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

SPONSOR Picraux **ORIGINAL DATE** 02/02/11 **LAST UPDATED** **HB** 94

SHORT TITLE Health Policy and Finance Department Act **SB**

ANALYST Earnest

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY11	FY12	FY13	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total		**SEE FISCAL IMPLICATIONS SECTION**				

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
Department of Health (DOH)
Aging and Long Term Services Department (ALTSD)
Health Policy Commission (HPC)
Public Education Department (PED)
Retiree Health Care Authority (RHCA)
General Services Department (GSD)
Public Schools Insurance Authority (PSIA)

SUMMARY

Synopsis of Bill

House Bill 94, over a three year period, consolidates the health care purchasing and planning functions of seven state agencies into a new unified cabinet department -- the Health Policy and Finance Department. The department would be responsible for Medicaid, behavioral health services, and purchase of health care services for state and other public employees, school district employees and public retirees.

Upon full implementation, the new department would comprise the Medical Assistance Division (from HSD), the Behavioral Health Services Division (from HSD), the Long Term Care Services Program (from ALTSD), the Medically Fragile and AIDS waiver programs from the Department of Health, the Retiree Health Care Authority, the Employee Group Benefits Program (from GSD), the Public School Insurance Authority (PSIA), and the health benefits program of the

Albuquerque Public School District.

A section-by-section summary follows.

Sections 1 and 2 title the act "the Health Policy and Finance Department Act" and provide definitions.

Section 3 specifies that the HPFD shall consist of, at a minimum, the Administrative Services Division, Medical Assistance Division, Behavioral Health Services Division, Long-Term Services Division and Health Policy and Planning Division.

As of July 1, 2011, the Act would transfer administration and operation of the Medical Assistance Division of the Human Services Department; the Behavioral Health Services Division of the Human Services Department; and the Interagency Behavioral Health Purchasing Collaborative to the Health Policy and Finance Department.

As of January 1, 2014, transfer administration and operation of home- and community-based waiver services and certain other long-term services programs to the Health Policy and Finance Department from the Aging and Long Term Services Department

Section 4 provides for appointment of a secretary and establishes duties, including personnel and rulemaking authority.

Section 5 provides for duties of the Health Policy and Finance Department. As of July 1, 2011, the Health Policy and Finance Department would be required to:

- Provide medical assistance pursuant to the provisions of the Public Assistance Act;
- Provide behavioral health services and operate the Interagency Behavioral Health Purchasing Collaborative pursuant to the provisions of Section 9-7-6.4 NMSA 1978;
- Conduct a study and, by September 1, 2012, make recommendations to the Legislative Health Committee and to the Legislative Finance Committee regarding the feasibility of transferring from the Department of Health and from the Human Services Department to the Health Policy and Finance Department all of the home- and community-based waiver services and other programs delivering services to individuals living with developmental disabilities, including the administrative, finance, service delivery and any other components of those programs;
- Undertake a feasibility study regarding the quality of care provided and cost-effectiveness of the state's reliance upon managed-care contracts to provide coordinated long-term services, behavioral health services through a statewide entity and other medical assistance. By September 1, 2014, the department shall provide the results of the feasibility study and make legislative recommendations pursuant to that study to the Legislative Health Committee and to the Legislative Finance Committee; and
- Implement a health care work force database and collect data pertaining to health care providers who apply for licensure or renewal of health care provider licensure pursuant to Chapter 61 NMSA 1978.

As of January 1, 2014, the department would be required to:

- Purchase health care benefits on behalf of the publicly funded health care agencies; and
- Administer long-term services as specified in the bill.

Section 6 provides for duties of the Behavioral Health Services Division.

Sections 7 through 10 amend statute to establish a Legislative Health Committee and define duties of the committee.

Section 11 provides for a director of the Legislative Health Committee

Sections 12 through 16 amend statute to create the interim Legislative Human Services Committee, define duties of the committee, and direct the Legislative Council Services to provide staff for the committee.

Sections 17 and 18 amend statute to reference the Health Policy and Finance Department, and change contracting requirements for behavioral health services provided through the Interagency Behavioral Health Purchasing Collaborative.

Section 19 requires a joint study and preparation for the transfer of state employee and retiree health care purchasing to the Health Policy and Finance Department.

Section 20 amends statute to replace references to the Welfare Reform Oversight Committee with the Legislative Human Services Committee.

Section 21 provides for the transfer of the Medical Assistance Division and Behavioral Health Services Division to the new department on July 1, 2011.

Sections 22 and 23 provide for the transfer of the Long Term Services programs and the DOH Medically Fragile AIDS waiver programs to the new department on January 1, 2014.

Section 24 repeals the Group Health Benefits Act, the Retiree Health Care Authority Act, the Health Care purchasing Act, and the Public School Insurance Authority Act.

FISCAL IMPLICATIONS

The table below is an illustration of the consolidation of the seven agencies into the new Health Policy and Finance Department (HPFD). All amounts are based on the LFC appropriation recommendation for FY12, except APS, which is an FY10 estimate. Amounts do not include inflation or enrollment growth. The HPFD would be responsible for the administration and purchase of about $4.8 billion in health care services, most of which comes from federal and other state funds. The state share, largely general fund revenue, would be about $1.58 billion (assuming 33 percent of the total purchase and administration).

	FY12	FY13	FY14	Recurring or Non-Rec	Fund Affected
HSD/MAD	(3,704,000)				General Fund and Federal Funds
HSD/BHSD	(53,100.0)				General Fund and Federal Funds
DOH			(3,000)		General Fund and Federal Funds
ALTSD			(3,400)		General Fund and Federal Funds
RHCA			(239,738)		Other State Funds
PSIA			(351,646)		Other State Funds
APS			(57,600)		Other State Funds
GSD			(359,100)		Other State Funds
LCS					
HPFD	3,757,100	3,757,100	4,771,584	Recurring	

Based on estimates provided to the Government Restructuring Taskforce for similar legislation, these departments employ about 340 FTE. Assuming the merger would allow for the elimination of duplicate positions, particularly financial and administrative, the new department might employ about 311 FTE, saving about $4 million in total administrative spending ($1.3 million in general fund revenue).

The bill requires the RHCA, PSIA, APS, GSD, and others to develop a transition plan for the 2014 consolidation of their agencies into the new department. While the bill repeals the entities, it does not specify an operational structure within the new department. Given the future development of a transition plan, it is difficult to determine costs or savings associated with this part of new agency. The Retiree Health Care Authority assumes, however, assumes full operational integration and suggests that the bill could carry significant transitional costs, including the following:

- Hire 5 FTE (1 FTE in each IBAC entity) to develop the transition plan ($1 million).
- Merger of IT Systems – Each health care agency uses and maintains its own platforms or contracts for a third party system (e.g., claims and customer service databases). Operational consolidation of IBAC functions would require IT consolidation as well. RHCA estimates that the replacement of the system could be $10.9 million. However,

while there would be initial setup costs, the state would realize savings by maintaining fewer systems.

House Bill 94 also requires, by 2014, the development of an all payer claims database. RHCA estimates the cost to be $1.2 million over four years. HSD suggests that "there would be a significant costs associated with an all-payer claims database," but did not provide an estimate of those costs.

The bill also requires two feasibility studies that may carry administrative costs, including:

- The transfer of home and community based services programs at DOH and ALTSD to the new agency.
- The quality of care and cost effectiveness of the state's reliance on managed care contracts for the provision of Medicaid and services.

HSD also reports the bill has no information technology impact on the current HSD ITD operations; however, the new Department will have to meet the challenge of bringing up a "health care work force database," an "all-payer claims database," and "…maintain a management information system" for behavioral health. Based on current information, there is no estimate on the cost for set up and operation of these systems.

SIGNIFICANT ISSUES

During the 2010 interim, the Government Restructuring Taskforce sought changes to structure of government and its programs to improve services and save money. GRTF received testimony about the state's fragmented purchase and administration of health care for employees, retirees, and Medicaid recipients. While the programs have difference constituencies, the agencies perform (or contract for) very similar services.

An LFC performance evaluation of the health benefits programs of the General Services Department and the Public School Insurance Authority found that **"**the state has not maximized the purchasing power for health benefits nor taken advantage of comprehensive quality improvement initiatives that would better contain costs…. Collectively, the New Mexico Retirees Health Care Authority, Albuquerque Public Schools, RMD and NMPSIA form the Interagency Benefits Advisory Committee (IBAC). The committee was created by the Health Care Purchasing Act (13-7 NMSA 1978) to jointly issue request for proposals, but do not require consolidated purchasing. The agencies are allowed to maintain separate administrative structures resulting in duplicative administrative costs, redundant administrative services, disparate benefits plans, and differing cost structures. The fragmentation of administration inhibits effective use of state resources."

Bringing these agencies together with the expertise and purchasing power of the Medicaid program could achieve administrative savings improve the state's health care programs. The LFC evaluation noted that the recent consolidated IBAC procurement of pharmaceutical benefits leveraging the state's procurement power, resulting in a projected four-year savings of $51.5 million.

The bill also requires the creation of an all-payer claims database to better track utilization and spending on healthcare services in New Mexico. According to the National Conference of State Legislatures (NCSL), all-payer claims databases "provide detailed information to help design

and assess various cost containment and quality improvement efforts. By collecting all claims into one data system, states gain a complete picture of what care costs, how much providers receive from different payers for the same or similar services, the resources used to treat patients, and variations across the state and among providers in the total cost to treat illness or medical event (e.g., heart attack or knee surgery)." The lack of access to common data was noted as a key impediment to health care planning for NMPSIA and GSD/RMD in the LFC program evaluation.

The bill provides for a phased implementation of the consolidation, as well as several studies and recommendations about the governing structure. In response to the bill, agencies raised the following concerns with the current version.

According to HSD:

> HSD is recognized as the single state agency for administration of the Medicaid program. Transfer of administration of the Medicaid program will require that a State Plan Amendment be submitted to the Centers for Medicare and Medicaid Services (CMS). HSD is currently required by CMS and by contractual obligation to oversee and monitor the MCO contracts to ensure cost-effectiveness and quality of care.
>
> The Income Support Division (ISD) within HSD is responsible for determining eligibility for medical assistance programs. MAD is responsible for administration of medical assistance programs. HB94 does not transfer ISD to the HPFD. A major concern with HB94 is the separation of ISD and MAD which means that eligibility and administration of medical assistance programs would be in separate departments. For the HPFD to be designated as the single state agency, ISD and MAD functions should not be separated.
>
> Responsibility for health care work force licensure is maintained by the DOH. The structure of the HPFD does not include the appropriate agencies to carry out this function.
>
> Section 5(D) of the bill proposes requiring a number of actions before a contract to provide behavioral health services or medical assistance through a managed care organization could be executed. Among those requirements is the provision of any bids received to the interim legislative health committees and the legislative finance committee. Bids for behavioral health services include proprietary information as well as cost proposals, both of which are reviewed in strict adherence to the state procurement rules. These provisions of HB94 may contravene procurement rules.
>
> Section 17 changes the collaborative's contracting process to provide that the Secretary of HPFD would execute contracts with one or more statewide entities and that the collaborative departments and agencies would make recommendations to the secretary of health policy and finance on provisions to be contained in a contract for operation of one or more behavioral health entities. The collaborative contract(s) with such entities include general funds and federal funds from a number of other cabinet level departments. Implementing this provision of HB94 is complex and will require a thorough examination of federal fund sources requirements, a careful legal review, and a study of the impact across multiple statutes.

According to DOH:

> Essentially, this bill allows administrative consolidation of all waiver programs in one place which could result in more consistency and better efficiency. However, the implementation of this change would need careful planning to avoid confusion to the public and prevent disruption of services for current clients. The new Department would need to continue to process the Waiver applications as they are submitted by health care providers. It would also need physician review of the medical necessity of the applications.
>
> Medically Fragile Waiver: The movement of the Medically Fragile waiver to the Health Policy and Finance Department would entail the establishment of a new process for the eligibility screening of individuals. Currently, eligibility screening and allocation processes are handled by the Medically Fragile Waiver Manager in collaboration with the Developmental Disabilities (DD) Services Division's Intake & Eligibility Bureau and is incorporated into the Central Registry database also used for the DD Waiver. Thus switching Medically Fragile Waiver to another department would require establishment of an alternative processes and data tracking system for intake and eligibility functions.
>
> AIDS Waiver Program – The AIDS Waiver Program was a large program throughout the 1990s because many people living with AIDS needed palliative and end-of-life care, often for long periods of time. The situation is very different now; with the availability of Highly Active Anti-Retroviral Therapy (HAART) medical treatment, patients are able to stay well much longer. Currently few clients qualify for the AIDS Waiver Program, with a caseload fewer than 10 clients in recent years. The AIDS Waiver eligibility process currently spans two Departments since part of the eligibility determination occurs at Income Support Division of HSD and part occurs at Public Health Division of the Department of Health.

According to the Retiree Health Care Authority:

1. NMRHCA Trust Fund – NMRHCA has accumulated approximately $191 million through 20 years of collecting contributions and premium payments from retirees and active employees (many of whom are now retirees). These funds are essential in order to maintain the actuarial viability of providing health care benefits to public retirees. Having been collected for the express purpose of providing these benefits, HB94 provides no indication that these funds may not be used to support other programs. The redirection of any of this fund will have a direct and negative impact on current and future retirees and could result in significantly diminished benefits, cost increases to retirees that make the plans unaffordable to all but the sickest members and has implication for solvency and the State's unfunded accrued liability.

2. Lack Of Mechanism To Ensure Significant Savings – All of the IBAC entities currently "self-insure" a large majority of their health care benefits. In other words, the entities all bear the actual health care cost incurred by its membership and pay only a small administrative fee (approximately 5%) to their contracted health plans. They do not pay a premium determined by the health plans. Consolidating these entities will not in any way change what each of their health care costs will be. This is determined by the demographics and health status of its members. Adding these disparate risk pools

together does not change or improve what their aggregate costs will be.

3. Differences In Constituencies With Conflicting Priorities – Each IBAC entity (as well as HSD) currently has as its main operational objective the viability and quality of their programs. As part of a large and complicated organizational structure that includes elements of NMPSIA, RMD, APS, HSD and DOH it is unlikely that any member group will receive the current level of customer service under the bureaucracy created in HB94. In fact, the different membership groups may have directly conflicting interests which may create processes that meet one group's goals at the expense of another's.

4. Uncertainty – Given the scale associated with the potential membership served by HPFD, HB94 creates uncertainty associated with the $4.75 billion spent on health care services. HB94 provides no structural changes to create savings while creating a large bureaucratic structure that has the potential to disrupt current benefit programs and reimbursement methodologies to the New Mexico's large number of health care providers.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

HB94 relates to HB37 (Legislative Human Services Committee).

HB94 may conflict with the following bills:

- SB14 (Health Care Work Force Data Collection),
- SB15 (Health Policy & Finance Dept. Act),
- SB21 (Behavioral Health Purchasing Contracts), and
- SB162 (Health Administration & Finance Consolidation).

BE/bym