



WHAT IS HAPPENING WITH MEDICAID PROVIDER REIMBURSEMENT CUTS?

Summary

In order to address the Medicaid shortfall for FY 2017, the HSD and lawmakers have several major options, each with associated possible risks and benefits. So far, the HSD has implemented cuts to MCO capitation rates and has proposed health care provider payment cuts. It is considering changes to the benefits and services offered under Medicaid as well as transfers to the Medical Assistance Division from other divisions within the HSD. Health care delivery and administrative efficiencies are already being implemented, though these efforts might be increased. Some health care providers and advocates urge that the Medicaid shortfall be offset in whole or in part by raising revenues — especially in the form of a health care provider tax such as other states have implemented that would achieve an increase in federal matching dollars if enacted in compliance with federal law and guidance. The option of health facilities making intergovernmental transfers (IGTs) to supplement Medicaid revenues to achieve more federal matching funds appears to be in peril, according to recent federal regulations.

Options that exist but that do not appear to be under discussion are a general tax increase or fee unrelated to Medicaid or health care; purging Medicaid rolls by making fewer New Mexicans eligible for Medicaid or by implementing administrative changes that make it more difficult to recertify; or enacting a new budget that reflects a reprioritization of funds in favor of the Medicaid program, either by reappropriating funds from other agencies and programs or by realizing any increase in state revenues that were unavailable when the budget passed during the 2016 regular session.

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Medicaid Budget

The legislature and governor passed a fiscal year (FY) 2017 budget in the 2016 regular session that allocated \$928.5 million in state funds for Medicaid. By July 2017, Medicaid is expected to experience a \$417 million funding shortfall.¹ This represents a \$20.8 million increase from FY 2016, but with increasing costs, this has resulted in what the HSD originally reported as an \$86 million deficiency for Medicaid.²

The state has only a few options for addressing a Medicaid shortfall. It can make cuts in spending, increase program efficiencies, raise revenues, move money from one agency or program to another or reduce the Medicaid rolls with changes in eligibility guidelines. This information bulletin addresses some of the factors and ideas that have been discussed about raising or transferring revenues and making cuts.

Spending Reductions

The HSD can reduce its spending by making cuts to the payments it makes, such as reimbursements to health care providers. These include payments to doctors, occupational therapists and psychotherapists; health facilities, such as hospitals, clinics and dialysis centers; and service providers, such as air and land medical transportation. The HSD has proposed to reduce provider payments³ in the following ways: canceling payment increases to 1,982 primary care doctors;⁴ cutting dentists' payments by \$3 million to \$4.5 million;⁵ cutting between three percent and eight percent of its normal payments to hospitals; and cutting what it would have paid to certain hospitals for providing care to individuals who cannot or do not pay for their care (uncompensated care).⁶

The state also has the option of making cuts in the amount Medicaid pays to managed care organizations' (MCOs') capitation rates, i.e., the payments Medicaid makes for each recipient per month to cover all benefits and services the MCO provides to enrolled Medicaid recipients as well as the MCO's administrative costs. In January 2016, the HSD made a net reduction of roughly 3.5 percent to the MCOs' per-member per-month payments and expects to reduce this monthly payment in July to reflect the cuts the HSD intends to make in health care provider payments.⁷

The HSD may also make cuts in administrative costs, which include everything from staff salaries to the amount spent on paper, information technology and travel expenses it uses to run the Medicaid program and all

of its other programs, such as cash assistance and child support enforcement programs.

Overall, the HSD has announced that these provider payment cuts, combined with a proposed intergovernmental transfer (IGT), could reduce the Medicaid shortfall from the originally projected \$86 million to roughly \$24 million.⁸

A subcommittee of the Medicaid Advisory Committee is also discussing the possibility of trimming the wide variety of services and benefits covered in the state's Medicaid program. While the federal government limits what can be cut,⁹ examples of services and benefits that the HSD has the option of cutting may be surprising: prescription drugs, adult dental care, hospice care, home- and community-based services for elderly and disabled individuals, outpatient clinic and surgical ambulatory center services, services in an intermediate care facility for developmentally disabled individuals and inpatient psychiatric care for individuals under the age of 21.¹⁰

The risk associated with cutting spending is the loss of federal reimbursement dollars. The state stands to forgo as much as \$127.5 million in federal matching funds for the payments to providers that the HSD proposes to cut.¹¹ Some argue that there is also a "multiplier effect", according to which \$1.00 in Medicaid spending generates much more economic effect and represents a much larger return on investment when spent and a much larger consequence when cut.¹² Others argue that Medicaid spending poses a serious threat to state and federal fiscal solvency and must be checked to preserve the viability of the economy.¹³ Some health professionals, health facilities and advocates raise concerns that health care professionals and health facilities will stop accepting Medicaid reimbursement or be forced to close their doors altogether or that New Mexico will be unable to attract new health professionals and health facilities to the state.¹⁴ The HSD projects that reductions in provider payments will not result in a reduction in recipient access to care.¹⁵

An option that has not been publicly discussed is to make changes to renewal requirements: shortened enrollment periods paired with automatic disenrollment by a certain deadline. Currently, most Medicaid recipients must recertify annually by filing an application and providing proof of continued eligibility such as proof of income.¹⁶ Shortening enrollment periods to less than a year may reduce Medicaid rolls as recipients' recertification

applications may show that they no longer qualify due to a change in circumstances or recipients may fail to timely file a renewal of their applications. A previous administration implemented sixth-month recertification requirements with automatic disenrollment during a Medicaid budget shortfall period¹⁷ and attributed \$2.3 million in savings to the practice.¹⁸ Critics of shorter enrollment periods say that dropping otherwise eligible Medicaid recipients raises the costs of uncompensated care in the state and imposes higher health care costs when re-enrolled recipients have deferred care and must be treated for more acute conditions. The administrative costs of processing applications on a more frequent basis also make this option unattractive.

Another option is to limit Medicaid eligibility. The extent to which this is feasible depends upon what sort of eligibility changes would be acceptable to the federal Centers for Medicare and Medicaid Services, which must approve any changes to eligibility. Secretary of Human Services Brent Earnest has stated that he does not want to explore this option at present.¹⁹ Arguments against reducing Medicaid eligibility include worsening health outcomes for ineligible applicants and the risk of increasing the cost and acuity of uncompensated care.

One of the central tenets of the Centennial Care waiver that has been implemented since January 1, 2016 is that Medicaid providers can increase efficiency and lower costs by delivering "the right amount of care at the right time".²⁰ Care is to be integrated and coordinated while Medicaid recipients are provided incentives to actively participate in their wellness and care.²¹ By achieving these goals, savings may be generated by avoiding high-cost, high-acuity care, such as emergency room visits and chronic disease management. One of the challenges for the Medicaid program at present is that New Mexico's Medicaid program, which provides health coverage to many who did not previously have coverage, is the high cost of pent-up demand.²² The following is an example of these costs: Ms. X is one of the many adults who was not previously eligible when Medicaid rules restricted coverage to those non-disabled adults who had children and nearly no income. Ms. X has a health condition for which she did not see a doctor due to a lack of health coverage. Ms. X then becomes eligible with the expansion of Medicaid eligibility. The care she receives now through Medicaid may be expensive because her condition likely worsened over time or because she has not established a relationship with a lower-cost primary care provider in lieu of costly emergency room care.

Raising Revenue

Some experts and advocates have proposed that the state solve its Medicaid budget shortfall by raising revenues in the form of fees or taxes, which could be raised on the general population or on certain sectors. Such a tax could be a gross receipts tax, income tax or property tax increase that all or most New Mexicans would pay. A tax or fee could also be on certain industries, services or sectors such as health care providers. The tax or fee would have to be imposed by enacting a law. The question remains whether the governor and the legislature would be in favor of any new taxes or fees.²³

There have been recent proposals to establish state taxes or fees upon health care practitioners or health facilities, whose payments would be offset indirectly by Medicaid reimbursement rates that are high enough to hold these fee-payers or taxpayers harmless. The federal government allows states to impose such provider taxes or fees so long as they follow certain guidelines.²⁴ In fact, every other state and the District of Columbia impose a provider tax to fund their Medicaid programs.²⁵ The National Conference of State Legislatures reports that these taxes generate billions of dollars in federal matching funds for states.²⁶

One form of provider tax is in place: New Mexico assesses a premium tax on MCOs and other insurers.²⁷ It has also implemented a health care provider tax in the past. In the mid-2000s, the state imposed an \$8.82 surcharge on nursing home daily fees²⁸ and used the proceeds to obtain more federal Medicaid matching funds.²⁹ However, the federal government fined New Mexico because, when the legislature enacted the surcharge, it also enacted an income tax credit for private-pay nursing home residents that essentially held these patients harmless for the nursing home surcharge.³⁰ In treating Medicaid patients differently from private-pay nursing home patients, the federal government found that New Mexico was violating federal guidelines for the imposition of such taxes and withheld payments to the state.³¹ The hold-harmless provision³² and the nursing home "bed tax"³³ have since been repealed.

If the legislature wishes to impose a tax or fee to raise federal matching funds, it may look at how other states have enacted provider taxes — on hospitals, clinics, nursing facilities or other providers — in order to craft it carefully to comply with federal law.

Some experts and advocates have proposed that the state

allow IGTs between the state and some health care providers deemed to be publicly owned, such as county hospitals or state-owned facilities. These IGTs would be used to build the state's federal Medicaid match. However, the federal government has issued new Medicaid rules that phase out such supplemental payments, which it calls "pass-through" payments, by 2027.³⁴

The HSD may exercise its option, under the 2017 budget bill, to make transfers from its various divisions — such as the Child Support Enforcement Division or the Income Support Division — to Medicaid,³⁵ and Secretary Earnest has indicated that the HSD intends to avail itself of this option.³⁶ He has also proposed that the University of New Mexico Health Sciences Center make a \$20 million IGT to the Medicaid program.³⁷

There is also the option for lawmakers to allocate to the Medicaid program any increase in revenues not previously projected when the 2017 budget was passed or to remove funds appropriated to another state agency or program and transfer those funds to the Medicaid program. However, lawmakers may only make these appropriations or funds transfers by passing a new budget into law³⁸ in a duly convened regular session,³⁹ a special session called by the governor⁴⁰ or an extraordinary session convened by a three-fifths' majority of legislators.⁴¹

¹ Dan Boyd, "NM Proposes Cuts to Medicaid Provider Rates", *Albuquerque Journal*, April 27, 2016 at A-1 and A-2.

² Legislative Finance Committee (LFC), "Medicaid Asks for \$86M Boost in State Funding", *LFC Newsletter*, Volume 16, Issue 04 (October 2015).

³ See above, Dan Boyd at FN15.

⁴ HSD, "Medical Assistance Program Manual Supplement" ("Supplement"), payment enhancement Number 16-01, April 29, 2016 at p. 5 (proposing to end the Primary Care Physician Enhanced Payment Program payment enhancement by \$5 million to \$6 million in state general funds, equaling approximately \$24 million to \$26 million when the federal match is included).

⁵ See above, Supplement at FN18 at p. 3 (\$600,000 to \$1 million in general funds, plus the federal match).

⁶ See above, Supplement at FN18 at pp. 5-6.

⁷ Kyler Nerison, HSD communications director, electronic mail, May 4, 2016.

⁸ Bruce Krasnow, "State to take \$30M slice from Medicaid program", *Santa Fe New Mexican*, May 9, 2016 at: http://www.santafenewmexican.com/news/local_news/state-to-take-m-slice-from-medicaid-program/article_of442b02-e6e6-5c4c-9c21-09d01097d43b.html (last visited May 10, 2016).

⁹42 C.F.R. §§ 440.210 and 440.215 (required services for the categorically and medically needy).

¹⁰42 C.F.R. § 440.225; see also CCH, "Health Care Compliance" (last updated January 18, 2016).

¹¹See above, Dan Boyd at FN 15 at A-2.

¹²See Kaiser Family Foundation, "The Role of Medicaid in State Economies and the ACA", available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/11/8522-the-role-of-medicaid-in-state-economies-looking-forward-to-the-aca.pdf> (last visited May 4, 2016) and New Mexico Center on Law and Poverty, "Five Reasons Why NM Should Fully Fund Medicaid", available at: <https://www.nmlegis.gov/handouts/LHHS%20111615%20Item%209%20Five%20Reasons%20Why%20NM%20Should%20Fully%20Fund%20Medicaid.pdf> (last visited May 4, 2016).

¹³Paul Gessing, Rio Grande Foundation, testimony before the Legislative Health and Human Services Committee, November 17, 2015, available at: <https://www.nmlegis.gov/handouts/LHHS%20111615%20Item%209%20Paul%20Gessing%20Testimony.pdf> (last visited May 4, 2016) (citing its study of United States Bureau of Labor Statistics data that showed no difference in economic growth between states that expanded Medicaid eligibility — where the "multiplier effect" would be expected — and those that did not expand Medicaid eligibility).

¹⁴See, e.g., the quotation of Presbyterian Health Care Plan's chief executive officer in Dan Boyd's article above, where he warns that his MCO may be unable to attract new physicians if physician Medicaid payment rates are cut. FN15 at A-2.

¹⁵See above, Supplement, FN18 at pp. 4-6.

¹⁶HSD, "Interim Policy & Procedure Memorandum", June 12, 2015, available at: <http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Procedures/ISD%20-%20IPPs/IPP%2015-10%20SNAP%20and%20Medicaid%20Changes%20and%20Recertifications.pdf> (last visited May 5, 2016).

¹⁷Leann Holt, "State Sued over Medicaid Rolls", *Albuquerque Journal*, April 15, 2005 at B-3 (referring to a \$60 million reduction in federal Medicaid matching funds).

¹⁸*Id.*

¹⁹See above, Dan Boyd, FN15 at A-2.

²⁰HSD, "Centennial Care Overview", <http://www.hsd.state.nm.us/LookingforAssistance/centennial-care-overview.aspx> (last visited May 5, 2016).

²¹HSD, "Centennial Care Demonstration Evaluation Design Plan", April 2, 2014 at 3.

²²See Felland L, Carrier E, and Gourevitch R, "Health Plans Prepare for Pent-Up Demand Under Medicaid Expansion", *Robert Wood Johnson Foundation Issue Brief*, November 2014, available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf417242 (last visited May 10, 2016).

²³See above, Dan Boyd, FN15 at A-2.

²⁴42 U.S.C. § 1396b(6)(w); 42 C.F.R. § 433.68.

²⁵National Conference of State Legislatures, "Health Provider and Industry State Taxes and Fees", February 1, 2016, available online at <http://www.ncsl.org/research/health/health-provider-and-industry-state-taxes-and-fees.aspx> (May 4, 2016).

²⁶*Id.*

²⁷Section 59A-6-2(A)(1) NMSA 1978.

²⁸Walter Rubel, "Bed Tax May Be Repealed", *Las Cruces Sun-News*, December 2, 2005 at 7-A.

²⁹New Mexico Laws 2004, Chapter 4 (Senate Bill 385).

³⁰New Mexico Laws 2004, Chapter 99 (Senate Public Affairs Committee Substitute for Senate Bill 436).

³¹Tamara N. Shope, "Federal Ruling Jars Medicaid Program", *The Albuquerque Tribune*, February 16, 2005 at B-7.

³²New Mexico Laws 2005, Chapter 91 (Senate Bill 534).

³³New Mexico Laws 2006, Chapter 24 (House Bill 365).

³⁴42 C.F.R. § 438.6(a)-(d).

³⁵House Appropriations and Finance Committee Substitute for House Bills 2 and 4, as amended (2016).

³⁶Electronic mail from HSD cabinet secretary, May 5, 2016.

³⁷See above, Bruce Krasnow at FN22.

³⁸See Constitution of New Mexico, Article 4, Section 15 ("No law may be passed except by bill. . .").

³⁹See Constitution of New Mexico, Article 4, Section 5.

⁴⁰See Constitution of New Mexico, Article 4, Section 6.

⁴¹*Id.*