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

SPONSOR Ortiz y Pino **ORIGINAL DATE** 01/28/17 **LAST UPDATED** **HB**

SHORT TITLE Remove Behavioral Health From Managed Care **SB** 83

ANALYST Boerner

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY17	FY18	FY19		
$0.0	($14,500.0)	($14,500.0)	Recurring	Premium Tax Revenue*

(Parenthesis ( ) Indicate Revenue Decreases)
* Of this amount, federal revenue is about $11.2 million

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)*

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Medicaid Program		$10,800.0	$10,800.0	$21,600.0	Recurring	GF/FF
Medicaid Administration		$4,205.0	$4,205.0	$8,410.0	Recurring	GF/FF
IT Related		$70.2	$25.2	$94.5	Recurring	GF/FF
TOTAL		$15,075.20	$15,030.20	$30,104.50	Recurring	GF/FF

(Parenthesis ( ) Indicate Expenditure Decreases)
*The federal funds match rate for FY18 is 71.16; therefore, for every $1 million dollars in total Medicaid funds expended, the state general fund will be impacted about $288.4 thousand.

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
Department of Health (DOH)

SUMMARY

Synopsis of Bill

Senate Bill 83 (SB 83) amends the Medicaid managed care section of the Public Assistance Act to mandate exclusion of behavioral health services from any services provided to Medicaid recipients through managed care. Behavioral health service is further defined in the act to include professional and ancillary services not only related to mental illness and substance use disorders, but also behavioral symptoms associated with developmental disability or trauma spectrum disorders.

The bill does not describe how behavioral health services would be provided for should this bill be enacted and exclude behavioral health services from services provided by HSD to Medicaid recipients through the managed care program. Presumably, behavioral health services would still be covered through Medicaid Fee for Service.

FISCAL IMPLICATIONS

HSD estimates as a result of this bill the state would forgo $14.5 million in premium tax revenue from carving out the behavioral health premiums from managed care, of that, federal revenue is nearly $11.2 million.

HSD notes also that the bill would have significant fiscal implications increasing costs to New Mexico's Medicaid program totaling $10.8 million per year. Additionally, the department would experience an increased administrative cost of $4.2 million.

Finally, DOH finds that if SB83 were enacted and NM Behavioral Health Institute (NMBHI) is not reimbursed for some inpatient psychiatric services, NMBHI could lose approximately $1.7 million annually and the NMBHI Community Based Services (CBS) outpatient program would lose an additional $1.2 million annually.

SIGNIFICANT ISSUES

HSD points out that the core of Centennial Care, New Mexico's Medicaid managed care program, is person-centered care with a robust care coordination program. New Mexico, as in states throughout the country, is working to further integrate primary and behavioral health (BH) services to address the needs of individuals with mental health and substance use conditions, whether they are seen in primary care or specialty behavioral health settings. Medicaid enrollees with behavioral health diagnoses often have an array of co-occurring physical health needs and if behavioral health services are carved out of managed care, the Medicaid Managed Care Organizations (MCOs) would only be treating the physical health conditions and would not be aware of BH needs. This creates a fragmented system of care without a single entity responsible for the individual's full spectrum of care and little to no coordination across providers.

Centennial Care facilitates an integrated approach with the goal of improving outcomes and reducing silos in the delivery system. Additionally, the MCOs have made significant progress working with the Federally Qualified Health Centers to deliver an integrated care model that treats the whole person. The integration of care has resulted in more efficient use of the delivery system resulting in lower per capita costs despite continued enrollment growth, with lower inpatient expenditures and higher utilization of physician services and behavioral health outpatient services.

On pages 42 and 43 of the Legislative Finance Committee's budget recommendation for the New Mexico Human Services Department for FY18, the LFC states, "For behavioral health, while limited access to care and prevalence of disease continue as major challenges for the state, there were promising indicators of improvement as 2016 came to a close. For example, New Mexico improved more than any other state in Mental Health America's *The State of Mental Health in America 2017* report, improving from 44th in the nation to 22nd. For access to care, New Mexico's ranking improved from 33rd to 23rd."

HSD notes also that exclusion of behavioral health services from New Mexico's Centennial Care program would result in the following significant issues:

- The loss of Premium Tax revenue, increased programmatic costs, increased administrative costs, and lower federal matching rates for required functions.
- Elimination of care coordination for Medicaid members experiencing chronic health conditions that include mental illness or addictions.
- Elimination of an integrated model of care for Medicaid members with physical and behavioral health conditions.
- The MCOs would lose flexibility in negotiating rates with healthcare providers. The Medicaid fee-for-service (FFS) rates set the floor for reimbursement to providers and in some instances the MCOs have the ability to negotiate higher reimbursement rates depending on network and access issues. Many behavioral health providers would be reimbursed at lower rates, in accordance with the Medicaid FFS rate schedule.
- This bill would require amendment of the current 1115 Medicaid Demonstration Waiver which will create an opportunity for the Centers for Medicare and Medicaid Services (CMS) to alter any portion of the current waiver. CMS must approve the proposed changes outlined in SB83.
- The bill would also require the amendment of the New Mexico State Plan to eliminate MCOs participation and oversight of Health Homes. CMS must approve this proposed change as well.
- This bill would require amendment of the New Mexico Administrative Code to eliminate behavioral health services from the Medicaid managed care rule.
- Finally, the Institution for Mental Disease (IMD) services would no longer be available to Medicaid members and other service provisions would need to be made for members requiring this service. CMS only allows IMD services under a managed care model.

Eliminating the behavioral health component of managed care may also have a negative impact on the BH provider network as the MCOs have more latitude to negotiate rates and build provider networks as part of their contractual requirements. MCOs have ability to pay incentive payments to providers when achieving quality metrics such as reduction of readmission rates for psychiatric inpatient stays.

Approximately 258,000 members of the Medicaid adult expansion population would no longer be able to secure specialty behavioral health treatment should they have mental health, trauma and substance use conditions. Behavioral health respite services, recovery support services and family support services are only provided to managed care members and would be lost to all individuals needing those new services.

The definition of behavioral health services proposed in SB83 mirrors the definition used in the Children's Code, Section 32A-64A-4B and includes behavioral symptoms associated with

developmental disabilities. There are a wide range of developmental disabilities that may be associated with symptoms than can be treated through a variety of educational and behavioral interventions. Those interventions or behavioral and educational therapies often differ from behavioral health therapies and clinical practices used to treat adults and children with serious emotional disturbances, mental illness, substance use disorders or trauma spectrum disorders. SB83 would require any services provided to address behavioral symptoms for a Medicaid eligible recipient with developmental disabilities to be provided outside managed care. This would be considered an expansion of Medicaid benefits and result in higher program costs.

The MCOs are contractually bound to promote integrated and comprehensive care through detailed care coordination requirements, quality standards, performance reporting and monitoring. Promising approaches to integration and collaboration led New Mexico to adopt Patient-Centered Medical Homes (PCMH), to initiate CarelinkNM (CLNM) health homes and to prepare for Certified Behavioral Health Clinics. The PCMH and CLNM efforts share aims to improve health outcomes and to reduce higher levels of care that take individuals away from their communities and jobs and families. All have whole person orientations with care plans developed in partnership by the patient, family, and the array of health providers with whom an individual may consult. In PCMHs and CLNM health homes intensive care management is provided at the point of service to help recipients manage their health and their use of the healthcare system. All also offer more flexible funding possibilities for providers, incentivizing quality outcomes rather than simply payment of a fee for a set time unit of service.

Finally DOH explains that DOH patients and clients who are Medicaid recipients would be impacted by this bill. Since the inception of the behavioral health collaborative until now, MCOs have covered some days for NMBHI clients to receive inpatient mental health treatment as a more cost-effective alternative than their members being in an acute setting; however, this is not part of their value-added service mix.

PERFORMANCE IMPLICATIONS

Removing behavioral health services from the managed care program would also remove HSD's existing tools for ensuring that providers throughout the state are held accountable for quality health outcomes including disease management programs for members with targeted behavioral health chronic conditions. Quality improvement targets, health outcome measures, value based payment initiatives and contractual sanctions are components of the managed care agreements.

ADMINISTRATIVE IMPLICATIONS

The 1115 Demonstration Waiver requires, as part of its terms and conditions, that the State not implement changes to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, budget neutrality or other program elements without prior CMS approval. Many of the administrative implications would require approval from the federal government before becoming operational.

Implementing SB83 would require 30 additional staff for HSD to administer the Medicaid FFS behavioral health program to include program management, policy development, rule promulgation, provider network development, provider relations, customer service, quality assurance and data support management. Substantial revisions to the current reporting and system requirements for MCOs, new report development for the FFS program, additional

contractor costs and new actuarial work to recalculate MCO rates. The estimated total additional cost of the 30 additional staff is $2.5 million. Currently, these staff are matched at an effective blended match rate of 80%. Their costs as state employees would drop below that percentage as some of their costs would be matched at 75 percent and some as low as 50 percent.

HSD contracts with a Third-Party Assessor (TPA) to conduct prior authorization reviews for behavioral health services for Medicaid FFS recipients, primarily Native Americans. HSD will be required to amend the TPA contract to include additional prior authorization reviews for the additional FFS members. An expansion to the TPA's scope of work will require an increase to the number of qualified staff needed to conduct medical necessity behavioral health reviews and fair hearings. The estimated total additional TPA costs for the additional prior authorization reviews for BH services is $1.04 million. Currently, these functions are matched at an effective blended match rate of 80percent. Their costs would drop below that percentage as their costs would be matched at 75percent.

HSD contracts with a Fiscal Agent, Conduent, to administer FFS provider enrollment and training, FFS claims payment and processing. SB83 would shift additional responsibilities from the MCOs to the Fiscal Agent that will require an additional 4 full time employees (FTE) at Conduent. Total cost of the four additional employees will be $665,000. Currently, these functions are matched at an effective blended match rate of 80%. Their costs as a contractor would drop below that percentage as some of their costs would be matched at 75% and some as low as 50%.

The IT impact is listed above as it pertains to the outsourced IT services. The internal costs for 30 additional staff would require provisioning of desktop, laptop, phone, email, and other IT related assets to adjust capacity (network related). The initial cost of desktop (equipment and possible network adjustments for 30 staff) can be rounded to about $1,500 each ($45,000). The ongoing costs (estimate from DoIT) for phone ($60) and email ($10) would total $2,100 per month ongoing, or $25,200 per year. First year is $70,200 and $25,200 annual thereafter.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

New Mexico would continue its efforts to integrate whole person care and to develop flexible payment mechanisms for care coordination by provider agencies. People in the expansion population would continue to receive both physical and behavioral healthcare. Individuals and families needing respite, recovery and family support services would continue to be eligible to receive them.

CB/sb/jle