Report
to
The LEGISLATIVE FINANCE COMMITTEE

Various State Agencies
Opportunities to Leverage Federal Medicaid Funds
October 27, 2015

Report #15-10

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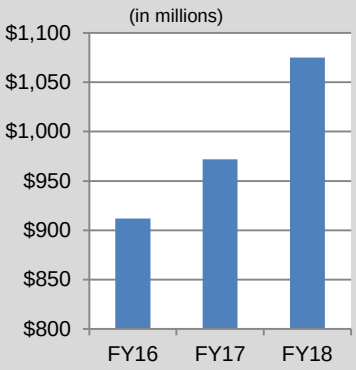
EXECUTIVE SUMMARY

Projected Medicaid General Fund Need FY16-FY18



Source: LFC Vol. III and May 2015 Medicaid Projection

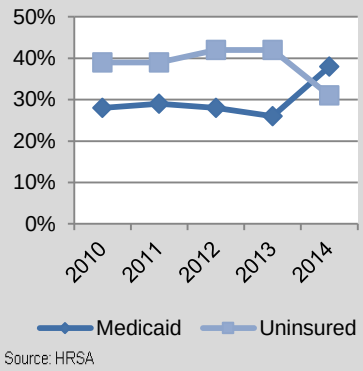
The passage of the Affordable Care Act (ACA) has resulted in significant changes in the healthcare landscape in New Mexico. About 20 percent of New Mexicans were uninsured in 2010, compared to less than 15 percent in 2014. The number of New Mexicans enrolled in Medicaid has increased from 539 thousand in FY13 to about 821 thousand at the end of FY15. The chief driver of this growth is the enrollment of childless adults with incomes up to 138 percent of the federal poverty level through Medicaid expansion. The federal government covers 100 percent of the costs of this population through CY16, but this percentage will decrease incrementally through CY21, requiring the state to assume a growing portion of these costs. The state share for the expansion population is expected to be $43 million in FY17 and will grow to an estimated $163 million in FY20.

As the state faces these increasing costs, it will be necessary to identify ways to leverage the ability to draw down federal Medicaid reimbursements to fund healthcare services that are currently supported by state or local funds. This evaluation analyzed 16 programs across seven state agencies for the potential to either replace state funds with Medicaid reimbursements or to enhance or reallocate revenues that could be used to draw down additional Medicaid funds. Further, this report proposes funding scenarios that take into account the potential for savings and revenue changes that could result from leveraging Medicaid in certain programs. Altogether, this evaluation identified potential savings or new revenue opportunities totaling between $82 million and $103 million.

The evaluation identified three main themes in more effectively leveraging Medicaid: increasing Medicaid billings for current services that are Medicaid eligible but receive state or local funds, expanding Medicaid eligible services for certain programs, and reallocating resources related to programs with diminished roles due to the ACA. Billing improvements could result in savings in the Department of Health's public health programs or offender healthcare services in the Corrections Department. Expanding Medicaid services to encompass early childhood home visiting could save state funding in the Children, Youth, and Families Department. The Human Services Department could adjust its support for Medicaid managed care administration to recognize scale efficiencies gained through expansion. Additionally, scaling back or closing the New Mexico Medical Insurance Pool could allow the state to recoup forgone revenue, and reallocating county funding for indigent health care could reduce the state's reliance on general fund spending for certain services.

The evaluation recommends the legislature consider statutory adjustments to eliminate service overlaps as a result of Medicaid expansion and the ACA and agencies continue to increase Medicaid enrollment, prioritize working with Medicaid-eligible service providers, and partner with HSD and MCOs to ensure healthcare services currently supported by the general fund are successfully transitioned to Medicaid as appropriate.

Percent of FQHC Patients Enrolled in Medicaid or Uninsured, New Mexico



Source: HRSA

NMCD requires providers of outpatient behavioral health services to probationers and parolees to bill Medicaid before using state funds.

KEY FINDINGS

The need for state general fund appropriations to support rural primary health care is decreasing. Medicaid payments to rural clinics and federally qualified health centers have increased substantially since FY13, reducing the need for state general fund appropriations to cover uninsured patients. Continuing improvement in Medicaid enrollment and billing at Rural and Primary Health Care Act (RPHCA)-funded clinics could further reduce the need for state support and save the general fund $4.6 million compared to budgeted FY16 spending. Alternatively, the state could use unspent county indigent funds to leverage Medicaid in support of RPHCA clinics.

Medicaid revenues for services offered by public health offices doubled between FY14 and FY15. Despite a downward trend in services delivered, the FY16 general fund operating budget for public health office services potentially billable to Medicaid is 6 percent higher than FY15 spending. Improved Medicaid billing for self-pay clients for certain public health services could reduce the need for state general fund spending by up to $3.5 million. The Department of Health (DOH) may also be able to realize savings from billing commercial insurance and through the leveraging of unspent county indigent funds.

School-based health centers that receive funding from DOH can bill Medicaid for services, but more data is needed to determine the need for general fund support. State support for school-based health centers (SBHCs) has increased by 12 percent since FY11. A previous LFC evaluation recommended DOH work to collect data on billings for services delivered by SBHCs in order to determine the need for ongoing state general fund appropriations.

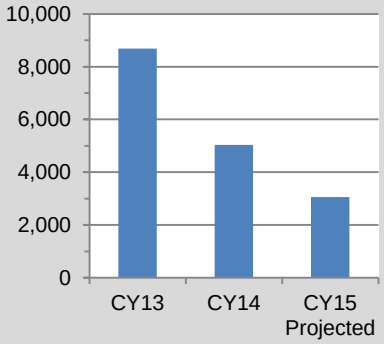
Tobacco settlement revenues could be freed up for other purposes by better leveraging Medicaid to support certain targeted public health programs at DOH. Billing Medicaid for tobacco cessation services currently supported by tobacco settlement funding may be able to save around $1.7 million. Certain Diabetes Prevention and Control Program services funded with tobacco settlement funds may also be eligible for Medicaid reimbursement.

General fund appropriations to the Trauma System Trust Authority do not pay for direct patient care services. Repurposing other earmarked health care funds could ensure statutory mandates for maintaining a trauma system can continue to be fulfilled. In addition to redirecting county-supported Medicaid funding from RPHCA to replace general fund appropriations, Medicaid MCOs could dedicate a portion of Medicaid funds to ensure the adequacy of the state's trauma network based on quality scale ratings to encourage improvement of centers rated below level 2.

The New Mexico Corrections Department (NMCD) can realize general fund savings by billing inpatient hospital stays to Medicaid when appropriate and increasing the use of Medicaid for services to probationers and parolees. NMCD reports initial savings of $579 thousand from Medicaid support for eligible inpatient hospital stays, but based on

The state could potentially save $4.6 million annually if the state fully expanded Medicaid coverage for home visiting services to eligible clients.

NMMIP Year-End Enrollment CY13-CY15



Source: NMMIP

national trends, using Medicaid for correctional inpatient admissions could save the general fund up to $5.1 million. Additionally, depending on enrollment and services, the state could save up to $5.3 million in general fund appropriations from billing Medicaid for outpatient services to probationers and parolees.

Early childhood home visiting funding has increased rapidly with FY16 funding based on higher costs per family served. Home visiting programs with a medical or clinical component, such as the Nurse Family Partnership and First Born, could be eligible for Medicaid reimbursement if their providers and staff meet certain qualifications. Other states provide examples of opportunities for using Medicaid to pay for early childhood home visiting services through a variety of means, including targeted case management, traditional Medicaid or managed care models, or different combinations of models. New Mexico may be able to pilot a managed care model for home visiting services.

Medicaid expansion is reducing the need for general funds to support non-Medicaid behavioral health initiatives. General fund savings realized through Medicaid expansion at the Behavioral Health Services Division of HSD should be reallocated to support the growing Medicaid program. As more behavioral health service clients are being served through Centennial Care, the need for a contracted behavioral health services administrator appears no longer necessary.

Reassessing funding of MCO Medicaid program overhead could save the state over $10 million. By reducing funds available for Medicaid administration and MCO profit by 1.5 percent, the state could save over $14 million in general fund revenues in FY17.

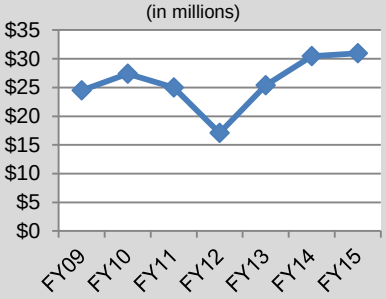
Enrollment in the New Mexico Medical Insurance Pool (NMMIP) is decreasing, as provisions of the Affordable Care Act have allowed enrollees to access previously unavailable coverage options. NMMIP was created to provide health insurance to those denied coverage elsewhere, rendering them uninsurable. However, the ACA eliminated the ability for a person to be denied insurance coverage. Furthermore, Medicaid expansion and the availability of insurance options through the health insurance exchange largely eliminate the need for a high-risk insurance pool such as NMMIP. Closing NMMIP would generate approximately $30 million in additional premium tax revenues annually, of which the majority would be available to help fund growing Medicaid obligations and other state budget priorities. Moreover, closing NMMIP would also save the state approximately $13.7 million in general fund appropriations paid to Centennial Care MCOs for NMMIP assessments.

Problem-solving courts in New Mexico present a prime opportunity to leverage Medicaid to expand this cost-effective, evidence-based model. A key component of the drug court model is treatment, which could be a Medicaid-eligible service, as long as providers are certified to bill for services and clients are eligible and enrolled. A survey of 30 problem-solving courts showed 74 percent of court participants were covered by

either Medicaid or another insurer in FY15. The survey went on to show 93 percent of treatment funding was directed to outpatient treatment. Freeing up funds distributed to these specialty courts by leveraging Medicaid would allow for expansion of a program demonstrated to be more cost-effective than incarceration with a strong evidence base for reducing recidivism.

The Local DWI Grant Program funds various county-level substance abuse treatment programs that could be funded through Medicaid. Between FY12 and FY15, counties expended $25 million through the LDWI program, funded through liquor excise tax revenues, for DWI treatment programs. The state could save approximately $2.5 million in liquor excise tax revenues annually by more effectively leveraging Medicaid for DWI treatment. In a 2014 LFC evaluation of the LDWI program, staff noted intensive outpatient treatment is a Medicaid-eligible service and counties should work with the Human Services Department (HSD) to ensure eligible participants are enrolled in Medicaid and treatment providers are able to bill Medicaid for this and other eligible substance abuse treatment services.

Statewide County Indigent Fund Balances FY09-FY15
(in millions)



Source: Unaudited Data from County Budgets

Increasing revenues from the County Indigent gross receipts tax increment could serve as a funding source for health care initiatives currently supported by the general fund. Indigent care expenditures continue to decline as a result of the Affordable Care Act, leaving growing fund balances at the county level. Based on LFC estimates, indigent care spending dropped 50 percent between FY13 and FY15, while indigent care revenues generated through the 2nd 1/8th GRT increment increased, and are anticipated to continue increasing. For FY15 alone, $31 million went unused in these statutorily earmarked funds. As the need to fund indigent care dissipates, county indigent funds could leverage Medicaid matching funds to replace over $30 million in general fund support for primary care and public health services.

New Mexico may be able to leverage local funding for Medicaid through increased use of certified public expenditures. The federal government allows local governmental units to certify expenditures for eligible Medicaid services to the state for the purposes of counting toward the state share of Medicaid. In New Mexico, Medicaid support from non-state public entities decreased by $18.5 million between FY13 and FY15. Other states have demonstrated savings from the use of CPEs at public hospitals to cover certain uncompensated costs and draw down federal DSH payments, which if adopted in New Mexico could reduce general fund expenditures currently used to provide the state match for these funds.

KEY RECOMMENDATIONS

The Legislature should consider:

- Amending the Indigent Hospital and County Health Care Act to require counties to contribute gross receipts tax revenue from the Health Care Assistance Fund (formerly the County Indigent Fund) as an intergovernmental transfer to leverage federal Medicaid matching funds for the purpose of funding uncompensated care at federally-qualified health centers and public health offices under the Department of Health.

- Amending section 27-10-3 NMSA 1978 to reallocate the current 9-percent set-aside for clinics under the Rural Primary Health Care Act (RPHCA) in the County-Supported Medicaid Fund to support the state share of Medicaid.

- Adjusting Centennial Care funding to the Medical Assistance Program in the General Appropriation Act to reflect a 1.5 percent reduction in funding of MCO administration and profit.

- Enacting statute to close the New Mexico Medical Insurance Pool by the end of calendar year 2017 and eliminate the NMMIP Assessment tax credit against premium taxes for health insurers licensed in New Mexico and require licensed health insurers in the state to offer Medicare supplemental coverage for recipients under the age of 65 as a condition of licensure with the Superintendent of Insurance; or

- Enacting statute to exempt MCOs from being required to pay NMMIP assessments on the Centennial Care program or sunset the NMMIP Assessment Tax Credit.

The Department of Health should:

- Continue to monitor the revenues of clinics receiving funding under RPHCA and require providers to justify the necessity of state funds for the coverage of uninsured clients.

- Work to maximize Medicaid billing for covered services provided to eligible individuals through public health offices and work with the current MCOs to allow for the private plans operated by the MCOs to reimburse for public health office services currently covered by Medicaid managed care.

- Continue efforts to collect and analyze school-based health center billing data and use it to assess the need for general fund support, and establish a plan for meeting reasonable payer mix levels as part of the budget cycle beginning September 1, 2016, as previously recommended by LFC.

- Work with HSD and Centennial Care MCOs to develop a methodology for billing Medicaid for eligible services provided to TUPAC clients, including cost allocation for being able to claim the 50 percent Medicaid administrative quitline match.

The Corrections Department should:

- Continue efforts to determine Medicaid eligibility of inmates requiring hospitalization, maximize Medicaid billing for these individuals, and collect data on Medicaid inmate hospitalization and costs so these factors can be taken into account in future healthcare contracts.

The Children, Youth and Families Department should:

- Work with HSD and the Centennial Care MCOs to create a pilot program for using Medicaid managed care to fund medically based home visiting services.

The Human Services Department should:

- Direct each Medicaid MCO to provide replacement funding to the Trauma Trust Fund to build and maintain network capacity.

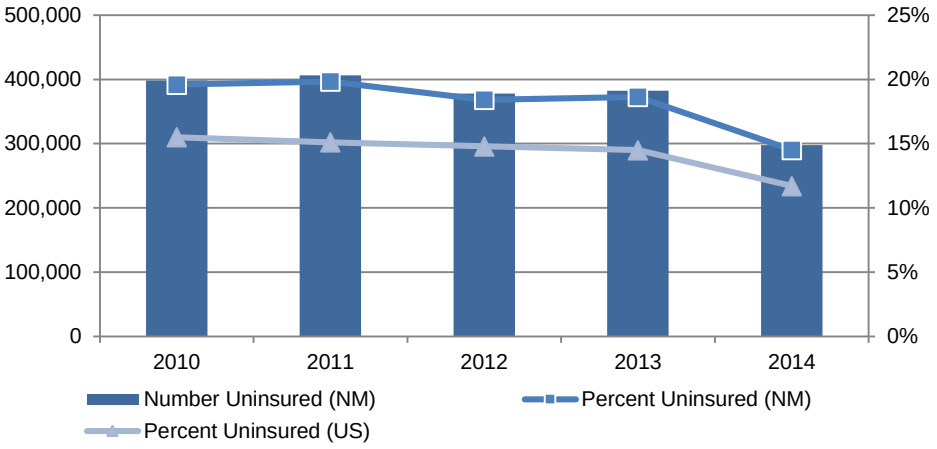
- Require MCOs to cover services related to home visiting in their Medicaid contracts, but consider requiring preauthorization to manage costs.

- Reallocate Medicaid expansion savings in the Behavioral Health Services Division to support the state share of Medicaid and bring management of non-Medicaid behavioral health funds into BHSD.

- Consider adopting a state plan amendment and cost protocol for using certified public expenditures from public hospitals toward the state share of Disproportionate Share Hospital payments.

Impact of the Affordable Care Act on the uninsured population. The number of uninsured New Mexicans has decreased by over 100 thousand individuals, or about 25 percent, since 2010. The uninsured made up close to 20 percent of the state's population in 2010, compared to under 15 percent in 2014, according to the latest figures from the U.S. Census Bureau's American Community Survey. Meanwhile, the percentage of Americans without health insurance dropped from just over 15 percent to about 12 percent during the same period. This puts New Mexico's 2014 uninsured rate roughly at the same level as the 2010 national rate.

Chart 1. New Mexico and U.S. Population Without Health Insurance 2010-2014



Source: American Community Survey

New Mexico was tied with Arkansas for having the sixth largest percentage point decline in uninsured population between 2011 and 2014, at 5.3 percentage points. In all, eight states saw declines of at least 5 percentage points in their uninsured populations. The overall change nationwide was a decrease of 3.4 percentage points.

Table 1. Percentage Point Change in Uninsured Population 2011-2014

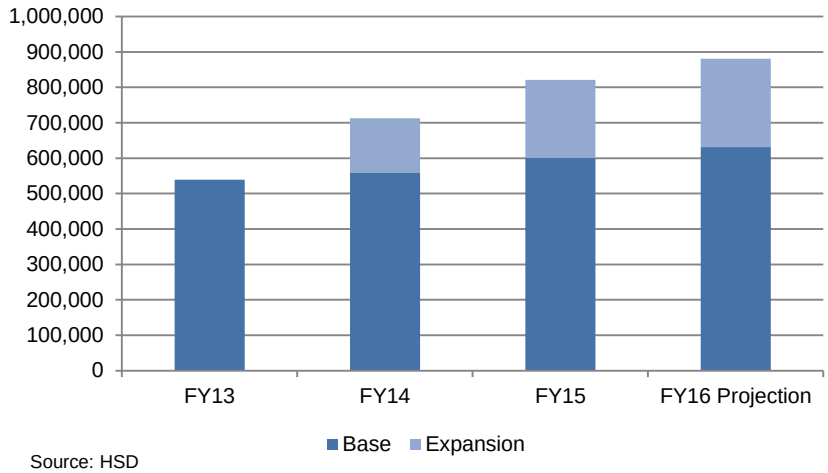
Nevada	-6.7
West Virginia	-6.3
Oregon	-6
Kentucky	-5.9
California	-5.7
Arkansas	-5.3
New Mexico	**-5.3**
Washington	-5
U.S.	**-3.4**

Source: LFC Analysis

With the previously uninsured able to access Medicaid and other coverage options, the need for many safety net funding programs will be greatly diminished, freeing up these funds to support the Medicaid program and other budget priorities.

Costs of Medicaid Expansion. Enrollment of eligible adults in the Medicaid expansion group is driving growth in the program, leading to an anticipated need for $43 million in additional state general fund spending in FY17. According to HSD's August 2015 Medicaid projections, the number of New Mexicans enrolled in Medicaid is expected to exceed 880 thousand by the end of FY16, mostly due to Medicaid expansion. Between the start of expansion enrollment during FY14 and the end of FY16, the base Medicaid population is projected to grow by 13 percent, while the expansion group is projected to increase by 61 percent. While the growth of the Medicaid expansion population is likely to slow after the initial burst of enrollment, overall enrollment is still expected to grow to about 915 thousand through FY17, according to the Human Services Department (HSD).

Chart 2. Year-End New Mexico Medicaid Enrollment, FY13-FY16

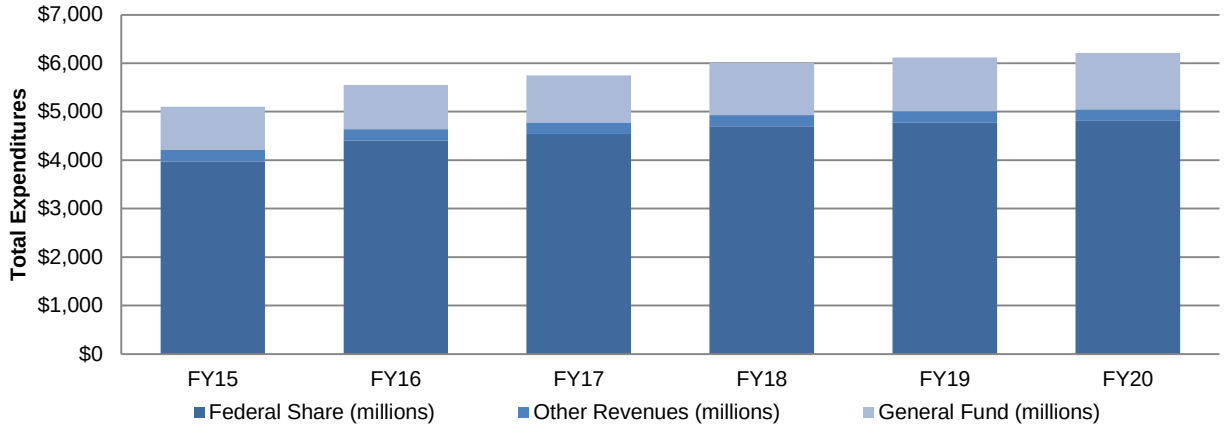


Source: HSD

On January 1, 2014, all adult residents of New Mexico with incomes up to 138 percent of the federal poverty level (FPL) became eligible for Medicaid under the Affordable Care Act. HSD projects enrollment in the expansion group will total about 249 thousand in FY16. Through FY16, the federal government will cover 100 percent of the cost of new enrollees. However, beginning in FY17, this percentage will begin to decline, reaching 90 percent by FY21. New Mexico does not have to pay a state share of Medicaid for newly eligible adults in FY16, but HSD projects the state share to begin at about $43 million in FY17. Earlier projections estimated the state share for this group would increase to $163.4 million by FY20, an increase of 280 percent.

Projected Medicaid expansion impact on general fund. LFC estimates a growing Medicaid budget through 2020 including an increased reliance on the general fund. This is due in part to continued increased enrollment and costs along with a phasing down of federal matching funds for the expansion group between 2017 and 2020 for Medicaid expansion. Because of this, New Mexico will be responsible for a growing percentage of costs for Medicaid expansion enrollees.

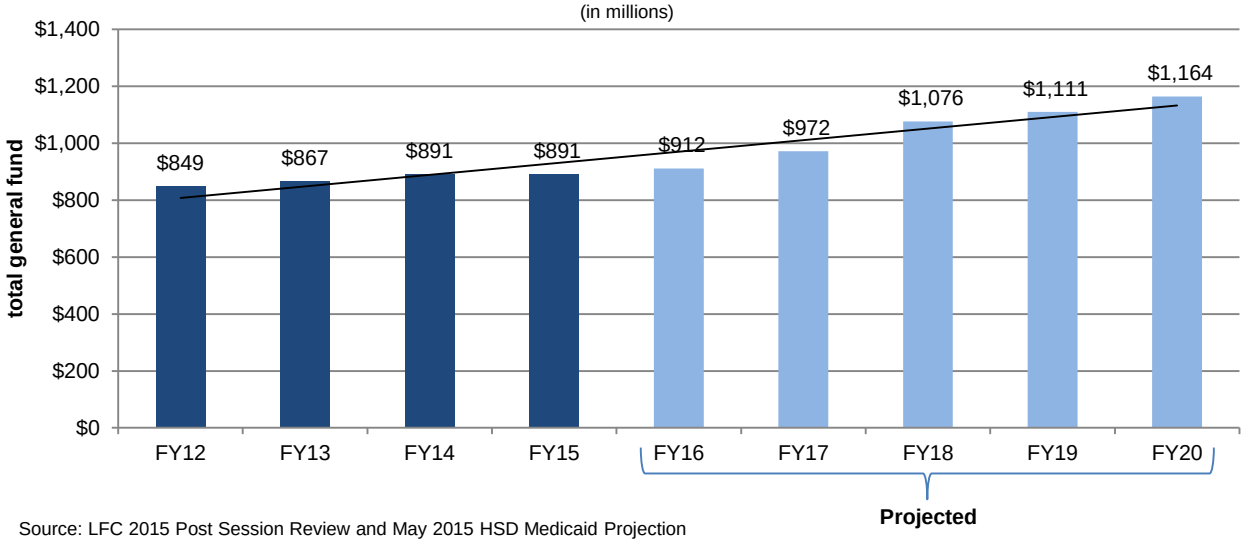
Chart 3. Projected Total Medicaid Expenditures
(in millions)



Note: Data adjusted to state fiscal years. ACA stipulates Medicaid expansion FMAP as 100 percent CY14-16, 95 percent for CY17, 94 percent for CY18, 93 percent for CY19, and 90 percent for CY20 and beyond.
Source: HSD May 2015 Projection

HSD provides quarterly Medicaid projections which include an analysis of projected expenditure impact from Medicaid expansion going forward into FY20. Based on the most recent long-range projection provided in May of 2015, general fund impact, driven in most part by New Mexico's Medicaid expansion, is expected to grow from FY15 to FY20 by $273 million. HSD notes that rates for expansion will likely decrease from CY2015 levels therefore $273 million might be over estimated.

Chart 4. Actual and Projected General Fund Impact From Medicaid FY12 to FY20
(in millions)

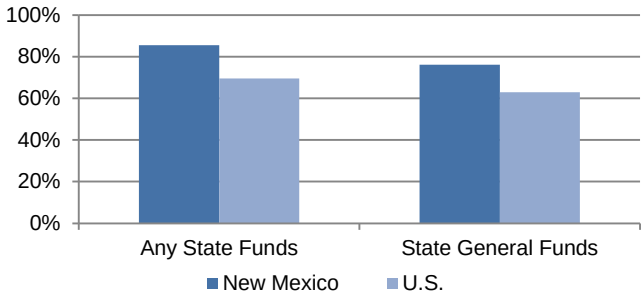


Source: LFC 2015 Post Session Review and May 2015 HSD Medicaid Projection
Note: FY12-FY14 are actuals, FY15 is operating budget

State share of Medicaid in New Mexico and other states. According to a 2014 report from the U.S. Government Accountability Office (GAO), New Mexico ranks well above the national average in the percentage of its nonfederal share of Medicaid that is made up of state funds, as opposed to local government or provider funds. In FY12, approximately 86 percent of New Mexico's nonfederal share consisted of state funds, including appropriations to the state general fund and other state funds, whereas the national average was about 70 percent. State general fund dollars totaled about 76 percent of New Mexico's state share, more than the national average of

63 percent. New Mexico was also only one of four states that do not use any funds from providers to support its Medicaid state share, the others being Alaska, Delaware, and Hawaii.

Chart 5. State Funds as a Percentage of the Nonfederal Share of Medicaid, New Mexico and U.S. FY12



Source: U.S. Government Accountability Office

Programs Reviewed in this Evaluation. Various programs within multiple state agencies, as well as programs managed by counties and the judiciary were reviewed for this evaluation to assess the impact of Medicaid expansion on program mission and funding:

Table 2. Programs Reviewed in This Evaluation

Agency/Entity	Program	Background
Department of Health	Rural Primary Health Care	The Rural Primary Health Care Act (RPHCA) was established in 1981 with the purpose to recruit and retain health care personnel and assist in the provision of primary care to better serve the health needs of the public. DOH supports FQHCs and RHCs via the general fund through what is known as RPHCA funding.
	Public Health	The purpose of the Public Health program is to provide a coordinated system of community-based public health services. There are four public health regions in the state and within these regions there are 54 public health offices providing an array of health care services including preventive care, family planning, cancer screening, and children's medical services. The Public Health program is funded through general fund, federal funds, other state funds (including tobacco settlement revenues), and Medicaid.
	School-Based Health Centers	The Office of Adolescent Health within the Public Health Division oversees 53 sponsored school-based health centers (SBHCs) across 26 counties. SBHCs can be sponsored by FQHCs, hospitals, and regional education cooperatives. SBHCs provided a variety of services ranging from primary care and immunizations to behavioral health and reproductive health.
	Tobacco Use Prevention and Control Program	The Tobacco Use Prevention and Control Program (TUPAC) follows guidelines from the Centers for Disease Control and Prevention (CDC) to address tobacco abuse and addiction in New Mexico. TUPAC offers community-based programs, cessation services, and public awareness and education. The program is funded through tobacco settlement revenues and federal funds.
	Diabetes Prevention and Control	The Diabetes Prevention and Control Program (DPCP) is funded through a combination of general fund, tobacco settlement revenues, and federal funds with the mission of preventing diabetes and diabetes-related complications and disability, and eliminating diabetes-related health disparities.
	Breast and Cervical Cancer Early Detection Program	The Breast and Cervical Cancer Early Detection Program (BCC) receives a combination of general fund, tobacco settlement revenues, federal funds, and private foundation funding to improve access to breast and cervical screening and diagnostic services to underserved women. The program also looks to increase public awareness through education.
	Trauma Trust Authority	The Trauma Trust Authority was established in 2006 with the purpose of sustaining existing trauma centers, support the development of new trauma centers, develop a statewide trauma system, and distribute the trauma system fund, which is funded through the general fund. The program is administered through DOH.
NM Corrections Department	Inmate Management and Control	NMCD contracts with Corizon Health to administer all health care services for incarcerated inmates in public and private state prisons in the amount of approximately $43.7 million for FY15.
	Community Offender Management	NMCD contracts directly with community providers for mental health and substance abuse services for those on probation and parole. This function had previously been handled by the Behavioral Health Collaborative through their contract with OptumHealth. All services are paid through the general fund.
Children, Youth, and Families Department	Home Visiting	CYFD uses a combination of general fund, TANF funding, and other federal grants to provide home visiting services. Different programs contracted through CYFD differ in scope and intensity. For example, some are restricted to first-time mothers, while other programs are focused on at-risk mothers. Services include health care, behavioral health, health education, counseling, and assistance with social services. Some programs, such as Nurse Family Partnership (NFP), follow evidence-based practices.

Source: LFC Files, New Mexico Statutes Annotated 1978

Table 2. Programs Reviewed in This Evaluation (Continued)

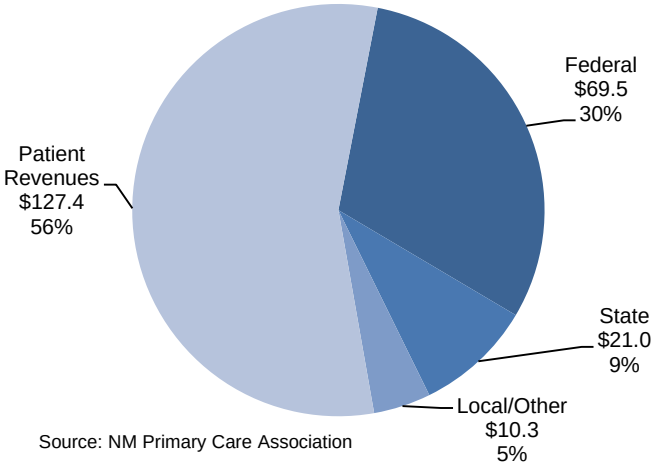
Agency/Entity	Program	Background
Human Services Department	Behavioral Health Services	The Behavioral Health Services Division of HSD (BHSD) oversees non-Medicaid behavioral health services and programs funded through federal grants and general fund revenues. The majority of programs are administered through a contract with OptumHealth.
Human Services Department	Centennial Care	The Centennial Care program is the state's Medicaid program operating under a five-year 1115 demonstration waiver, combining all managed care components of physical, behavioral and long-term health services, along with Medicaid expansion. HSD contracted with four managed care organizations to oversee the program: Presbyterian, Blue Cross Blue Shield, Molina Healthcare, and United Healthcare. Based on the current Medicaid FMAP, the state covers 30 percent of Medicaid expenses, while the federal government pays 70 percent (in the case of Medicaid expansion enrollees, the federal government will pay 100 percent until FY17, when the state will be responsible for 2.5 percent of expansion enrollee expense.)
New Mexico Medical Insurance Pool	N/A	The New Mexico Medical Insurance Pool (NMMIP) was created in 1987 with the purpose of providing access to health insurance coverage to all residents of New Mexico who are denied adequate health insurance and are considered uninsurable. Health Insurers licensed in the state are subject to an assessment which constitutes 80 percent of NMMIP's revenues, with the remaining 20 percent paid through enrollee premiums. Insurers can take a credit against their premium tax liability of up to 50 percent in some cases. Sixty percent of NMMIP enrollees are eligible for premium subsidies.
Administrative Office of the Courts	Problem-Solving Courts	New Mexico Problem-Solving Courts work with repeat offenders whose criminal activity is driven by underlying substance abuse or mental illness. As alternatives to incarceration, these programs focus on the successful rehabilitation of participants through early, continuous, and intense judicial oversight, treatment, mandatory periodic drug testing, and use of appropriate sanctions, incentives, and other community-based rehabilitation services. There are currently 52 problem-solving courts across 27 counties funded through general fund, liquor excise tax revenues, and federal funds.
County-Level Programs	LDWI Program	The Local DWI Grant program was established in 1993 to make grants to counties and municipalities to institute programs to prevent and reduce incidence of DWI, alcoholism, alcohol abuse, drug addiction, drug abuse, and domestic violence. Program funding comes from state liquor excise tax revenues. The LDWI Grant Council awards funds and the Local Government Division of DFA oversees the program. Grant recipient entities can fund a fixed amount of program functions including prevention, treatment, participant supervision, and evaluation.
	Indigent Care	The Indigent Hospital and County Health Care Act authorizes counties to pay for indigent healthcare claims by dedicating revenue from a second 1/8th increment of county gross receipt tax revenues (GRT). Thirty-one counties participate in this method of funding local indigent care. Counties may also choose to dedicate 50 percent of an optional 3rd 1/8th GRT increment to funding indigent care. Bernalillo County is a statutory exception, in that it contributes a flat $1 million per year to its indigent care fund.

Source: LFC Files, New Mexico Statutes Annotated 1978

DEPARTMENT OF HEALTH – RURAL PRIMARY HEALTH CARE

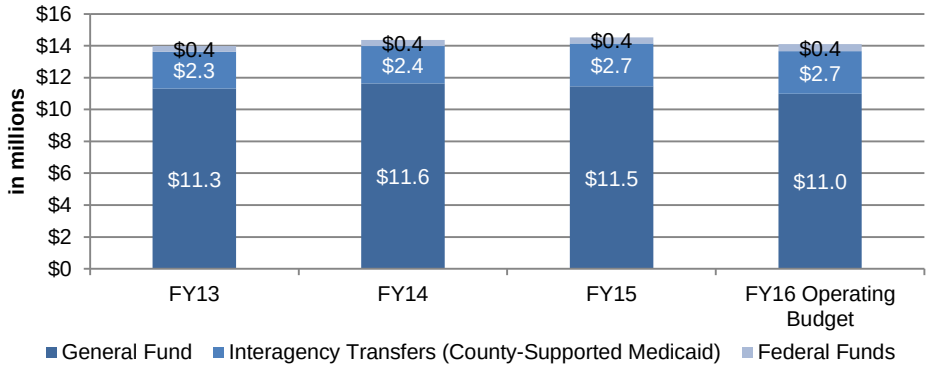
The need for state general fund appropriations to support rural primary health care is decreasing. The Department of Health (DOH) receives about $14.1 million, including about $11 million from the general fund, to distribute to 97 clinic sites statewide under the Rural Primary Health Care Act (RPHCA), including clinics operated by 16 federally qualified health centers (FQHCs). General fund spending for RPHCA peaked in FY14 at $11.6 million. The FY16 DOH operating budget sets general fund spending levels for RPHCA at just under $11 million, down slightly from FY15 expenditures, as Medicaid becomes an option for more of the eligible population. RPHCA also receives some federal funds and interagency transfers from the County-Supported Medicaid Fund (Chart 7).

Chart 6. FQHC Revenues by Source 2014



Source: NM Primary Care Association

Chart 7. DOH Contractual Services Spending for RPHCA Clinics FY14-FY16



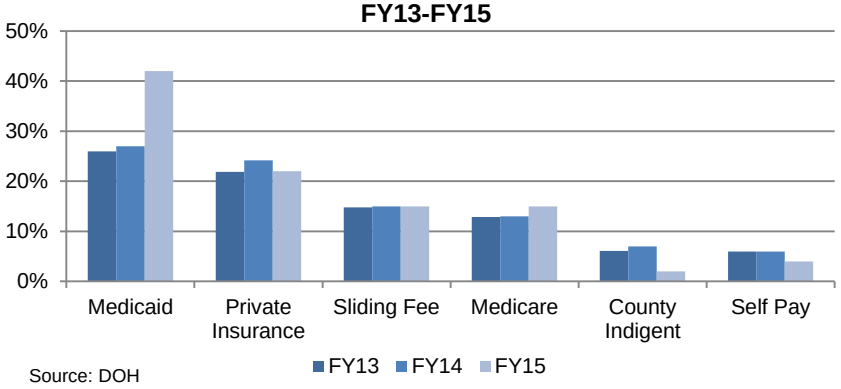
Source: DOH

Both program regulations and the contracts between DOH and RPHCA clinics require providers to adopt policies and procedures to ensure that no client is denied services due to an inability to pay, specifically for clients between 100 percent and 200 percent of the federal poverty level without access to a third party payer. Regulations and

contracts also require providers to maximize patient collections, including billing Medicaid and assisting with patient eligibility determinations and enrollment. However, contracts do not explicitly require providers to use state funds only for Medicaid-ineligible services or patients.

Medicaid is paying for substantially more patient visits at rural clinics and FQHCs. Under RPHCA, DOH contracts with rural clinics, FQHCs, and other qualifying clinics in underserved areas to provide funds for personnel and other costs associated with the provision of primary medical care to underserved populations. Medicaid payments comprised 26 percent of transactions for patient visits at RPHCA-funded clinics in FY13, but increased to 42 percent in FY15. At the same time, as illustrated in Chart 8, visits paid for from most other sources either declined or remained relatively flat. Both Medicaid and RPHCA support most allowable outpatient services provided by FQHCs, including physician, laboratory, preventive care, pharmacy, dental, and behavioral health services.

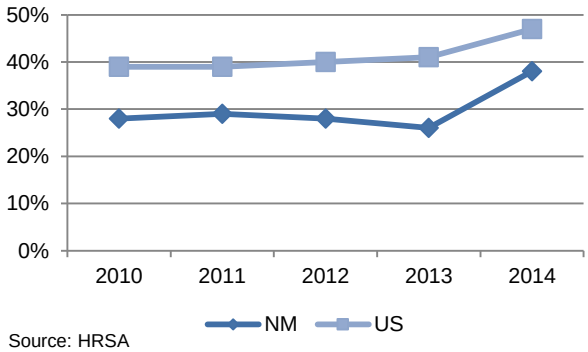
Chart 8. Payment Sources for RPHCA Clinic Visits FY13-FY15



Source: DOH

<u>New Mexico still lags the nation in Medicaid patients using FQHCs, but is closing the gap after expansion.</u> As shown in Chart 9, the gap between New Mexico and the rest of the country in the percentage of federally qualified health center (FQHC) patients who were enrolled in Medicaid narrowed from 2013 to 2014 with the implementation of Medicaid expansion. According to the federal Health Resources and Services Administration, New Mexico's percentage jumped from 26 percent to 38 percent, compared to an increase from 41 percent to 47 percent for the nation. Overall, about 111 thousand out of 257 thousand total FQHC patients in New Mexico were enrolled in Medicaid in 2014. Thirty-eight percent of New Mexico's population was enrolled in Medicaid in 2014, compared to about 20 percent of the nation's population.

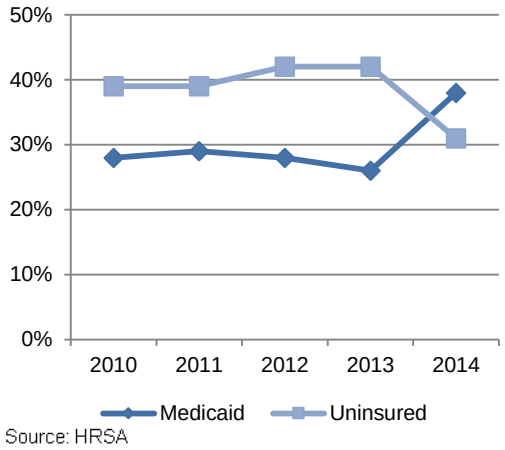
Chart 9. Percent of FQHC Patients Enrolled in Medicaid, 2010-2014



Source: HRSA

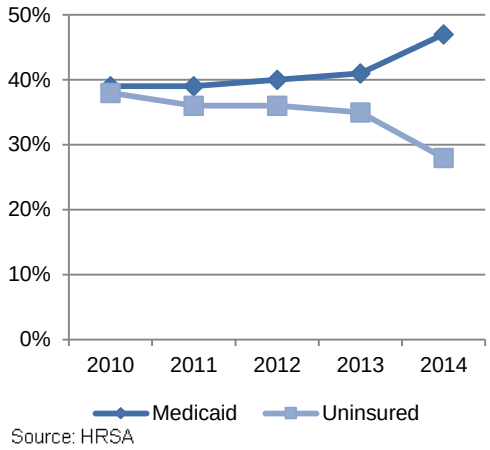
Additionally, while New Mexico had more Medicaid patients than uninsured patients using FQHCs for the first time in 2014, the state still has room to expand its use of Medicaid and reduce the number of uninsured patients at these facilities. Thirty-one percent of FQHC users in New Mexico, or about 90 thousand patients, were uninsured in 2014, compared to 28 percent nationwide. This is well above the roughly 15 percent of New Mexico's population, and 12 percent of the national population, that was uninsured in that year.

Chart 10. Percent of FQHC Patients Enrolled in Medicaid or Uninsured, New Mexico



Source: HRSA

Chart 11. Percent of FQHC Patients Enrolled in Medicaid or Uninsured, U.S.



Source: HRSA

Improving Medicaid enrollment and billing at RPHCA clinics could save the general fund up to $4.6 million compared to FY16 funding. RPHCA contracts require participating clinics to assess patients for Medicaid eligibility and conduct on-site eligibility and presumptive eligibility determinations "as appropriate." The general fund could save $4.6 million, which would be accounted for as federal Medicaid funds paid by HSD to clinics through increased Medicaid utilization. This estimate assumes 47 percent of potential clients who are eligible for but not currently enrolled in Medicaid, and presumes most of those not currently enrolled would be eligible for the expansion group, assuming an average of 90 percent federal financial participation (FFP) for new Medicaid billings for FY17.

Improving Medicaid billing would not eliminate uncompensated care at FQHCs. According to data from the New Mexico Primary Care Association, the state's FQHCs reported $99 million in uncompensated care in FY14, the most recent year for which data is available. The largest share of this amount, about 37 percent or $36 million, was attributable to uninsured or self-pay patients. These individuals include those for whom RPHCA funding is targeted. Total revenues from federal, state, and local grants exceeded uncompensated care costs at FQHCs by $1.8 million in FY14. RPHCA total spending of $14.4 million was the equivalent of just under 40 percent of the uncompensated care costs of the uninsured or self-pay patients at FQHCs in that year.

Undocumented farm workers represent about $1.2 million in costs that would not be Medicaid reimbursable. About 6 percent of FQHC clients, or about 17 thousand individuals, were classified as agricultural workers or dependents in FY14, according to the New Mexico Primary Care Association. The U.S. Department of Agriculture's Economic Research Service estimates that about 48 percent of migrant agricultural workers are undocumented immigrants. Extrapolating this data to apply to the FY15 RPHCA population results in an estimate of 9,700 such individuals served by RPHCA clinics in FY15 at an estimated cost to the general fund of about $1.2 million. As this population is not eligible to be covered by Medicaid, these costs would continue to be borne by the general fund. Data on undocumented non-farm labor is not readily available, making it plausible total impact of undocumented persons seeking care at FQHCs is higher than current estimates.

Given the potential for savings from leveraging Medicaid, continuing the set-aside of county-supported Medicaid funds for RPHCA may be unnecessary. State statute requires 9 percent of appropriations to the County-Supported Medicaid Fund to be allocated to DOH for use pursuant to the Rural and Primary Health Care Act (Section 27-10-3 NMSA 1978). In FY16, this amounts to roughly $2.7 million. However, the significant increase in Medicaid billings at RPHCA clinics and concurrent decrease in general fund appropriations demonstrate a diminishing need for funding to support care that would otherwise be uncompensated, calling into question the need to continue to set aside these funds.

Alternative savings could be achieved by legislation amending the county-supported Medicaid statute to no longer require 9 percent of those funds to be set aside for RPHCA. These funds could then be redirected to support the state Medicaid match.

The state could use unspent county indigent funds to leverage federal Medicaid dollars in support of RPHCA clinics. As discussed later in this report, as of the end of FY15, counties reported $31 million in unspent county indigent funds. The state could use these funds to draw down federal Medicaid dollars in support of RPHCA clinics and replace general fund appropriations. This could be accomplished by transferring approximately $4.3 million of these funds to the state to provide the nonfederal share.

Recommendations

Table 3. Recommended Scenarios for Replacing General Fund Appropriations with Medicaid

Program: RPHCA - Scenario 1	**Current (FY16)**	**Recommendation**	**Net Change**
General Fund (DOH)	$10,986	$6,339	**($4,647)**
Federal Funds from HSD	$0	$4,647	**$4,647**
* Estimate to cover eligible but currently uncovered RPHCA clients			
Program: RPHCA - Scenario 2	**Current (FY16)**	**Recommendation**	**Net Change**
General Fund (DOH)	$10,986	$0	**($10,986)**
County-Supported Medicaid	$2,687	$0	**($2,687)**
Intergovernmental Transfer from County Indigent Funds	$0	$4,350	**$4,350**
Federal Funds from HSD	$0	$10,150	**$10,150**

Source: LFC Analysis

The Legislature should consider:
Reallocating unspent county indigent funds to leverage federal Medicaid dollars for RPHCA clinics and

Amending Section 27-10-3 NMSA 1978 to reallocate the current nine-percent RPHCA set-aside in the County-Supported Medicaid Fund to the state Medicaid match.

DOH should:
Continue to monitor the revenues of RPHCA participating clinics and require providers to justify the necessity of state funds for the coverage of uninsured clients and

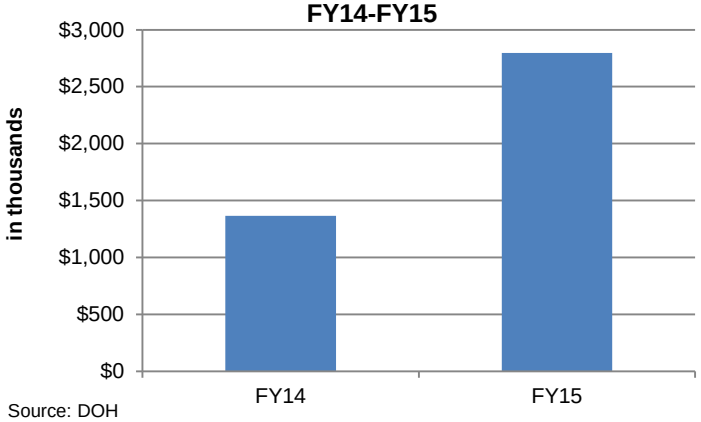
Consider strengthening the language in its contracts with RPHCA participating clinics to require that the state be a payer of last resort.

DEPARTMENT OF HEALTH – PUBLIC HEALTH OFFICES

Medicaid revenues for services offered by public health offices doubled between FY14 and FY15. DOH has 58 local and regional public health office locations statewide, divided into four regions, operated by the Public Health Division (PHD). These facilities provide a limited array of primary healthcare services, including preventive care, family planning, cancer screening, and children's medical services, among others. Not all services are offered at every location. Programs use a combination of state general funds, other state funds, federal funds, and Medicaid to deliver services. Medicaid revenues for PHD programs totaled about $1.4 million in FY14 and $2.8 million in FY15.

Programs that reported Medicaid revenues include breast and cervical cancer screenings, family planning, harm reduction, immunizations, refugee health, sexually transmitted disease (STD) intervention, tuberculosis prevention, and services provided in response to epidemiological concerns such as rabies and lice treatments. DOH could not attribute about $46 thousand in FY14 and $115 thousand in FY15 to a particular program. Appendix C includes a table breaking down these revenues by program.

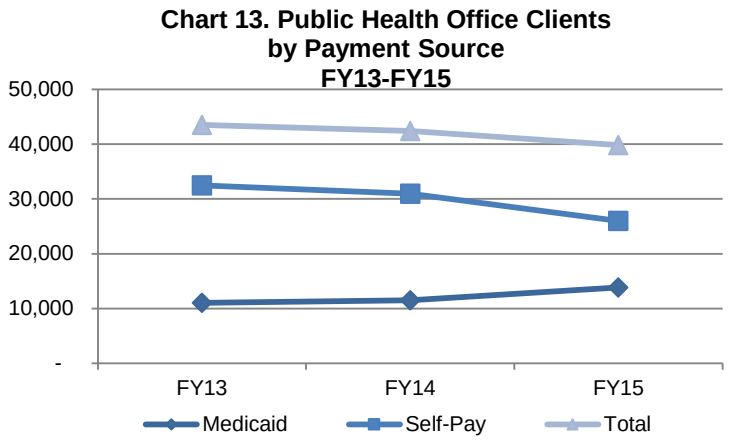
Chart 12. Public Health Division Medicaid Revenues FY14-FY15



Source: DOH

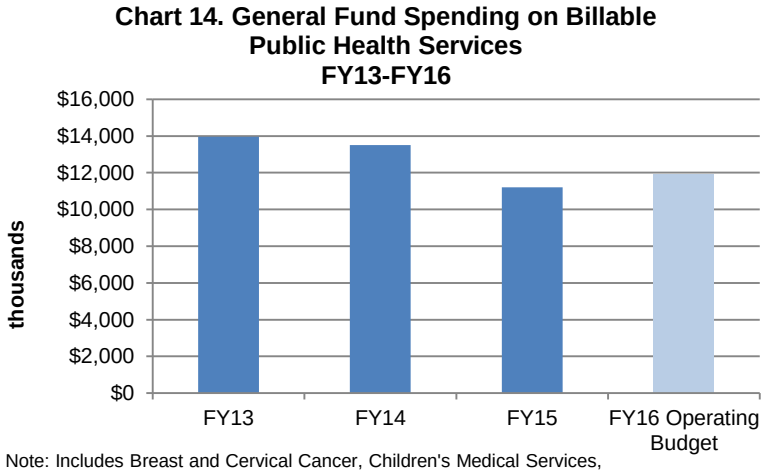
Medicaid utilization of potentially billable public health office services is growing, while self-pay clients are decreasing. DOH categorizes patients who visit public health offices for certain services as either Medicaid or self-pay clients[1]. The estimated number of self-pay clients for five PHD programs for which DOH was able to identify a client's payment source (family planning, sexually transmitted disease visits, tuberculosis visits, refugee health visits and breast and cervical cancer visits) decreased by 17 percent from FY13 to FY15, from over 32 thousand to about 26 thousand. Meanwhile, the number of Medicaid clients grew by 30 percent, from 11 thousand to almost 14 thousand (Chart 13). It is likely many clients previously in the self-pay group are eligible for Medicaid in the wake of Medicaid expansion and the implementation of Centennial Care. About 36 percent of these clients could be attributed to Medicaid in FY15. This compares to statewide enrollment of 39 percent in July of 2015, and a projected enrollment rate of 42 percent by the end of FY16.

[1] The self-pay group consists of uninsured and underinsured clients, those with private insurance, and those who pay according to the Department's sliding fee scale. However, DOH cannot currently break out the number of clients in the self-pay group who fall into any of these subcategories



Note: Includes family planning, STD intervention, tuberculosis prevention, refugee health, and breast snd cervical cancer screening clients
Source: LFC Analysis

Despite a downward trend in services delivered, the FY16 general fund operating budget for public health office services potentially billable to Medicaid is 6 percent higher than FY15 spending. State general fund spending for the billable public health services identified above decreased by 17 percent between FY14 and FY15, from $13.5 million to $11.2 million, corresponding to the implementation of the Affordable Care Act and Medicaid expansion. In FY16, the general fund operating budget totals $11.9 million, about 6 percent above FY15 spending levels. A portion of these funds will be required to match federal Title V Maternal and Child Health (MCH) block grant funding used by the Family Planning and Children's Medical Services programs, as well as the federal Breast and Cervical Cancer Early Detection grant. These matching funds made up between about 19 percent and 25 percent of general fund spending on these programs between FY13 and FY15.



Note: Includes Breast and Cervical Cancer, Children's Medical Services, Families First, Family Planning, Harm Reduction, Immunizations, Refugee Health, STD Intervention, and Tuberculosis programs
Source: LFC Analysis

DOH contracts with Medicaid MCOs for certain PHD services, including the Children's Medical Services, Family Planning, and Families First programs. These programs have their own provider codes enumerated in the contracts. All other services are only identified as being billed to PHD. DOH does not attribute public health office costs billed to Medicaid to specific offices, nor are reimbursements for these costs explicitly enumerated in PHD's budget.

Improved Medicaid billing for self-pay clients of certain public health services could reduce the need for state general fund appropriations by up to $3.5 million. The state could reduce general fund spending by roughly $3.5 million and account for those dollars through the federal share of Medicaid, assuming 42 percent of clients currently classified as self-pay enroll in Medicaid. This analysis also assumes that additional Medicaid billing would have the effect of reducing the need for the federal Title V and Breast and Cervical Cancer grants, thereby also reducing the amount of state matching funds spent on those programs. Under the latter program, eligible women screened and diagnosed are presumptively eligible for Medicaid for treatment.

DOH may also be able to realize savings from billing commercial insurance. DOH confirms public health offices still do not bill commercial insurance for services delivered to individuals enrolled in private plans. According to a 2012 LFC evaluation of public health offices, nearly all clients who visit the offices are placed at a zero-pay level. In response to that evaluation, DOH estimated about 10 percent of public health office clients had private insurance, a number which is likely to be higher now due to the ability to purchase plans from the New Mexico Health Insurance Exchange and other provisions of the Affordable Care Act.

Assuming that public health offices can bill as many as 15 percent of their self-pay clients for commercial insurance, DOH could save up to $1.5 million from the general fund. According to DOH, it is continuing to explore billing commercial insurance, but faces barriers in contracting with insurers as a provider. However, DOH contracts with the state's Centennial Care MCOs, which also offer private plans on the commercial market, the New Mexico Health Insurance Exchange, or both. DOH should work with HSD and the MCOs to explore the possibility of billing these insurers' commercial plans for services also covered through Centennial Care.

The state could use unspent county indigent funds to leverage federal Medicaid dollars in support of public health office services. As discussed later in this report, as of the end of FY15, counties reported $31 million in unspent county indigent funds. The state could use a portion of these funds to draw down federal Medicaid dollars in support of public health office services and replace general fund appropriations. This could be accomplished by transferring approximately $3.6 million of these funds to the state to provide the nonfederal share.

Recommendations

Table 4. Recommended Scenario for Replacing General Fund Appropriations with Medicaid

Program: Public Health Office Services - Scenario 1	Current (FY16)	Recommendation	Net Change
General Fund	$11,914	$8,411	**($3,503)**
Federal Funds*	$0	$3,503	**$3,503**
* Medicaid federal share for estimated eligible but currently uncovered PHD clients			
Program: Public Health Office Services - Scenario 2	**Current (FY16)**	**Recommendation**	**Net Change**
General Fund	$11,914	**$0**	**($11,914)**
Intergovernmental Transfer for Public Health Offices	$0.0	$3,570	**$3,570**
Federal Funds from HSD	$0.0	$8,330	**$8,330**

Source: LFC Analysis

DOH should:
Work to maximize Medicaid billing for covered services provided to eligible individuals through public health offices and

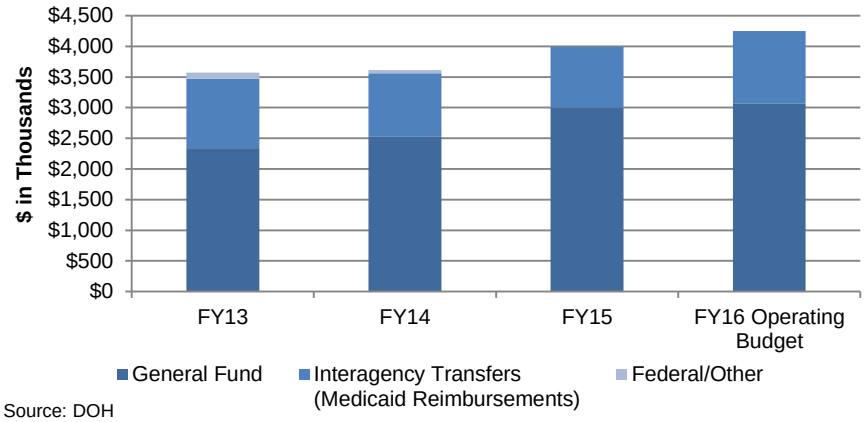
Work with HSD and the current MCOs to allow for the private plans operated by the MCOs to reimburse for public health office services currently covered by Medicaid managed care, and work with other private insurers to capture payments from commercial insurance where appropriate.

DEPARTMENT OF HEALTH – SCHOOL-BASED HEALTH CENTERS

School-based health centers that receive funding from DOH can bill Medicaid for services. School-based health centers (SBHCs) operate under contract in schools to provide various primary care services, such as immunizations, preventive care, reproductive care, behavioral health services, and youth engagement programs. They are typically operated by nonprofit organizations or health clinics and receive state funding through contracts with DOH. DOH currently provides funding for SBHC administrative costs with a combination of state general fund appropriations and Medicaid reimbursements passed through from HSD. According to an LFC evaluation from May 2015, in order to bill Medicaid for services, SBHCs must be overseen by DOH.

Total DOH spending on SBHCs increased by 12 percent from FY13 to FY15, from roughly $3.6 million to just under $4 million. The FY16 operating budget totals $4.2 million, of which general fund appropriations account for $3.1 million.

Chart 15. DOH Spending on SBHCs FY13-FY16



Source: DOH

More data on Medicaid billings at SBHCs is needed to estimate potential savings. The previous LFC evaluation found that better tracking of billing data could help determine the need for general fund support for SBHCs and recommended that DOH establish a plan to collect and analyze school-based health center billing data for all provider sites in FY16. DOH responded that 2017 would be a more feasible target date for this initiative. Until enough data is available on SBHC billings for services, a reliable estimate for potential general fund savings is not possible. The previous evaluation recommended that DOH establish a plan to use this data to develop a new formula for distributing general fund allocations to school-based health centers to prioritize centers with the greatest needs.

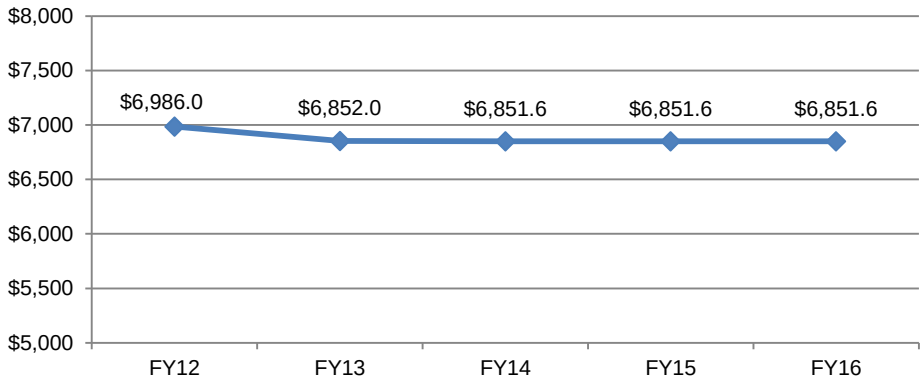
Recommendations

DOH should:
Continue efforts to collect and analyze SBHC billing data and use it to assess the need for general fund support, and establish a plan for meeting reasonable payer mix levels as part of the budget cycle beginning September 1, 2016, as previously recommended by LFC.

DEPARTMENT OF HEALTH – TOBACCO SETTLEMENT FUND PROGRAMS

Tobacco settlement revenues could be freed up for other purposes by better leveraging Medicaid to support certain targeted public health programs at DOH. Between FY12 and FY16, just under $7 million was appropriated from tobacco settlement funds to health programs at the Department of Health, as noted in Chart 16.

Chart 16. DOH Tobacco Settlement Appropriations
FY12-FY16
(in thousands)



Source: 2013-2015 LFC Volume III and 2015 Post-Session Review

The majority of these funds go to four programs at DOH: Hepatitis and harm reduction within the Infectious Disease Bureau, the Tobacco Use Prevention and Control Program (TUPAC), the Diabetes Prevention and Control Program, and the Breast and Cervical Cancer Early Detection Program (BCC). While some of these programs have requirements excluding Medicaid enrollees from receiving services, as previously mentioned in the case of the BCC Program, others do not specify eligibility requirements, such as TUPAC, which can create risk for service overlap or duplication with Medicaid.

Billing Medicaid for tobacco cessation services currently supported by tobacco settlement funding may be able to save around $1.7 million. Currently, regular Medicaid in New Mexico covers smoking cessation services for recipients age 21 and under, and for pregnant women, with possible additional benefits available through a Centennial Care MCO. Services are covered for all members of the adult expansion group under the state's Alternative Benefit Plan. Currently, however, the TUPAC program does not receive Medicaid reimbursements for services. In addition to counseling and state support for the 1-800-QUIT-NOW telephone line, the TUPAC program offers free cessation services and products, such as nicotine patches, without a screening requirement for Medicaid or other health care coverage.

Tobacco settlement fund spending in the TUPAC program has increased by 4 percent since FY13, from $5.4 million to just under $5.7 million in the FY16 operating budget. The program served 8,195 individuals in FY15.

Table 5. Tobacco Settlement Revenue Spending for Tobacco Use Prevention and Control
FY13-FY16
(in thousands)

FY13	FY14	FY15	FY16 Operating Budget
$5,442	$5,648	$5,655	$5,662

Source: DOH

Assuming TUPAC billed regular Medicaid for services to 42 percent of its clients, the state could save roughly $1.7 million in tobacco settlement funding that could be redirected to other purposes (Table 6). The remaining 30 percent of the cost would be borne by the state as the nonfederal share, and could either be paid from tobacco settlement funds or the general fund through HSD. HSD received a transfer of $20.8 million in tobacco settlement revenues for the state Medicaid match in the FY16 GAA.

Table 6. Recommended Scenario for Replacing Tobacco Settlement Fund Appropriations with Medicaid

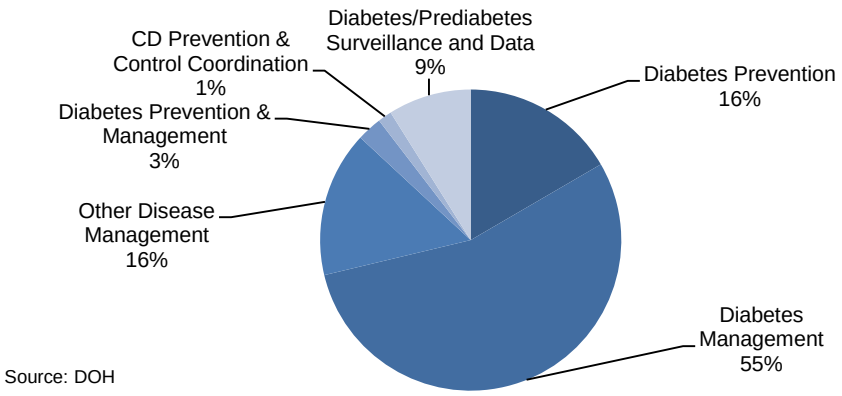
Program: TUPAC	Current (FY16)	Recommendation	Net Change
Tobacco Settlement Fund	$5,662	$3,999	**($1,663)**
Federal Funds*	-	$1,663	**$1,663**

Source: LFC Analysis
* Medicaid federal share for estimated eligible but currently uncovered TUPAC clients

New Mexico could leverage Medicaid to pay for tobacco quitline services. In FY16, New Mexico's contract for operating its tobacco cessation telephone line, or "quitline," totals $1.6 million in tobacco settlement funds. Since 2011, states have been able to claim a 50-percent federal administrative match from Medicaid for the costs of operating a quitline. As of February 2015, 12 states have drawn down this funding (Alabama, Arizona, Arkansas, Colorado, Georgia, Indiana, Louisiana, Maryland, Massachusetts, Montana, Oklahoma, and Texas), according to the Association of State and Territorial Health Officials. CMS allows states to claim the match only to the degree that the quitline serves Medicaid beneficiaries. Since New Mexico does not currently require any income verification for services, HSD and DOH would likely need to develop a methodology for identifying Medicaid beneficiaries who use the quitline in order to allocate costs accordingly and claim the match. For example, Maryland's quitline entered into a memorandum of understanding (MOU) with its state Medicaid agency to use a cost allocation plan developed for its poison control center to determine the costs associated with Medicaid clients.

Certain Diabetes Prevention and Control Program services funded with tobacco settlement funds may be eligible for Medicaid reimbursement. The Diabetes Prevention and Control Program (DPCP) receives revenues from various sources including the general fund, tobacco settlement funds, and federal funds, most notably from the Centers for Disease Control and Prevention (CDC). Total spending on DPCP was $1.3 million for FY15. Of this amount, about $452 thousand was allocated for contracted professional diabetes prevention and management services. Of the amount set aside for services, tobacco settlement funds made up $336 thousand, or 74 percent. These funds were allocated to diabetes prevention and disease management programs as shown in Chart 17.

Chart 17. Use of Tobacco Settlement Funds for the Diabetes Prevention and Control Program, FY15



Source: DOH

Of this amount, only certain activities within the diabetes management and other disease management categories are potentially eligible for Medicaid. The total amount allocated for these activities was about $215 thousand in FY15, all from tobacco settlement funds. No state general fund revenues were used for these programs. Education and prevention programs likely would not be Medicaid-eligible services, but chronic disease self-management and healthy eating classes could potentially be incorporated into disease management programs through Medicaid, including chronic disease health homes. Beneficiary participation in diabetes self-management activities, including cooking and nutrition classes, are eligible for incentives under the Centennial Rewards program as outlined in HSD's contracts with the MCOs, and spending on the program may be counted towards administrative costs for the purposes of the state's medical expense ratio. Nutritional counseling services are an allowed benefit under the Alternative Benefit Plan.

Table 7. Potentially Medicaid-Eligible DPCP Activities, FY15

Category	Activity	Tobacco Settlement Funds
Diabetes Management	Kitchen Creations cooking schools	$137,000
	Blood pressure management	$25,000
Other Disease Management	Chronic Disease Self- Management	$52,600
Total		**$214,600**

Source: LFC Analysis

If the state billed Medicaid under administrative claiming procedures for all eligible costs under the DPCP program, it could save up to $151 thousand in tobacco settlement funds that could be repurposed assuming the regular federal participation rate of 70 percent. However, while the DPCP includes low-income individuals as a target population, it does not have any income-based eligibility criteria, so actual savings would likely be less.

Recommendations

Table 8. Recommended Scenario for Replacing Tobacco Settlement Fund Appropriations with Medicaid

Programs: Tobacco Use Prevention and Control/Diabetes Prevention and Control	Current (FY16)	Recommendation	Net Change
Tobacco Settlement Fund	$5,877	$1,878	**($1,814)**
Federal Funds*	-	$1,814	**$1,814**

* Medicaid federal share for estimated eligible but currently uncovered clients
Source: LFC Analysis

DOH should:
Work with HSD and Centennial Care MCOs to develop a methodology for billing Medicaid for eligible services provided to TUPAC clients, including cost allocation for being able to claim the 50 percent Medicaid administrative quitline match; and

Explore options to use Medicaid funding for DPCP services currently supported by tobacco settlement revenues.

DEPARTMENT OF HEALTH- TRAUMA CENTER FUNDING

General fund appropriations to the Trauma System Trust Authority do not pay for direct patient care services. The total state trauma fund appropriation available to New Mexico hospitals and the Department of Health for FY16 is $2.9 million. Nearly $350 thousand of the annual allocation goes directly to DOH for the operation of the state's trauma registry, departmental overhead expenses, and injury prevention interventions. The remainder, about $2.6 million, is distributed to trauma centers statewide.

In 2006, legislation created the Trauma System Fund Authority to sustain existing trauma centers, support the development of new centers, develop a statewide trauma system, and distribute the trauma system fund. The trust funds are generated through state general fund appropriations and a small portion from provider fees. The funds are allocated annually based upon the recommendations from the Trauma Advisory and System Stakeholder Committee. Use of the funds is limited to educational offerings culminating in emergency medicine certification or licensure, purchase of equipment, telemedicine programs, and data collection. Most of the smaller hospitals use the funds for data collection support. Each trauma-designated facility must provide a cash or in-kind contribution equal to 10 percent of funds received from the Trust.

Regulations also address payment for physician services relating to trauma care. New Mexico's Trauma Care rules (7.27.7.9 NMAC) require a trauma team physician to establish fee schedule for services that accurately reflects the cost of services rendered and the associated financial risk associated with the physician service delivery. The physician is to enter into reimbursement agreements with managed care organizations and other insurers which adequately reimburse the physician. The trauma team physician, or organization acting on the physician's behalf, shall not discount or otherwise attempt to collect charges and fees less than the trauma fee schedule developed by the physician. The statute requires the insurer to adequately reimburse for physician services.

Despite funding targeted to trauma system development, most trauma centers in New Mexico do not meet national standards and the second largest urban area does not have a designated trauma center. New Mexico has 12 hospitals designated as trauma centers, of which University of New Mexico Hospital is the only level 1 trauma center as verified by the American College of Surgeons (Appendix D). Each state can regulate and designate independent trauma centers at Levels 2 and below. However, DOH has not designated any Level 2 centers in New Mexico. Moreover, there is not a designated trauma center in Las Cruces, the 2nd largest urban area in the state. However, DOH has identified Mountain View Regional Medical Center, in Las Cruces, as a "developing center" and has supported the hospital with $28 thousand in funding in FY16. However, the funding does not assure that a center will be established. Maintaining and further developing the state's trauma system is important, as a 2012 study published in the Annals of Medicine ranked New Mexico third for injury deaths and 35th for access to trauma services in the nation. Isolated states are considered "high risk" for poor trauma outcomes.

Repurposing other earmarked health care funds could ensure statutory mandates for maintaining a trauma system can continue to be fulfilled. While rules require trauma centers to create a fee schedule for services, other non-service related mandates require funding. Regulations include a requirement of the Department of Health to establish a statewide trauma registry to collect and analyze data on the incidence, severity, and causes of trauma. Most of the information is received from the designated trauma centers. Required reporting for the centers is complex, requiring retrieval of data elements from several sources (Appendix E).

HSD's contracts with Centennial Care MCOs require regular monitoring of network adequacy which could be expanded to include the state's trauma system. HSD could direct Medicaid MCOs to fund the DOH Trauma Trust Fund. This would not be dissimilar to HSD's direction to MCOs to fund Project ECHO at UNM HSC for network adequacy and enhancement.

Alternately, reducing trauma funding for DOH and hospitals receiving greater than $100 thousand annually by 20 percent and reducing funding for smaller hospitals by 10 percent would generate $545 thousand in general fund savings.

Other recommendations are made to eliminate the need for any general funding to the Trauma Trust Authority.

Recommendations

Table 9. Recommended Scenario for Replacing General Fund Appropriations with Medicaid

Program: Trauma Centers	Current (FY16)	Recommendation	Net Change
Scenario 1: Reduce Trauma Funding at Hospitals and DOH			
General Fund	$2,935	$2,390	**($545)**
Scenario 2: Replace Trauma Funding Via MCOs			
General Fund	$2,935	$0	**($2,935)**
Medicaid MCO Payments		$2,935	**$2,935**

Source: LFC Analysis

The Legislature should consider:
Reducing the general fund appropriation to DOH for the Trauma Trust Authority by $500 thousand to free general fund for other purposes.

DOH should:
Reduce funding to hospitals receiving more than $100 thousand annually by 20 percent and reducing annual funding for remaining hospitals by 10 percent and

Validate, through MCO and other insurer provider contract reviews, all trauma centers have maximized, per state statute, appropriate reimbursement for trauma services from insurers; or

Evaluate the need for continued state funding of the Trauma Trust Fund in consideration of the lack of trauma system development, as demonstrated through the absence of Level 2 centers in key geographic areas.

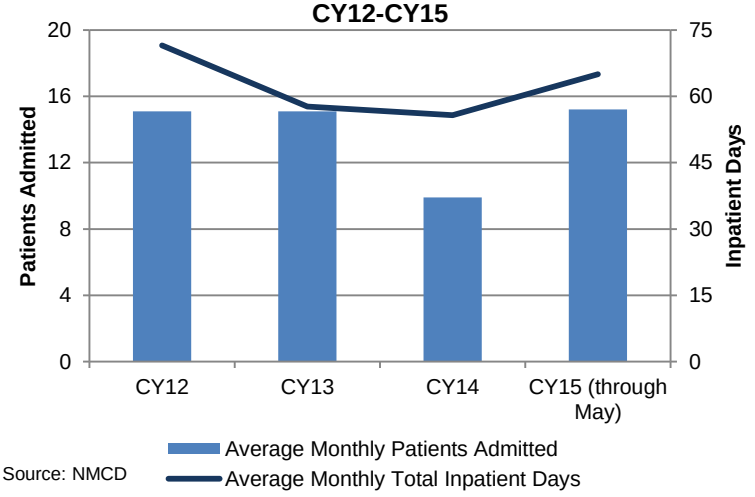
HSD should:
Direct each Medicaid MCO provide replacement funding to the Trauma Trust Fund to build and maintain network capacity.

CORRECTIONS DEPARTMENT

The New Mexico Corrections Department (NMCD) is realizing general fund savings by billing inpatient hospital stays to Medicaid when appropriate. Under Medicaid expansion, Medicaid may cover the costs of inpatient hospital stays of 24 hours or greater for incarcerated individuals who are determined eligible under the expanded adult Medicaid population. In each of calendar years 2012 and 2013, 181 total NMCD patients were admitted for hospital stays of at least 24 hours. This fell by 34 percent to 119 patients in CY14. During the same period, the total number of inpatient days incurred by NMCD inmates decreased from 858 in 2012 to 668 in 2014, a 22 percent decrease.

While both the total number of inmates admitted for hospital stays of at least 24 hours and the total number of inpatient days incurred by these patients decreased between 2012 and 2014, these numbers are currently on pace to increase in 2015. As shown in Chart 18, the average number of patients admitted per month has increased through the first five months of 2015, along with the average number of inpatient days per month.

Chart 18. State Prison Inmates with Inpatient Hospital Stays of 24 Hours or More CY12-CY15



Source: NMCD

NMCD reports, for the first five months of CY15, calculated savings of approximately $579 thousand to its healthcare costs from the ability to bill Medicaid for reimbursement of 24-hour or longer inpatient stays. These reimbursements have been credited against billings by the Department's contracted prison healthcare provider, Corizon Health. However, NMCD cautions that it is still developing a formal process for crediting Medicaid reimbursements alongside HSD and its healthcare provider. NMCD is working with HSD to establish a memorandum of understanding and train staff on processing paperwork for short-term Medicaid inpatient treatment for inmates.

Based on national trends, using Medicaid funding for correctional inpatient admissions could save the general fund up to $5.1 million. A Pew Charitable Foundation study of prison inmate hospital admissions in 10 states from 2007 through 2011 showed inpatient hospitalization accounted for 20 percent of prison health care spending. NMCD's inmate healthcare contract totals $41.8 million in FY16. Assuming 15 percent of that is designated for profit and administration, the amount available in FY16 contract amount for health care services would be approximately $35.5 million. At 20 percent of service costs, hospitalization would total about $7.1 million. Assuming 80 percent of inmates would qualify for Medicaid, as suggested by the U.S Government Accountability Office (GAO), and most of them would be eligible for enhanced federal reimbursement under the expansion group, the total savings to the general fund would be approximately $5.1 million.

Although NMCD is assisting pre-release inmates and newly incarcerated individuals in applying for Medicaid benefits, the department does not have the ability to track actual enrollment. NMCD has allocated $7.3 million in state funds in FY16 to provide behavioral health services to probationers and parolees. Historically this funding has been needed since offenders generally do not qualify for Medicaid. With the implementation of the ACA and expansion of Medicaid in New Mexico, and if this state mimics others as suggested by the GAO, 80 percent to 90 percent will qualify for Medicaid benefits.

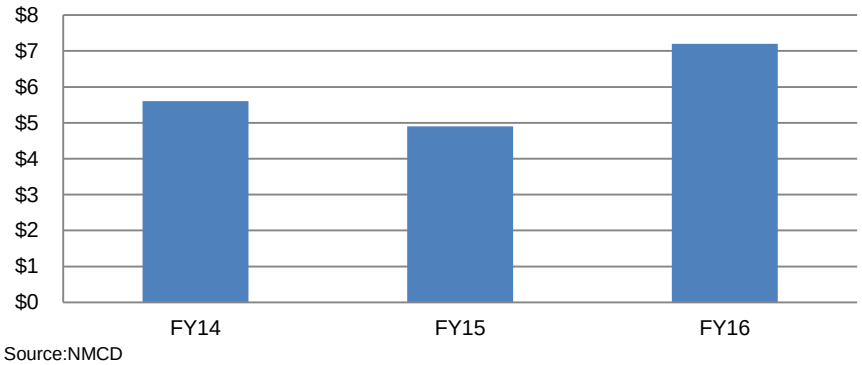
SB 42, passed by the Legislature in 2015, specifies that an incarcerated person who was not enrolled in Medicaid at the time of incarceration may apply for Medicaid enrollment prior to the person's release. The act also states that incarceration is not a basis for denying or terminating an individual's Medicaid eligibility, although federal law still prohibits Medicaid from paying for the care of an incarcerated individual. NMCD uses facility-based case workers who are trained by HSD to determine the eligibility of inmates for Medicaid prior to their release and assist them with submitting applications.

NMCD began tracking the submission of pre-release Medicaid applications for inmates in the second quarter of FY15. Between October 1, 2014 and June 30, 2015, about 1,400 NMCD inmates submitted applications for Medicaid enrollment prior to their release, or roughly 65 percent of the approximately 2,100 potentially eligible inmates released during that period. However, NMCD does not track the number of released inmates who are actually enrolled in Medicaid. Also, due to the need for time to process applications, there could be a significant lag between an inmate's release from a correctional facility and when the individual is actually enrolled.

General fund expenditures on Probation and Parole outpatient services decreased in FY15. As research has shown that addressing health issues of probationers and parolees has proven to decrease recidivism, the Corrections Department, through service contractors, funds outpatient behavioral health services for probationers and parolees. In the past year, the department has terminated the service agreements with the Behavioral Health Services Division and OptumHealth and has assumed responsibility for those functions. As shown in Chart 19, outpatient service expenditures for FY15 decreased by 13.5 percent from FY14, from $5.6 million to $4.8 million. The department has attributed the decrease to payment delays by the former third party administrator. The contractor has until 2015 year-end to close out the account. However, previous issues requiring recoupment of funds from the contractor will require close monitoring by NMCD to ensure proper accounting by the end of the year. NMCD has also expressed concern the former contractor was not monitoring utilization of provider allocations and was not reallocating funds to providers who could have delivered the services.

The FY16 operating budget is $7.3 million. The increase is a transfer of the administrative fee from the former contractor to the services budget.

Chart 19. Probation and Parole Outpatient Services Expenditures
(in thousands)



Source:NMCD

Depending on enrollment and services, the state could save up to $5.3 million in general fund appropriations from billing Medicaid for outpatient services to probationers and parolees. NMCD was unable to provide an accounting of service types delivered. Lacking that information and not knowing whether services provided are Medicaid reimbursable or if there is pent up demand for services, it is difficult to calculate savings in the outpatient program. In the request for proposals (RFP) issued for outpatient behavioral health contractors, NMCD included Medicaid certification as a pass/fail criterion and requires that all Medicaid-certified providers bill Medicaid before billing NMCD for services.

However, as previously mentioned, NMCD does not currently track actual Medicaid enrollment of released inmates, but a 2014 report from the U.S. Government Accountability Office (GAO) suggests that as many as 80 percent to 90 percent of probationers and parolees in Medicaid expansion states may be eligible for services. This analysis presumes an estimate of an 80 percent Medicaid enrollment among released inmates and that most enrollees would be eligible for the expansion group, for an average 90-percent federal financial participation rate. Based upon the FY16 budget of $7.3 million for behavioral health contracts, state savings for outpatient services would be would be approximately $5.3 million.

The Corrections Department could also benefit from available Medicaid reimbursement for administrative functions relating to Medicaid enrollment. This reimbursement is equal to 50 percent of amounts expended by the state, as found necessary for the proper and efficient administration of the state plan. Cost accounting and projected revenues for plan administration is not available. Information is not available identifying the amount of administrative expenses associated with department employees or contractors participating in the Medicaid enrollment process, for which the department could be reimbursed.

Recommendations

Table 10. Recommended Scenario for Replacing General Fund Appropriations with Medicaid

Program: Corrections Department	Current (FY16)	Recommendation	Net Change
General Fund - Inmate Hospitalization	$7,107	$1,990	**($5,117)**
General Fund - Probation and Parole Behavioral Health	$7,331	$2,052	**($5,279)**
Federal Funds*	-	$10,396	**$10,396**

Source: LFC Analysis
* Medicaid federal share for services not currently billed to Medicaid

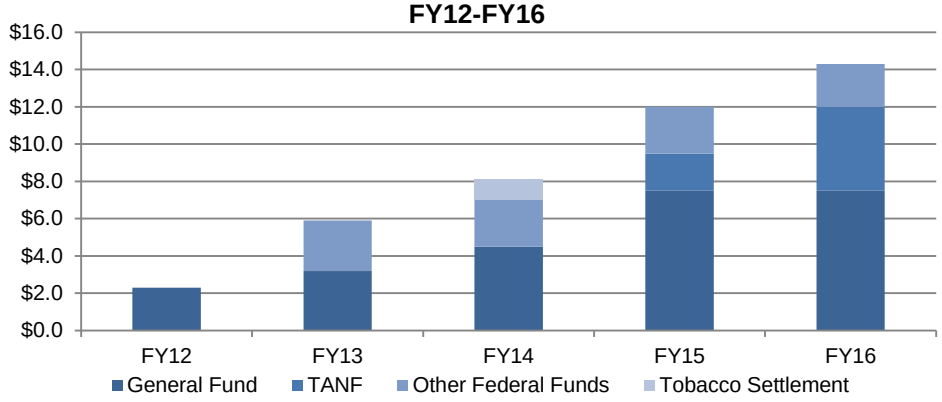
NMCD should:
Work with HSD, as part of its Memorandum of Understanding for Medicaid enrollment of released inmates, to develop a process to collect data on former inmates who enroll in Medicaid and receive services after eligibility is determined.

Continue efforts to determine Medicaid eligibility of inmates requiring hospitalization, maximize Medicaid billing for these individuals, and collect data on Medicaid inmate hospitalization and costs so these factors can be taken into account in future healthcare contracts.

CHILDREN, YOUTH AND FAMILIES DEPARTMENT – HOME VISITING

Home visiting funding has increased rapidly, coupled with increasing costs per participant family. Total funding for home visiting services administered through the Children, Youth, and Families Department (CYFD) stands at $14.3 million in FY16. General fund support has more than doubled between FY12 ($2.3 million) and FY16 ($7.5 million). While funding from other sources, including federal grants such as Temporary Assistance for Needy Families (TANF) and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, has also increased, the program still heavily relies on the general fund. Home visiting, as a comprehensive program, is not currently a Medicaid-billable service.

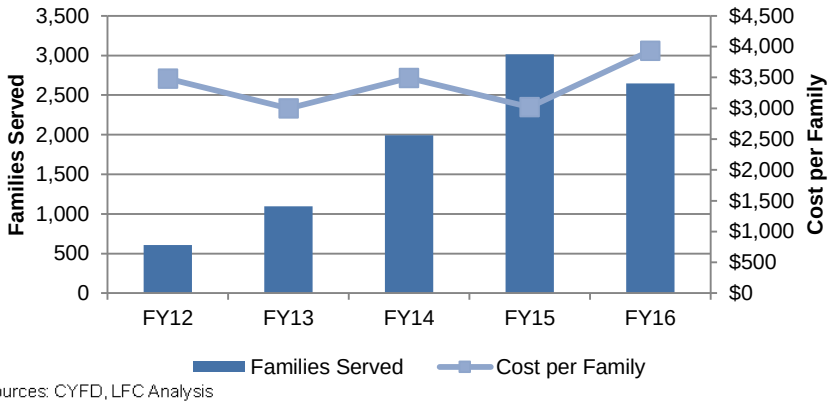
Chart 20. Home Visiting Appropriations by Source FY12-FY16



Source: 2015 LFC Post Session Review

For FY16, CYFD contracted with 33 providers to offer home visiting services to approximately 2,600 families, for a total of $10.4 million. This represents about a 14 percent increase in contract funding from $9.1 million in FY15; however, the FY16 contracts are to serve about 370 fewer families, a 12 percent decrease. Based on these contracted service levels, the average cost per family increases by 30 percent, from $3,018 to $3,931. This cost change is due to a new methodology CYFD is using for classifying providers based on the level of service provided, taking into account factors such as higher travel costs in rural areas.

Chart 21. Home Visiting Families Served and Cost per Family, FY12-FY16



Sources: CYFD, LFC Analysis

Potentially Medicaid-eligible home visiting services make up a little over 20 percent of all home visiting funding. A January 2015 LFC report assessing early childhood programs in New Mexico found that there are substantial gaps in home visiting services in certain areas of the state and recommended targeting services to low-

income, at-risk families. Some of these gaps could be filled by expanding home visiting services with medical component that could be at least partially reimbursed by Medicaid. Currently, New Mexico has a limited array of program models in practice that may meet qualifications for potentially reimbursable, medically-based services. These include the Nurse-Family Partnership (NFP) and the First Born Program.

The sole provider operating NFP in New Mexico is the UNM Center for Development and Disability, using federal MIECHV grant funding passed through CYFD. This program is currently supported at a level of roughly $750 thousand. Since it is entirely federally supported in New Mexico, the program cannot bill Medicaid for its services. First Born currently operates in 16 counties through a variety of providers, but not all receive funding through CYFD. Contracts for First Born providers totaled about $1.3 million in FY15 and increased to nearly $2.2 million in FY16. However, while NFP has been officially designated as an evidence-based model by the federal government, First Born has not.

Other states provide examples of opportunities for using Medicaid to pay for early childhood home visiting services. While not all home visiting services are necessarily eligible for Medicaid reimbursement, states and localities have found several ways in which various services can be funded through Medicaid. A 2012 report from the Pew Charitable Trusts included case studies of several states that incorporate maternal and early childhood home visiting into their Medicaid programs. These are listed and described in Appendix G. Of these, Michigan and Minnesota provide examples of more comprehensive approaches, using traditional Medicaid and managed care, respectively, to reimburse for professional home visits by nurses and social workers. Michigan's Maternal and Infant Health Program (MIHP) operates on a fee-for-service basis separately from other models and providers, such as Nurse Family Partnership, and incorporates managed care organizations to the extent that MCOs are required to provide outreach and referrals to the MIHP for Medicaid-eligible recipients. In Minnesota, the Family Home Visiting Program uses a model whereby local health offices contract with providers, and may receive Medicaid reimbursement pursuant to contracts between MCOs and the local health offices. The Minnesota Department of Health coordinates the program at the state level and provides consultation and training to local health departments in implementing evidence-based home visiting models, such as NFP and Healthy Families America.

New York City provides another example of using Medicaid to fund home visiting services. In 2010 and 2011, it implemented a $130 thousand grant from the New York State Health Foundation to implement a billing system to support Medicaid targeted case management for NFP services that could be used as a model for other NFP programs in New York State. Initial Medicaid billings from implementing the system at seven NFP sites totaled over $340 thousand.

New Mexico may be able to incorporate home visiting services into Medicaid managed care. By adopting a model similar to that used in Minnesota, New Mexico could leverage Medicaid's ability to pay for certain services performed during home visits, such as maternal and child wellness screenings and assessments. Centennial Care managed care organizations could contract with current home visiting providers using models that offer these services and require them to bill Medicaid for services provided to eligible clients. To keep costs manageable, MCOs could require clients to obtain preauthorization before claiming costs associated with home visiting. A limited pilot program of roughly $500 thousand per year, targeting an area with a high potential for Medicaid utilization, could be used to test the viability of this model in New Mexico. Such a pilot could serve about 128 families at an average cost of roughly $3,900 per family, and could save the general fund $350 thousand that would instead be accounted for as federal Medicaid reimbursements.

The state could potentially save $4.6 million annually if the state fully expanded Medicaid coverage for home visiting services to eligible clients. Based on FY16 LFC home visiting client and cost estimates and an assumed Medicaid birth rate of 80 percent, 3,010 clients could use Medicaid to access home visiting services if HSD executed a state plan amendment to make qualified home visiting a Medicaid-eligible service. Adopting a state plan amendment to make home visiting fully Medicaid-reimbursable could remove the need for federal TANF funds to support the program, an assumption reflected in the Scenario 2 estimate in Table 12. However, LFC staff estimates an additional 7,038 potential clients will not be able to access home visiting services based on currently available funding.

If home visiting was Medicaid-funded, the state could meet total demand for services with federal Medicaid dollars financing 41 percent of the total cost. LFC staff estimates total home visiting demand at 10,800 clients, with a cost of $41 million. Of that, $31 million could be tied to Medicaid-eligible clients, of which $22 million would be the federal share. It is important to note that not all current home visiting programs would meet Medicaid eligibility criteria. Therefore, in order to maximize Medicaid leveraging for home visiting services, MCOs would need to work with the provider community to ensure adequate access to Medicaid-eligible services.

Table 11. Home Visiting Client Totals and Funding

	Number of Clients	**Funding/Anticipated Funding Need** (in millions)
FY16 Appropriation	3,762	$14.3
Pent Up Demand	7,038	$26.8
Total Demand	**10,800**	**$41.1**

Source: LFC Files

Recommendations

Table 12. Recommended Scenario for Replacing General Fund Appropriations with Medicaid

Program: Home Visiting	**Current (FY16)**	**Recommendation**	**Net Change**
Scenario 1: Medicaid Pilot Program			
General Fund	$7,500	$7,150	**($350)**
Federal Funds*	-	$350	**$350**
Scenario 2: State Plan Amendment			
General Fund	$7,500	$2,880	**($4,620)**
Federal Medicaid Funds*	$0	$6,720	**$6,720**

*Notes: Medicaid federal share for services not currently billed to Medicaid for Scenario 1.
Scenario 2 excludes TANF and other federal grant funding.
Source: LFC Analysis

CYFD should work with HSD to:
Propose a state plan amendment to add qualified home visiting services to the list of Medicaid-eligible services or

Alternately, create a pilot program for using Medicaid managed care to fund medically based home visiting services.

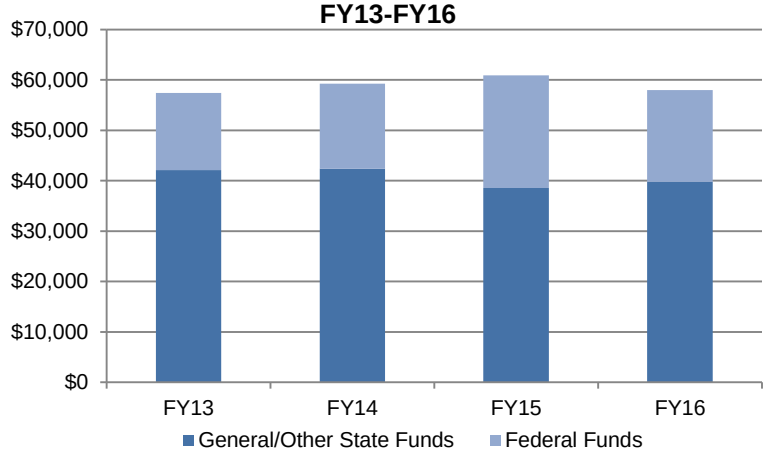
HSD should:
Require MCOs to cover services related to home visiting in their Medicaid contracts, but consider requiring preauthorization to manage costs.

HUMAN SERVICES DEPARTMENT – BEHAVIORAL HEALTH SERVICES DIVISION

Medicaid expansion is reducing the need for general funds to support non-Medicaid behavioral health initiatives. The Division is no longer involved in the administration of Medicaid-sponsored behavioral health services due to the implementation of Centennial Care. Moreover, the implementation of the ACA and Medicaid expansion provide greater access to services funded either through Medicaid or other means, reducing the need for general fund support of behavioral health services.

The FY16 general funding is a $2.3 million decrease since FY13, despite the improved array of behavioral health services through Centennial Care, as shown in Chart 22.

Chart 22. BHSD Appropriations by Source FY13-FY16



However, HSD has recognized increased general fund savings due to Medicaid expansion in its FY17 budget request.

General fund savings realized through Medicaid expansion at BHSD should be reallocated to support the growing Medicaid program. In HSD's FY17 budget request, the department recognizes a reduced need for mental health and substance abuse services funded through the general fund as more clients can be served through Medicaid. HSD reduced these programs by a total of $5.3 million for FY17. However, the department requests these funds be invested in new general fund initiatives at BHSD. At minimum, 30 percent, if not all, of these savings should be reallocated to support the increasing state share requirements for the Medicaid program.

As more behavioral health service clients are being served through Centennial Care, the need for a contracted behavioral health services administrator appears no longer necessary. HSD anticipates putting $51 million, of which $37 million is general fund, under management for FY17 through contracted services with OptumHealth. However, with the vast majority of behavioral health services being managed through the four Centennial Care MCOs, BHSD could take on the role of administering non-Medicaid behavioral health funds. Moreover, two agencies (NMCD and CYFD) have taken over management of their behavioral health funding, with Optum now managing only funds for HSD. Moving management of federal grant and general fund behavioral health dollars would also save the state a potential $5 million annually in administration fees.

Recommendations

Table 13. Recommended Scenario for Reducing General Fund Appropriations to BHSD

Program: Behavioral Health Services Division	FY17 Request	Recommendation	Net Change
General Fund - Agency-Projected Medicaid Expansion Savings	$5,278	$0	**($5,278)**
General Fund - OptumHealth Administration*	$5,212	$0	**($5,212)**
General Fund- Build Out BHSD Claims Tracking and Reporting Capability	$250	$250	**$0**
General Fund - Medicaid State Share	$0	$11,204	**$11,204**

* Estimate based on FY16

Source: LFC Analysis

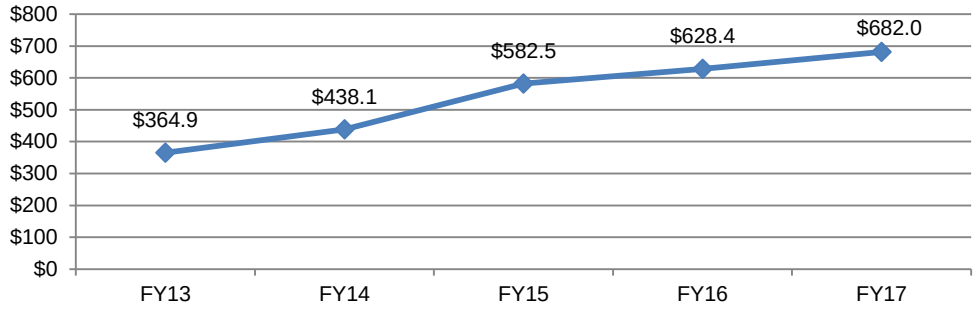
HSD should:
Bring management of non-Medicaid behavioral health funds into BHSD and

Reallocate savings from Medicaid expansion and taking over administration of non-Medicaid services and federal grants to support the state share of Medicaid.

HUMAN SERVICES DEPARTMENT – OTHER OPTIONS

Reassessing funding of MCO Medicaid program overhead could generate substantive savings to the state. Medicaid funds available for MCO administration and profit increased 20 percent in FY14 and another 33 percent in FY15, primarily due to Medicaid expansion. Between FY13 and FY17, the funds for administrative overhead and MCO profit built into capitation rates averaged $539 million.

Chart 23. Medicaid Funds Available for MCO Administration and Profit, FY13-FY17
(in millions)



Source: LFC Analysis of HSD Medicaid Projections

Reducing funds available for Medicaid administration and MCO profit by 1.5 percent could save over $14 million in general fund revenues in FY17. Analysis of HSD budget projections anticipates $128 million will go to MCO administration from the general fund in FY16 for the physical health, behavioral health and long-term service and support programs under Centennial Care. The state did not pay for Medicaid expansion enrollees, as the Medicaid expansion group was 100 percent federally-funded. In FY17, federal funding of the expansion population will step down to 97.5 percent. Adding the 2.5 percent state share for Medicaid expansion enrollees would push the total state responsibility for MCO administration and profit to $144 million for FY17.

Adjusting the funds available for administrative overhead and MCO profit related to Centennial Care would more effectively recognize scale efficiencies gained. In other words, the current assumption is that every Medicaid enrollee has the same administrative burden. However, as economies of scale come into play, each additional enrollee could be anticipated to have a smaller marginal overhead cost. Therefore, adjusting assumptions in the capitation rate setting process for these cost efficiencies is warranted.

Recommendations

Table 14. Scenario for Reducing Funds for MCO Administration and Profit
(in thousands)

Program: Centennial Care	FY17	Recommendation (1.5% Reduction)	Net Change
General Fund	$143,638.9	$129,275.0	**($14,363.9)**

Source: LFC Analysis of FY16 HSD Medicaid Projection (August 2015)

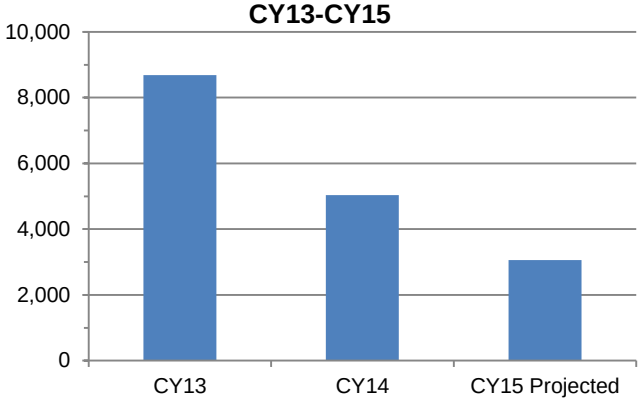
The Legislature should consider:
Adjusting Centennial Care funding to the Medical Assistance Program in the General Appropriation Act to reflect a 1.5 percent reduction in funding of MCO administration and profit.

HSD should:
Direct its contracted actuary to adjust rate setting assumptions to reduce funding available for MCO administration and profit to better recognize scale efficiencies in administration of the Centennial Care program.

NEW MEXICO MEDICAL INSURANCE POOL

Enrollment in the New Mexico Medical Insurance Pool (NMMIP) is decreasing, as provisions of the Affordable Care Act have allowed enrollees to access previously unavailable coverage options. NMMIP was statutorily created in 1987 to provide health insurance to those denied coverage elsewhere, rendering them uninsurable. The pool is mostly funded through assessments levied on those licensed to sell health insurance in New Mexico. In CY14, NMMIP assessed health insurers $168 million to provide health coverage to 5 thousand enrollees. However, the ACA eliminated the ability for a person to be denied insurance coverage. Furthermore, Medicaid expansion and the availability of insurance options through the health insurance exchange largely eliminate the need for a high-risk insurance pool such as NMMIP, as demonstrated by a 42 percent enrollment decrease between CY13 and CY14 as shown in Chart 24.

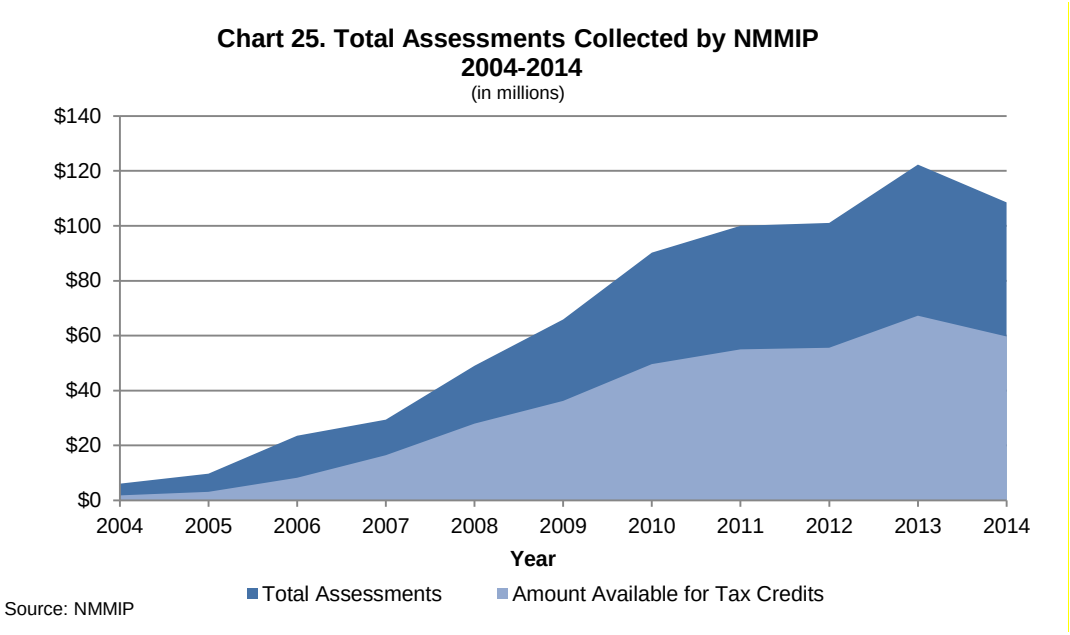
Chart 24. NMMIP Year-End Enrollment CY13-CY15



Source: NMMIP

As NMMIP enrollment declines, decreases in assessment revenue and associated insurer premium tax credits allow the general fund to collect previously forgone revenue. In CY14, NMMIP reported 82 percent of its revenues consisted of assessments charged to insurers, amounting to $108.5 million. Of this amount, 55 percent, or $59.7 million, was eligible for tax credits to insurers against the amount they owe in premium taxes. These credits are based on a percentage of the insurer's assessment for that year. The remaining 18 percent of NMMIP revenue ($24.2 million) consisted of premiums paid by beneficiaries.

As shown in Chart 25, total assessments began to decrease for the first time in 2014 as enrollment dropped. As enrollees leave the pool, the number and amount of claims will also fall. There will be a corresponding decrease in assessments charged to insurers, which are calculated based on the pool's operating costs. This will lead to a decrease in tax credits authorized. A reduction in tax credits will increase general fund revenues generated through premium taxes. The state will need to determine how, as NMMIP sheds its population, it will use any resulting gain in premium tax revenues paid to the Office of the Superintendent of Insurance.



Source: NMMIP

Closing NMMIP could generate approximately $34 million in additional premium tax revenues annually. Health insurers licensed to operate in New Mexico pay a total of 4 percent tax on all premiums underwritten. However, the NMMIP tax credit allows insurers to reduce their premium tax liability, by as much as 50 percent in some cases, based on the amount of assessments paid into the pool. For 2015, LFC staff estimates $34 million of foregone premium tax revenue due to the NMMIP tax credit. In closing NMMIP and sunsetting the associated credit, health insurers would be subject to the full 4 percent premium tax.

Exempting the Medicaid program from NMMIP assessments could save the state approximately $12 million in general fund built into Centennial Care. The Centennial Care program is not exempt from NMMIP assessments, therefore NMMIP assessments are built into capitation rates. Based on CY14 average enrollment, NMMIP assessments are estimated to have cost the Medicaid program $45.5 million, of which $12.4 million was state general fund. The state's share of NMMIP assessments will increase as federal support of the Medicaid expansion population decreases.

NMMIP anticipates transitioning approximately 75 percent of its participants to either Medicaid or other insurance options as part of its eligibility recertification process to be completed by 2018. Due to provisions of the Affordable Care Act (ACA), NMMIP members who could not obtain coverage due to pre-existing conditions, as well as those not previously eligible for Medicaid, can now obtain coverage either through Medicaid expansion or the federal health care exchange. In June 2015, the NMMIP Board of Directors approved a phased transition plan for recertifying the eligibility of policyholders and moving those eligible for alternative coverage out of the pool. The plan was originally slated to occur over the next three open enrollment periods, between 2015 and 2017, for completion prior to the 2018 coverage year.

However, in September 2015, the NMMIP Board voted to delay this process by one year, starting instead with the 2016 enrollment period, and completing the recertification project in 2018 for the 2019 coverage year. The board cited Blue Cross Blue Shield's exit from the exchange as well as concerns related to overall market stability as reasons for delaying the recertification process. The impact of this delay on premium tax revenues was not accounted for in the August 2015 revenue estimates, but will be considered in new estimates to be released in December. Individuals will be selected for recertification each year based on their birth month and will be permitted to apply for an extension of pool coverage due to being in active treatment or certain other circumstances.

Of those unable to move to Medicaid or the health insurance exchange from NMMIP, the majority are Medicare-covered persons, whose coverage needs could be addressed through statutory change. Disabled persons or those diagnosed with end stage renal disease (ESRD) are eligible for Medicare coverage. However, unlike Medicare recipients over the age of 65, the under-65 population cannot access supplemental coverage for services not covered by Medicare unless states require this coverage be offered. Twenty-five states require health care insurers to offer supplemental coverage plans for both disabled and ESRD Medicare recipients. However, New Mexico is not one of these states. NMMIP reported in September 2015 covering 683 Medicare recipients under age 65.

Another group of NMMIP participants who cannot readily transition to other health care alternatives are those deemed ineligible for Medicaid outside of the federal marketplace open enrollment period and undocumented persons ineligible for Medicaid. CMS has not addressed whether closure of a high-risk pool would qualify as a special circumstance allowing for off-cycle enrollment into the health care marketplace, therefore, those pool enrollees deemed ineligible for Medicaid may face a coverage gap until the next exchange enrollment period. Moreover, undocumented NMMIP enrollees would likely become recipients of uncompensated care at New Mexico hospitals.

Recommendations

Table 15. Scenario for Reallocating Revenues Based on NMMIP Closure
(in thousands)

Program: NMMIP	Current Situation	Recommended Scenario	Net Change
Premium Tax Revenues (Forgone)/Realized to General Fund	($34,000.0)	$34,000.0	**$34,000.0**
Medicaid MCO NMMIP General Fund Obligation (Savings)	$13,700.0	$0.0	**($13,700.0)**

Note: Increased premium tax revenue from NMMIP tax credit being eliminated would go to the general fund and other allocations as designated in current statute. Medicaid MCO impact reflects general fund revenues no longer required for NMMIP assessment.

Source: LFC Analysis of NMMIP Data

The Legislature should consider enacting statute to:
Close the New Mexico Medical Insurance Pool by the end of calendar year 2017 and eliminate the NMMIP Assessment Tax Credit against premium taxes for health insurers licensed in New Mexico; or

Exempt MCOs from being required to pay NMMIP assessments on the Centennial Care program; or

Sunset the NMMIP Assessment Tax Credit; and

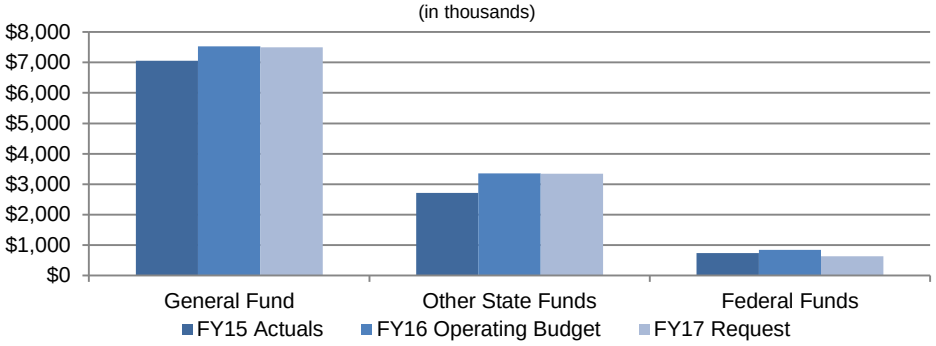
Require licensed health insurers in the state to offer Medicare supplemental coverage for recipients under the age of 65 as a condition of licensure with the Superintendent of Insurance; or

The New Mexico Medical Insurance Pool should:
Extend 2015 open enrollment and re-certify all NMMIP enrollees in one open enrollment cycle for the 2016 plan year to fully identify who should be transitioned to other available coverage options and be better informed of how to address coverage needs of remaining pool members.

ADMINISTRATIVE OFFICE OF THE COURTS – PROBLEM-SOLVING COURTS

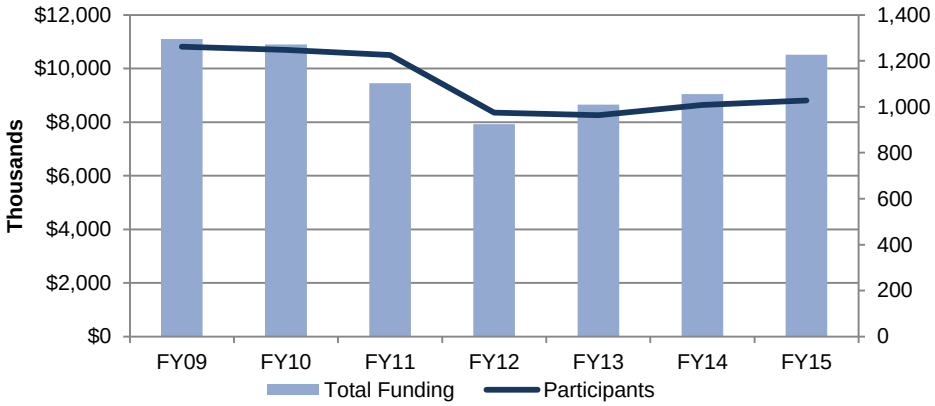
Problem-solving courts in New Mexico present a prime opportunity to leverage Medicaid to expand this cost-effective, evidence-based model. There are 50 active problem-solving courts in New Mexico, serving 27 counties across the state (Appendix H). These programs include 47 drug courts (adult/felony, juvenile, family dependency, and DWI) and five mental health/treatment courts. They are funded through a mix of general, other state, and federal funds. In FY15, problem-solving courts used $10.5 million to serve just over 1,000 participants. Drug court participation dropped an average of 3 percent since FY09, with funding also down an average of 2 percent over the same time period. Effectively leveraging Medicaid dollars would allow greater participation in the state's problem-solving courts.

Chart 26. Problem-Solving Courts Budget by Source
FY15-FY17
(in thousands)



Source: AOC

Chart 27. Drug Court Funding and Participants
FY09-FY15



Note: Includes Magistrate DWI Courts and Metro Court.
Source: LFC Files and AOC

A key component of the drug court model is treatment, which could be a Medicaid-eligible service, as long as providers are certified to bill for services and clients are eligible and enrolled. All problem-solving courts in New Mexico are built on the drug court model, even though they may target other non-substance abuse-related issues, as is the case with mental health courts. AOC notes average daily cost per drug court client was $21.84 in FY14, whereas the daily cost of incarceration through NMCD was $92.98 and $64.76 at county detention centers. Moreover, the three-year recidivism rate for drug courts is an average 15 percent, compared to a three-year

recidivism rate of 45 percent at NMCD. In a 2013 LFC Results First report on evidence-based programs to reduce recidivism and improve public safety, staff noted a $3 return on investment for every dollar invested in drug courts.

A survey of 30 problem-solving courts showed 74 percent of court participants were covered by either Medicaid or another insurer in FY15. The survey went on to show 93 percent of treatment funding was directed to outpatient treatment. A review of Medicaid-covered behavioral health and substance abuse services shows a variety of options where Medicaid funding could be leveraged to provide services to problem-solving court participants. Freeing up funds distributed to these specialty courts by leveraging Medicaid would allow for expansion of a program demonstrated to be more cost-effective than incarceration with a strong evidence base for reducing recidivism.

Recommendation

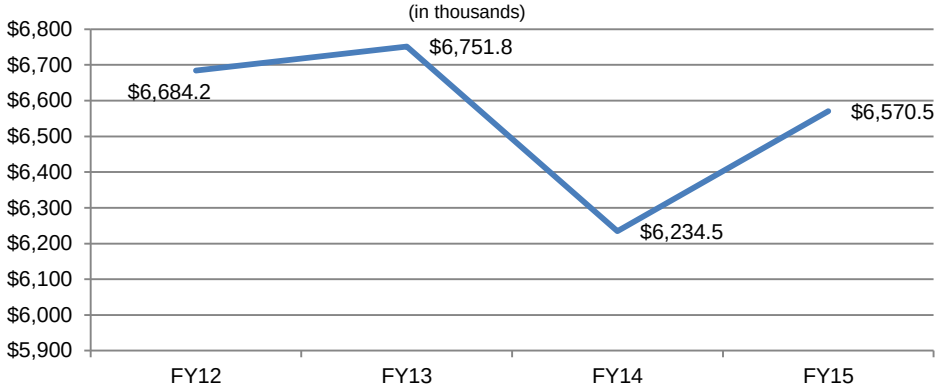
District and Magistrate Courts should:

With the support and oversight of the Administrative Office of the Courts, continue to expand problem-solving courts as well as number of people served through these courts by using increased federal funding made available through leveraging of Medicaid for treatment services.

COUNTY SUBSTANCE ABUSE AND HEALTH CARE PROGRAMS

The Local DWI Grant Program funds various county-level substance abuse treatment programs that could be funded through Medicaid. Between FY12 and FY15, counties expended $25 million through the LDWI program, funded through liquor excise tax revenues, for DWI treatment programs. The counties spending the most on treatment programs were Bernalillo, San Juan, Sandoval, Santa Fe, and Rio Arriba, representing 84 percent of total expenditures over the four-year period. All of these counties offer varying levels of outpatient treatment, as well as jail-based treatment. Additionally, all of these counties, except Rio Arriba, also provide some form of detoxification services. Increased leveraging of Medicaid for DWI treatment will allow for more effective deployment of limited resources.

Chart 28. LDWI Treatment Expenditures FY12-FY15
(in thousands)



Note: Does not include in-kind matching from counties.
Source: DFA Analysis of County Applications for LDWI Funding FY14-FY16

The LDWI program could save approximately $2.5 million in liquor excise tax revenues by more effectively leveraging Medicaid for DWI treatment. In a 2014 LFC evaluation of the LDWI program, staff noted intensive outpatient treatment is a Medicaid-eligible service and counties should work with the Human Services Department (HSD) to ensure eligible participants are enrolled in Medicaid and treatment providers are able to bill Medicaid for these services. Other levels of outpatient substance abuse treatment are not as clearly called out as Medicaid-eligible services at this time, but there are some services that may allow for outpatient substance abuse services to be covered under Medicaid. Moreover, inpatient detoxification in a hospital setting is a Medicaid-covered service. Jail-based services are not eligible to be covered by Medicaid per federal mandate, but the eligibility under Medicaid of court-mandated inpatient programs that occur outside of a jail setting, such as one operating in San Juan County, is unclear at this time.

It is important to note that any savings from leveraging Medicaid would likely be retained in the LDWI program due to current statute governing disbursement of liquor excise tax revenues.

Recommendations

Table 16. Scenario for Reinvesting LDWI Program Revenues by Leveraging Medicaid for Treatment Services

(in thousands)

Program: LDWI	Current Situation	Recommended Scenario	Net Change
Liquor Excise Tax - DWI Treatment Expenditures	$6,570.5	$4,125.3	**($2,445.2)**

Note: Recommended scenario based on proportion of DWI offenders who are unemployed or not in the workforce according to DOH-collected data.

Source: LFC Analysis of DFA Data and DOH New Mexico DWI Offender Characteristics and Recidivism Report 2003-2013

Counties should utilize liquor excise tax revenues freed up through increased treatment funding through Medicaid to:

Partner with the Department of Health to establish a risk-based model to assess DWI funding needs across counties to better target LDWI funds;

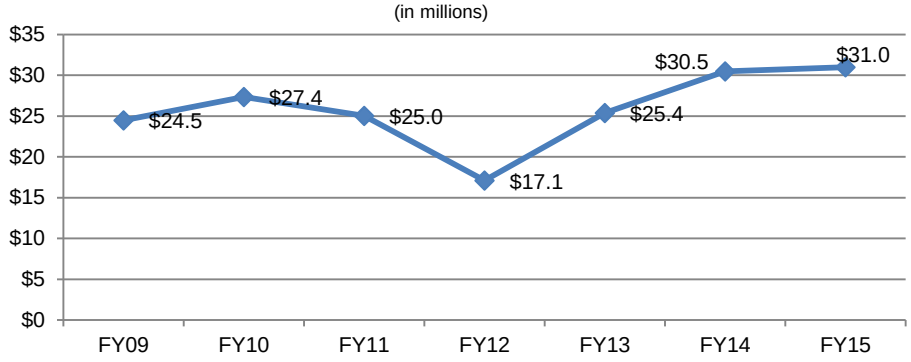
Provide funding for counties to evaluate and report performance measures on different programs funded through the LDWI program; and

Allocate funding in partnership with magistrate courts to support the state's DWI courts.

Increasing revenues from the County Indigent gross receipts tax increment could serve as a funding source for health care initiatives currently supported by the general fund. A 2014 LFC evaluation of county indigent care spending stated as the ACA was implemented (Medicaid expansion and access to health insurance exchanges), the need for indigent care programs would diminish significantly. This, combined with expected growth in gross receipts tax revenue collections, would result in increasing fund balances specifically earmarked for indigent health care going unused.

Indigent care expenditures continue to decline as a result of the ACA, leaving growing fund balances at the county level. Based on county-supplied data, indigent care spending dropped between FY13 and FY15. However, indigent care revenues generated through the 2nd 1/8th GRT increment increased over the same time period, and are anticipated to continue increasing. As these funds are specifically earmarked by statute for indigent care, counties will be left with growing fund balances in upcoming years. For FY15 alone, $31 million went unused in county indigent funds as noted in Chart 29.

Chart 29. Statewide County Indigent Fund Balances FY09-FY15
(in millions)



Source: Unaudited Data from County Budgets

While some counties use excess indigent care funds to meet requirements for County-Supported Medicaid (1/16th of 1 percent GRT) and the Safety Net Care Pool (1/12th of 1 percent GRT), indigent care revenues could be repurposed to support the health care system in New Mexico more effectively post-Medicaid expansion.

As the need to fund indigent care dissipates, county indigent funds could leverage Medicaid matching funds to replace over $30 million in general fund support for primary care and public health services. LFC analysis shows, based on expected GRT revenue growth through FY17, an equivalent of 1/46th of 1 percent GRT from county indigent funds would be sufficient for the state to draw down federal match to fund FQHCs and RHCs (currently funded via general fund revenues through RPHCA), and public health offices (funded through the general fund in the DOH agency budget.)

One mechanism to leverage indigent funds would be to replicate the Safety Net Care Pool model for FHQCs, RHCs, and public health offices. By statute, counties are required to contribute to local public health offices for lease and personnel costs, but a 2012 LFC evaluation showed counties were not contributing to the public health system in a consistent manner. Creating a mechanism for counties to contribute funds that draw down federal Medicaid matching funds could fulfill this statutory requirement. By more effectively leveraging Medicaid to fund primary care and public health services, currently unmatched general fund revenues used to fund these programs could be made available to fund other state budget priorities.

Recommendations

Table 17. Scenario for Reinvesting Leveraged County Indigent Funds for RPHCA and Public Health Offices
(in thousands)

Program: County Indigent	Current Situation	Recommendation	Net Change
Unspent County Indigent Funds	$31,000.0	$23,080.0	**($7,920.0)**
Intergovernmental Transfer for RPHCA (Medicaid State Share)	$0.0	$4,350.0	**$4,350.0**
Interagency Transfer for RPHCA (Medicaid Federal Share)	$0.0	$10,150.0	**$10,150.0**
Intergovernmental Transfer for Public Health Offices (Medicaid State Share)	$0.0	$3,570.0	**$3,570.0**
Interagency Transfer for Public Health Offices (Medicaid Federal Share)	$0.0	$8,330.0	**$8,330.0**

Note: Based on FY15 expenditures for public health offices and RPHCA-recipient clinics and county-reported indigent fund balances at the end of FY15.

Source: LFC Analysis of County Budgets, TRD GRT Data, DOH Expenditures, and Consensus Revenue Estimates

The Legislature should consider:
Amending the Indigent Hospital and County Health Care Act to require counties contribute gross receipts tax revenue from the Health Care Assistance Fund (formerly the County Indigent Fund) as an intergovernmental transfer to leverage federal Medicaid matching funds for the purpose of funding uncompensated care at federally-qualified health centers and public health offices under the Department of Health. Funds should not revert. Also require counties to provide DFA's Local Government Division and HSD quarterly financial statements on the status of the Health Care Assistance Fund.

HSD should:
Initiate any required state plan amendments to create a safety net care pool for federally-qualified health centers and public health offices to leverage federal Medicaid matching funds and establish reporting requirements for applying for funds and reporting uncompensated care data similar to current requirements for hospitals receiving funding through the Safety Net Care Pool.

CERTIFIED PUBLIC EXPENDITURES

New Mexico may be able to leverage local funding for Medicaid through increased use of certified public expenditures. Federal regulations specify two main methods for including public funds from local governments and other eligible entities in the state's nonfederal share of Medicaid funding. These are intergovernmental transfers (IGTs) and certified public expenditures (CPEs) (42 CFR 433.51). IGTs involve the direct transfer of funds between a local governmental entity and the state Medicaid agency, while using CPEs only requires local entities certify to the state the amounts they spend on Medicaid-eligible activities. Those amounts can then be counted toward the state's nonfederal share for purposes of receiving the federal match.

New Mexico uses a much smaller share of local funds to support its nonfederal share of Medicaid than other states. According to a 2014 report by the U.S. Government Accountability Office (GAO) that studied local and provider funds in financing Medicaid, about 15 percent of the nationwide nonfederal share of Medicaid consisted of IGTs and CPEs in FY12. In New Mexico, this portion was approximately 8 percent, amounting to $82.7 million of the total nonfederal share of $1 billion in that year.

Table 18. Local Funds as Percentage of Nonfederal Share of Medicaid FY12

U.S.	15.5%
New Mexico	8.2%

Source: GAO

Medicaid support from non-state public entities in New Mexico decreased by $18.5 million between FY13 and FY15. As shown in Table 19, support for the Medicaid state share derived from counties, the University of New Mexico Hospital and Physician Group, and school districts totaled $96.7 million in FY13 and $78.1 million in FY15 owing to a decrease of over $20 million due to the change from the Sole Community Provider Hospital program to the Safety Net Care Pool (SNCP). All of these funds have been accounted for as IGTs through FY15. However, beginning in FY16, HSD's agreements with school districts and other local education agencies (such as rural education cooperatives) for the Medicaid School-Based Services Program switch to a CPE methodology that requires the provider to certify eligible expenses to HSD for Medicaid reimbursement.

Table 19. New Mexico Medicaid Revenues from Other Public Entities FY13-FY15
(in thousands)

Entity	Agreement Type	Program	FY13	FY14	FY15 (Estimate)
Counties	Statute	County Supported Medicaid Fund	$25,728	$25,709	$27,737
Counties	Statute	Sole Community Provider Hospital (SCPH)/Safety Net Care Pool (SNCP)	$47,451	$25,921	$24,591
UNM Hospital	Memorandum of Understanding/IGT	State Coverage Insurance (SCI) Program	$16,286	$9,018	-
UNM Hospital	Memorandum of Understanding/IGT	SCPH/SNCP, Indirect Medical Education (IME)	-	$11,841	$18,660
UNM Physician Group	General Service Agreement/Invoice for State Share	Physician - Upper Payment Limit	$3,539	$1,780	$2,096
School Districts	General Service Agreement/Invoice for State Share	Medicaid School Based Health Services	$3,649	$2,759	$5,031
Total			**$96,653**	**$77,028**	**$78,115**

Source: HSD

Other states have demonstrated savings from the use of CPEs to cover certain uncompensated costs and draw down federal DSH payments. Certified public expenditures may used by states to fund the nonfederal share of Medicaid through payments by public hospitals. This can be done by allowing hospitals to certify certain uncompensated costs attributable to Medicaid patients and unreimbursed by Medicaid, to the state Medicaid agency for the purposes of drawing down federal Disproportionate Share Hospital (DSH) payments. States must adopt a cost reporting protocol for this process that needs to be approved by CMS. In the case of New Mexico, the state share of DSH payments is currently borne by the general fund.

In the case of New Mexico, any general fund savings realized through this process would depend on the cost protocol and methodology adopted, which would likely require a state plan amendment. This method of financing the state share would also only apply to public hospitals funded at least in part by tax dollars and that meet the criteria for receiving DSH payments. States such as Florida, Michigan, and Washington have used this method of financing and have reported savings to their state general funds. For example, the Michigan Senate Finance Agency reported in 2008 that state saved $75.9 million in general fund over two years from the use of CPEs by public hospitals. In Florida, CPEs represented 34 percent of the state share of DSH payments in FY13.

Recommendations

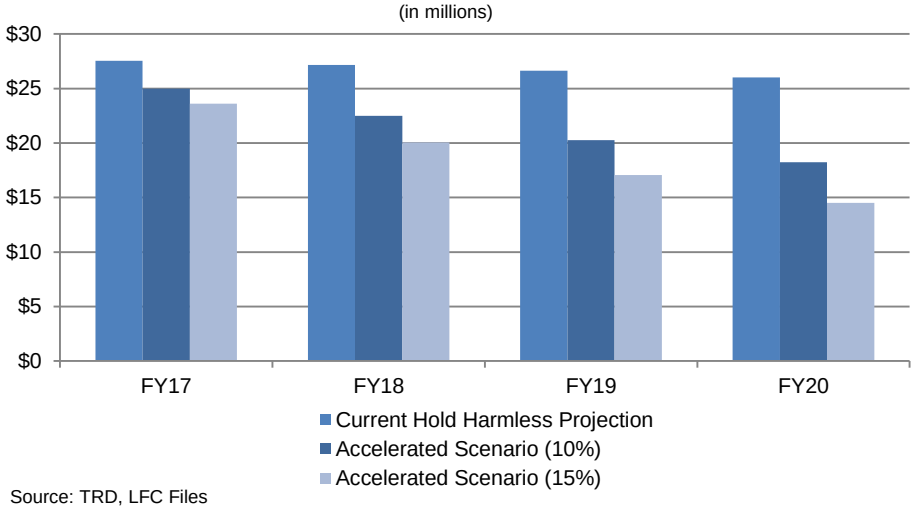
The Human Services Department should:
Consider adopting a state plan amendment and cost protocol for using certified public expenditures from public hospitals toward the state share of DSH.

MEDICAL GROSS RECEIPTS TAX HOLD HARMLESS PAYMENTS

Hold harmless payments to counties and municipalities related to the gross receipts tax exemption for medical services will continue to be relatively unchanged until they are phased out in FY20. In 2004, the Legislature passed a hold harmless payment to counties and municipalities to offset the repeal of the gross receipts tax on food and certain medical services. In 2013, legislation was passed to phase out the hold harmless payments over a 15-year period. A 2014 LFC report noted projected medical inflation and the economic base on which the payments are based exceed the amount the payments are to be reduced. The Taxation and Revenue Department projects medical hold harmless payments to only be reduced a total of $1.5 million between FY17 and FY20, after which the remaining $26 million in hold harmless would be phased out all at once, creating a fiscal cliff for counties and municipalities.

Increasing the rate at which hold harmless payments are reduced between FY17 and FY20 would allow counties and municipalities to absorb the lost revenue more effectively. LFC staff analyzed two scenarios, one where payments were reduced an additional 10 percent annually through FY20, and the other where payments were reduced by an additional 15 percent annually. If payments were reduced 10 percent, this would result in an average $2.4 million less annually in hold harmless payments overall, and a total of $18.2 million would be phased out after FY20. If payments were reduced by 15 percent, the result would be an average $3.3 million less overall in hold harmless payments annually, with the final phased out amount totaling $14.5 million after FY20.

Chart 30. Projected Medical Hold Harmless Payments FY17-FY20
(in millions)



Source: TRD, LFC Files

Increasing the rate at which hold harmless payments are reduced would more closely match the original intent of legislation, potentially make more revenue available to the general fund, and allow counties to more effectively adjust budgets.

Recommendations

The Legislature should consider:
Amending statute to increase the rate at which hold harmless payments to counties and municipalities are reduced between FY17 and FY20.

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary

October 26, 2015

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

Dear Mr. Abbey:

The New Mexico Human Services Department (HSD), the New Mexico Department of Health (DOH), the New Mexico Corrections Department (NMCD), the Children, Youth and Families Department (CYFD), and the Department of Finance and Administration (DFA) have reviewed the Legislative Finance Committee's evaluation report, Leveraging Federal Medicaid Funds, in the short amount of time given. This letter and corresponding attachments, submitted by HSD and on behalf of DOH, NMCD, CYFD, and DFA, serve as our preliminary review.

Given the high rate of federal funds provided per dollar of State funds in most Medicaid programs, it is important that states carefully review opportunities to leverage federal funding. However, given the critical nature of the services being funded through State-funded health care programs, it would be irresponsible to simply assume that patients currently being served by State-funded programs will be funded by Medicaid and therefore to reduce State funding. In addition, the LFC should be aware that state agencies are continually reviewing all programs to determine the most appropriate source of funding. It is important to recall that Medicaid spending is not free to the state, and that Medicaid funded programs are already expanding at a rapid rate. Managing the growth in the program is already one of the largest financial challenges facing the state.

Conducting a comprehensive analysis of the LFC's proposed changes in the methods of funding critically important healthcare services was not possible given the limited amount of time that LFC has allowed for our responses. We will continue to identify where opportunities exist to expand Medicaid reimbursement and to reduce General Fund expenditures where appropriate. All of the agencies would like to emphasize that the LFC study should be viewed as a preliminary step in our common interest to maximize Medicaid reimbursement where appropriate but that the study needs further analysis and validation.

Revising reimbursement processes of the magnitude envisioned in the LFC study have significant operational and systematic impacts that cannot be immediately implemented. If the state were to implement these changes, sufficient lead time for programmatic and budget changes would be necessary to prevent disruptions to essential healthcare services. The DOH is particularly concerned by LFC's urgency because last year the LFC cut its Office of Facilities

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Management's budget by $3 million due to a premature analysis of when Medicaid reimbursement revenues would accrue to the Department. The DOH made very clear that those dollars would not accrue until much later than LFC was projecting. The LFC disregarded this information, the Department faced a significant disruption to its operations, and a $4 million supplemental was appropriated late in the year. DOH would ask that LFC consider the costs and negative impacts on essential public health services by driving insufficiently validated budgetary changes into policy.

The HSD is committed to continuing to work with other state agencies to optimize federal funds. The HSD agrees that increasing use of certified public expenditures is appropriate for certain programs. For example, we are working with the Medicaid school-based providers to implement a certified public expenditure process for that program and will continue to explore additional opportunities to do the same with other programs, such as with the DSH program. At the same time, it must be noted that increasing the use of certified public expenditures introduces additional risk into the Medicaid program as the Centers for Medicare and Medicaid Services (CMS) closely monitors and regularly audits such arrangements; Approval from CMS is not guaranteed.

For more specific responses to the LFC's recommendations, HSD, DOH, NMCD, CYFD and DFA have prepared separate attachments to this letter. Agency staff is available to work with the LFC on the common objectives of improving health outcomes while providing cost-effective health services to New Mexicans. We will continue to provide frequent updates to the committee and look forward to working with the Legislature over the next several years to continue to improve cost effective services for New Mexicans.

Sincerely,

Brent Earnest
Cabinet Secretary

cc: Retta Ward, Cabinet Secretary, DOH
Gregg Marcantel, Cabinet Secretary, NMCD
Monique Jacobson, Cabinet Secretary, CYFD
Tom Clifford, PhD, Cabinet Secretary, DFA
Michael Nelson, Deputy Secretary, HSD
Nancy Smith Leslie, Director, Medical Assistance Division, HSD

5 Attachments

SUSANA MARTINEZ, GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

RETTA WARD, CABINET SECRETARY

23 October, 2015

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

Response to LFC's 2015 Opportunities to Leverage Federal Medicaid Funds Study

Dear Mr. Abbey:

DOH has made a preliminary review of this study. A comprehensive analysis of LFC's proposed changes in the methods of funding critically important public health services would be impossible in the extremely limited amount of time that LFC has allowed for our response. DOH is providing here a summary of technical errors and insufficiently analyzed assumptions that are part of the current study draft (please see attachment), and has requested additional time to work with LFC staff to validate where opportunities exist to expand Medicaid reimbursement and to reduce General Fund, as well as to validate the actual fiscal impact of those potential reimbursements. LFC has refused to extend the time for our initial response, and is choosing to keep to the original release schedule. With that in mind, the Department would like to respond as follows:

- We agree with LFC that where opportunities exist to reduce General Fund expenditures via an expansion in Medicaid reimbursement for covered services, it is good fiscal policy to expand reimbursement. DOH is already aggressively working on this with respect to the impacts on a post Affordable Care Act public health operating arena.

- LFC is choosing to rush a study of this critically important fiscal issue into potential policy without sufficient vetting by the programs that manage these processes. The Department cannot emphasize more strongly that the LFC study is a preliminary step in our common interest in maximizing Medicaid reimbursement that needs to be further validated.

- DOH is particularly concerned by LFC's urgency because last year LFC cut our Office of Facilities Management's budget by $3 million due to a premature analysis of when Medicaid reimbursement revenues would accrue to the Department. DOH made very clear that those dollars would not accrue until much later than LFC was projecting. LFC disregarded this information, the Department faced a significant disruption to its operations, and a $4 million supplement was needed late in the year. DOH would ask that LFC consider the costs and negative impacts on essential public health services by driving insufficiently validated budgetary changes into policy.

- The potential programmatic impact if LFC's scenario recommendations in this report were to be implemented would likely result in cuts to critically important public health services.

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- Revising reimbursement processes of the magnitude envisioned in the LFC study have significant operational and systematic impacts that cannot be immediately changed. If the state were to implement these changes, a three year interim period would be a minimum requirement to prevent disruption to essential public health services.

- More broadly, LFC staff are legitimately concerned about rapid increases in health care costs, in which the rate of increase is clearly unsustainable over time, especially in the area of chronic disease. The Department has developed aggressive strategy and strategy implementation to reduce costs and improve health status by moving upstream with preventive health and wellness initiatives that invest in preventing rather than treating disease, and is working with partners across the health system to reduce costs and improve health outcomes in a post ACA world. As this is the only viable and cost effective approach to prevail against the growing cost of health care, the Department finds it counterproductive that LFC appears to be focused on cutting public health investments rather than working to prioritize them.

Again, the Department is available to work with LFC on our common objective of providing cost-effective health services to New Mexicans. LFC's Medicaid expansion study has limited value because the critically important steps of analysis and validation have not been done.

Sincerely,

/s/

Retta Ward
Cabinet Secretary
New Mexico Department of Health

Cc: James Ross
Lynn Gallagher
Jeremy Averella
Tres Schnell
Cathy Rocke
Brent Earnest
Mark Williams
Cathy Stevenson
Dawn Hunter
Nancy Smith-Leslie

Attachment: HSD Response to LFC Report, "Leveraging Medicaid"

New Mexico Department of Health Recommendations

The potential programmatic impact if LFC's recommendations in this report were to be implemented would likely result in cuts to critically-important public health services. The DOH believes that several recommendations in the report would not result in additional opportunities to leverage federal funds as those programs receive general fund allocation to support administrative functions and not direct services. For example, the school-based health center (SBHC) program utilizes the general fund monies to support staffing and administrative functions its SBHCs. The SBHCs receive reimbursement for medical services directly from the managed care organizations (MCOs). The Department provides federal match to DOH for its administrative costs related to oversight of the school-based health centers through a General Services Agreement (GSA 16-8-8000).

Additionally, due to current budgetary constraints in the Medicaid program, it is not optimal to seek state plan amendments for expansion of services at this time. The LFC recommends an expansion of services for special populations, such as users of tobacco cessation services or diabetes management and control. The MCOs have existing programs for these special populations, including effective disease management programs. Also, licensing of tobacco cessation counselors would require additional Medicaid funding since federal rules do not allow funding of group counseling without a licensed counselor. Similar requirements would apply to disease prevention and control services.

New Mexico Corrections Department Recommendations

The Department has actively engaged with the NMCD to leverage Medicaid funds for reimbursement of short-term inpatient hospital admissions for its jail-involved population. This program began in early 2015 and continues to expand. The Department supports this recommendation.

Children, Youth and Families Department Recommendations

The report suggests that the Department reduce the percentage of administrative costs paid to the MCOs, yet recommends that the MCOs expand administrative functions and assume existing costs of CYFD's home visiting program as well as DOH's trauma trust fund. These recommendations are less about leveraging existing funds and more about replacing one funding stream with another. The Department has established a care coordination system in Centennial Care that includes home visits for members with complex conditions and needs. At this time, considering the Medicaid budgetary implications, the Department does not plan to submit a state plan amendment to expand Medicaid services.

New Mexico Human Services, Behavioral Health Services Division Recommendations

While the Department is exploring the option to bring the management of non-Medicaid behavioral funds into the Behavioral Health Services Division (BHSD), it disagrees with recommendation for the BHSD to reallocate savings garnered from the Medicaid expansion.

Non-Medicaid funds are being used to support services that Medicaid does not pay for, such as NMCAL and its warm line, and adult substance use disorder and residential treatment services. With increasing deaths due to drug use in New Mexico, the recommendation does not appear to be in the best interest of the state. Also, there remains a subset of individuals without insurance coverage who rely on the behavioral health services provided with non-Medicaid funds.

New Mexico Human Services, Other Options Recommendations

The report expands its defined scope of identifying additional opportunities to leverage Medicaid funds to include recommendations about the capitation rate development process for Centennial Care, and restates recommendations that were previously presented in the LFC's Centennial Care evaluation report earlier this year. An entire report section is devoted to reducing managed care organizations' administrative costs. While outside of the scope of leveraging funds, the recommendation to reduce the administrative costs incorrectly assumes that the MCOs are paid a fixed rate of 15 percent in the capitation rates for administrative costs. This is not correct; and, therefore, conclusions based on that erroneous assumption are incorrect.

Administration and underwriting gain is developed and applied to the projected medical cost; however, for calendar year 2015, these loadings were not applied to the increased medical cost associated with the safety net hospital fee increases or increases related to Hepatitis C treatment costs. The LFC is applying 15 percent to the total projected cost of the managed care program that includes such increases. This overstates administration costs.

Analysis of the Centennial Care CY 14 MCO financial experience reflected an overall administrative expense of 8.7 percent and 5.4 percent for the provision of assessments and premium taxes, including the health insurance provider fee. The underwriting gain or profit is specifically developed and should not be a consideration for reduction. It is currently at about 2.25 percent. The LFC's conclusion to reduce the allowable MCO profit to 1.5 percent does not seem to factor the costs associated with the NMMIP assessment and premium taxes in the capitation premium. NMMIP assessments and premium taxes are fixed amounts that cannot be adjusted or reduced.

There are three primary components that comprise the total premium amount. To state it simply: premium amount = medical costs + administration + profit. In its contract with the MCOs, the Department has fixed two of these components--the amount available for administration (15%) and the amount available for profit (3%) and currently pays the MCOs at a lower rate for both of those components in the capitation payment. The LFC recommendation is to further reduce both the administration rate and the profit, which then leaves the MCOs with only one flexible lever with which to manage the program—medical costs. This restrictive strategy is not likely to produce the intended results we are striving to achieve, namely increased access to care and better health outcomes under Centennial Care.

New Mexico Medical Insurance Pool (NMMIP) Recommendation

The NMMIP serves as a perfect example of successful leveraging of Medicaid funds. Individuals who were unable to purchase insurance in the commercial market were able to have healthcare coverage through a high-risk pool, heavily subsidized with federal funds leveraged through the Medicaid program. This report, however, recommends discontinuing such leveraging of Medicaid funds for NMMIP, which contradicts the overall purpose of the report.

County Indigent Funds Recommendation

The recommendation that the Department establish a safety net care pool for federally-qualified health centers (FQHCs) would require a state plan amendment. Proposing rate increases or supplemental payments to FQHCs without including additional services that are to be provided by the FQHCs is not likely to be approved by CMS.

Attachment: CYFD Response to LFC Report, "Leveraging Medicaid"

From Report:

"Home visiting funding has increased rapidly, coupled with increasing costs per participant family. *Total funding for home visiting services administered through the Children, Youth, and Families Department (CYFD) stands at $14.3 million in FY16. General fund support has more than doubled between FY12 ($2.3 million) and FY16 ($7.5 million). While funding from other sources, including federal grants such as Temporary Assistance for Needy Families (TANF) and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, has also increased, the program still heavily relies on the general fund. Home visiting, as a comprehensive program, is not currently a Medicaid-billable service.*

For FY16, CYFD contracted with 33 providers to offer home visiting services to approximately 2,600 families, for a total of $10.4 million. This represents about a 14 percent increase in contract funding from $9.1 million in FY15; however, the FY16 contracts are to serve about 370 fewer families, a 12 percent decrease. Based on these contracted service levels, the average cost per family increases by 30 percent, from $3,018 to $3,931. This cost change is due to a new methodology CYFD is using for classifying providers based on the level of service provided, taking into account factors such as higher travel costs in rural areas."

CYFD Response:

In State Fiscal Year 2015, the total number of families contracted to be served was originally overstated due to prenatal visits being added to the total, in error. Prenatal visits were already included in the total number of families to be served in the contracts/agreements.

The State Fiscal Year 2015 corrected total number of families to be served is 2,281. The State Fiscal Year 2016 total number of families contracted to be served is 2,646.

The above statement highlighted in yellow should read: "This represents about a 14 percent increase in contract funding from $9.1 million in FY15. The FY16 contracts are to serve about 365 additional families, which represents an increase of 16 percent."

From Report:

Currently, New Mexico has a limited array of program models in practice that may meet qualifications for potentially reimbursable, medically-based services. These include the Nurse-Family Partnership (NFP) and the First Born Program.

CYFD Response:

First Born is not yet a nationally recognized Evidence-Based Model. CYFD is not aware of formal documentation which identifies "Medicaid Eligible" Home Visiting Models. The two models implemented in New Mexico that are recognized by MIECHV are Nurse Family Partnership and Parents as Teachers.

When New Mexico considered home visiting models, based on MIECHV available funding and the needs of the diverse population to be served, it was necessary to preserve a mixed model of both Standards Based (with the implementation of an approved researched-based curriculum) and Standards Based Plus (with the implementation of an evidence model).

From Report:

The sole provider operating NFP in New Mexico is the UNM Center for Development and Disability, using federal MIECHV grant funding passed through CYFD.

CYFD Response:

Currently, there are no other entities that can sustain this model. CYFD operates as more than a pass-through agent. The administration of the program requires monitoring for compliance with the fidelity of the model, development of training and technical assistance for implementation, recording and reporting data and providing ongoing reports for accountability and outcomes to the federal government as well as reporting for the annual HV accountability report.

From Report:

First Born currently operates in 16 counties through a variety of providers, but not all receive funding through CYFD.

CYFD Response:

Considering all of the HV First Born Programs, CYFD does not fund CHI St Joseph's Children, FBP Hidalgo County and part of the First Born of Northwest New Mexico. Programs are encouraged to apply when the RFP process is released and they can select a model that meets the needs of their community as long as the Standards are met as a base for services.

From Report:

In Minnesota, the Family Home Visiting Program uses a model whereby local health offices contract with providers, and may receive Medicaid reimbursement pursuant to contracts between MCOs and the local health offices.

CYFD Response:

It is CYFD's understanding that Minnesota's funding is not stable and the state does not have an integrated Home Visiting system. One of their concerns is the state's dependence on federal funding – particularly MIECHV. The potential cuts that this funding may be facing in future years may eliminate their Home Visiting System at its current level. Minnesota recently reached out to CYFD (November 2014 to be specific) and requested that we share our model (Standards Based with the choices of evidence model) and the HV Accountability Act, funding, etc. They

were particularly interested in the model being unified as a single state system based on specific researched-based standards, with a comprehensive training and technical assistance support component and a robust data system that has allowed New Mexico to make funding decisions.

From Report:

New Mexico may be able to incorporate home visiting services into Medicaid managed care. *By adopting a model similar to that used in Minnesota, New Mexico could leverage Medicaid's ability to pay for certain services performed during home visits, such as maternal and child wellness screenings and assessments.*

CYFD should work with HSD to:
Propose a state plan amendment to add qualified home visiting services to the list of Medicaid-eligible services or

Alternately, create a pilot program for using Medicaid managed care to fund medically based home visiting services.

HSD should require MCOs to cover services related to home visiting in their Medicaid contracts, but consider requiring preauthorization to manage costs.

CYFD Response:

Currently, the State does not have the infrastructure to support the recommendations in a state-wide effort. In addition, the possibility of reimbursement by Medicaid may not be sufficient to sustain expansion in unserved (or currently served) areas since, based on feedback from other states (such as Minnesota), the funding fluctuates making continuity of care challenging.

Attachment: DFA Response to LFC Report, "Leveraging Medicaid"

Legislative Finance Committee (LFC) staff provided an excerpt from the embargoed copy of "Opportunities to Leverage Federal Medicaid Funds" to DFA Local Government Division (LGD) staff on Thursday, October 22. LGD staff was instructed to provide a response by Friday afternoon October 23. This is not an adequate amount of time for LGD staff to thoroughly evaluate the proposals included in the draft report. The following comments are therefore a preliminary response only, and additional time will be required to adequately evaluate the proposals in the LFC report.

On pages 43 and 44 of the embargoed copy of "Opportunities to Leverage Federal Medicaid Funds", the argument is made that the Local DWI Grant Fund (LDWI Fund) funds various county-level substance abuse treatment programs that could be funded through Medicaid. Specifically the report mentions: (1) intensive outpatient treatment; (2) inpatient detoxification services; and (3) other outpatient substance abuse treatments not clearly eligible for Medicaid but potentially eligible. The report provides an estimate of $2.445 million in LDWI program revenues that could be freed up for other services by substituting Medicaid funding. It is not clear from the report how this estimate was derived. Thus, LGD is unable to provide feedback on the accuracy or inaccuracy of the estimate.

There is not enough information contained in the draft report to determine whether DWI Offender treatment currently funded by the LDWI program could be funded through Medicaid. DFA is concerned that there may be significant obstacles to such a proposal. The following is a preliminary list of concerns, which will require additional research to verify:

1. DWI Offenders are court-ordered to treatment and there is a limited amount of time (the probation period) in which the court and the compliance monitoring programs have jurisdiction over an offender to ensure that he completes the treatment that is mandated by the court and the screening process.
2. To qualify for Medicaid services, the offender first must receive a clinical diagnosis from a Licensed Mental Health Counselor (LMHC), Licensed Professional Clinical Counselor (LPCC) or greater licensure which shows the services requested are medically needed. Most counties do not have access to counselors with this licensure so Medicaid would not pay for treatment of DWI offenders.
3. In counties where counselors with LMHC, LPCC or greater licensure are available through outside providers, the wait time for assessments could be up to 6 months just to schedule appointment for assessment to determine need. Treatment for DWI offenders is time sensitive given that the Judge orders it to be completed while they are on probation. 1st offenders are usually on probation for less than one year.
4. County LDWI programs offer evidence based treatment modalities known to reduce recidivism such as Moral Recognition Therapy (MRT), Craft (CRA), Motivational Interviewing (MI), etc. It is not clear if Medicaid providers are using evidence based treatment modalities.
5. San Juan County provides jail-based treatment and, as noted in the LFC report, Medicaid does not cover the cost of jail-based treatment.

6. The detoxification grant funds are intended to fund social detoxification programs, and not medical detoxification programs. (See LDWI Program Guidelines p. 36).

Some of the county programs administering LDWI funds already take steps to coordinate funding with the Medicaid program. Rather than cutting program funding as recommended in the draft LFC report, DFA recommends these programs be carefully reviewed to determine whether they may have lessons learned that may be transferable to other counties.

Attachment: NMCD Response to LFC Report, "Leveraging Medicaid"

The draft report makes several assumptions that are unfounded in New Mexico and based on studies from other states. Recommendations should not be made until empirical data is collected. Assumptions being presented concerning savings from Medicaid reimbursements and reductions in General Fund may significantly impact the ability to pay our vendors and put NMCD at risk. NMCD is under a series of uncertainties as in the process of issuing an RFP to procure medical services and costs are anticipated to increase. Additionally NMCD has begun the mandatory treatment of Hepatitis C to qualified inmates at great expense to the State.

The LFC is also not taking into account that NMCD has expanded services based on changing to direct service provider with the knowledge that services needed (residential and transitional) are not covered by Medicaid. The money we have saved has been reinvested into those services. If they cut our budget by 5.2 million with anticipation of the cost savings, we will be forced to close our expansions because we will not be able to sustain without the funding.

Response to the first sentence on the third paragraph on page 25:

The calculated savings was for nearly the entire 2015 fiscal year, not the first five months of FY16. Cost savings in future fiscal years may not be typical. Please note that identifying Medicaid reimbursement is labor intensive and NMCD is limited in the staff available to continue the process, but NMCD will continue to do its best to capture these savings.

Response to the first sentence on the third paragraph on page 26:

This statement is misleading. The FY15 figures provided were YTD paid claims at the time of the request for information and are not complete. Claims are still being paid by Optum for services until December of 2015. As of September 28, 2015, Optum has paid the providers $5,244,302 and will continue to make payments and most likely spend the $5,681,494 awarded to them.

Response to the first sentence on the first paragraph on page 27:

This report suggests that NMCD could potentially save up to $5.3 million; however, services were not identified as described in the report and assumptions were blindly made about services qualifying for Medicaid reimbursement. Offenders may be eligible for Medicaid but the services provided may not be eligible for Medicaid reimbursement.

New Mexico Medical Insurance Pool

October 26, 2015

Mr. David Abbey, Director
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87505

Dear Mr. Abbey,

Thank you for the opportunity to respond to the LFC's "Program Evaluation: Opportunities to Leverage Federal Medicaid Funds", as it relates to the New Mexico Medical Insurance Pool (NMMIP). The NMMIP has played a vital role in the overall health system in New Mexico for almost 30 years and takes its role in that system and its transformation very seriously.

The NMMIP continues to serve its historical two-fold purpose: 1) a safety net for those who don't otherwise have access to health insurance coverage and 2) a buffer to stabilize the market from the shock of high-risk, high-cost patients. The implementation of the Affordable Care Act (ACA), with "guaranteed issue" without underwriting, does not negate either of these functions. The system is very complex, and implementation of the ACA has not been smooth nor has enrollment in the Exchange market been stellar. The market is not yet stable or without significant glitches and gaps in coverage. Furthermore, the exit of BCBSNM from the individual market has created additional disruption.

While the Board has been making concerted efforts to transition individuals from the NMMIP into Medicaid or the private (Exchange) market, they are committed to doing so responsibly, recognizing the impact that such transition of high-risk individuals may have, both on the individuals served, as well as the rest of the market. The legislature gave responsibility to the NMMIP for providing a safety net for the underinsured and uninsurable; and it is only prudent to avoid unnecessary disruption of such a complex system until the likely results are better understood, in order to avoid unintended consequences and the premature loss of a critical safety net or contributing to the failure of system transformation by overburdening the market.

The NMMIP Board respectfully requests that the recommendations put forth in this LFC report to expedite closure of the NMMIP be reconsidered and deferred. The Board will continue to work on depopulation of the NMMIP in a fiscally responsible and reasoned manner, being cognizant of the developments in the market and the appropriate role of the NMMIP in system transformation.

To fully understand this complicated issue, I offer a review of the history of the NMMIP and a discussion of the systems issues and gaps in coverage that still exist.

Background and Purposes of NMMIP

The NMMIP is a legislatively created nonprofit entity (NMSA 59A-54) developed in 1987 to address the needs of persons who were unable to obtain health insurance due to their occupation or health status. Its statutory stated purpose is to "to provide access to health insurance coverage to all residents of New Mexico who are denied adequate health insurance and are considered uninsurable." Coverage provided by the NMMIP is required to be equivalent to that provided in the small group market and premiums are set above market rates for similar coverage, rather than upon health status, but not more than 150% of the standard premium in the private market.

Over the years, other target populations were added to the statute to provide access to coverage without underwriting. *("Underwriting" means that premiums are based upon health status and anticipated cost of claims.)* Namely, those losing group coverage after being continuously insured for at least 18 months (mandatory Federal HIPPA requirements) and persons who are under 65 but on Medicare due to End-Stage Renal Disease or other disabilities and, therefore, do not have access to supplemental coverage. Medicare beneficiaries age 65 and above have guaranteed access to supplemental coverage without underwriting, but not those under age 65. Therefore, the needs of this population remain relevant. (The coverage of HIPPA-eligible individuals, while technically still required, is essentially moot, since they have full access to the private market.)

The NMMIP also serves the purpose of stabilizing the rest of the private health insurance market by keeping persons with high-risk (costly) health conditions in a separate experience pool, so that their high claims history don't negatively impact premiums for the rest of the private market. This has kept the premiums for the remainder of individuals lower.

The Funding Mechanism Allows the Risk to Be Spread Over a Larger Basis

To cover the costs of these high-risk individuals, when their premiums were not allowed to be set based on heath status, the legislature created a unique funding mechanism for the NMMIP. The losses, or costs of the program that are above and beyond that covered by premiums, are assessed to the health insurance companies doing business in New Mexico. As a condition of selling health insurance in New Mexico, all carriers have to pay their share of the losses, based on their share of premium business in the state. Since there are more than 200 insurance companies doing business in the state, this allows the losses of the NMMIP enrollees to be spread over a much larger population that includes insured individuals, those on Medicaid and small and large employer group plans. (Self-insured plans are not included.)

To ease the impact of the losses on premiums in the rest of the market, the legislature provided premium tax credits for the insurers who were paying the assessment of losses. The legislature also agreed to consider the state portion of Medicaid payments to MCOs as "premiums" for purpose of assessment. (The state Medicaid contribution is built into the rates and, therefore, eligible for federal match.) The premium tax credits received by the insurance companies are approximately 55% of the amount assessed. Thus, only about 45% of the amount assessed is actually passed on to the rest of the market through premium rates.

Enrollment and assessments reached an all-time high in 2013. With the implementation of the Affordable Care Act, enrollment in the NMMIP has been steadily declining and is expected to continue declining, as projected below. The 2015 projections are based upon actual experience. The 2016 budget is a conservative estimate based on actuarial projections.

Calendar YEAR	Year-End ENROLLMENT	Total ASSESSMENT	Estimated TAX CREDIT
2013	8,686	$122,987,911	$67,258,351
2014	5,038	$108,526,848	$59,689,766
2015 (Projected)	3,226	$59,927,268	$32,959,997
2016 (Budget)	2,530	$55,940,976	$30,767,537

Closing or Modifying NMMIP Presents Grave Consequences for the Insurance Market

State law requires health insurance carriers to spend at least 85% of premiums on direct health care. This is referred to as the "Medical Loss Ratio" (MLR). The other 15% is allocated to administrative costs and any profit. The cost to administer the NMMIP is about 5%. To put the cost of NMMIP enrollees into perspective, the MLR for NMMIP fluctuates between 450-500% of premiums. To state another way, the NMMIP premiums are set 30% above the average of an equivalent plan on the private market and still the premiums cover only about 20% of the cost. If all the NMMIP members were in the private market they would pay standard premiums, instead of NMMIP premiums that are 30% higher. Thus, the MLR for these members would be even greater.

If the NMMIP were closed, as proposed in the LFC report, the excess costs of these high-risk individuals would be spread over the small number of people enrolled in the individual private (Exchange) market only, rather than spread over the entire market of individuals, small and large employer groups and Medicaid. In other words, the costs - $55 million estimated for 2016 - would be spread to the relatively small number of individuals covered in the market rather than just $30 million spread over more than a third of the state population. This would result in a substantial increase in premiums for individual coverage.

Additionally, if essentially all NMMIP members were transitioned out of the NMMIP by the end of this year, as suggested by this report, the losses discussed above would actually fall solely on the four (4) carriers offering coverage in the individual market. They could not pass the costs on to the market in the form of higher premiums for 2016, since their rates are already set and cannot be adjusted for the increased costs. This would pose a substantially negative financial impact on these carriers. These four carriers must already absorb the negative impact of enrolling the individuals previously covered by BCBSNM, who were significantly more expensive than those enrolled in the other plans, without being able to adjust their rates to accommodate the higher claims expected. The full impact to the individuals insured would not hit until 2017 when premiums could be raised substantially. The serious impact of BCBSNM individuals moving into the rest of the market is the primary reason the Board decided to delay aggressive strategies for transitioning NMMIP members to the market, which would only add to the significant impact on the four carriers affected.

Finally, it is unclear whether this report correctly assessed the impact of closing the NMMIP on Medicaid. While it is correct that the Medicaid MCOs would no longer be assessed for their share of the NMMIP losses, they would also not be receiving any premium tax credits. The full cost of premium taxes would be built into the Medicaid rates and, thus, the positive impact to Medicaid by closure of the NMMIP might not be as high as projected by LFC. However, including Medicaid in the assessment of losses for the NMMIP has the added benefit of leveraging Federal Match to help cover the high costs of NMMIP members.

Populations that Still Need NMMIP: *Medicare Enrollees Under Age 65*

The NMMIP serves about 650 Medicare beneficiaries who are under the age of 65 and are enrolled in Medicare due to disability, many of whom are on dialysis. These individuals are enrolled in NMMIP's Medicare Carve-Out plan. This group does not have access to secondary coverage to help them pay for their high costs of care. They do not have access to the Exchange market and carriers currently do not have to offer coverage to this population. They also cannot select a Medicare HMO plan (Medicare Advantage) if they need dialysis, as those plans do not cover dialysis. The cost of high-cost services such as dialysis can be financially devastating to those without supplemental coverage.

While some states do mandate that all carriers offer coverage to this population if they offer plans to the 65+ population, it will require a statutory change to mandate such coverage in New Mexico. Such a change would need to be carefully considered or carriers may simply decide to no longer offer supplemental Medicare coverage to any age. And, as with the rest of the market, moving these individuals out of NMMIP will result in a higher premium for many more people.

Populations that Still Need NMMIP: *People Living with HIV/AIDS and Medically Fragile Children*

Currently, the NM Department of Health pays NMMIP premiums for two population groups, in order to be able to serve more people with the limited funds they have available. Those populations are medically fragile children and persons with HIV/AIDS. The children are low income but are not eligible for Medicaid and are unable to obtain other coverage due to their immigration status, including some who are legally present. The individuals with HIV/AIDS represent persons who are in the Medicare Carve-Out plan (discussed above), as well as those who are undocumented or not of the appropriate immigration status to allow enrollment in other plans. NOTE: Most of the medically fragile children and some of the HIV/AIDS individuals did move to private market coverage in 2015. However, BCBSNM was the only carrier offering coverage to individuals regardless of immigration status and, with their exit from the individual market, those former NMMIP enrollees will be coming back to the NMMIP in January since the NMMIP is the only remaining source of coverage.

It is not an appropriate solution to discontinue the only coverage available for these sick individuals, as suggested in this report. The risk of transmission of HIV/AIDS, in particular, poses a significant public health issue for New Mexico and cannot be dismissed without regard. Without affordable access to treatment, there is a very real risk of further spread of the virus and the State of New Mexico has an obligation to protect the health and well-being of all New Mexicans. In regard to the children, there may not be the same public health concern. However, there is a moral, and perhaps legal, obligation to fulfill the commitment undertaken by the State of New Mexico to care for these children. They cannot simply be dropped from coverage and put at risk for further deterioration in their health status, including possible death. The NMMIP is currently the most efficient means to assure appropriate care is available for these individuals.

Populations that Still Need NMMIP: *Gaps in Coverage and Need for Safety Net*

In addition to the under-65 Medicare individuals, medically fragile children and persons with HIV/AIDS, there are a number of other gaps in the current system of health insurance coverage. Until such time as Congress amends the ACA to address system gaps, and technical or administrative glitches are fixed, there remain a number of problems that result in barriers to individuals who are trying to obtain coverage; these gaps lock them out of the market and force them to be uninsured for some period of time. Having a safety net like the NMMIP available for New Mexicans who desperately need it is a responsible solution. Below are examples of what we are seeing in the market:

The “family glitch” is a significant barrier to affordable coverage for all family members. An employer may offer coverage for family members, but doesn’t have to pay any share of that coverage. However, the fact that group coverage is even offered, disqualifies low-income family members from going to the Exchange and getting subsidized coverage.

Self-insured employer plans, which are regulated by the federal government, are not required to provide comprehensive health insurance coverage. They must only meet very minimal coverage, which may consist of wellness and prevention benefits only – not hospitalization, pregnancy-related coverage, behavioral health, prescription drugs and so forth. While this is not common, we have had individuals apply to the NMMIP for whom this is occurring. We are concerned that, with the rising cost of health care, this could become an increasing trend.

There have been many people falling through the cracks related to Medicaid enrollment. As an example, someone could apply for Medicaid toward the end of Open Enrollment or apply to the Exchange and are initially denied the ability to enroll because it appears they may be eligible for Medicaid; but if the Medicaid determination of ineligibility is not received until enrollment in the market is closed, they are still barred from enrollment, even though they tried to enroll at the appropriate time. It’s important to understand it is not just the Exchange market that closes enrollment, but the entire private market.

There are also many people who are dropped from their private coverage due to premium lapse. There does not appear to be much, if any, flexibility or room for error in this regard. We have talked to individuals who moved and experienced a delay in receiving their forwarded mail so they missed invoices or communication about deadlines; individuals who have experienced identity theft or bank fraud and had to close accounts and make new arrangements for payment; individuals who were very sick or hospitalized and missed a timely payment; and individuals who attempted to pay their premium but had the incorrect amount. These are just a few examples but, unfortunately, when one of these situations occurs and the individual's coverage is dropped, they cannot reapply for coverage until the next open enrollment period.

Thank you for your consideration of the issues presented. The NMMIP Board is committed to responsible action in regard to the NMMIP, avoiding any unintended consequences, while duly considering the fiscal impact of the NMMIP on the State, the market and the people we serve.

Sincerely,

Deborah Armstrong
Executive Director

NEW MEXICO ASSOCIATION OF COUNTIES

October 26, 2015

Brian Hoffmeister
Program Evaluator
New Mexico Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87501

Via Email: brian.hoffmeister@nmleg.gov

Re: Leveraging Medicaid Funds Report

Dear Brian:

On behalf of the New Mexico Association of Counties (NMAC) and the NMAC Health Services and DWI Affiliates, we would like to thank you for the opportunity to respond to the portions of the Legislative Finance Committee (LFC) report on leveraging Medicaid funds that pertain to New Mexico counties. As always, NMAC appreciates the work that the LFC does with counties and the collaborative relationship we have shared over the years. Importantly, the insights and recommendations that the LFC makes on various county programs are always helpful in assisting counties in evaluating the effectiveness of and improving their programs.

It is important to emphasize that the community-based DWI and indigent care programs operated by the counties provide an essential safety net for our most vulnerable New Mexicans. As you know, these programs have assisted thousands of people over the years, and our county employees work on a very close and personal level with county residents. Counties' obligations to provide critical services continue to grow and expand, often without a commensurate increase in revenues. Notwithstanding this, we are committed to providing the highest level of services and to being responsive to the needs of our residents.

Our responses to the specific recommendations are included below:

DWI Program

- NMAC supports increased leveraging of Medicaid for treatment of DWI, to the extent this is feasible. There are a number of practical and legal impediments that make it difficult to have many clients treated by Medicaid providers.
- To begin with, most counties do not have access to counselors with the required licensure to qualify as Medicaid providers. This is especially true in rural areas.
- Wait times just for assessments with outside providers are often six months or longer.

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- There is often a need for wrap around services for these clients, most of which are not covered under Medicaid (for example, Medicaid does not reimburse for compliance monitoring (probation), anger management, domestic violence batters intervention treatment, case management, or aftercare, among others). In addition, Medicaid providers may not be using evidence-based treatment modalities.
- The number of clients that can be seen could be substantially reduced and the cost of treatment increased since Medicaid providers require additional support staff and treatment providers to comply with the myriad Medicaid requirements. Moreover, those with two or more DWI convictions are statutorily required to attend 26 weeks of substance abuse treatment, and Medicaid requires re-approval for treatment every six weeks. This could result in interruption of treatment which could have serious consequences, or in the provider continuing treatment without authorization resulting in the county having to pay the charges.
- LDWI-funded treatment is generally more comprehensive and has proven effective in reducing recidivism. Treatment begins within two weeks of the judgment and sentence, coverage and treatment is more comprehensive, and evidenced-based modalities that are known to reduce recidivism are used (e.g., moral recognition therapy, craft, and motivational interviewing).
- Some counties use this funding for jail-based treatment, which is not covered by Medicaid.

Indigent Healthcare Program

- The LFC report suggests that increasing revenues from the county indigent gross receipts tax increment could serve as a funding source for health care initiatives currently supported by the general fund. This is wholly unacceptable to counties, and makes a presumption—that the county indigent GRT is producing increasing revenues—that is not true in many counties. To begin with, the second 1/8 GRT increment is imposed locally by county commissions for the benefit of indigent residents in their counties. By mandating intergovernmental transfers, the state would once again be utilizing locally-imposed county taxes for a state purpose. This would result in significant shortfalls to many counties. It is inequitable and inappropriate to continue to require counties to impose taxes locally to fund state programs like Medicaid.
- In 2014 the Legislature passed SB 268 which imposed on counties an obligation to fund the Safety Net Care Pool (the equivalent of a 1/12 GRT increment). These funds are used to leverage federal funds for uncompensated care for sole community hospitals and for funding a Medicaid base rate increase. Many counties pay this requirement from the second 1/8 GRT, which severely limits the amount of funds available for county healthcare assistance programs. Only two counties have actually imposed the 1/12 increment authorized under SB 268 (Colfax and San Miguel Counties).
- GRT revenues in many counties are actually diminishing over time due to the phase out of the state hold harmless payments to counties for the food and medicine GRT, as well as the stagnation in the economy.
- The LFC report states that the statewide county indigent fund balance is approximately $31 million, and suggests "repurposing" these revenues and allowing the state to intercept them. The LFC reports erroneously states that in FY 15 $31 million "went

unused in county indigent funds." Ending fund balances do not take into account the fact that a substantial portion of these funds are encumbered and will be expended. It is important that the LFC show a detailed breakdown of fund balances as of July 1, 2014, the beginning of the fiscal year, total revenues and expenditures ending on June 30, 2015 (including the Safety Net Care Pool) for individual counties, and ending fund balance as of June 30, 2015.

- Counties are obligated to provide healthcare services to individuals incarcerated in their jails, as well as indigent undocumented immigrants. In addition, counties are often taking on responsibility for providing healthcare for individuals in their community who have substance abuse and behavioral health issues. This increasing obligation can be funded, in part, from the indigent health account. If the state intercepts these funds, it will leave the counties and many needy county residents in an untenable position.
- Counties continue to provide assistance to those individuals who do not qualify for Medicaid and who are not insured. In addition, counties cover services not covered by Medicaid and services provided by agencies and providers who are not eligible to receive Medicaid funds. (For example senior citizen dental services and substance abuse services.)
- Please see the attached graphs which depict how Doña Ana, San Juan, and Santa Fe Counties' FY 15 fund balance plus the indigent healthcare revenues will be spent in FY 16. As you can see, 80% of the FY 15 expenditures for San Juan County are for state-mandated programs, primarily the Safety Net Care Pool and county-supported Medicaid.

NMAC respectfully submits this response and requests that these comments are taken into account before the LFC moves forward with any legislative initiatives or program changes. NMAC and its affiliates are committed to continued collaboration with the LFC and all stakeholders to strengthen these important programs and to utilize dwindling resources and funding. Again, we thank the LFC staff for taking the time to work with New Mexico counties and to take input from our subject matter experts. We look forward to following up with them on the matters identified in this report, and to working with them in the future.

Sincerely,

Steven Kopelman
Executive Director

cc: Sharon Stover, NMAC President
David Abbey, LFC Director

APPENDIX A: OBJECTIVES, SCOPE, AND METHODOLOGY

Evaluation Objectives.

- Inventory key services and programs at HSD and other agencies that currently support Medicaid-eligible health care services using state or local funds;
- Identify existing barriers to using Medicaid funds for these services and possible solutions to overcome them; and
- Estimate potential savings in state and local dollars if services are transitioned to Medicaid funding.

Scope and Methodology.

- Interview agency staff;
- Review state and federal laws, regulations and policies – goals and objectives of reviewed programs;
- Review previous LFC evaluations and identify recommendations for better leveraging of expanded Medicaid funding;
- Review vendor contracts for health care services for NMCD and other agencies;
- Review department reports, Medicaid plans, waivers and any related documentation from CMS and CDC;
- Review public (CMS, GAO, other states) and private research and evaluations of health care financing and impacts of the Affordable Care Act;
- Collect financial and other aggregate utilization data from agencies;
- Review agency procedures for screening for Medicaid eligibility and working with Medicaid-qualified service providers;
- Review other state models for financing health care;
- Review county budgets and gross receipt tax collections;

Evaluation Team.

Brian Hoffmeister, Lead Program Evaluator
Maria D. Griego, Program Evaluator
Pam Galbraith, Program Evaluator

Authority for Evaluation. LFC is authorized under the provisions of 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 subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conferences. The contents of this report were discussed with the Secretary of the Human Services Department and his staff on October 19, 2015.

Report Distribution. This report is intended for the information of the Office of the Governor, the Department of Health, Human Services Department, 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.

Charles Sallee
Deputy Director for Program Evaluation

APPENDIX B: NET ESTIMATED FISCAL EFFECT OF RECOMMENDATIONS

Potential Net Savings and New Revenues from Opportunities to Leverage Medicaid
(in thousands)

Leveraging Medicaid Scenario 1	(Net Savings or New State Revenue in Parentheses)			
	General Fund	Federal Funds	Local Funds	Other
Department of Health - Improved Billing Only	($8,695)	$9,813		($1,814)
Corrections Department	($10,396)	$10,396		
CYFD - Home Visiting Pilot	($350)	$350		
HSD - Behavioral Health Services Division	($70)			
HSD - Reduce MCO Administration and Profit	($14,364)			
NMMIP - Collect Previously Forgone Revenues*	($47,700)			
LDWI				($2,445)
Total	**($81,575)**	**$20,559**	**$0**	**($4,259)**

Leveraging Medicaid Scenario 2	(Net Savings or New State Revenue in Parentheses)			
	General Fund	Federal Funds	Local Funds	Other
Department of Health - Improved Billing and Replacement of General Fund with Local Funds and MCO Payments	($25,835)	$20,143	$7,920	($1,566)
Corrections Department	($10,396)	$10,396		
CYFD - Home Visiting State Plan Amendment	($4,620)	$6,720		
HSD - Behavioral Health Services Division	($70)			
HSD - Reduce MCO Administration and Profit	($14,364)			
NMMIP - Collect Previously Forgone Revenues*	($47,700)			
LDWI				($2,445)
County Indigent Funds			($7,920)	
Total	**($102,985)**	**$37,259**	**$0**	**($4,011)**

* NMMIP effects represent a decrease in premium tax credits and assessments paid by MCOs

APPENDIX C: MEDICAID REVENUES TO PROGRAMS DELIVERED AT PUBLIC HEALTH OFFICES

Medicaid Revenues to Programs Delivered at Public Health Offices, FY14-FY15

	FY14	FY15
Breast & Cervical Cancer Screening	$3,510	$1,897
Epidemiology Services	$23,173	$6,516
Family Planning	$787,016	$1,478,491
Harm Reduction	$24,973	$107,043
Immunizations	$161,365	$262,510
Refugee Health	$75,646	$142,905
Sexually Transmitted Disease Intervention	$215,432	$624,951
Tuberculosis Prevention	$28,155	$56,875
Undefined	$46,043	$115,701
Total	**$1,365,313**	**$2,796,889**

Source: DOH

APPENDIX D: NEW MEXICO TRAUMA CENTERS

Facility	Level	FY16 Funding
University of New Mexico Hospital	1	$929,191
Carlsbad Medical Center	3	$164,821
Christus St Vincent's	3	$296,844
Eastern NM Medical Center	3	$164,183
Gallup Indian Medical Center	3	$168,387
Gerald Champion Medical Center	3	$185,084
San Juan Regional Medical Center	3	$301,044
Miners Colfax Medical Center	4	$61,967
Nor-Lea Regional Medical Center	4	$80,596
Roosevelt Medical Center	4	$72,619
Sierra Vista Hospital	4	$74,495
Union County Medical Center	4	$64,076
Mountain View Regional Medical Center	Developing	
Total FY16 Funding		**$2,591,474**
Trauma System Allocation (DOH)		**$197,196**

Source: DOH

APPENDIX E: TRAUMA CENTER REPORTING REQUIREMENTS

Trauma Center Data Reporting Requirements

Unique patient identification number assigned to the patient by the facility
Level of transporting agency
Pre-hospital run sheet number
Date of ED arrival
Time of ED arrival
Date of incident
Initial hospital
Facility patient was transferred from
Name or name code
Date of birth
Sex
Race
Patient's trauma identification number (same as b above in section 1)
Social security number
Home zip code
Mechanism of injury (narrative)
E Code, including E Code 849
Occupational injury (yes/ no)
Safety restraint/ device used
Time of patient radio report
Trauma team activated (yes/ no)
Activation response times
(a) Time of activation
(b) Time of call to surgeon
(c) Time of arrival of surgeon in ED
(d) Time of arrival of subspecialist
Initial vital signs in ED
(a) Systolic blood pressure
(b) Respiratory rate
(c) First temperature
(d) Glasgow coma score

ED respiratory status
ED procedures performed
ED discharge time
ED discharge disposition
Admitting service
CT scan of head done (yes/ no)
(a) Date of head CT scan
(b) Time of head CT scan
Initial surgery
(a) Date and time patient arrived or
(b) Date/ time operation started
(c) ICD-9- CM procedure code
(d) Infused red blood cells
Length of primary stay in ICU
Co- morbidity complications
Disability at acute care discharge
(a) Feeding
(b) Locomotion
(c) Expression
(d) Rehabilitation potential
Date of facility discharge
Discharge disposition
Extended care facility ID number
Autopsy done (yes/ no)
Date of death
Organ/tissue donor (yes/ no)
Final ICD-9 discharge code
Unplanned readmission
Payer source
Total billed charges

Source: NMAC 7.27.7.34

APPENDIX F: TRAUMA CENTER FUNDING IN OTHER STATES

Sources of Trauma System Funding by State			
State	**Source of Funding**	**Estimated Annual Revenue**	**Year Initiated**
Arizona	Indian Gaming Tax (28%)	$19 million-$23 million	2002
Arkansas	Cigarette Tax (56 cents/pack	$25 million maximum	2009
Georgia	"Superspeeder" Fines	$23 million/year	2009
Hawaii	Cigarette Tax, general fund, and variety of traffic violations	$4.7 million	2006
Maryland	Motor Vehicle Registration	$14 million	2004
Mississippi	Motor vehicle moving violations	$12.7 million	2008
Ohio	Seatbelt Fines	$750 thousand/biennium	Not available
Pennsylvania	Subset of Disproportionate Care	$15.1 million federal and $12.5 million state	2004
Tennessee	Cigarette Tax	$12million	2007
Texas	DUI offenses and interest from Tobacco Settlement	$23 million	Not available
Virginia	Drivers license and motor vehicle registration reinstatement fee and subsequent (after 2nd) DUI offenses	$7.1 million	2004
Washington	Motor vehicle moving violations ($5/occurrence) and motor vehicle registration ($4)	$16.3 million	1997
Wyoming	Gasoline tax (25 cents/gallon)	Not available	2010

Source:JLARC of Virginia Legislative Assembly

The amounts generated by state actions suggest medical services may be funded. New Mexico's Trauma Trust Authority only reimburses for non-clinical services associated with trauma education and system data collection for provider and administrative expenses for the managing state agency. New Mexico relies totally on general funding for these functions.

APPENDIX G: MEDICAID HOME VISITING MODELS IN OTHER STATES

Selected Medicaid-Funded Home Visiting Programs in Other States

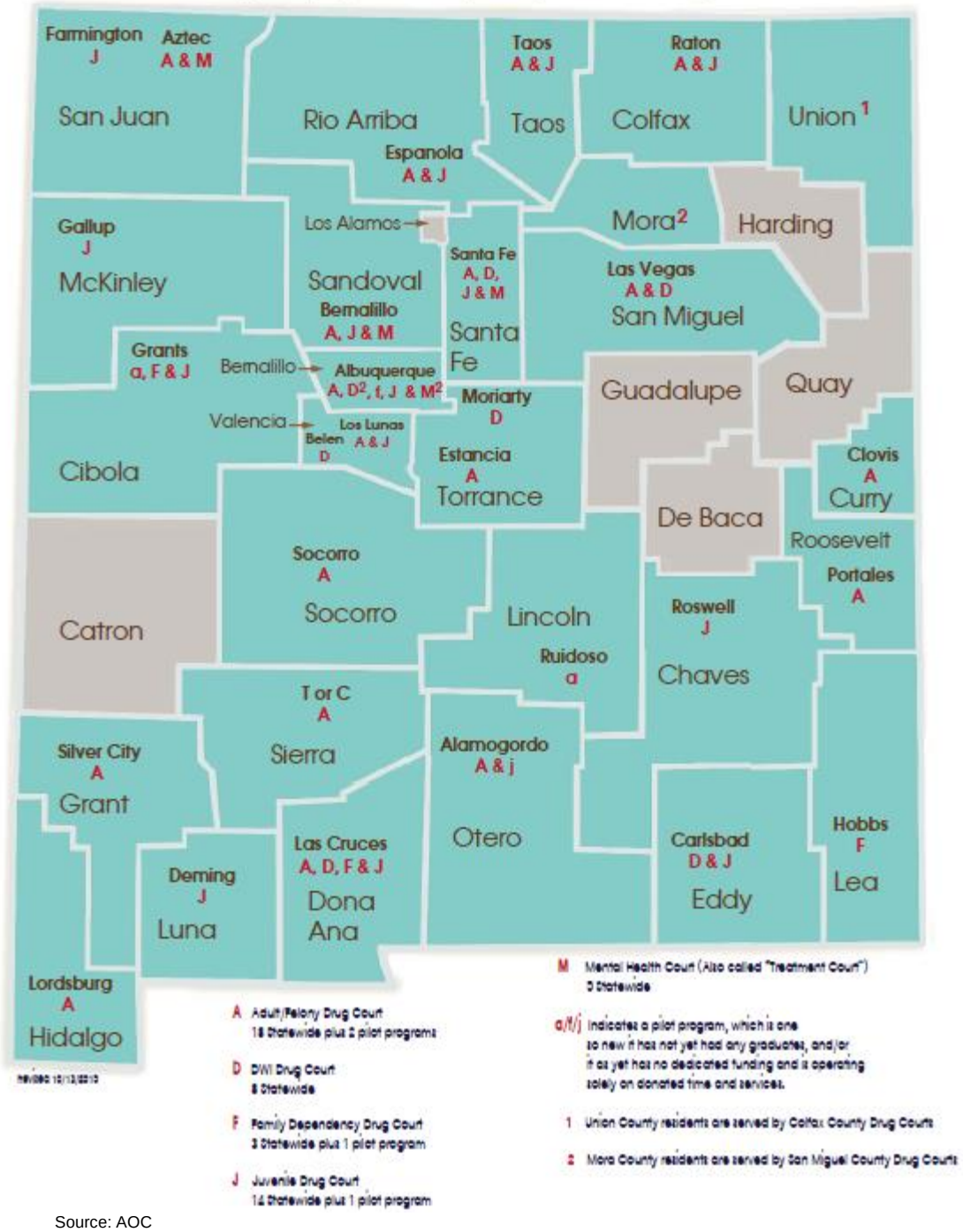
State/Entity	Medicaid Funding Mechanism	Description
Illinois	Administrative Case Management	Qualified case managers in Family Case Management Program may conduct home visits prenatally and during first year of child's life. Medicaid is billed on a FFS basis for outreach and case management for "coordination of medical and medically-related services." Uses state general fund revenues with a 50 percent federal match.
Kentucky	Targeted Case Management	HANDS Program provides home visits to new and expectant parents. The state used a state plan amendment to make the program available to Medicaid-enrolled parents under targeted case management, and it receives the full FMAP. The program was expanded from first-time parents to include parents who already have a child in The program bills Medicaid using codes for professional and paraprofessional home visits as well as intake assessments. Prenatal home visiting is billed using the parent's Medicaid number, while services after birth are billed using the child's number.
Michigan	Traditional Medicaid	The Maternal and Infant Health Program (MIHP) is essentially a benefit of the traditional state Medicaid program. Care coordination and intervention services are provided by registered nurses and licensed social workers, and may also include registered dieticians and infant mental health specialists. Home assessments and professional home visits are billable benefits. While not included in managed care, contracts require MCOs to provide outreach and referrals to MIHP services for eligible beneficiaries where appropriate.
Minnesota	Managed Care	The Family Home Visiting Program is locally focused. Local health departments screen participants for eligibility and risk factors and contract with providers. Local health departments receive formula-based block grants, and services may be reimbursed by Medicaid FFS, or via managed care through contracts between MCOs and local health departments.
Vermont	Global Section 1115 Waiver	Home visiting services are provided through the Nursing and Family Support portion of the Children's Integrated Services (CIS) Program. This portion of the CIS program is funded through Medicaid as a TCM component under a section 1115 waiver and is open to all Medicaid enrollees who are identified at risk. The state uses billing codes for home health visits for women, infants, and children aged 1-5, with rates based on risk levels. A pilot program within this is using bundled payments to regions, which pay providers monthly rates for each client. Under the waiver, unspent funds may be used for clients who are not otherwise Medicaid-eligible.
Washington	Targeted Case Management and Traditional Medicaid	The Maternity Support Services (MSS) and Infant Case Management (ICM) components of the First Steps Program allow for services to be delivered at a beneficiary's home. Services are delivered by local interdisciplinary teams established by providers. MSS is provided through 60 days after birth, and ICM may be provided from the first day of the month following pregnancy through the month of the first birthday. Medicaid reimburses MSS on a FFS basis, and ICM through Targeted Case Management in 15-minute service units.

Source: Pew Charitable Trusts, Illinois Department of Human Services, Kentucky Cabinet for Health and Family Services, Michigan Department of Health and Human Services, Minnesota Department of Health, Department of Vermont Health Access, Washington State Health Care Authority

APPENDIX H: MAP OF PROBLEM-SOLVING COURTS

NEW MEXICO PROBLEM-SOLVING COURTS:
DISTRICT, METROPOLITAN, AND MAGISTRATE

As of July 2015, 27 counties (green-colored) have at least one drug court program, while only 6 (beige-colored) do not yet.



Source: AOC