



New Mexico Human Services Department

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The Honorable Danice Picraux, Chair
Legislative Health & Human Services Committee
4308 Avenida la Resolana, NE
Albuquerque, New Mexico 87110

The Honorable Dede Feldman, Vice-Chair
Legislative Health & Human Services Committee
1821 Meadowview, NW
Albuquerque, New Mexico 87104

Dear Chairwoman Picraux and Vice-Chairwoman Feldman:

Thank you for the opportunity to testify before the Legislative Health and Human Services Committee (LHHS) at its June 2 hearing. My notes from that meeting listed several items of follow-up that were requested by the Committee members, and which are addressed in this letter:

Co-Pay Amounts

Senator Rodriguez requested a list of co-pays and corresponding income levels for the Children's Health Insurance Program (CHIP), Working Disabled Individuals (WDI) program, and State Coverage Insurance (SCI) program. These co-pay amounts are outlined below.

Program	Income Level	Co-Pay Amount(s)
CHIP	185% - 235% FPL	<ul style="list-style-type: none"> • \$5 per outpatient physician visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session, or behavioral health session • \$5 per dental visit • \$15 per emergency room visit • \$25 per inpatient hospital admission • \$2 per prescription (applies to prescription and non-prescription drug items)
WDI	Up to 250% FPL	<ul style="list-style-type: none"> • \$7 per outpatient visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session, or behavioral health session • \$7 per dental visit • \$20 per emergency room visit

		<ul style="list-style-type: none"> • \$30 per inpatient hospital admission • \$5 per prescription (applies to prescription and non-prescription drug items)
SCI	Up to 100% FPL	<ul style="list-style-type: none"> • \$3 per prescription
	101% - 150% FPL	<ul style="list-style-type: none"> • \$5 per outpatient physician visit, hospital inpatient maternity visit, home health visit, outpatient therapy session, urgent care visit, or behavioral health session • \$5 for durable medical equipment (DME)/supplies • \$25 per inpatient hospital admission, including maternity • \$25 per inpatient behavioral health visit or inpatient detox • \$15 per emergency room visit • \$3 per prescription
	151% - 200% FPL	<ul style="list-style-type: none"> • \$7 per outpatient physician visit, hospital inpatient maternity visit, home health visit, outpatient therapy session, urgent care visit, or behavioral health session • \$7 for DME/supplies • \$30 per inpatient hospital admission, including maternity • \$30 per inpatient behavioral health visit or inpatient detox • \$20 per emergency room visit • \$3 per prescription

It should be noted that there are certain co-pay exclusions, which are exempt from co-pay responsibilities. These include:

- Preventive, prenatal care and contraceptive management services;
- Services provided at Indian Health Service (IHS) facilities, by urban Indian providers and by tribal 638 programs;
- Services provided during presumptive eligibility or retroactive eligibility periods; and
- Services provided to Native Americans.

There are also co-pay maximums for these programs, which must be tracked by enrolled individuals or families. The family maximum co-pay for CHIP ranges from three to five percent of annual income, based on FPL; for WDI, the maximum ranges from \$600 to \$1,500 per year based on FPL; and for SCI, the maximum is five percent of family income per benefit year.

MCO Reductions

Senator Ortiz y Pino requested a list of reductions that were considered in the *Salud!* managed care organization (MCO) rates for FY10. These reductions included:

- Changing vision benefits for adults to every three (rather than every two) years;
- Eliminating coverage of bariatric surgery (gastric stapling, etc., for weight loss);
- Raising the scale on orthodontic services;
- Implementing rate reductions for most providers;
- Revising radiology rates for outpatient hospital to equal Medicare rates;
- Increasing third-party liability (TPL) activities;
- Reducing the MCO profit cap to three percent; and
- Lowering rates to ensure that the MCOs paid the state maximum allowable cost (SMAC) price for pharmacy drugs.

Colorado Hospital Provider Tax

Several committee members requested additional information about a hospital provider tax that was implemented in Colorado in 2009. Colorado is using a 5.5 percent assessment on hospital providers as a mechanism to generate new in-state funds and match them with federal dollars for its Medicaid program. It should be noted that the cost of the tax in Colorado has been promised back to providers through an increase in Medicaid reimbursement rates. (If the taxes returned to a provider are less than 5.5 percent of the provider’s revenues, federal prohibitions against guaranteeing the return of tax funds are not violated. As a result, a state can impose a provider tax of 5.5 percent, return those revenues back to those providers in the form of a Medicaid “payment”, and receive a federal match for those amounts.)

In Colorado, implementation of the hospital provider tax is expected to raise \$600 million annually, which will be matched with \$600 million in federal Medicaid funds. The resulting money – as much as \$1.2 billion – will be used to expand health coverage for Colorado’s uninsured population.

Medical Assistance Division (MAD) staff has calculated estimates of how much a hospital provider tax of 5.5 percent could generate in New Mexico. These numbers are based on the most recent fiscal projections for the Medicaid program:

- A 5.5 percent tax on in-state, inpatient hospitals would generate approximately \$6.2 million (state and federal funds combined); and
- A 5.5 percent tax in-state inpatient and outpatient hospitals would generate approximately \$10.1 million (state and federal funds combined).

Implementation of LFC Recommendations

Representative Chavez requested information from the Department regarding the measures that were and were not implemented as a result of the Legislative Finance Committee’s (LFC) 2009 Medicaid managed care audit. Please refer to the matrix on the following pages for a complete listing of the LFC’s recommendations and HSD’s responses to each finding:

LFC Recommendation	HSD Response
Recover an estimated \$107.4 million in managed care savings (FY06-FY08) through a performance bond and/or by reducing FY09 and FY10 rates.	Disagree with recommendation. No such savings exist.
Cap non-medical expenses, administration and profit at no more than 15 percent of income earned through the contract.	Agree with recommendation; implementation complete.
Define income as gross premiums from capitations, interest earnings, third-party recoveries, reinsurance recoveries, and pharmacy rebates.	Disagree with recommendation; not consistent with industry standards.
Cap the amount of provider incentive bonus payments that an MCO may count as a medical expense at no more than one percent. Require the MCOs to explicitly report these payments.	Disagree with recommendation to cap provider incentive payments, which are a form of pay-for-performance and increasingly used as a method to increase quality. Agree that contracts should clarify the definition of administrative expenses; implementation complete.
Make available to LFC information on Medicaid MCO contract rates, complete actuarial rate certification letters/reports, and amounts paid to MCOs by client type as requested.	HSD and LFC have agreed to sign a confidentiality agreement that will allow the ongoing exchange of MCO rates information. HSD is working on developing the confidentiality agreement and, in the meantime, has already shared some of the information.
Work with LFC and the Department of Finance and Administration (DFA) to develop a regular report format for Medicaid physical health managed care as part of regular projection meetings.	Agree with this recommendation, though some areas may require inclusion in the confidentiality agreement noted above. Revision of the regular report format is complete.
LFC may consider breaking up Medicaid appropriations into smaller appropriation components.	Disagree with recommendation. This will likely increase administrative costs for HSD, DFA and LFC without an increase in accountability.
Require MCOs to submit additional data and information on the use of sub-capitation arrangements with primary care providers (PCPs).	Agree with recommendation; implementation complete.
Assess whether practice and utilization patterns are better than average for clients assigned to PCPs receiving sub-capitation payments than for those not receiving sub-capitation payments.	Agree with recommendation; implementation complete.
Require MCOs to submit regular utilization reports for PCPs receiving sub-capitation	Agree with recommendation; implementation complete.

payments using a similar format as the overall managed care program utilization reports.	
Consider capping or eliminating the use of sub-capitation payments given the results of HSD analysis of the information above.	Agree with recommendation. Sub-capitation payments are under the purview of the MCOs; however, HSD reviews them periodically to ensure appropriateness.
Report the results of HSD analysis and activities taken to the LFC.	Agree with recommendation. HSD continues to communicate with the LFC.
Modify the auto-assignment algorithm to steer more Medicaid members not choosing a plan to the lowest priced plans, and to not assign members through this process to higher priced plans.	Agree with recommendation; implementation complete.
For FY11, reduce the number of MCOs to no more than three, and lock rates for both FY11 and FY12.	The number of MCOs and whether to lock-in rates for multiple years are determined during each procurement and contracting cycle.
Explore options to introduce price sensitivity into clients' choice of MCOs.	Agree to evaluate whether this will increase or decrease costs and how access may be affected. While MCO rates are not public at this time, HSD intends to move to rate setting.
Align requirements for maximum timeframe for provider credentialing from 180 days to 45 days in accordance with Division of Insurance (DOI) requirements. Require a consolidated provider credentialing agency for all Medicaid MCOs.	Agree with recommendation; implementation complete.
Recover and revert general fund portions of unspent provider fee increases from FY07 and FY08.	Disagree with recommendation. Provider increases have been expended.
Continue monitoring rates paid by MCOs on a risk basis.	Agree with recommendation; implementation ongoing.
Transition to Medicare's payment methodology for outpatient services.	Agree with recommendation; implementation in process.
Expand Medicaid regulations requiring providers to submit claims electronically.	Agree with recommendation; implementation complete.
Amend contracts to increase the amount of premiums that must be earned through performance from .5 percent to at least one percent in FY10 and two percent in FY11.	Agree with recommendation; implementation complete. The Challenge Fund is currently one percent.
Work with LFC and DFA to overhaul performance measures reported on an annual and quarterly basis.	Agree with recommendation. Working with LFC and DFA to establish work group.
Provide Medicaid clients at the time of enrollment with comparative information on the cost and quality of each MCO.	Agree with recommendation; however, no resources are currently available to accomplish.
Review and determine whether any of the	Agree with recommendation; implementation

required MCO reports can be eliminated or streamlined.	in process.
HSD Internal Audit Bureau should conduct a staffing and efficiency review of MAD to determine whether staffing levels, organization, and expertise need modification.	Agree with recommendation; however, no resources are currently available to accomplish.
Eliminate EQRO activities where NCQA accreditation or standards can be used to meet federal requirements.	Analysis performed. EQRO activities that are currently performed are federal requirements. The Centers for Medicare and Medicaid Services (CMS) has verified that activities currently performed may not be waived and are required by federal regulation.
Validate financial data contained in medical spending reports submitted by MCOs that are used for developing rates.	Agree with recommendation; implementation complete.
Validate encounter data, particularly facility and other services with high unit costs, submitted by the MCOs.	Agree with recommendation; however, limited resources make it difficult to accomplish.
Require uniform reporting of income, including pharmacy rebates, third-party liability recoveries, collections from overpayments and all interest income.	Agree with recommendation; implementation complete.

Provider Work Group

Several committee members offered input regarding participation in a Provider Work Group to review and discuss Medicaid program and policy changes in FY11. While the Department is still in the early stages of convening the work group and has yet to make formal appointments, I want to assure the committee that we will consider its input as we determine which provider sectors should be included.

In conclusion, I want to thank you for this opportunity to respond to the issues raised by the Committee at its June 2 hearing. If you have any questions or would like additional information about the items addressed in this letter, please do not hesitate to let me know.

Sincerely,



Katie Falls
Secretary

Cc: LHHS Committee Members
Karen Wells
Michael Hely