

LFC HEARING BRIEF

AGENCY: Human Services Department

DATE: July 9, 2014

PURPOSE OF HEARING:

To facilitate discussion of current state and county funding mechanisms to fund a hospital safety net for uncompensated care, the role of county-funded indigent care, and how new Medicaid dollars can be leveraged to address outstanding healthcare needs.

To provide an update on the Behavioral Health Collaborative and status of NM behavioral health provider audits.

WITNESS:

Brent Earnest, Deputy Secretary, Human Services Department; Steve Kopelman, Director, New Mexico Association of Counties; Jeff Dye, New Mexico Hospital Association

PREPARED BY: Boerner

EXPECTED OUTCOME:

Informational

Effective January 1, 2014, the Safety Net Care Pool replaced the Sole Community Provider program in New Mexico

BACKGROUND INFORMATION

Medicaid expansion provides New Mexico the opportunity to reallocate state resources previously used for uncompensated care and ineligible populations and improve service delivery. The federal government will cover 100 percent, stepping down to 90 percent, of the cost of covering newly eligible Medicaid enrollees. Now that 137,000 New Mexicans will have medical insurance through the program (estimates at 163,000 by June 2015), the need for state and local funded subsidies for uncompensated care or separate coverage programs is lessened. Likewise, the need for the state to fund behavioral health outside Medicaid is diminished as these individuals access Medicaid behavioral health services.

With Medicaid expansion, national data show significant declines in uncompensated care costs in expansion states (around 30 percent). Nevertheless, a subset of the population remains without health care coverage, requiring continued need for an uncompensated care payment mechanism.

Effective January 1, 2014, the Safety Net Care Pool (SNC) replaced the Sole Community Provider program in New Mexico. However, some counties and hospitals have concerns about how SNC Pool funds will be distributed, and the role of counties to ensure indigent access to services, including primary and dental care, behavioral health, and health care for individuals before and after incarceration.

New Mexico needs to evaluate the impacts of ACA and Medicaid expansion, in particular, whether current funding mechanisms are efficient to fund county and hospital uncompensated care costs, and how new Medicaid dollars can be leveraged to address outstanding healthcare needs. To do this effectively, the state must consider tax reform, including county tax authority and existing health care tax credits, and must coalesce around an effective funding solution for hospitals providing indigent care.

At its peak, the Sole Community Provider program provided over \$275 million in county and federal funding annually to hospitals. However, problems surfaced with the methods some counties used to provide the match for federal funds, as well as the methodology used by HSD to calculate program payments. As a result of these issues, and the projected decrease in uncompensated care due to Medicaid expansion, the Sole Community Provider program is being replaced by the federally-approved SNC Pool, now estimated at \$69 million. To offset the loss of Sole Community Provider funds for hospitals, HSD originally proposed a hospital provider rate increase of approximately \$123 million to supplement the \$69 million SNC Pool. It is important to remember the SCP program has always been financed locally.

FUNDING THE SAFETY NET CARE POOL

Last year the Legislature amended Senate Bill 268 to comply with federally-approved changes to the Sole Community Provider program.

HSD reported 137,000 new Medicaid enrollees as of June 2014

Current HSD projected funding cost for hospitals includes approximately \$69,000,000 for SNC Pool distributions and \$171,000,000 in increased Medicaid rates for hospitals.

Large hospitals are concerned their distribution of SNC Pool funding will negatively impact the array of services they currently support for indigent populations.

As of January 1, 2014, the SNC Pool replaced the Sole Community Provider program.

The governor signed the bill applying line item vetoes to certain provisions which included eliminating a three-year sunset clause of the mandatory county transfers and striking language allowing counties to cover indigent patient health premiums and out-of-pocket costs, and language limiting the ability of hospitals to send indigent claims to collection.

Post-Session Status of Hospital Payment Package. Last session, the Human Services Department (HSD) proposed a \$192 million hospital payment program to replace the Sole Community Provider program for FY15, comprised of \$69 million for the SNC Pool and \$123 million for a Medicaid rate increase for hospitals. The estimated \$60 million in state matching money would be funded approximately as follows: a \$36 million transfer from counties from the equivalent of a 1/8th gross receipts tax (GRT) increment, \$9 million in state general fund contributions, and \$14 million from a University of New Mexico Hospital inter-governmental (GRT) transfer.

**Hospital Payment Plan
Revenues and Expenditures**

Revenues	HSD Original Projection	Post-Session Projection*	Current HSD Projection**
Counties	\$36,000,000	\$26,000,000	\$24,000,000
SB 313 GAA	\$9,000,000	\$9,000,000	\$9,000,000
Federal	\$133,000,000	\$101,000,000	\$182,000,000
UNM	\$14,000,000	\$14,000,000	\$14,000,000
State Match (not accounted for)			\$ 11,000,000
Total	\$192,000,000	\$150,000,000	\$240,000,000
Expenditures	HSD Original Projection	Post-Session Projection	Current HSD Projection
SNC Pool	\$69,000,000	\$69,000,000	\$69,000,000
Rate Increase	\$123,000,000	\$81,000,000	\$171,000,000
Total	\$192,000,000	\$150,000,000	\$240,000,000

*Post-session, HSD reported total spending could increase above \$150 million if savings from other Medicaid programs were reprogrammed.

**Current HSD estimate. \$240 million for both SNC Pool and Medicaid rate increases; however, state funding match is approximately \$11 million short to obtain all needed federal contribution.

HSD estimates \$1 million to \$2 million may be redistributed to larger hospitals after initial smaller hospital distributions become final.

HSD states larger hospitals will benefit from approximately \$171 million in Medicaid rate increases.

However, counties raised concerns about the equivalent of a 1/8th GRT mandatory contribution, noting they had other needs for indigent funds, particularly behavioral health and indigent care not covered by Medicaid. The final bill's compromise contained a mandatory 1/12th increment and counties received the authority to impose an additional gross receipts tax increment of 1/16th or 1/12th if needed to finance the transfer.

HSD Current Projection for Hospital Payment Package. HSD now projects a total cost of \$240 million for both the SNC Pool and Medicaid rate increases for hospitals. The equivalent of a 1/12th gross receipts tax increment was projected to bring in \$26 million, but the latest HSD estimate is that about \$24 million will be collected. State general fund contributions from SB 313 remain at \$9 million; and UNM remains at \$14 million. HSD estimates a state match shortfall of approximately \$11 million dollars—the amount needed for additional federal dollars to bring total funding to approximately \$240 million.

Hospital Concerns Regarding Hospital Payment Distributions. The federally-approved SNC Pool payment methodology under Centennial Care divides hospitals into groups, allocating 60 percent of available funding to the smallest hospitals (30 or fewer beds); 30 percent to small hospitals (31-100 beds); 10 percent to medium hospitals (101-200 beds); and no distributions to hospitals with more than 200 beds (St. Vincent, San Juan Regional, and Memorial Medical).

However, large hospitals argue their distribution of the SNC Pool funding is inadequate, which will decrease their ability to continue to support the current array of services for indigent populations in their areas.

Nevertheless, HSD notes if the total allocation to any particular group exceeds uncompensated care costs for the group, the balance of funding will be made available to the next group of larger hospital. HSD estimates \$1 million to \$2 million will be available to the largest hospitals when smaller hospital distributions are final.

Medicaid Rate Increase. HSD notes larger hospitals that treat more clients will also benefit from approximately \$171 million in Medicaid rate increases (assuming the needed additional \$11 million in state match funding is identified).

COUNTY FUNDING AUTHORITY AND ACCESS TO CARE

County Tax Authority. The Indigent Hospital and County Health Care Act provides counties with a 1/8th local option GRT tax increment for indigent healthcare, referred to as the “second 1/8th” increment. Most counties participate in this method of funding for local indigent care. A third 1/8th and another 1/16th increment are available for general purposes. Counties may choose to dedicate 50 percent of the optional 3rd 1/8th increment to the county indigent care fund. Counties may use other sources of funding as well, including the sale of property, mill levy taxes, investment income, and grants. In

San Juan County Commission is set to vote on cuts of up to 75 percent of its projected indigent fund to meet state requirements for the SNC Pool.

LFC requested HSD provide an update regarding the quality of services provided by the new Arizona-based behavioral health providers.

December 2011, LFC reported over \$100 million was raised annually by counties to support county indigent programs, to participate in the funding of Medicaid programs, and to contribute to the support of the (now replaced) Sole Community Provider program for hospitals.

Counties use indigent care funds for everything from indigent care claims to funding preventive care clinics, county inmate healthcare, and detox and sobering centers. Counties may also use the funds for transfer to the SNC Pool or to the County Supported Medicaid Fund, a mandatory program in which counties provide funding to the state to draw down federal matching dollars for Medicaid.

Bernalillo County is a statutory exception, contributing a flat \$1 million per year to community and Indian health centers for indigent care.

County Concerns Regarding Indigent Care Funds. During the last legislative session, counties opposed an early proposal to transfer a 1/8th GRT increment equivalent to support the SNC Pool and Medicaid rate increase, stating county indigent care funds would be depleted and services cut. Yet, despite passage of a lesser 1/12th increment transfer to the SNC Pool and additional taxing authority, counties continue to voice concerns.

For example, the San Juan County Commission is set to vote on cuts to its indigent fund to provide the \$3 million required county transfer the state's SNC Pool, about 75 percent of its projected indigent fund. The county expects to cut reimbursement rates for providers and tighten household eligibility requirements for residents to receive help paying medical bills.

It is also important to point out that under the previous (Sole Community Provider) program, counties received funding for the Sole Community Provider match from hospitals as a grant, which is no longer allowed under the new SNC Pool. Counties must now use tax authority to provide the match.

BEHAVIORAL HEALTH UPDATE

Status of Behavioral Health Audits of New Mexico Providers. The Attorney General's Office continues to investigate 15 New Mexico behavioral health care provider fraud claims, but has cleared two providers to date.

However, new information indicating the state paid at least one Arizona-based provider large payments before the audit was even complete—and for rates and service some call excessive—has brought the issues to the forefront again.

LFC requested HSD provide an update regarding the quality of client services from Arizona-based providers, including cost per client, visits per client and utilization within the areas of the shuttered New Mexico providers, and timeliness and accuracy of billing.

The BHSD director noted that at its inception, the Behavioral Health Collaborative was viewed across the nation as an exciting innovation.

The state must reevaluate and redistribute resources where necessary to fully leverage Medicaid revenues to address service gaps and needs.

Additionally, it is not clear whether HSD intends to seek a claw-back from OptumHealth of funds withheld from New Mexico providers which resulted in a number of agencies closing their doors. In December 2013, LFC reported the total for provider pay holds was \$13.6 million.

Status of Behavioral Health Collaborative. In June, the Collaborative released a request for proposals for a behavioral health entity to provide administrative functions related to the delivery and payment of non-Medicaid behavioral health services. The Collaborative intends to award a three and one half year contract beginning January 1, 2015.

In December 2013, LFC reported HSD was questioning the role of the Collaborative. Although the responsibilities of the Collaborative are defined in New Mexico law, recent years' history of the entity appears to demonstrate waning interest on behalf of statutorily-identified members and at least two agencies have chosen to assume management of funds previously dispersed through the Collaborative.

To date, the Collaborative continues to struggle to more effectively administer and deliver behavioral health services in New Mexico. HSD's new director for the Behavioral Health Division states the division will reassess the Collaborative and make recommendations to the department secretary. The Collaborative next meets on July 10, 2014 at 1:00 pm in Santa Fe.

OPPORTUNITIES EXIST TO LEVERAGE RESOURCES FOR OUTSTANDING GAPS AND NEEDS

With Medicaid expansion, nearly 140,000 newly-eligible adults now have healthcare coverage; however, the infusion of Medicaid dollars into the state health care system and corresponding decreased demand on county indigent care funds has heightened the need for New Mexico to carefully evaluate the impacts of ACA.

Areas of opportunity include the changing need for local funding of healthcare and county tax authority, as well as the value and effectiveness of healthcare tax incentives. The state must reevaluate funding need under ACA and redistribute resources where necessary to fully leverage Medicaid revenues to address continuing gaps such as access to primary care doctors and dentists, early childhood services, such as home visiting, behavioral health, and health care for individuals on their way to or from the state's jails and prisons.

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