F I S C A L I M P A C T R E P O R T

SPONSOR Foley **DATE TYPED** 3/7/05 **HB** 963

SHORT TITLE Consumer-Driven Medicaid Benefit Package **SB**

ANALYST Hanika-Ortiz

APPROPRIATION

Appropriation Contained		Estimated Additional Impact		Recurring or Non-Rec	Fund Affected
FY05	FY06	FY05	FY06		
			$15.4	Non-Recurring	General Fund
			$138.4	Non-Recurring	Federal
			$2,869.7	Recurring	General Fund
			$2,869.7	Recurring	Federal
			$187.5	Non-Recurring	General Fund
			$562.5	Non-Recurring	Federal

SOURCES OF INFORMATION
LFC Files

Responses Received From
Department of Heath (DOH)
Human Services Department/Medical Assistance Division (HSD)

SUMMARY

Synopsis of Bill

HB 963 enacts a new section of the Public Assistance Act to provide for a consumer-driven calendar-year-based Medicaid benefit program for persons entitled to Medicaid benefits pursuant to Title 19 (Medicaid) or Title 21 (State Children's Health Insurance Program) of the federal Social Security Act. The benefit amount will not exceed the average cost for a Medicaid beneficiary two years prior with adjustments for inflation, economic and geographic factors. The benefit amount will be prorated for those who become eligible after January 1.

Cost-sharing, using any combination of deductibles, co-payments, coinsurance or other methods will be included, not to exceed twenty percent of the benefit amount but may be lower based on a sliding schedule that takes household income into consideration. An electronically readable eli-

gibility card with the benefit amount will be issued to the beneficiary. Preventive care services will be exempt from cost sharing except for a nominal co-payment. The benefit package would be equal to the benefits mandated by federal law. Additional benefits may be provided if the Department can demonstrate that they will provide a cost-benefit to the state and that the program will remain actuarially sound.

Balances remaining on eligibility cards at the end of a calendar year will roll over to the next calendar year with the beneficiary not accumulating a balance greater than five times the benefit amount for the current calendar year and the card not containing a balance greater than two times the benefit amount for the current calendar year. The beneficiary will be able to access accumulated balance upon verification of eligibility and service. When the balance has been exhausted and the beneficiary has met the annual cost-sharing amount, they will continue to be enrolled in the Medicaid program in a "benefits-exhausted" status for the remainder of the year. They may be billed for services from a Medicaid-participating provider at the Medicaid rate. The Department may establish rules to provide for exceptions in cases of catastrophic illnesses or financial hardship.

HSD shall provide educational materials, workshops, customer service, online information and ongoing health care consumer training that provides information on health care services, cost-sharing requirements, benefit limitations, planning, preventive care financial implications and other health care considerations to ensure that Medicaid beneficiaries make the most appropriate use of health care services and financing.

Significant Issues

HSD has the following comments:

HB963 represents a totally new approach to the provision of health care to the state's poorest citizens and will create a distinctly different Medicaid program in New Mexico. Benefits for each individual will be "capped "each year. As Medicaid is an "entitlement" program (those eligible are entitled to receive medically necessary services), HSD/MAD remains doubtful that a waiver of this entitlement, particularly for mandatory Medicaid populations, will be granted.

All beneficiaries will be entitled to the same amount of benefits each year based upon the average costs. This does not take into account the varying needs of individuals. The healthiest will not use the allotted benefits. Those with serious chronic conditions will have insufficient benefits and once they exhausted their allotment their health care needs will likely go untreated. The economic level of this population makes it doubtful that they could pay the provider.

This bill imposes cost-sharing which could be as much as twenty percent of the benefit amount. Federal regulations require that cost sharing be nominal, that coinsurance not exceed five percent of the payment the agency makes for services, and that co-payments not exceed $3.00. These amounts can be waived, but allowing twenty percent is extremely doubtful. Nominal co-payments will be required for preventive care services. This may result in a barrier to accessing these services, resulting in poor health conditions which could have been prevented, had these services been accessed.

The New Mexico Medicaid program currently provides several optional services. HB963 will have the state's benefit package include only the mandated services, unless it could be shown that optional services were a cost-benefit. The benefit package would no longer include such things as the services of optometrists, psychologists, physical and occupational therapists, speech and language pathologists, and dentists, as well as excluding prescribed drugs, dentures, prosthetic devices and eyeglasses.

HB963 will exclude the home and community based waiver programs from this program, yet it is silent on individuals in institutional care. The waiver populations and institutional care populations are the same and must be treated equally. The waiver programs cannot exist without institutional care.

PERFORMANCE IMPLICATIONS

HSD/MAD notes that the General Services Department will essentially take over the administration of the program, including enrollment. Federal regulations require that eligibility be determined by the Single State Medicaid Agency, which is the Human Services Department. The Income Support Division of the Department conducts all of the eligibility determinations for Medicaid, except for Supplemental Security Income (SSI) recipients. The role of the Human Services Department will appear to be limited to education and training activities.

By October 1, 2005, HSD will be required to request a waiver from and submit a state Medicaid plan to the Centers for Medicare and Medicaid Services (CMS) in order to implement this program, provide policy and legislative recommendations to the interim Legislative Health and Human Services Committee, and provide its financing and budget findings and recommendations to the Legislative Finance Committee.

FISCAL IMPLICATIONS

HSD reports that with a capped benefit for each recipient the cost of the Medicaid program should decrease. As fewer people access services, and those services are capped, it may be expected that the costs will go down each year.

Omnicaid, the current Medicaid Management Information System that maintains and delivers Medicaid benefits, will need to be changed at an estimated cost of $750 thousand. $562.5 will be federal monies and $187.5 will be from the general fund.

HB 963 will require that an additional category of eligibility be added to the ISD2 system at HSD. HSD/ISD estimates $153.75 thousand is needed to program ISD2 (HSD's eligibility determination/benefits issuance system). Of these costs, $138,375 will be federal monies and $15,375 will be from the general fund.

There will be a need for significant coordination in terms of systems and administrative procedures between HSD and GSD. HSD/ISD estimates that additional staff of 112 FTE will be required. HSD/ISD estimates that it will cost $5,739,440 to fund these positions, of which $2,869,720 will be federal monies and $2,869,720 will be from the general fund.

ADMINISTRATIVE IMPLICATIONS

The General Services Department will provide administrative support through contracts with a third party administrator for enrollment, claims payment, customer service, provider networks, case or disease management and related activities.

TECHNICAL ISSUES

The bill gives responsibility for customer service to both GSD and HSD. The bill also states that a beneficiary cannot accumulate "a balance greater than five times the benefit amount for the current calendar year…", yet also states that the card cannot contain "a balance greater than two times the benefit amount for the current calendar year." The reason for this is unclear.

DOH notes that HB 963 exempts persons enrolled in Medicaid waiver services, but several other client groups have average costs that are inferentially far higher than the average cost for a Medicaid beneficiary. These groups include children with special health care needs eligible for the Family Infant Toddler (FIT) Program, children and adults with developmental disabilities, and children receiving services under Medicaid Early Periodic Screening Diagnosis & Treatment (EPSDT) Special Rehabilitation Services Program. The DOH recommends exempting these groups from the provisions of HB 963.

OTHER SUBSTANTIVE ISSUES

DOH has the following comments:

Children eligible under the FIT Program are defined under Medicaid as being "Children with Special Health Care Needs" which is defined as "Individuals under the age of 21, who have or are at an increased risk for chronic physical, developmental, behavioral or emotional conditions, and who also require health and related services of a type or amount beyond that required by most children". Children with special health care needs have an increased need for services and care coordination due to the chronic nature of their conditions. Currently, Medicaid SALUD contractors are required to identify children with special health care needs and provide an enhanced benefit package to meet and coordinate their needs. In addition to intensive medical and health care services, children with developmental delays and disabilities who are eligible for the FIT Program also receive Medicaid (EPSDT) special rehabilitation services. These services include speech, physical and occupational therapy; development instruction, counseling and case management.

The average annual per-capita cost of early intervention services, including service coordination and the initial developmental evaluation for children in the FIT Program is $8,340.00. These costs are in addition to other health and medical expenses they may have.

It may be inferred that Children and adults with diagnosed developmental disabilities, including mental retardation, autism spectrum disorders, cerebral palsy and epilepsy, who are not allocated to a Medicaid Waiver program, also have increased need for medical and health services that would be above the average cost for a Medicaid beneficiary. These may include durable medical equipment, such as wheelchairs, walkers, augmentative communication devices, feeding equipment, or diapers, specialist clinic care and transportation to specialty providers. Due to the

greater costs of serving the above groups, the DOH recommends that they be exempted from the provisions of the bill.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL?

A consumer-driven calendar-year-based benefit program for beneficiaries entitled to Medicaid benefits under Title 19 or Title 21 of the Federal Social Security Act will not be implemented.

POSSIBLE QUESTIONS

DOH recommends an amendment to Section 1(A)(7) page 3, line 6, after the word "patients" add "…children with special health care needs, children eligible for the Family Infant Toddler Program and children and adults with a developmental disability".

AHO/lg