherwise provided by law" exception incorporates statutes and agency rules that are "promulgated in accordance with the statutory mandate to carry out and effectuate the purpose of the applicable statute"). Similarly, we believe that an agency is not obligated to provide information to LFC under Section 2-5-7 if the information is "made confidential by law," i.e., by statute or court rule.[1]

2. Protection for Confidential Information Obtained by LFC

As discussed above, NMSA 1978, Section 2-5-7 allows agencies to deny LFC access to requested records and information that are made confidential by law. If an agency nevertheless chose to provide LFC with confidential information, LFC might not be able to keep the information confidential if a person made an IPRA request to inspect records containing the information.

Once in LFC's possession, information and data provided by agencies are "public records" under IPRA. See NMSA 1978, § 14-2-6(E) ("public records" include documents and other materials "that are used, created, received, maintained or held by ... a public body and relate to public

business...”). LFC, like all agencies subject to IPRA, must make its records available for inspection upon request, unless an exception applies. An exception that allowed an agency to deny public inspection of a record in its custody could apply once the agency transferred the record to LFC. However, this is not necessarily always the case. Compare NMSA 1978, § 14-6-1 (1977) (health information pertaining to specific patients in the records of any governmental agency is “strictly confidential”) with Rules 11-503 & 11-511 NMRA (client waives privilege for lawyer-client communications if the client voluntarily discloses the communication to a third party). Thus, absent a statutory amendment,[2] LFC cannot guarantee protection for confidential information it obtains from other agencies.

If we may be of further assistance, please let us know. Your request to us was for a formal Attorney General's Opinion on the matters discussed above. Such an opinion would be a public document available to the general public. Although we are providing you our legal advice in the form of a letter instead of an Attorney General's Opinion, we believe this letter is also a public document, not subject to the attorney-client privilege. Therefore, we may provide copies of this letter to the public.

Sincerely,

ELIZABETH A. GLENN
Assistant Attorney General

cc: Albert J. Lama, Chief Deputy Attorney General

[1] Under IPRA, an agency may deny inspection of public records if they are protected by a “countervailing public policy.” See State ex rel. Newsome v. Alarid, 90 N.M. 790, 797, 568 P.2d 1236 (1977). The “countervailing public policy” exception, also known as the “rule of reason,” is a judicially created, “non-statutory confidentiality exception.” Board of Comm’rs v. Las Cruces Sun-News, 2003-NMCA-102, ¶ 17, 76 P.3d 36, 43. See also Spadaro v. University of New Mexico Bd. of Regents, 107 N.M. 402, 404-405, 759 P.2d 189 (1988) (rule of reason applies “only to claims of confidentiality asserted for public records that do not fall into one of [IPRA’s] ... statutory exceptions to disclosure”). It applies when the harm to the public interest from allowing inspection outweighs the public’s right to know. See Newsome, 90 N.M. at 798. The countervailing policy exception is unique to requests for public records under IPRA. An agency could not rely solely on countervailing public policy to deny LFC access to information it requested in connection with its statutory duties. Unless information is “made confidential by law,” Section 2-5-7 requires an agency to make it available to LFC upon request.

[2] For example, Hawaii has a law providing that an agency statutorily authorized to receive government records from another agency “shall be subject to the same restrictions on disclosure of the records as the originating agency.” Haw. Rev. Stat. § 92F-19(b) (1994).

On the web:
http://www.nmag.gov/pdf/12-4-08-Information_Requests_to_Agencies.pdf

New Mexico Human Services Department

Bill Richardson, Governor
Pamela S. Hyde, J.D., Secretary

Office of the Secretary
PO Box 2348
Santa Fe, NM 87504-2348
Phone: (505) 827-7750; Fax: (505) 827-6286

December 31, 2008

Charles Salle
Program Evaluation Manager
New Mexico Legislative Finance Committee
325 Don Gaspar – Suite 101
Santa Fe, New Mexico 87501

Re: Response to LFC Request – Previously Denied Information

Dear Mr. Sallee:

I would first like to apologize for the delay in responding to your email request. I have been extremely busy as the year has come to a close. Concerning your renewed request, since we have already sent you the cost effectiveness section of the current Salud waiver, it does not appear that item 4 in your email is still an issue. As for item 5 in your email, as we have told you previously there are no internal audit reports responsive to your request and, as such, we cannot provide you with something we do not have.

As for items 1-3 in your email, those items are confidential and as the Attorney General's advisory opinion makes clear "an agency is not obligated to provide information to LFC …. If the information is 'made confidential by law'" and that if "an agency nevertheless choose to provide LFC with confidential information, LFC might not be able to keep the information confidential if a person made an IPRA request to inspect records containing information."

While we appreciate your promise to try to keep these records from disclosure should an IPRA request be made, your idea, in that respect, would be in and of itself a violation of IPRA. Basically, once we give it to you we have waived our confidentially arguments, even if you returned the documents to us and retain no copies. I would direct you to the portion of the advisory letter that reads, "absent a statutory amendment, LFC cannot guarantee protection for confidential information it obtains from other agencies."

Should you have any further questions, please do not hesitate to contact me.

Respectfully,

Paul R. Ritzma
General Counsel

cc: Pamela Hyde
Carolyn Ingram

Access • Quality • Accountability