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

SPONSOR Ortiz y Pino **ORIGINAL DATE** 02/03/11 **LAST UPDATED** **HB**

SHORT TITLE Medical Assistance Through Direct Contracts **SB** 206

ANALYST Earnest

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Non-Rec	Fund Affected
FY11	FY12	FY13		
	($75,200.0)	($75,200.0)	Recurring	General Fund

(Parenthesis ( ) Indicate Revenue Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY11	FY12	FY13	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Staff		$68,060.2	$68,060.2	$136,120.4	Recurring	General Fund and Federal Funds
Staff, Nonrecurring		$2,232.8		$2,232.8	Nonrecurring	General Fund and Federal Funds
IT		$943.8		$943.8	Nonrecurring	General Fund and Federal Funds
IT		$1,123.3	$1,123.3	$2,246.6	Recurring	General Fund and Federal Funds
IT Staff		$500.0	$500.0	$1,000.0	Recurring	General Fund and Federal Funds

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Department of Health (DOH)
Human Services Department (HSD)
Aging and Long Term Services Department (ALTSD)

SUMMARY

Synopsis of Bill

Senate Bill 206 requires the Human Services Department to contract directly with providers to deliver the medical coverage to recipients of Medicaid, the Children's Health Insurance Program (CHIP) and the State Coverage Insurance program (SCI). The bill prohibits HSD from contracting with managed care organizations (MCOs) for provision of health care services. The bill amends existing statute, created by the 2003 Medicaid reform law, to remove mention of Medicaid managed care.

FISCAL IMPLICATIONS

In FY10, HSD paid approximately $2.584 billion to the seven managed care organizations (MCOs) -- Blue Cross and Blue Shield, Presbyterian, Lovelace, Molina, OptumHealth NM, Amerigroup and Evercare -- to provide services to clients in the Medicaid, Children's Health Insurance Program (CHIP), and the State Coverage Insurance (SCI) programs. This cost includes both direct medical services and administrative expenses. For FY12, this ratio, commonly known as the medical loss ratio, will be 87 percent on direct services and 13 percent on administration (87/13). Assuming this ratio and spending level for FY12, the seven managed care organizations will spend $2.248 billion on direct services, premium taxes, and the NM Medical Insurance Pool (NMMIP) assessment and spend about $335.9 million for administration and profit.

HSD estimates that the bill could require the department to employ about 860 FTE, carrying a total cost of $68.1 million annually, of which about $27.4 million would be from the general fund. The significant increase in staff would be required because the bill, according to HSD,

> "Would transition approximately 400,000 Medicaid-eligible members back into the fee-for-service (FFS) program. This would require a significant increase in FTEs to provide administrative oversight and member support. Currently, the seven MCOs devote approximately 1,144 full time personnel to the Medicaid product line. If HSD were to employ only 75% of these FTEs, this would require the hiring and training of an additional 858 FTEs."

HSD also notes that the department has a contract with Molina to act as Medicaid's Third Party Assessor (TPA). "Molina TPA estimates that they would have to increase their FTEs significantly to accommodate the increase in FFS enrollment. Affiliated Computer Services (ACS), HSD current fiscal agent, estimates that their contract amount would triple if 400,000 additional Medicaid members were placed in FFS."

Medicaid MCOs also pay the premium tax (4.003%), and by eliminating managed care, this bill carries a significant impact on general fund revenue due to lost premium tax receipts. On the same $2.584 billion of spending, gross premium tax receipts, before credits, would be about $103.4 million. However, due to a premium tax credit for the NM Medical Insurance Pool assessment, these receipts would be reduced by about $28.2 million, resulting in a total premium tax collection of $75.2 million. The federal fund share of this premium tax payment will be about 70 percent, or $52.6 million.

HSD also reports that if New Mexico stops contracting with the MCOs, a greater share of the NMMIP assessment will be paid by commercial insurance plans and could result in higher insurance premiums.

According to HSD, it is difficult to estimate savings by eliminating MCO profits. "Currently, the MCOs' profit is contractually capped at 3% of revenue generated in the aggregate for the Medicaid programs. Excess profit margins shall be expended on service-related programs as designated by HSD/MAD. Many of the MCOs do not earn the 3% contractually allowed and the newer MCOs are experiencing losses. The MCOs also have a limit on administrative costs of 14% to 15% of revenue, depending on the different program."

SIGNIFICANT ISSUES

HSD provided the following comments:

> SB 206 eliminates contracting with managed care organizations for the delivery of the Medicaid benefit services. HSD/MAD has been contracting on a risk-based per member per month capitation basis with the Salud! managed care MCOs since 1997, the Single Statewide Entity (SE) for behavioral health services and the Salud! managed care MCOs for the State Coverage Insurance program since 2005 and the CoLTS MCOs since 2008. The MCOs have been responsible for the contracting, credentialing and recredentialing process for all of their providers. Many of their providers are not currently contracted with Medicaid FFS and the contracting process would be a lengthy one.
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> The Code of Federal Regulations (CFR) mandates specific activities and standards for MCOs that provide Medicaid services. These include, but are not limited to, extensive quality initiatives, care coordination for individuals with special health care needs, access to care standards and solvency requirements including reinsurance for catastrophic cases. HSD/MAD has been monitoring health outcomes since the implementation of the programs and seen an increase in many areas including, but not limited to, preventive care and immunizations. These federal mandates are not requirements for FFS Medicaid and have not been provided in the past. In addition, all of the MCOs have been providing value-added services, which are services that are not included in the capitation rate. Value-added services include, but are not limited to, financial assistance in setting up a household for members discharging from a Nursing Facility and the provision of the entire Medicaid benefit package to members who are only eligible for pregnancy-related services. In fiscal year 2010, the MCOs provided approximately $9,604.4 (dollars in thousands) in value-added services. FFS would not be providing these value-added services. The members being transitioned would likely lose access to many important services if this bill is implemented.
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> There has been no clear provision for the oversight of many of the provisions in SB 206. The MCOs are held responsible for providing access to a high quality of care/services for eligible members and this includes oversight of their contracted providers. SB 206 does not address access or provider oversight.
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> If this bill goes into effect on July 1, 2011, a comprehensive transition plan would need to be developed to ensure continuity of care. The MCOs could continue to provide services during a phased in transition to FFS. If this phase-in is by population and/or geographic

> area, it could take up to two years to adequately complete. The current Salud! and CoLTS contracts expire on July 1 and August 1, 2012 respectively. A request for proposal (RFP) will have to be issued in order to continue these programs after these dates. Enacting this bill would not incent our current MCOs to bid on a new RFP and this could result in a short and very difficult transition time for the Medicaid populations.

According to DOH, the removal of MCOs in the Medicaid system would require that the Department of Health work more closely with numerous health care professional organizations (such as the New Mexico Primary Care Association, Hospital Association, Medical Society, and other health care professional groups) to ensure that public health issues and concerns are adequately addressed to the use of community health promoters and assessment and referral needs.

ADMINISTRATIVE IMPLICATIONS

HSD also reports that the bill would require an extensive reorganization of current staff and a significant number of new FTE positions to handle the administrative requirements. The significant numbers of additional staff will require additional office space.

The additional following IT issues would arise from this bill:

> The IT systems required to meet the schedule of this bill may not be available in time to meet the stated deadline. Other information systems for fraud and abuse, utilization management, or other health delivery services are not addressed here. The time required to evaluate current market offerings, procure these systems, and implement would require substantial time and unknown costs.

HSD estimates the following additional administrative costs:

- Purchase of 858 computer workstations at a cost of $1,100 per staff for a total of $943,800 with replacements every four years thereafter.
- Telecom lines are approximately $810,000 per year. This does not include printers, network expansion costs, email accounts, basic software costs, or increased IT help desk costs to support these employees. Costs for the first three years would be estimated to be $3.37 million for these identified items.
- For IT Systems Support for additional staff, it is expected that HSD ITD would have to add eight systems staff and two help desk support staff. The estimated annual cost for these employees would be $500,000 per year based on estimated IT industry salaries.

BE/bym