NM center on law and poverty

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November 15, 2017

Secretary Brent Earnest
Human Services Department
PO Box 2348
Santa Fe, NM 87504

VIA ELECTRONIC MAIL

Dear Secretary Earnest,

The New Mexico Center on Law and Poverty sent a public records request to the Human Services Department on September 8, 2017, requesting impact studies and analysis related to the Medicaid Centennial Care 2.0 waiver application. We are alarmed that HSD has not completed even a preliminary assessment of its proposals to cut Medicaid, or may be withholding this analysis.

The Centennial Care 2.0 plan will leave thousands of patients without healthcare coverage, damage our healthcare system and increase long-term costs for the State. The proposal cuts eligibility and services through premiums and copays, the elimination of retroactive coverage, elimination of the Transitional Medical Assistance program, and elimination of important health benefits for parents living in deep poverty and children who are 19 and 20 years old. These proposals have faced nearly unanimous opposition in every public forum during the last eight months.

The Center requested any studies, research, data, and information that were used by HSD to determine how these proposals would impact patients, providers, health outcomes and costs. Medicaid provides vital coverage to more than 850,000 New Mexicans and supports more than 50,000 jobs in the healthcare sector. This analysis should have been conducted and readily available to the public. Instead, HSD responded that the request was "burdensome" and then took two months to produce minimal records.

To date, we have received 64 unduplicated records that provide sparse information – or nothing at all in some instances. The data that we did receive shows that tens of thousands of low-income patients will face coverage restrictions that are known to aggravate health and financial hardships, healthcare providers will lose major revenues from lost federal funding, and the State will be required to expend new administrative resources.

1. **Premiums:** HSD has proposed raising premiums for adults in the Medicaid Expansion with incomes between 100% to 138% of the poverty level, Working Disabled Individuals, and the Children's Health Insurance Program. The monthly fees will range from $10 to $25 in the first year, and could be increased to up to $20 to $50 in the future. Patients will be locked out of coverage for at least 3 months if they cannot pay premiums.

   The Center and other stakeholders at public hearings and in written comments have cited numerous studies and decades of research about the experiences in other states. Premiums ranging from $6 to $20 resulted in 50,000 people losing coverage in Oregon, and $5 to $10 premium increases in other states resulted in 10% to 61% of patients losing Medicaid. Studies of several states also found the administrative costs were higher than the amount collected in premiums. However, none of these studies were mentioned in HSD documents.

   19 records were produced, but only 4 documents mention the impact on patients or costs. They show:

- Premiums will be charged for 65,900 Medicaid patients, including 13,124 children, 2,844 people with disabilities, and 56,504 low-income adults (living just above the poverty line).
- Patients will be charged premiums totaling $10.8 to $14 million per year, but New Mexico will only save $1 to $3 million in state general funds (because federal matching funds will be lost).
- This figure does not account for "attrition of enrollment" from people losing coverage.
- HSD will spend $600,000 next year just to notify patients and providers of new premiums and copays.

5 of the records mention premiums in other states, and past premiums in New Mexico's SCI program, but there is no information about the impact of these fees on patients or providers.

2. **Copays**: The Department's proposal to raise copays has met with widespread opposition from stakeholders, including parents and individuals with disabilities, who have described in public hearings how costs would add up for families and force untenable choices between paying for rent, food or medical care. Healthcare providers have also opposed the proposal because the costs will often be shifted to them. The copays target low-income adults in the Medicaid Expansion with incomes between 100-138% of the poverty level, Working Disabled Individuals, and the Children's Health Insurance Program. They will be charged $5 for office visits, $50 for hospital stays or surgeries, and $2 for each prescription. Every Medicaid patients will also be charged $8 for emergency room visits if the condition is not a true emergency, and $8 for "non-preferred" prescriptions.

   39 records were produced that mostly comprise notices or summaries about the proposal. The only records describing the impact on patients and providers show:

   - Patients will be charged copays totaling $4 million per year, but New Mexico will only save $1 million in general fund (because federal matching funds will be lost).
   - No studies were produced or cited to support HSD's position in the waiver application that copays will increase the "appropriate" use of services.
   - HSD received 10 letters on behalf of 41 community agencies and providers -- all opposing the proposal or raising concerns about its administration. They cited numerous studies from other states showing copays deter access to necessary care, worsen health conditions, and increase utilization of emergency rooms.
   - An internal document summarizing feedback from managed care organizations (MCOs) cites numerous concerns from the MCOs about patients not getting timely care that will result in costlier conditions, administrative burdens, and numerous technical problems with collecting copays for providers. The HSD document does not propose solutions to most of these issues.

3. **Eliminating Retroactive Coverage:** HSD's proposal ends retroactive coverage for patients that pays for the medical bills incurred in the three months before a person applied for Medicaid. These patients may not have known they qualified for Medicaid, faced application barriers, or had personal hardships. Commentators at public hearings have described how hospital bills are especially devastating for families, often ranging from $10,000 to more than $100,000. Healthcare providers were also especially concerned about lost revenues that would threaten the quality of care provided to all patients.

   7 records were produced about the proposal to eliminate retroactive coverage that show:

   - 11,492 patients received retroactive coverage in calendar year 2016
   - Healthcare providers would have lost $157.6 million in payments for CY2016 if retroactive coverage had been eliminated (most of which is comprised of federal match funds).

- Although HSD has repeatedly stated that it would offer "Real Time Eligibility" (RTE) enrollment to justify eliminating retroactive coverage, HSD has delayed its implementation of the RTE system until 2018 because of the intensive resources required to design the system.
- There are no documents analyzing the impact on patients that cannot apply for Medicaid right away due to emergencies, health conditions, or other hardships, even if Real Time Eligibility could be achieved.

4. **Ending Transitional Medical Assistance:** The Centennial Care 2.0 plan would eliminate Transitional Medial Assistance (TMA) – a program that provides extended Medicaid coverage for up to one year for very low-income parents and caretakers who have been living in deep poverty when they have a change of earnings that make them no longer eligible for traditional Medicaid. This program helps families recover from financial debt and maintain continuous healthcare coverage without interruption as they gain new employment, take on raises, or have temporary changes in earnings. Public commentators have described the challenges of affording health insurance on the private market, even with the help of Exchange subsidies. Studies show affordability is the number reason why individuals remain uninsured. At a recent public hearing in Albuquerque, a woman who had undergone cancer treatment described that she would have had to choose between taking on a new job and remaining unemployed if she would have lost Medicaid coverage.

   2 records were produced about Transitional Medical Assistance showing:

   - 1,929 parents or caretakers will lose Transitional Medical Assistance. In an email, the Medicaid director remarked this is a "very small number" compared to total enrollment in Medicaid.
   - TMA costs $11.5 million per year (in state and federal funds combined).

5. **Reducing health benefits for parents living in deep poverty, and eliminating EPSDT coverage for 19 and 20 year-olds:** HSD's proposal cuts health benefits for very low-income parents that have incomes under 45% of the poverty level, by moving them into an "Alternative Benefits Plan" that no longer covers certain vision services such as eyeglasses, hearing tests or hearing aids, certain behavioral health supports, and most disposable medical supplies. Short-term physical, speech and occupational therapies would be limited to two months, and long-term therapies would not be covered.

   The proposal also eliminates Early and Period Screening, Diagnostics, and Treatment services for children ages 19 and 20. Children would no longer have access to comprehensive services, such as hearing tests or eyeglasses or speech and occupational therapies, at a critical time in adolescent development.

   No records were produced by the Department about either proposal.

These damaging proposals should be withdrawn because they have not been sufficiently analyzed. HSD has failed to consider the administrative resources and costs for implementing the proposals or the overwhelming evidence and commentary provided by stakeholders about the harms to patients and our healthcare system. New Mexicans deserve a plan that will improve healthcare delivery, not take away coverage from the most vulnerable residents.

Sincerely,

Sireesha Manne
Supervising Attorney, Healthcare

Excerpts:

HSD Responses to Public Records Request for Impact Data on Medicaid Centennial Care 2.0 Plan

October 11, 2017

Retro Enrollment - CY15

Program	Retro Months	Retro Capitation	Average
PH	165,851	$ 140,418,174.00	$ 846.65
LTSS	22,947	$ 95,669,309.24	$ 4,169.14
OAG	174,108	$ 94,017,659.41	$ 540.00
PH-BH	165,851	$ 7,700,432.48	$ 46.43
LTSS-BH	22,943	$ 2,091,369.74	$ 91.16
OAG-BH	197,051	$ 6,981,764.25	$ 35.43
PH, LTSS OAG	362,906	$ 346,878,709.12	$ 955.84

Retro Enrollment - CY16

Program	Retro Months	Retro Capitation	Average		
PH	112,847	$ 134,570,278.86	$ 1,192.50		
LTSS	20,746	$ (32,464,339.20)	$ (1,564.85)		
OAG	100,418	$ 45,807,651.96	$ 456.17		
PH-BH	112,848	$ 5,746,306.46	$ 50.92		
LTSS-BH	20,769	$ 245,214.78	$ 11.81		
OAG-BH	106,291	$ 3,702,865.31	$ 34.84		
PH, LTSS OAG	234,011	$ 157,607,978.17	$ 673.51	78003.66667	$ 52,535,993
					$ 105,071,985
TMA					$ 23,115,837

Category	Mm Counts	FYE Population	Cost	Per Capita Cost
027	132	11	$ 31,140	$ 1,153
028	13,882	1,157	$ 5,356,488	$ 4,630
Total	14,014	1,168	$ 5,387,628	$ 4,613

$ 11,533,384

$ 500	PMPM	100,000	
$ 10,000	Persons	$ 5.00	
$ 5,000,000	Monthly	$ 6,000,000.00	
$ 60,000,000	Yearly		
$ 6,000,000	GF at 10%		

	Parent/Caregiver adults		81,012	from 3.14.17 Per capita doc	add	
	CHIP Children		13,124	from 3.14.17 Per capita doc		
	Elig for adult Dental		325,057	from 3.14.17 Per capita doc	add	incl exp
	CHIP Kids in Dental		13,124	from 3.14.17 Per capita doc	add	
	Total Dental Premium		338,181			
		10m GF after discussion with Mercer				
	Elig for adult Dental	$	10,000.0	Cost Savings document	add	incl exp
	CHIP Kids in Dental	$	1,084.0	from mercer document	add	
	Total Dental Premium	$	11,084.0			
		10m GF after discussion with Mercer				
	FP ind >45		24,642	from YZ		
	FP 2016 Cost	$	697,352	from YZ		
	GF Cost	$	153,417	calc		out
Premiums	Children > 100% FPL		-	from 3.14.17 Per capita doc		
Premiums	Children > 100% FPL($CHIP)		-	from 3.14.17 Per capita doc		
Premiums	PW >100% FPL		-	from 3.14.17 Per capita doc	calc	out
Premiums	OAG >100% FPL		56,504	from 3.14.17 Per capita doc YZ		
Premiums	aged >100% FPL		-	from 3.14.17 Per capita doc	calc	
Premiums	Disabled >100%		2,844	from 3.14.17 Per capita doc	calc	
Premiums	FP >100%		-	from 3.14.17 Per capita doc	calc	
Premiums	CHIP		13,124	from 3.14.17 Per capita doc		
	Na's Exempt from Premiums		(6,573)	from YZ		
						72,473
	Subtotal		**65,900**	members subject to Premiums		-0.09069
		$	13.75	Ave Monthly premium		
		$	906,128	total monthly premium collected @$13.75		
		$	10,873,536	Yearly Premium collected		
	Respite from 100 to 300 hrs	$	1,135,414	from Mercer		
	GF Cost	$	249,791	calc		
	TMA enroll		2,500	Est Enrollment in New waiver		
	TMA $	$	4,613.00	ave yearly cost		
	Projected total Cost	$	11,532,500	Calc		
	Projected total Savings	$	5,766,250.00	at 50%		
	Projected GF Savings	$	1,268,575	calc		

From:	Sanchez, Jason S, HSD
To:	Carlton, Angela, HSD
Cc:	Padilla, Celeste, HSD; Smith-Leslie, Nancy, HSD; Medrano, Angela, HSD; Armijo, Kari, HSD; Gonzales, Linda, HSD
Subject:	RE: FY19 Admin Request Contractual
Date:	Monday, August 14, 2017 4:52:34 PM

Good Afternoon Angie!!!

The contractual position request is good to go.

Additionally, we are requesting an increase for CC2.0 in the contractual services category to cover costs associated with increased mailings (700,000+) during the open enrollment period, CMS required additional client notification requirements associated with premiums and co-pays and other changes, CMS required provider notifications. This would be an additional $600,000 total dollars at 50% GF. This would cover the pass through costs regardless if they were incurred in the Adelante or Conduent contract.

Thanks.

Jason Sanchez
Deputy Director, MAD
505-827-6234
Jasons.sanchez@state.nm.us

From: Carlton, Angela, HSD
Sent: Thursday, August 10, 2017 8:06 PM
To: Sanchez, Jason S, HSD
Cc: Padilla, Celeste, HSD
Subject: Re: FY19 Admin Request Contractual

Thank you!

I think this is exactly what Brent was asking for. I'll wait to hear from you tomorrow.

I am available to help you with anything you may need just call!

Angie

From: Sanchez, Jason S, HSD
Sent: Thursday, August 10, 2017 5:39 PM
To: Carlton, Angela, HSD
Cc: Padilla, Celeste, HSD

Subject: FY19 Admin Request Contractual

Good Evening Angie!!!

Please see attached. I do not have approval from Nancy to submit, but I wanted you to see the direction we are going so that you and make sure that we are going in the right direction.

Thanks.

Jason Sanchez
Deputy Director, MAD
505-827-6234
Jasons.sanchez@state.nm.us

From: Smith-Leslie, Nancy, HSD
To: Esquibel, Ruby Ann
Subject: FW: Follow-Up re Medicaid Hearing
Date: Tuesday, August 29, 2017 4:22:00 PM
Attachments: NMMIP analysis 8-23-17.xlsx
image006.jpg
image001.png

Hi Ruby Ann,
Responses below and additional spreadsheet attached. Have a great day!

Nancy Smith-Leslie
Director
Medical Assistance Division/HSD
P.O. Box 2348, Santa Fe, NM 87504
(505) 827-7704
nancy.smith-leslie@state.nm.us

From: Esquibel, Ruby Ann [mailto:RubyAnn.Esquibel@nmlegis.gov]
Sent: Thursday, August 17, 2017 10:35 AM
To: Smith-Leslie, Nancy, HSD
Cc: Sanchez, Jason S, HSD
Subject: Follow-Up re Medicaid Hearing

Good morning, Nancy. Thank you again for making the trek up to Taos Ski Valley yesterday for the LFC hearing. Per our discussion, I had the following questions on HSD's presentation:

1. What amount of funds is HSD transferring for its assessment for the high risk pool from FY16-FY18? Please see attached spreadsheet.
2. What are co-pays projected to generate in FY17, FY18 and FY19? Copays are being delayed until implementation of CC 2.0 waiver in Cy 2019. We are projecting a $4 million total dollar amount in the projection with $1 million as GF for a full year effect. Are you proposing additional co-pays in Centennial Care 2.0, and if so, what are these projected to generate? No additional, launching all of the proposed copays as part of the waiver renewal.
3. What are the proposed premiums in Centennial Care 2.0 projected to generate in FF/GF? The premiums in CC2.0 will not generate revenue. They will offset expenses to the MCOs. We are projecting a full year expenditure reduction of $10 million to $14 million ($1million to $3 million GF)which does not take into account the potential attrition of enrollment due to non-compliance with premium requirements.
4. Expansion FMAP steps down again on January 1, 2018 to 93%--what is the FF/GF effect of the 1% step down? The increased GF cost is 14.7 million.

Thank you, RubyAnn

Ruby Ann M. Esquibel
NM Legislative Finance Committee
505.986.4560
rubyann.esquibel@nmlegis.gov

MCO Comments
Medicaid Co-Payment Proposal & Notice of Opportunity to Comment
March 17, 2017

Proposed Language	Comments/Clarifications	Solutions	MCO Impacts	Provider Impacts
The total amount of co-payments paid by a Medicaid member household cannot exceed five percent of the family's total income during a calendar quarter (January-March, April-June, July-September, and October-December). If a family reaches the five percent limit, then no more co-payments will be charged during the remainder of that quarter. HSD will have a process in place to track co-payments and to notify households of their co-payment responsibilities and tracked amounts.	There is a large percentage of our membership that does not have an income that would reach this threshold. Members that have no income will automatically be exempted from co-payments because any dollars spend will be over the 5% of the household income. Will HSD give MCOs a begin date and end date in the roster file for the Federal Poverty Level (FPL)? The begin and end dates will help ensure that the member is receiving the proper benefits for the appropriate months. If the MCOs do not receive this information, the MCOs will be unable to facilitate proper changes in the FPL. If a member has a break in coverage, does the 5% start over? Would it be appropriate based on federal and state rules to indicate an FPL on a Member ID card? If the MCOs do provide a FPL on the ID card, would the MCOs be required to send the ID cards monthly? This would result in increased costs.	The quarterly out of pocket maximum creates administrative complexities that are felt by both providers and members alike. To address these concerns, we would like to propose an out of pocket maximum with one or more of the following features: To address these concerns, the MCOs would like to propose an out of pocket maximum with one or more of the following features: • In the event CMS relaxes the current maximum per household requirement, change to an individual out of pocket, not the household. • In the event CMS relaxes the current quarterly maximum out of pocket requirement, change to a	**<u>PHP and Molina</u>** A family's income can change within a quarter causing a FPL to change and make it more difficult for the MCO to adjust accumulators. It would be even more difficult if there are retroactive changes to the FPL for the MCO to track accumulators. There are associated costs to configuring out of pocket maximums and the complexity associated with those fluctuating FPL's, including: • The need to send a new ID card if there are changes in the FPL if this information is displayed on the ID card. • Sending notification of accumulators and EOB's to members.	A provider has 90 days to submit a claim. Copayments are collected prior to services being rendered. There may be a delay in determining if a member has exceeded their 5% maximum. The provider will not know where the member stands with their out of pocket maximum at the time of service which would create a need to call the MCO; or the provider may collect the co-pay and then once the claim has adjudicated, reimbursement is sent to the member. This may cause rework and create an undue burden for the providers, subcontractors, and members. There are a high number of members who could exceed the maximum with the first copay applied for services. Because of the claims lag, we would not have an out of pocket maximum configured. Providers could deny services if the member cannot afford the co-pay. Our pharmacy benefits manager is limited in their ability to configure an adjustable out of pocket maximum. Pharmacy claims are real time, collection of a co-payment when a member has potentially hit an out of pocket maximum and the costs

Proposed Language	Comments/Clarifications	Solutions	MCO Impacts	Provider Impacts
	Will FPL (for determining out of pocket max) be sent/updated monthly? Will there be retroactive changes to the FPL? Will HSD have the capability to send these COE and FPL effective dates on the enrollment files?	calendar year maximum, not a quarterly maximum. • In reviewing current enrollment data, it has been found that many members have very minimal quarterly out of pocket amounts. Based on this, with a $50.00 copayment for one service, it's likely that many members will reach their out of pocket amount within one claim, which will not yield much cost savings. • In the event CMS relaxes the current out of pocket maximum requirement based on household income, establish one set out of pocket amount for all members. **United Healthcare** Per CFR tracking household income is only required if	• Revising member and provider materials including provider education. • An increase in call volume for both member and provider lines.	associated with conducting a reimbursement on a transaction is difficult to administer.

Proposed Language	Comments/Clarifications	Solutions	MCO Impacts	Provider Impacts
		there is a risk of actually reaching the aggregate family limit. I'd suggest a limit per *federal fiscal year per household size based on 101% FPL. *FPL is updated per federal fiscal year. Household of 1 cap per year is $49.50. Household of 2 cap per year is $66.75.		
Non-Emergency Medical Transportation - $2/trip for Other Adult Group recipients with income above 100% FPL, WDI and CHIP. Applies only to travel for residents living in the Albuquerque Metro area and the cities of Santa Fe and Las Cruces, to destinations in within those same areas, in which free or low-cost public transportation is readily available.	How would it be determined "Applies only to travel for residents living the ABQ Metro/SF/LC to destination within those same areas." This is not configurable unless we are given unique criteria to configure ie: modifier, CPT, dx etc. Providers would have to bill the appropriate modifiers and we would need to know what the modifiers are and have to set those up to apply the copay. What if the member needs change or does not have cash? How will payment disputes be handled? If a member cannot pay the copayment, should they be denied the transport? (this is being asked based on the proposal that reads: "The state proposes allowing providers to require individuals to pay	Propose implementing a limitation on use of transportation in lieu of collecting co-payments due to the complexity.	Complexity and cost associated with co-pays being reported and payment from the transportation vendors to the MCO. If a member is discharged from the hospital and cannot afford the co-pay for transportation, the hospital will not discharge them thus incurring additional inpatient charges for the MCO. The MCOs expect a significant increase in grievances as a result of the copay.	Implementing this would create safety concerns for the transportation company drivers that would need to carry cash in their vehicles. The risk is far too great to expect this and implementing an alternative means of collecting the money would far exceed the savings of collecting $2/trip. **Superior Medical Transportation** Concerns with drivers collecting co-pays as implementing this would cause additional oversight of transportation providers. Providers ultimately absorb the loss of revenue due to missed appointments because of a member's inability to pay the co-pay.

Proposed Language	Comments/Clarifications	Solutions	MCO Impacts	Provider Impacts
	copayments as a condition for receiving items or services when the household has income above 100% FPL". If a member is receiving a service that is exempt from co-pays does that apply to the associated transportation trip? **Superior Medical Transportation** Who would be responsible for collecting the copay, the driver, at the time of scheduling the transport?		The MCOs are concerned about the impact to HEDIS measures if members do not go to their appointments as a result of the copay. The MCOs are concerned that we will see an increase in missed appointments.	
Outpatient Office Visits - $5/visit for Other Adult Group (also referred to as the Medicaid Expansion or Category of Eligibility (COE) 100) recipients with income above 100% of the federal poverty level (FPL), Working Disabled Individuals (WDI) and the Children's Health Insurance Program (CHIP). Includes non-preventive care outpatient office and clinic visits or hospital outpatient department visits for physician or other practitioner services, dental visits, urgent care visits, and outpatient professional therapies. Only one co-payment is allowed per visit or session. Behavioral health outpatient visits, preventive care visits, prenatal visits/pregnant recipients, and laboratory, radiology and diagnostic laboratory tests and measurements ordered by a practitioner are exempt from any co-payment. Services provided to individuals in CHIP that are	Clarify if we are deducting this co-pay amount from the claims payment to providers. Please clarify if exempt members be categorized as the same as standard members? For example, no copayments beside non-emergency ER and non-preferred prescription drugs. Does this apply to FQHC's or School Based Health Centers? **PHP** Will members be able to appeal co-pays and have fair hearing rights? To properly administer the proposed co-pay this would require a new benefit structure that relies on		Applying these co-payments could result in missed appointments which could affect HEDIS measures and targets. Increase in administrative costs: Changes to member materials Provider Education/Materials Explanation of Benefits New ID Cards with co-pays listed Increased calls to customer service Changes to web systems and Interactive Voice Response systems	Result in higher no show rate.

Proposed Language	Comments/Clarifications	Solutions	MCO Impacts	Provider Impacts
protected under state minor consent laws are also exempt.	accurate and Timely FPL. If there are changes to the members FPL than the member will be changing benefit plans which would cause additional Id cards along with potential of member and provider dissatisfaction on what benefits the member should be administered.		The $5 office visit copay can incentivize patients to not get appropriate care in a timely manner, thus allowing for more harmful, costly conditions to develop.	
Inpatient Hospital Stays - $ 50/entire stay for Other Adult Group recipients with income above 100% FPL, WDI and CHIP. Inpatient psychiatric hospital stays and labor/delivery inpatient obstetric stays are exempt from any co-payment. Only one co-payment is allowed per inpatient stay, including when a patient is transferred from one hospital to another hospital.	Please clarify if exempt members be categorized as the same as standard members? For example, no copayments beside non-emergency ER and non-preferred prescription drugs. Will members be required to pay the $50 copay for re-admits?			
Outpatient Surgery - $50/procedure for Other Adult Group recipients with income above 100% FPL, WDI and CHIP. Applies to outpatient surgeries performed in office settings, outpatient facilities and ambulatory surgical centers that are performed separately and distinct from an office or clinic outpatient visit. The co-payment applies only to the primary surgical procedure performed. Services provided to individuals in CHIP that are protected under state minor consent laws are exempt from any co-payment.	If office visit and surgery done on same visit, which copay is taken office visit or surgery? Please clarify if exempt members be categorized as the same as standard members? For example, no copayments beside non-emergency ER and non-preferred prescription drugs.			
Prescription Drugs - $2/prescription for Other Adult Group recipients with income above 100% FPL, WDI and CHIP. The co-	**PHP** What will classification of preferred/non-preferred drugs be		If there will be an exception process, the MCOs expect that a	

Proposed Language	Comments/Clarifications	Solutions	MCO Impacts	Provider Impacts
payment is not charged if the higher co-payment for non-preferred prescription drugs is applied, as described below. Contraceptives and family planning supplies are exempt.	based on? Does HSD have logic i.e. medications belonging to protected classes = preferred or is designation going to be left up to MCO's? Will there be exception process for patients who are unable to pay or refuse to pay medication copayment i.e. if patient is unable/unwilling to pay copay will pharmacy be expected to call MCO for over-ride and removal of copay or will pharmacies be expected to refuse service? Please clarify if exempt members be categorized as the same as standard members? For example, no copayments beside non-emergency ER and non-preferred prescription drugs.		large portion of membership will not pay the copayment. If pharmacies refuse service, the MCOs will expect increased medical costs due to poorer management of acute and chronic conditions. Due to the complexity and variability, the majority of this process currently is managed outside of medical and pharmacy billing systems and is manual. The MCOs are able to manage because the volume is low. The MCOs anticipate that this will increase volume significantly and additional resources will be required.	
Non-Preferred Prescription Drugs - $8/prescription for Other Adult Group, WDI, CHIP, and most other Medicaid beneficiaries, unless described as exempt below. Certain behavioral health drugs are exempt. Contraceptives and family planning supplies are exempt.	Same as above.			
Non-Emergency use of the Emergency Room - $8/visit for Other Adult Group, WDI, CHIP and most other Medicaid beneficiaries, unless described as exempt below. Screening	How would the MCO know when the claim comes in whether the service is emergent or non-emergent?	Suggest applying a $25 co-pay to each emergency room visit regardless if it is non-emergency use. The copay	The MCOs are unable to configure this benefit unless given a specific list of diagnosis or CPT	The copay would never be collected upfront and would create increase cost for the provider to bill the member for the $8 copay.

Proposed Language	Comments/Clarifications	Solutions	MCO Impacts	Provider Impacts
required in accordance with 42 CFR §489.24, and all requirements outlined in the State Plan must be met to assess co-payment.	How will non-emergency use of the ER be determined? Is there an intention to supply the MCO's with criteria to determine non-emergency use of the ER? **PHP** Would the MCO use the same set of codes provided in the DSIF targets to determine non-emergency use of the ER?	would only be waived if admitted to the hospital. This eliminates the need to determine what is non-emergent and is configurable and understandable. We recommend a larger spread between the copays for these services. This is for the following reasons: Members of this population can find it difficult to attend an appointment during normal office hours. The extra $3 for an ER visit may not be enough of a deterrent for visiting the ER after hours.	codes that are not considered emergent, which is in direct conflict with federal regulation. This goal is more effectively achieved at the time of service through initiatives such as the emergency department patient navigation program. Once services have been rendered, the claims department would have no effective way of identifying claims representing non-emergent use of the emergency room. Administering in this manner could conflict with "prudent layperson" decisions on use of the emergency room for this level of treatment. Administering "Prudent Layperson" standard is difficult and subjective.	**PHP** The emergency department, due to EMTALA, still does a screening of the patient to assess clinical status. These codes still apply a co-pay even if the member is moved to a lower level of care. This creates a co-pay for the provider to collect after the claim has been processed.
Individuals who are not covered under WDI or CHIP, and Other Adult Group recipients with income at or below 100% FPL, are exempt from most co-payments. However,	Will there be a specific ID card for this population?			Providers will need a way to identify those members that should not have a co-pay. If this is not on the ID card this could cause administrative

Proposed Language	Comments/Clarifications	Solutions	MCO Impacts	Provider Impacts
most Medicaid beneficiaries **will** be charged co-payments for Non-Emergency use of the Emergency Room and Non-Preferred Prescription Drugs, including: - Persons who are enrolled in the Other Adult Group with income at or below 100% FPL - Persons who are enrolled in the Parent & Caretaker Relatives category - Children who are enrolled under Title XIX Medicaid, including newborns - Persons who are enrolled in Transitional Medical Assistance - Persons who are enrolled in Medicaid as refugees - Women who are enrolled in a Medicaid pregnancy category - Persons who are receiving Supplemental Security Income (SSI) Medicaid - Persons who are enrolled in an adoption or foster care category - Women who are receiving Medicaid under the Breast and Cervical Cancer program - Persons who are receiving Institutional Care or other Long-Term Services and Supports, including individuals who are enrolled in the 1915(c) Developmentally Disabled (DD) or Medically Fragile (MF) waiver program, and individuals who are enrolled in the *Mi Via* self-directed waiver program.				burden on the provider if they have to call the MCO for each member they see.
Co-payments **are not to be** charged for the following exempt individuals: - Native Americans who are active or previous users of the Indian Health Service (IHS), tribal 638 health programs, or urban Indian health programs	For our respective plan, this percentage of membership would be excluded from co-pays based on our current files. *** **Please see attachment 1.**			

Proposed Language	Comments/Clarifications	Solutions	MCO Impacts	Provider Impacts
- Persons who are receiving care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) - Persons who are enrolled in the Qualified Medicare Beneficiary (QMB), Specified Low Income Beneficiary (SLIMB) or Qualified Individuals program - Persons who are covered only under the Medicaid Family Planning program - Individuals who are enrolled in the Program of All Inclusive Care for the Elderly (PACE)	There are situations where the member has more than one COE and the MCOS have no knowledge of the secondary COE. Is it HSD's expectation that the MCOs apply the exception based on the primary COE? HSD does not pass the effective date of the COE on the enrollment file. How should the MCOs identify when the exceptions should begin or end?			
Co-payments **are not to be** charged for the following exempt services: 1. Family planning services and supplies 2. Pregnancy-related health care, including tobacco cessation treatment for pregnant women 3. Emergency services 4. Preventive services, such as Well-Child visits and immunizations 5. Services provided to minors that are protected under minor consent laws 6. Provider preventable services	**DentaQuest** The proposal states that there are no co pays for provider preventable services. Is HSD able to explain how that applies to dental? What services will fall under this category?			
The state proposes allowing providers to require individuals to pay co-payments as a condition for receiving items or services when the household has income above 100% of the federal poverty level (FPL). Providers may not deny services to individuals with household income at or below 100% FPL, or to Medicaid recipients who are considered exempt from co-payments, as described above. Providers may not charge co-payments on any exempt items or services, as described above.	What is the provider's recourse if the member refuses to pay the copay? **PHP** Can a provider refuse to see the patient if they can't pay at the time of service? If the providers are required to see the member and bill them for the services, can they treat them as any		If exceptions are granted to not require a co-pay, there will be an increased administrative burden on administering the copayments.	If exceptions are granted to not require a co-pay, there will be an increased administrative burden on administering the copayments. Providers will need a way to identify those members that should not have a co-pay. If this is not on the ID card this could cause administrative burden on the provider if they have to call the MCO for each member they see.

Proposed Language	Comments/Clarifications	Solutions	MCO Impacts	Provider Impacts
	other patient and follow their office policy after so many non-payments? I.E dismisses the member as their patient for nonpayment of co-pays? Can a pharmacy turn away a member if they are unable to pay a copay? Is it permissible based on State and Federal guidelines to add the member's FPL to the ID card? Will Appeal and Grievance requirements be updated to handle service denials based on providers refusing care? Would a member have Fair Hearing rights if they were refused care?			

From:	Smith-Leslie, Nancy, HSD
To:	Burt, Roy J., HSD; Padilla, John H, HSD; Armijo, Kari, HSD
Subject:	FW: Retro Medicaid and TMA
Date:	Wednesday, June 14, 2017 8:48:00 AM
Attachments:	image001.jpg image002.png

Never mind—just saw this! Thanks

Nancy Smith-Leslie
Director
Medical Assistance Division/HSD
P.O. Box 2348, Santa Fe, NM 87504
(505) 827-7704
nancy.smith-leslie@state.nm.us

From: Burt, Roy J., HSD
Sent: Wednesday, June 14, 2017 8:45 AM
To: Smith-Leslie, Nancy, HSD; Armijo, Kari, HSD
Subject: Retro Medicaid and TMA

Hello:

For calendar year 2016 the retro report contains the following:
11,492 unduplicated clients were approved for retro Medicaid.
1,427 unduplicated clients are Native Americans
12% of the total clients approved for retro are Native Americans

The summary section on the retro report contained the following applications totals:
9,801 applications for CY 16 contained individuals with approved retro Medicaid.
100,181 total applications for CY 16
9.8% of total applications for CY 16 had individuals approved for retro Medicaid.

TMA totals:
26,707 clients-January 2013
20,387 clients-January 2014
16,412 clients-January 2015
963 client-January 2016
1,733-January 2017
1,929-June 2017

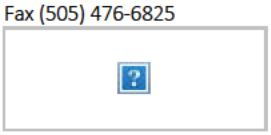
As you can see by the numbers TMA has dropped substantially. That is due to a number of factors. TMA prior to ACA was tied to JUL (family) Medicaid and covered both adults and children. TMA after ACA is tied to Parent/Caretaker Medicaid which only contains adults. Adults losing Parent/Caretaker

Medicaid would transfer to TMA while their children would remain on MAGI Children coverage. Additionally, since New Mexico is an expansion state, individuals are evaluated for other full Medicaid prior to moving to TMA. Thus, TMA is basically the full Medicaid coverage of last resort.

TMA was not part of the normal Medicaid category cascade. For someone to be approved for TMA a caseworker had to be aware that the client was eligible and do an override to approve. That changed April 2017 when the TMA change request was implemented into ASPEN. Now ASPEN approves TMA correctly after evaluation for full Medicaid. Thus, all these factors contributed to the decline in TMA enrollment.

Thanks.

Roy Burt
Bureau Chief, Eligibility Bureau
HSD/Medical Assistance Division
Phone (505) 476-6898
Fax (505) 476-6825



From: Smith-Leslie, Nancy, HSD
To: Burt, Roy J., HSD; Armijo, Kari, HSD; Earnest, Brent, HSD
Subject: RE: TMA
Date: Monday, June 12, 2017 11:14:00 AM
Attachments: image002.png
image003.jpg

Out of 900,000 that's very small number.

Nancy Smith-Leslie
Director
Medical Assistance Division/HSD
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(505) 827-7704
nancy.smith-leslie@state.nm.us

From: Burt, Roy J., HSD
Sent: Monday, June 12, 2017 10:34 AM
To: Armijo, Kari, HSD; Smith-Leslie, Nancy, HSD
Subject: RE: TMA

1,929 are on TMA according to the latest MER.

Roy Burt
Bureau Chief, Eligibility Bureau
HSD/Medical Assistance Division
Phone (505) 476-6898
Fax (505) 476-6825

From: Armijo, Kari, HSD
Sent: Monday, June 12, 2017 10:25 AM
To: Burt, Roy J., HSD
Subject: TMA

Hi Roy,
Do you have current numbers of people getting TMA? Nancy wants asap, if possible.

Thanks, Kari

Sent from my Verizon 4G LTE smartphone

NM center on law and poverty

924 Park Ave SW, Ste. C
Albuquerque, NM 87102
505.255.2840
nmpovertylaw.org

September 8, 2017

Brent Earnest, Secretary
New Mexico Human Services Department
Pollon Plaza – 2009 South Pacheco
Santa Fe, New Mexico 87505

VIA ELECTRONIC MAIL

Dear Secretary Earnest:

Pursuant to the New Mexico Inspection of Public Records Act, §14-2-1 *et seq.* NMSA 1978, I am writing to request that the Human Services Department (HSD) make all public records[1] available for inspection that will provide the following information related to the HSD's Centennial Care 2.0 proposal, released on September 5, 2017:

Premiums:

- Any impact studies, research, data, and information on the effect of charging premiums to Medicaid patients, healthcare providers and health outcomes that were used to determine HSD's Centennial Care 2.0 proposal for premiums.

- The amount HSD expects to gain in Medicaid budget savings by charging premiums, in total, as well as broken down by each category of eligibility.

- Any planning documents, meeting notes, studies, assessments, and other records describing all of the agency administrative changes and new processes, including information technology changes, required to implement new premiums.

Co-Pays:

- Any impact studies, research, data and information on the effect of charging co-pays to Medicaid patients, healthcare providers, and health outcomes that were used to determine HSD's Centennial Care 2.0 proposal for co-pays.

[1] Inspection of Public Records Act, 14-2-6(G). Public record means all documents, papers, letters, books, maps, tapes, photographs, recordings, and other materials, regardless of physical form or characteristics, that are used, created, received, maintained or held by or on behalf of any pubic body and relate to public business, whether or not the records are required by law to be created or maintained.

- The amount HSD expects to gain in Medicaid budget savings by charging co-pays, in total, as well as broken down by each category of eligibility.

- Any studies, records, or research about how many emergency room visits by Medicaid patients are for non-emergent services.

- Any planning documents, meeting notes, studies, assessments, and other records describing all of the agency administrative changes and new processes, including information technology changes, required to implement co-pays.

- Any policies, directives, guidance, memoranda, and notices given to New Mexico's managed care organizations to provide instructions and oversight on co-pay collection, management, and administration.

- Any internal policies, procedures, methodologies, and other records describing how income levels of each patient are communicated to New Mexico's managed care organizations to determine co-pay amounts for each service and aggregate co-pay cap limits that are based on the patient's income.

Retroactive Coverage:

- Any impact studies, research, data, and information on the effect of eliminating retroactive coverage on Medicaid patients, healthcare providers and health outcomes that were used to determine HSD's Centennial Care 2.0 proposal.

- The amount HSD expects to gain in Medicaid budget savings by eliminating retroactive coverage.

- Any policies, directives, guidance, instructions, memoranda, agreements and notices given to New Mexico's managed care organizations describing the process for paying out retroactive claims.

- Any policies, directives, guidance, memoranda, and notices describing HSD's process for implementing real-time eligibility enrollment.

- The number of claims made for retroactive coverage in the years 2016 and 2017, broken down by claims made by Medicaid applicants for retroactive payments and those claims made by healthcare providers.

- The total amount paid out in retroactive claims in years 2016 and 2017.

- A list of healthcare providers that made claims for retroactive coverage in years 2016 and 2017 and the amount paid to each.

Transitional Medicaid Assistance:

- The amount HSD expects to gain in Medicaid budget savings by eliminating Transitional Medicaid Assistance.

- Any documents showing how many Transitional Medicaid Assistance patients disenroll from Medicaid at the end of their coverage period and how many return to Medicaid through a new category. Information responsive to this should include a breakdown of the categories to which such patients return.

- Any impact studies, research, data and information on the effect of eliminating Transitional Medicaid Assistance on Medicaid patients that were used to determine HSD's Centennial Care 2.0 proposal.

Benefits/Services for Parent Caretakers and 19/20-Year-Old Patients Receiving EPSDT:

- The amount HSD expects to gain in Medicaid budget savings from waiving EPSDT coverage for 19 and 20 year olds.

- The amount HSD expects to gain in Medicaid budget savings from switching parent/caretaker Medicaid patients from the traditional Medicaid benefits package to the Alternative Benefit Package (ABP).

- Any impact studies, research, data and information on the effect of waiving EPSDT coverage for 19 and 20 year olds on these patients, healthcare providers and health outcomes that were used to determine HSD's Centennial Care 2.0 proposal.

- Any impact studies, research, data and information on the effect of switching parent/caretaker Medicaid patients from the traditional Medicaid package to the Alternative Benefit Package (ABP) on these patients, healthcare providers and health outcomes that were used to determine HSD's Centennial Care 2.0 proposal.

Thank you for your attention to this request. Should you have any questions, please contact me at 505-255-2840 or abuko@nmpovertylaw.org.

Sincerely,

Abuko D. Estrada
Staff Attorney
New Mexico Center on Law and Poverty

cc: Kyler Nerison, Public Records Custodian, HSD
Public Records Custodian
PO Box 2348
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KylerB.Nerison@state.nm.us