

MEDICAID REFORM COMMITTEE

FINDINGS AND RECOMMENDATIONS

December 2002
Legislative Council Service

December 2002

The Medicaid Reform Committee is pleased to submit its report to the Forty-sixth Legislature, First Session. The report includes the committee's findings and recommendations for the state's Medicaid program.

The committee wishes to acknowledge the active participation of the advisory members; the assistance of the Human Services Department, the Department of Health, the Children, Youth and Families Department, the New Mexico Health Policy Commission and the Legislative Finance Committee; the informative testimonies and presentations; the substantive input from numerous members of the general public; and the work of the Legislative Council Service staff and contractors.

If you have questions concerning this report or the work of the committee, please feel free to contact us or Raúl Burciaga, staff attorney, Legislative Council Service.

Sincerely,

DEDE FELDMAN
Senator, District 13
Co-chair, Medicaid Reform Committee

JAMES ROGER MADALENA
Representative, District 65
Co-chair, Medicaid Reform Committee

Table of Contents

Acknowledgments

Findings and Recommendations 1

Appendices 11

1	New Mexico Medicaid expenditures and enrollment, state fiscal years 1991-2003	13
2	New Mexico Medicaid enrollment, September 2001 - September 2002	17
3	Medicaid program expenditures, overview of state general fund needs, fiscal years 2000 through 2004	21
4	Federal poverty level and selected characteristics	25
5	New Mexico Medicaid expenditures by categories of service	29
6	New Mexico Salud! managed care organizations (MCO) expenses	33
7	New Mexico MCO performance	37
8	Average annual growth rates of U.S. Medicaid expenditures 1990-2001 <i>and</i> Growth in state FY2002 initial appropriations for education, corrections and Medicaid	43
9	Annual increase in health insurance premiums, 1992-2001 <i>and</i> Annual change in HMO premiums, 1988-2002	47
10	Projected total Medicaid spending per enrollee, 2001-2005 <i>and</i> Medicaid payments vs. recipients U.S. in 2002	51
11	Senate Bill 379, 45 th Legislature, Second Session (Laws 2002, Chapter 96)	55
12	Medicaid Reform Committee and advisory group membership	67
13	Medicaid Reform Committee – agendas and minutes	73
14	Medicaid Reform Committee – work plan, meeting schedule and budget	199
15	Options proposed to Medicaid Reform Committee	205
16	Proposed options – Ranking and voting outcome	293
17	Proposed options – Recommendations with estimated general fund impact	301
18	Letter to Representative Luciano "Lucky" Varela, chair, Legislative Finance Committee from Human Services Secretary-Designate Robin Dozier Otten, December 21, 2001	311
19	Letter to Senator Ben D. Altamirano, chair, Senate Finance Committee and Representative Max Coll, chair, House Appropriations and Finance Committee from Human Services Secretary-Designate Robin Dozier Otten, January 24, 2002	317
20	Glossary of Medicaid terms and acronyms	325

MEDICAID REFORM COMMITTEE
FINDINGS AND RECOMMENDATIONS

Medicaid is a joint federal-state program designed to provide health care for low-income persons. Within a broad federal framework, each state determines how the program is administered, how providers are reimbursed and what optional benefits and eligibility are provided above the federal minimum requirements.

Medicaid was created in 1965 as Title XIX of the Social Security Act, at the same time as Medicare, which is Title XVIII. Medicaid and Medicare have grown considerably since their creation. This year, Medicaid is poised to overtake Medicare as the largest government health care program in the country. Nationwide, Medicaid enrollment is projected to be about 47 million while enrollment in Medicare is projected at over 40 million. Part of the recent growth in Medicaid has been the establishment in 1997 of the State Children's Health Insurance Program, or Title XXI, the largest expansion of Medicaid since its inception.

Medicaid growth in New Mexico has been similar to that nationwide. In 1991, the total state and federal expenditures in Medicaid were approximately \$341 million of which the state contributed about \$88 million, or 25 percent. Twelve years later, the state contribution alone is expected to exceed \$380 million, or 25 percent of a program that has grown to about \$1.9 billion. It is expected to exceed \$2 billion in fiscal year 2004, requiring a state contribution of over \$400 million. Medicaid enrollment has tripled during that 12-year period, growing from about 129,400 in 1991 to a projected 400,000 by the end of fiscal year 2003. (See Appendices 1-3 for expenditures and enrollment information.)

Medicaid has become a critical component of the health care system in the state and covers approximately one in five New Mexicans. Twenty percent of New Mexicans are without public or private health care insurance, compared to 15 percent uninsured nationwide. (See Appendix 4 for selected uninsured characteristics and federal poverty level information.)

The Medicaid program in New Mexico is broken into two major components: managed care and fee-for-service (FFS). Three managed care organizations (MCOs) provide coverage for about two thirds of the Medicaid population under the *Salud!* Medicaid managed care program. Each MCO is paid on the basis of a per member per month (PMPM) rate, an amount negotiated with the Human Services Department (HSD) that must cover all services rendered to a Medicaid beneficiary, regardless of whether the MCO pays more or less than the PMPM rate. The remaining one third of the Medicaid population is covered under an FFS arrangement that includes little or no management or coordination of a person's health care. (See Appendices 5-7 for Medicaid MCO and FFS information.)

The growth in Medicaid is attributable to a number of factors. Medical inflation is higher than regular inflation and is projected to exceed 10 percent for the next five to 10 years. In a national survey conducted during the summer of 2002, state officials were asked to report the top three factors increasing Medicaid expenditures. Pharmacy (44 states), enrollment (39 states), health care costs (28 states) and long-term care (15 states) were reported among the top three factors. New Mexico officials reported, in order of priority, pharmacy, enrollment and cost inflation as the top three factors contributing to the growth in spending. (See Appendices 8-10 for Medicaid cost increase information.)

Nationally, Medicaid spending as a portion of a state's general fund doubled between 1987 and 2002, growing from 8.1 percent to 16 percent. New Mexico's budget portion attributable to Medicaid was half the national average partly because of how the state funds public education. However, the state's expenditures similarly doubled from about four percent in 1991 to about eight percent in 2002. The slowing economy, rise in Medicaid costs and increasing demand on the state budget for other needs prompted officials to focus their attention on the Medicaid program.

In light of the demands that the Medicaid program was placing on the state budget, the Medicaid Reform Committee was created pursuant to Senate Bill 379, 45th Legislature, Second Session (Laws 2002, Chapter 96). The committee was charged with reviewing the program's services,

delivery, funding and policy, and with reporting its findings and recommendations regarding the Medicaid program's resources and needs. The committee's 30 members included 12 legislators and 18 public advisory members. (See Appendices 11-12 for legislation and committee membership information.)

The committee held 21 full-day meetings that included over 40 testimonies and presentations with accompanying question-and-answer sessions, more than 100 written and verbal public input comments, and over 2,000 pages in written testimony, handouts, reports and graphs. (See Appendix 13 for agendas and minutes of all meetings.)

The Medicaid Reform Committee based its work plan on the general direction provided in SB 379. The more focused approach was based on the strategies provided in a two-part report by the National Conference of State Legislatures (NCSL): *Managing Medicaid Costs - A Legislator's Tool Kit* and *Cost-Cutting Strategies*. The cost-cutting strategies provided 10 approaches to Medicaid cost-containment and funding initiatives. (See Appendices 14-15 for initial work plan and complete options information.)

During its November 13-15, 2002 meeting, the committee considered almost 100 short- and long-term cost-cutting strategies. Legislators and advisory members ranked the strategies between 1 (strongly oppose) and 5 (strongly in favor). The legislators then voted on those strategies that received an average ranking at or above 2.5. (See Appendices 16-17 for information on the proposed options and ranking and voting outcomes.)

The Medicaid Reform Committee endorsed the following options, categorized by the NCSL cost-cutting strategies (and two other strategies). Some options may overlap with others, but it is the committee's intent that HSD implement those options that are the most cost-effective.

The first four cost-cutting strategies were focused on maximizing the available funding for Medicaid by generating additional federal funding to enhance the state's Medicaid budget.

1. *Medicaid maximization* involves the identification of services that are potentially reimbursable through Medicaid but are currently funded solely by general fund dollars. The committee considered various options to maximize state general fund dollars dedicated to health care programs and services by redirecting some of that funding. The committee recognized the concerns about possible expansion of Medicaid eligibility and subsequent funding needs or an erosion of the health care safety net programs for those not eligible for Medicaid and subsequent uncompensated costs. The committee recommended that:
 - general fund dollars allocated for programs or services reimbursable under Medicaid be matched with federal funds (option F01);
 - HSD apply for waivers for specific populations served by other agencies' programs or services (option N04); and
 - primary care clinics be reimbursed for Medicaid outreach and enrollment activities not currently being matched (option F06B).
2. *Low-match to high-match* initiatives identify services that are Medicaid-reimbursable at a Federal Medical Assistance Percentage (FMAP) that may be higher. HSD had already undertaken various initiatives to ensure that Medicaid services were being matched at the appropriate highest level possible. The committee recommended that:
 - HSD maximize the use of Indian Health Service or tribally operated facilities for Medicaid services rendered to Native Americans so that the state can take advantage of the 100 percent FMAP (option F02); and
 - HSD work with other departments to ensure that services are appropriately categorized at the most favorable FMAP available (option F01).
3. *Intergovernmental transfers* include the transferring of funds between different levels of government to obtain federal matching dollars. The committee heard testimony about the limit imposed on New Mexico for disproportionate share hospital (DSH) funding while other states enjoy a far more favorable funding level. Congressional efforts to raise the DSH funding level have been unsuccessful as of the date of this report. The intergovernmental transfers strategy is similar to Medicaid maximization, particularly as it relates to agency programs. The committee recommended that:

- HSD work with the counties to determine if county medical indigent funds can be matched under Medicaid without adversely affecting the counties' ability to fund health care for indigents (option F08).
4. *Private sector cost-sharing* includes the recovery of some of the Medicaid costs from employers, families or individuals. Under the Robert Wood Johnson State Coverage Initiative, HSD had previously applied for and subsequently obtained a waiver for a lower-level benefits package for adults up to 200 percent of the federal poverty level. That program is expected to be funded by employer, employee, state and federal contributions. Most of the committee's discussion regarding private sector cost-sharing involved the application of copayments or premiums on certain Medicaid beneficiaries or services. Federal law prohibits the application of both premiums and copayments on the same eligibility group and mandates a cap on the annual cost-sharing amount. The committee recommended that:
- a monthly premium on selected Medicaid beneficiaries be imposed (option L01);
 - a copayment be imposed on emergency room services unless the patient is subsequently admitted (option L02);
 - a tiered copayment be required on higher-cost prescription drugs to provide incentives for greater use of generic drugs when there is a generic or lower-cost equivalent available (option L03); and
 - a copayment be required for drugs not on the preferred drug list (option L03B).

The next three NCSL cost-cutting strategies include financing and delivery incentives to reduce or contain costs.

5. *Reconfiguring the long-term care delivery system* includes emphasizing home and community care services that are generally more favorable to the patient and less costly than institutional care. The committee heard various presentations on long-term care that included cost-containment options as well as recommendations for greater coordination between medical and social services. The committee recommended that:
- the analysis necessary for the global funding waiver that has been under consideration for approximately two years be completed (option C12);

- a cost-benefit analysis of the personal care option be conducted with an evaluation of consumer-directed vs. consumer-delegated care (option C13);
 - outreach be provided for increased consumer awareness of the consumer-directed personal care services (option C14);
 - the Program of All-Inclusive Care for the Elderly (PACE) be expanded to an urban area beyond that currently served in Albuquerque (option C17); and
 - long-term care services provided by the Department of Health, the Children, Youth and Families Department, HSD and the State Agency on Aging be consolidated into a cabinet-level agency for all services from birth to death (option C18B).
6. *Pharmacy cost-containment strategies* include utilization and pricing management to contain pharmaceutical costs, one of the biggest drivers in the increase in Medicaid costs. The committee's discussions around pharmacy cost-containment included numerous options as well as hearing testimony before the Legislative Health and Human Services Committee. Both committees will be jointly endorsing some of the prescription drug legislation. The committee recommended that:
- a uniform, preferred drug list be used for Medicaid managed care and FFS with or without other potential purchasers of prescription drugs (options C01A and C01B);
 - the use of the federal 340B discount drug program be maximized (option C02);
 - HSD conduct a cost-benefit analysis on the carveout of pharmacy from Medicaid managed care (option C03C);
 - a prescription drug purchasing cooperative be established to combine the buying power of Medicaid, other government programs and other potential purchasers (option C05A);
 - an analysis be conducted by an outside firm on how pharmaceuticals are used, what trends exist and how to identify and obtain cost savings (option N02); and
 - HSD reverse its policy that took away incentives for pharmacists to use generic prescription drugs (option N03).
7. *Rate adjustments* include revising, freezing or reducing provider rates. HSD had already frozen some provider rates by not providing market basket index increases and had reduced some personal care option reimbursement rates. The committee did not endorse proposals to reduce other provider or MCO rates. The committee recommended that:

- an alternative payment methodology be established for federally qualified health centers that will allow true reimbursement of 100 percent of costs (option F06A).

The last three NCSL strategies included fine-tuning managed care and selectively contracting for certain services to reduce costs and improve how the care is managed.

8. *Managing health care better* included efforts to expand care coordination and disease and case management strategies. Numerous presentations and discussions focused on the need for early intervention and treatment through targeted disease and case management initiatives that keep chronic cases from becoming catastrophic and more costly. The committee recommended that:

- the use of community health representatives be expanded for outreach and education on primary and preventive care, as well as helping consumers with program and service requirements (option C06B);
- MCOs be required to strengthen disease management programs and coordinate more closely with primary care providers (option C07A);
- case management be included as a core medical service provided within disease management programs for Medicaid managed care and FFS (option C07C);
- a disease management firm be used to design a pilot program for FFS by using key health status indicators (option C07D); and
- fraud and abuse detection, reporting and recovery efforts be strengthened (option C21).

9. *Expanding (or contracting) managed care* includes revisiting the way care is managed and expanding or contracting the populations served or the services provided. The committee heard extensive testimony on the role of the three MCOs and their efforts to contain costs. The committee also received presentations on some variations in managed care arrangements. The committee recommended that:

- a comprehensive feasibility study and cost-benefit analysis be conducted on replacing the current managed care model with a statewide primary care case management model (option C08);
- a pilot/demonstration project be implemented through a federal grant for primary care case management with the FFS population or a sub-population (option C09);

- a cost-effectiveness analysis be conducted of the various models available for non-emergency transportation (option C10C);
 - a pilot project be conducted in a rural and an urban area for non-emergency transportation in FFS (option C10D); and
 - the primary care provider gatekeeper concept be re-evaluated to ensure collaboration and communication with other practitioners (option L06.2Ia).
10. *Selective contracting* includes identifying services that may be more effectively provided whether under managed care or through a selective contract under FFS. The committee considered various options for certain services or functions to be included in or excluded from the managed care model. These are included in the options above to consider a carveout of pharmacy (option C03C) and transportation (option C10C).

Two other strategies that the committee considered were not part of the NCSL strategies.

However, the committee determined it was important to address these issues as well.

- *Alternative funding mechanisms* include other sources of revenue to address the tremendous fiscal demand of Medicaid specifically and the health care system generally. These options included tax and earmarking provisions. The committee recommended that:
 - the tax code be amended to provide tax credits for the purchase and maintenance of long-term care insurance with the expectation of a lesser demand on Medicaid for long-term care in the future (option C19);
 - a percentage of the general fund be earmarked based on gaming revenues (option F04B);
 - the percentage of the tobacco settlement funds dedicated to support Medicaid be increased (option F05);
 - the statutory provision be removed that exempts the MCOs from paying the premium tax on the PMPM rates paid by the state (option F09);
 - an additional excise tax be imposed on alcohol sales for a combination of Medicaid funding and the development of a statewide trauma system (option F12); and
 - the cigarette tax be increased for additional Medicaid support (option F13).
- *Eligibility and benefits strategies* include the optional Medicaid eligibility categories and benefits that could be restructured or reduced for general fund savings. The committee

considered over 30 strategies to reduce or eliminate certain eligibility groups or benefits. (See Appendices 18-19 for information on which eligibility and benefits reductions were considered.) Discussions centered around the need to control costs and growth, the recognition that reductions would result in reduced access for consumers and more uncompensated care for health care providers, and the potential increase in uninsured or underinsured populations. The committee rejected the majority of the proposals for reductions or eliminations. The committee recommended that:

- eye exams and eyeglass services for adults be limited (option L06.3J);
- federal waivers be explored for reducing benefit packages (option L07.4); and
- the look-back period for disposal of assets be increased from three to five years as permissible by federal law (option N05).

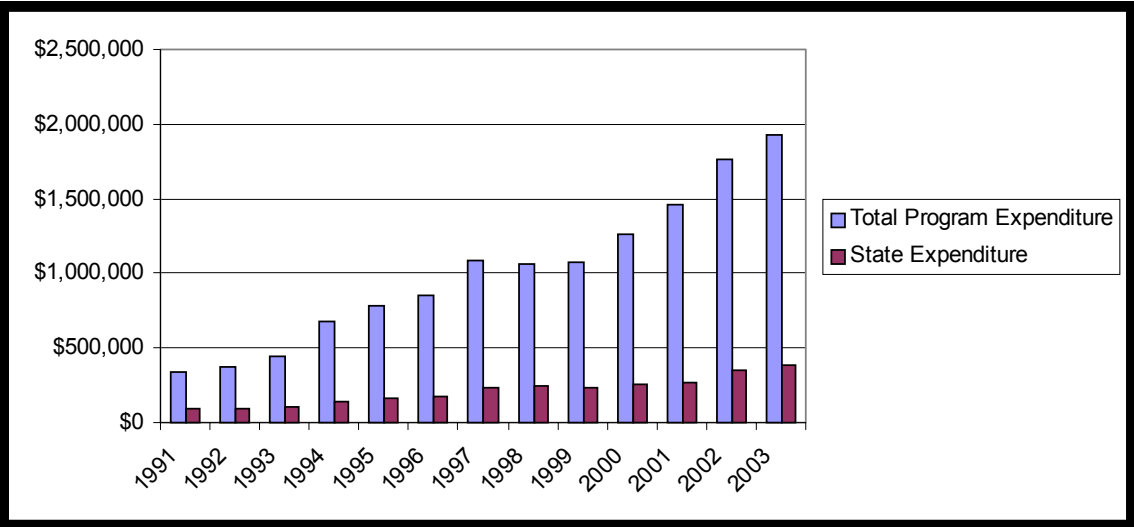
The recommendations made by the Medicaid Reform Committee included:

- 24 program changes, enhancements and cost-containment initiatives aimed to provide between \$8.5 million and \$22.5 million in savings to the state general fund;
- 11 studies, pilots and waiver requests for cost-benefit analyses that may cost the state up to \$250,000 (or less if private grants are obtained); these initiatives have the potential of saving the state millions of dollars in general funds over the long run;
- four tax initiatives to supplement Medicaid funding in light of double-digit medical inflation; these may provide between \$68 million and \$118 million in additional funding; and
- two initiatives to earmark gaming and tobacco settlement money for Medicaid funding support.

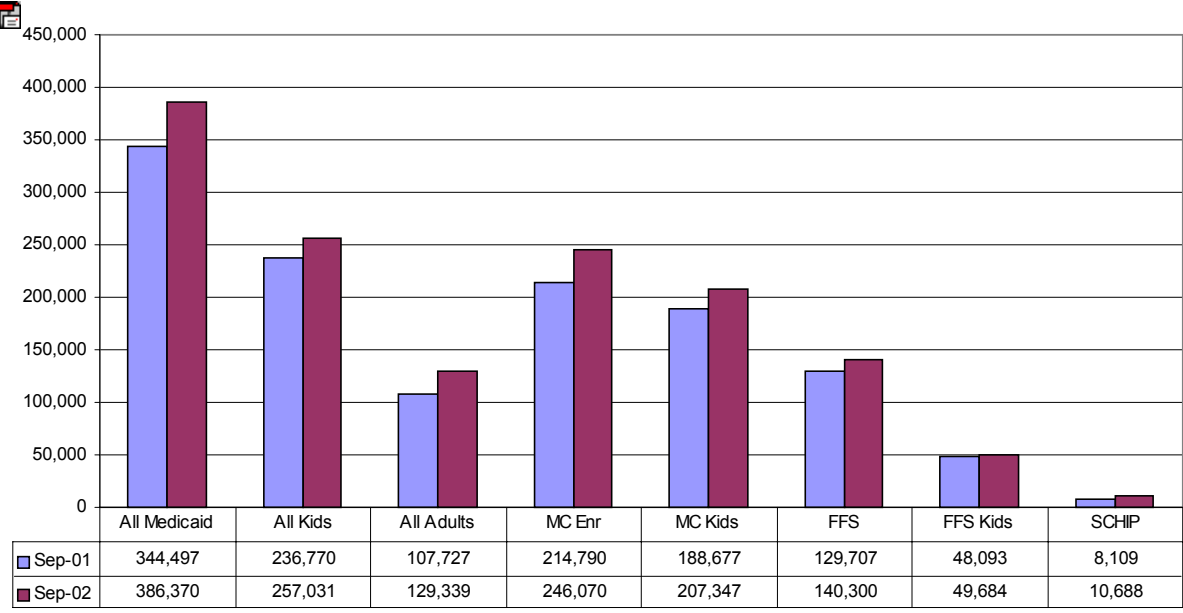
APPENDICES

APPENDIX 1

FY	Total Program Expenditure	Increase over previous year	State Expenditure	Increase over previous year	Enrollment	Increase over previous year	Program cost per enrollee	State cost per enrollee
1991	\$341,090		\$88,152		129,402		\$2,635.89	\$681.23
1992	\$378,997	11.11%	\$94,645	7.37%	165,407	27.82%	\$2,291.30	\$572.19
1993	\$441,217	16.42%	\$108,463	14.60%	194,919	17.84%	\$2,263.59	\$556.45
1994	\$678,520	53.78%	\$143,541	32.34%	209,569	7.52%	\$3,237.69	\$684.93
1995	\$781,360	15.16%	\$169,285	17.93%	213,344	1.80%	\$3,662.44	\$793.48
1996	\$849,200	8.68%	\$179,100	5.80%	239,857	12.43%	\$3,540.44	\$746.69
1997	\$1,089,700	28.32%	\$237,600	32.66%	264,186	10.14%	\$4,124.75	\$899.37
1998	\$1,064,800	-2.29%	\$244,492	2.90%	250,914	-5.02%	\$4,243.69	\$974.41
1999	\$1,077,000	1.15%	\$232,103	-5.07%	277,300	10.52%	\$3,883.88	\$837.01
2000	\$1,256,149	16.63%	\$262,400	13.05%	303,383	9.41%	\$4,140.47	\$864.91
2001	\$1,455,573	15.88%	\$266,033	1.38%	325,051	7.14%	\$4,477.98	\$818.43
2002	\$1,760,775	20.97%	\$350,003	31.56%	360,069	10.77%	\$4,890.10	\$972.04
2003	\$1,932,070	9.73%	\$380,833	8.81%	395,790	9.92%	\$4,881.55	\$962.21



APPENDIX 2



APPENDIX 3

MEDICAID PROGRAM EXPENDITURES

Overview of State General Fund Needs Fiscal Years 2000 through 2004

Fiscal Year	State General Fund Dollars in Millions (\$)	Notes
2000	\$ 0	Per June 2002 actual
2001	\$ 11.9	Surplus (per June actual) will be come \$0 when HSD identifies this amount as a reservation of fund balance in the FY2001 audit and a budget adjustment request is submitted to use surplus in FY2003
2002	\$ (25.3)	Shortfall
2003	\$ (25.8)	Shortfall, contingent upon 2003 State Board of Finance action to provide \$9.75* million to Medicaid that will partially offset the projected shortfall of \$35.6 million (*this amount represents the second one-half of the \$19.5 million appropriated to offset the shortfall for FY2003)
Subtotal 2000 - 2003	\$ (39.2)	
2004	\$ 417.8	Projected expenditure
Total 2000 - 2004	\$ 457.0	Projected general fund needs

23

Federal Medical Assistance Percentage (FMAP)

	State share	Federal share
Medicaid (Title XIX)	25.44%	74.56%
SCHIP (Title XXI)	17.81%	82.19%

Source: HSD, DFA and LFC - Projections based on September 2002 actual expenditures

APPENDIX 4

Federal Poverty Level (FPL)

Family Size	100% FPL	100% FPL	133% FPL	133% FPL	185% FPL	185% FPL	200% FPL	200% FPL	235% FPL	235% FPL
	Per year	Per month	Per year	Per month	Per year	Per month	Per year	Per month	Per year	Per month
1	\$8,860	\$738	\$11,784	\$982	\$16,391	\$738	\$17,720	\$1,477	\$20,821	\$738
2	\$11,940	\$1,990	\$1,841	\$1,990	\$2,338	\$1,841	\$0	\$1,990	\$11,940	\$2,338
3	\$15,020	\$1,252	\$19,977	\$1,665	\$27,787	\$2,316	\$30,040	\$2,503	\$35,297	\$2,941
4	\$18,100	\$1,508	\$24,073	\$2,006	\$33,485	\$2,790	\$36,200	\$3,017	\$42,535	\$3,545
5	\$21,180	\$1,765	\$28,169	\$2,347	\$39,183	\$3,265	\$42,360	\$3,530	\$49,773	\$4,148
6	\$24,260	\$2,022	\$32,266	\$2,689	\$44,881	\$3,740	\$48,520	\$4,043	\$57,011	\$4,751
7	\$27,340	\$2,278	\$36,362	\$3,030	\$50,579	\$4,215	\$54,680	\$4,557	\$64,249	\$5,354
8	\$30,420	\$2,535	\$40,459	\$3,372	\$56,277	\$4,690	\$60,840	\$5,070	\$71,487	\$5,957

Distribution of Nonelderly Uninsured by FPL, 1999-2000

	NM	US
Under 100%	43%	36%
100%-199%	29%	28%
200% or more	28%	36%

Distribution of Nonelderly Medicaid Enrollees by FPL, 1999-2000

	NM	US
Under 100%	56%	56%
100%-199%	28%	28%
200% or more	16%	16%

Distribution of Uninsured by age, 1999-2000

	NM	US
Children 18 & under	24%	12%
Adults 19-64	29%	18%
Nonelderly adult women	29%	17%
Nonelderly adult men	30%	19%
Nonelderly 0-64	27%	16%

APPENDIX 5

Category of Service	FY2002	FY2003	FY2004
Inpatient Psychiatric	\$1,849	\$1,671	\$1,755
Inpatient Hospital	\$98,247	\$99,894	\$105,728
Graduate Medical Education	\$6,350	\$6,668	\$6,875
Indirect Medical Education	\$22,986	\$20,884	\$20,884
Sole Comm Provider Hospital	\$60,573	\$71,580	\$73,799
Disproportionate Share Hosp	\$12,290	\$13,270	\$13,681
Physician Services	\$32,698	\$33,810	\$34,438
Prescription Drugs	\$69,037	\$78,763	\$84,621
Dental Services	\$9,611	\$11,053	\$11,258
Non-Emergency Transport	\$7,759	\$9,160	\$9,330
Prosthetics	\$170	\$168	\$176
Lab & Xray	\$1,757	\$1,903	\$1,938
Rural Health Clinics	\$438	\$398	\$415
EPSDT	\$1,057	\$1,539	\$1,568
Intermed. Care Fac. (ICF) Public	\$24,063	\$24,987	\$26,138
Personal Care Option	\$127,592	\$131,332	\$133,772
ICF - Private	\$145,488	\$151,139	\$158,103
ICF - MR Private	\$18,271	\$20,890	\$21,853
Nurse Aide Training	\$313	\$313	\$319
Clinic Services	\$5,835	\$4,887	\$4,894
Federally Qualified Health Ctr	\$15,148	\$17,312	\$18,021
Other Practitioners	\$28,780	\$32,217	\$32,816
Medical Supplies	\$18,859	\$17,359	\$18,158
Ambulance	\$2,556	\$2,577	\$2,625
Case Management Services	\$4,895	\$3,048	\$2,762
Hospice	\$4,010	\$4,578	\$4,663
Home Health	\$1,077	\$1,136	\$1,158
Outpatient Hospital	\$26,394	\$28,185	\$28,708
Outpatient Psychiatric	\$57	\$75	\$76
Maintenance	\$105	\$94	\$96
Group Health Ins Premiums	\$145	\$145	\$148
Buy-in PART A	\$1,483	\$1,404	\$1,430
Buy-in PART B	\$26,389	\$28,593	\$29,124

Medicaid in the Schools (MITS)	\$6,252	\$7,811	\$10,076
MITS expansion		\$4,000	\$4,000
Coord. Comm. In-home Care	\$193,656	\$173,314	\$191,227
Disabled & Elderly Waiver		\$28,508	\$28,508
Title XIX expansion		\$2,798	
State Coverage Initiative		\$0	\$0
Parity - nurses/caregivers		\$200	
CYFD case management	\$11,672	\$12,002	\$12,567
Subtotal	\$987,862	\$1,049,665	\$1,097,708
Managed Care	\$707,683	\$818,963	\$938,672
Total	\$1,695,545	\$1,868,628	\$2,036,380

Source: HSD, DFA and LFC actuals and projections, December 11, 2002.

APPENDIX 6

**New Mexico Salud!
Managed Care Organizations
Expenses**

	Member Months	Physical Health	Behavioral Health	Pharmacy	Dental	Transportation	Administration	Profit	Total Premium
Cimarron	670,420	\$98,643,952	\$17,418,456	\$17,327,709	\$8,164,769	\$3,808,507	\$15,883,916	\$3,107,205	\$164,354,514
		60.0%	10.6%	10.5%	5.0%	2.3%	9.7%	1.9%	
Lovelace*	592,750	\$65,336,199	\$20,804,292	\$13,114,305	\$7,461,581	\$2,714,142	\$18,689,001	\$17,421,934	\$145,541,454
		44.9%	14.3%	9.0%	5.1%	1.9%	12.8%	12.0%	
Presbyterian	1,302,444	\$181,147,464	\$57,249,148	\$30,622,407	\$17,674,477	\$6,889,598	\$28,523,907	\$7,551,217	\$329,658,218
		55.0%	17.4%	9.3%	5.4%	2.1%	8.7%	2.3%	
Combined		\$345,127,615	\$95,471,896	\$61,064,421	\$33,300,827	\$13,412,247	\$63,096,824	\$28,080,356	\$639,554,186
		54.0%	14.9%	9.5%	5.2%	2.1%	9.9%	4.4%	

* Lovelace reported medical expense IBNR adjustments of \$3.891 million which would increase the Physical Health amount to \$69,227,199 or 47.57% of premium and decrease the Profit to \$13,530,934 or 9.30% of premium. Lovelace files as an integrated system and a portion of its hospital and physician group are reported as Administration. Lovelace's internal method of treating all hospital and physician group costs as medical would reduce Administration costs to 10.4% of premium and increase Physical Health costs to 50% of premium.

APPENDIX 7

	2001	Change From	Change From	2000	Change From	1999	Change From	1998
1 UTILIZATION	PMPM/100	1998 to 2001	Prior Year	PMPM/100	Prior Year	PMPM/100	Prior Year	PMPM/100
	0			0		00		0
2 CIMARRON								
3 Member Months	670,420	25%	11%	601,983	-2%	615,887	15%	535,784
Ambulatory								
4 Encounters-Physician	450.00	-6%	5%	430.00	-19%	530.00	10%	480.00
5 Ambulatory Encounters-Other	1,290.00	279%	-13%	1,490.00	96%	760.00	124%	340.00
6 Hospital Patient Days	66.60	174%	3%	64.9000	23%	52.60	116%	24.30
7 LOVELACE								
8 Member Months	592,750	29%	3%	577,455	8%	534,333	17%	458,628
Ambulatory								
9 Encounters-Physician	460.00	15%	10%	420.00	-16%	500.00	25%	400.00
1								
0 Ambulatory Encounters-Other	100.00	-38%	-44%	180.00	20%	150.00	-6%	160.00
1								
1 Hospital Patient Days	10.60	-72%	-71%	36.50	-4%	38.10	0%	38.10
1 PRESBYTERIAN								
1								
3 Member Months	1,302,444	16%	3%	1,264,086	-7%	1,362,758	21%	1,126,807
1 Ambulatory								
4 Encounters-Physician	470.00	62%	-15%	550.00	20%	460.00	59%	290.00
1								
5 Ambulatory Encounters-Other	340.00	-90%	17%	290.00	-63%	780.00	-78%	3,510.00
1								
6 Hospital Patient Days	42.10	-15%	30%	32.30	0%	32.30	-35%	49.50

PMPM/1000: Per Patient Per Month x 1000 = Per 1000 patients per month

HIGH = Highest for line item among all MCOs over four years

LOW = Lowest for line item among all MCOs over four years

	2001		2000		1999		1998	
	PMPM	% TOTAL	PMPM	% TOT AL	PMPM	% TOT AL	PMPM	% TOTAL
17 REVENUE AND EXPENSE								
18 CIMARRON								
19 REVENUE								
20 PREMIUM EARNED	\$ 245.15	100%	207.61	99%	\$ 189.03	99%	\$ 189.06	100%
21 OTHER RELATED REVENUE			1.59	1%	\$ 1.32	1%		
				100		100		
22 TOTAL REVENUE	<u>\$ 245.15</u>	<u>100%</u>	<u>\$ 209.20</u>	<u>%</u>	<u>\$ 190.35</u>	<u>%</u>	<u>\$ 189.06</u>	<u>100%</u>
23 EXPENSE								
24 Health Care Expense	\$ 216.75	90%	\$ 179.34	86%	<u>\$ 165.71</u>	87%	\$ 162.49	89%
25 Administrative Expense	\$ 23.69	10%	\$ 28.68	14%	\$ 23.85	13%	\$ 19.48	11%
				100		100		
26 TOTAL EXPENSE	<u>\$ 240.44</u>	<u>100%</u>	<u>\$ 208.02</u>	<u>%</u>	<u>\$ 189.56</u>	<u>%</u>	<u>\$ 181.98</u>	<u>100%</u>
27 MARGIN AFTER ADM*	<u>\$ 4.71</u>		<u>\$ 1.18</u>		<u>\$ 0.79</u>		<u>\$ 7.08</u>	
28 % MARGIN AFTER ADM	<u>1.92%</u>		<u>0.56%</u>		<u>0.41%</u>		<u>3.75%</u>	
29 LOVELACE								
30 REVENUE								
31 PREMIUM EARNED	\$ 245.54	100%	\$ 218.42	100 %	\$ 211.35	99.6 %	\$ 198.75	99.5%
32 OTHER RELATED REVENUE					\$ 0.77	0.4%	\$ 1.03	0.5%
				100		100		
33 TOTAL REVENUE	<u>\$ 245.54</u>	<u>100%</u>	<u>\$ 218.42</u>	<u>%</u>	<u>\$ 212.11</u>	<u>%</u>	<u>\$ 199.78</u>	<u>100%</u>

CALENDAR YEARS ENDING
12/31/98-12/31/01

MCO MEDICAID
PERFORMANCE

PER ANNUAL STATEMENT
TO INSURANCE DIVISION

34 EXPENSE

35 Health Care Expense	\$ 184.61	85%	\$ 177.20	87%	\$ 219.38	96%	\$ 168.40	86%
36 Administrative Expense	\$ 31.53	15%	\$ 25.53	13%	\$ 9.54	4%	\$ 27.13	14%
37 TOTAL EXPENSE	\$ 216.14	100%	\$ 202.73	100%	\$ 228.92	100%	\$ 195.52	100%
38	\$ 29.39		\$ 15.69		\$ (16.81)		\$ 4.26	
39	11.97%		7.19%		-7.92%		2.13%	

40 PRESBYTERIAN

41 REVENUE

42 PREMIUM EARNED	\$ 253.11	99.6%	\$ 221.91	100.0%	\$ 219.10	100.0%	\$ 201.64	100.0%
43 OTHER RELATED REVENUE	\$ 1.14	0.4%					\$ 0.06	
44 TOTAL REVENUE	\$ 254.24	100%	\$ 221.91	100%	\$ 219.10	100%	\$ 201.71	100%

45 EXPENSE

46 Health Care Expense	\$ 226.55	91%	\$ 193.11	92%	\$ 188.83	89%	\$ 177.09	89%
47 Administrative Expense	\$ 21.90	9%	\$ 17.63	8%	\$ 23.80	11%	\$ 22.83	11%
48 TOTAL EXPENSE	\$ 248.45	100%	\$ 210.74	100%	\$ 212.63	100%	\$ 199.92	100%
49 MARGIN AFTER ADM*	\$ 5.80		\$ 11.17		\$ 6.47		\$ 1.78	
50 % MARGIN AFTER ADM	2.28%		5.04%		2.95%		0.88%	

* Excluding Provision for Federal
Taxes

**HIGH = Highest for line item
among all MCOs over four years**

MCO MEDICAID
PERFORMANCE

PER ANNUAL STATEMENT
TO INSURANCE DIVISION

*LOW = Lowest for line
item among all MCOs over
four years*

	2001	Change From 1998 to 2001	Change From Prior Year	2000	Change From Prior Year	1999	Change From Prior Year	1998
	PMPM			PMPM		PMPM		PMPM
51 TRENDS								
52 CIMARRON								
53 REVENUE								
54 PREMIUM EARNED	\$ 245.15	30%	18%	207.61	10%	\$ 189.03	-0%	\$ 189.06
55 OTHER RELATED REVENUE				1.59	21%	\$ 1.32		
56 TOTAL REVENUE	<u>\$ 245.15</u>	<u>30%</u>	<u>17%</u>	<u>\$ 209.20</u>	<u>10%</u>	<u>\$ 190.35</u>	<u>1%</u>	<u>\$ 189.06</u>
57 EXPENSE								
58 Health Care Expense	\$ 216.75	33%	21%	\$ 179.34	8%	<u>\$ 165.71</u>	2%	\$ 162.49
59 Administrative Expense	\$ 23.69	22%	-17%	\$ 28.68	20%	\$ 23.85	22%	\$ 19.48
60 TOTAL EXPENSE	<u>\$ 240.44</u>	<u>32%</u>	<u>16%</u>	<u>\$ 208.02</u>	<u>10%</u>	<u>\$ 189.56</u>	<u>4%</u>	<u>\$ 181.98</u>
61 MARGIN AFTER ADM*	<u>\$ 4.71</u>	<u>-33%</u>	<u>299%</u>	<u>\$ 1.18</u>	<u>50%</u>	<u>\$ 0.79</u>	<u>-89%</u>	<u>\$ 7.08</u>
62 % MARGIN AFTER ADM	<u>1.92%</u>	<u>-49%</u>	<u>241%</u>	<u>0.56%</u>	<u>36%</u>	<u>0.41%</u>	<u>-89%</u>	<u>3.75%</u>
63 LOVELACE								
64 REVENUE								
65 PREMIUM EARNED	\$ 245.54	24%	12%	\$ 218.42	3%	\$ 211.35	6%	\$ 198.75
66 OTHER RELATED REVENUE						\$ 0.77	-26%	\$ 1.03
67 TOTAL REVENUE	<u>\$ 245.54</u>	<u>23%</u>	<u>12%</u>	<u>\$ 218.42</u>	<u>3%</u>	<u>\$ 212.11</u>	<u>6%</u>	<u>\$ 199.78</u>
68 EXPENSE								
69 Health Care Expense	\$ 184.61	10%	4%	\$ 177.20	-19%	\$ 219.38	30%	\$ 168.40
70 Administrative Expense	<u>\$ 31.53</u>	<u>16%</u>	<u>24%</u>	<u>\$ 25.53</u>	<u>168%</u>	<u>\$ 9.54</u>	<u>-65%</u>	<u>\$ 27.13</u>
71 TOTAL EXPENSE	<u>\$ 216.14</u>	<u>11%</u>	<u>7%</u>	<u>\$ 202.73</u>	<u>-11%</u>	<u>\$ 228.92</u>	<u>17%</u>	<u>\$ 195.52</u>

MCO MEDICAID

72	\$ 29.39	-213%	-215%	\$ (25.53)	191%	\$ (8.77)	-66%	\$ (26.10)
73 % MARGIN AFTER ADM	11.97%	-100%	ERR	??	ERR	-1146.05	-55%	-2534.89%
74 PRESBYTERIAN								
75 REVENUE								
76 PREMIUM EARNED	\$ 253.11	26%	14%	\$ 221.91	1%	\$ 219.10	9%	\$ 201.64
77 OTHER RELATED REVENUE	\$ 1.14							\$ 0.06
78 TOTAL REVENUE	\$ 254.24	26%	15%	\$ 221.91	1%	\$ 219.10	9%	\$ 201.71
79 EXPENSE								
80 Health Care Expense	\$ 226.55	28%	17%	\$ 193.11	2%	\$ 188.83	7%	\$ 177.09
81 Administrative Expense	\$ 21.90	-4%	24%	\$ 17.63	-26%	\$ 23.80	4%	\$ 22.83
82 TOTAL EXPENSE	\$ 248.45	24%	18%	\$ 210.74	-1%	\$ 212.63	6%	\$ 199.92
83 MARGIN AFTER ADM*	\$ 5.80	225%	-48%	\$ 11.17	73%	\$ 6.47	263%	\$ 1.78
84 % MARGIN AFTER ADM	2.28%	158%	-55%	5.04%	70%	2.95%	234%	0.88%

* Excluding Provision for Federal Taxes

HIGH = Highest for line item among all MCOs over four years

LOW = Lowest for line item among all MCOs over four years

NOTES

Utilization:

Lines 3, 8 and 12, Member Months:

Member months have been distributed at roughly 50% to Presbyterian and 25% each to Cimarron and Lovelace throughout the MCO contract periods.

Lines 4, 9 and 14, Ambulatory Encounters-Physician:

Physician ambulatory encounters have varied from a low of 420 per thousand PMPM (Lovelace, 2000) to a high of 550 per thousand (Pres, 2000).

There is little variation between the rates of the 3 MCOs in 2001 (.45, .46 and .47), but all other service years show greater variation between and within MCOs.

Lines 5, 10 and 15, Ambulatory Encounters-Other:

Non-physician ambulatory encounters are highly variable between and within MCOs and service years.

Cimarron's PMPM rates (1290 per thousand in 2001; 1490 per thousand in 2000) are consistently greatly higher than Lovelace's extreme lows (100 per thousand in 2001, 180 per thousand in 2000) and Pres's .34 and .29 for these same two years.

There is insufficient data in the Insurance Reports to fully evaluate this wide variation in utilization relative to access, clinical outcomes, etc.

Lines 6, 11 and 16, Hospital Patient Days:

Cimarron has the highest PMPM hospital days for all years, the highest in 2001, 66.60 per thousand, 56 per thousand higher than Lovelace's low of 10.6 per thousand for the same year. As with non-physician ambulatory encounters, the wide variation in utilization needs further analysis.

Change From 1998 to 2001 (2nd Column):

This column is the % of change in PMPM between the 1998 PMPM (the first full service year) and the 2001 PMPM.

Utilization rates have often changed radically and inconsistently from year to year for all three MCOs.

Cimarron has radically increased both non-physician ambulatory encounters and hospital days while reducing ambulatory physician encounters by 6%.

Pres and Lovelace have both reduced non-physician ambulatory encounters and hospital days while increasing physician ambulatory encounters, but by very different percentages for each of the three utilization types.

Revenue and Expense:

Revenue:

Lines 20, 31 and 42, PREMIUM EARNED:

Premium has consistently risen for all 3 MCOs. Cimarron has always received the lowest premium and Pres the highest.

In 2001, the highest, Pres, at \$253.11 PMPM is 3% greater than Cimarron's 245.15 PMPM.

Expense:

Lines 26, 37 and 48, TOTAL EXPENSE:

Expenses have been highly variable between and within MCOs and service years.

In 2001, the highest total expense, Pres, at \$248.45 PMPM is 15% greater than Lovelace's 216.14 PMPM for total expense.

Lines 24, 35 and 46, Health Care Expense:

Lovelace has had the lowest Health Care Expense PMPM for the past two years.

Pres's 2001 PMPM of \$226.55 is the highest annual recorded Health Care expense from all 3 MCOs and exceeds Lovelace's 2001 low of \$184.61 by 23%.

Lines 25, 36 and 47, Administrative Expense:

In 2001, Lovelace, however, exceeds both Cimarron and Pres by 35% and 44% respectively in Administrative costs.

TRENDS:

PMPM Change From 1998 to 2001 (2nd Column):

All Revenue and Expenses for all the MCOs have increased since 1998, with the exception of Adm Expense for Pres, line 43, decreased 4%.

Cimarron has had the greatest overall expense increase since 1998, 32%. Pres has increased 24%, Lovelace 11%.

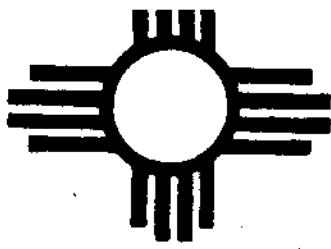
For none of the MCOs has the overall expense increase evolved consistently over time, and wide variations have taken place for each in different years: this situation makes future spending projections rather unpredictable.

APPENDIX 8

APPENDIX 9

APPENDIX 10

APPENDIX 11



The Legislature
of the
State of New Mexico

45th Legislature, Second Session

LAWS 2002

CHAPTER 96

SENATE BILL 379, as amended,

with emergency clause

Introduced by

SENATOR STUART INGLE AND SENATOR TIMOTHY Z. JENNINGS
SENATOR SUE WILSON BEFFORT



EMERGENCY CLAUSE

AN ACT

RELATING TO MEDICAID; CREATING A JOINT INTERIM LEGISLATIVE MEDICAID REFORM COMMITTEE; MAKING AN APPROPRIATION; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. TEMPORARY PROVISION--MEDICAID REFORM COMMITTEE CREATED.--There is created a joint interim legislative committee that shall be known as the "medicaid reform committee". The committee shall function from the date of its appointment until the first day of December prior to the first session of the forty-sixth legislature.

Section 2. TEMPORARY PROVISION--MEMBERSHIP--ADVISORY MEMBERS--APPOINTMENT--VACANCIES.--

A. The medicaid reform committee shall be composed of twelve members. Six members of the house of representatives shall be appointed by the speaker of the house of representatives and six members of the senate shall be appointed by the committees' committee of the senate or, if the appointments are made in the interim, by the president pro tempore of the senate after consultation with and agreement of a majority of the members of the committees' committee.

B. Members of the medicaid reform committee shall be appointed from each house so as to give the two major

political parties in each house the same proportional representation on the committee as prevails in each house; however, in no event shall either party have less than one member from each house on the committee. Vacancies on the committee shall be filled by appointment in the same manner as the original appointments. The chairman and vice chairman of the committee shall be elected by the committee.

C. An eighteen-member medicaid advisory group comprised of experts in medicaid or health care shall assist and advise the medicaid reform committee. The governor, the speaker of the house of representatives and the president pro tempore of the senate shall each appoint six members to the medicaid advisory group. The governor, the speaker and the president pro tempore shall coordinate their appointments to ensure representation from the following groups: health care and legal consumer advocates; community-based providers; mental and behavioral health providers; health care information management organizations; health care financial management organizations; health care payers and insurers; hospitals and other institutional providers; and physicians, nurses and other health care professionals.

D. No action shall be taken by the committee if a majority of the total membership from either house on the committee rejects such action.

Section 3. TEMPORARY PROVISION--DUTIES.--

A. After its appointment, the medicaid reform committee shall hold one organizational meeting to develop a work plan and budget for the ensuing interim.

B. In developing the work plan, the medicaid reform committee shall take into consideration current resources and projected needs for the state medicaid program's services, delivery, funding and policy, including:

(1) the current operating structure of the medicaid programs in New Mexico;

(2) the level of oversight authority necessary for the medicaid-related divisions of the human services department and health care payer and provider contractors under the medicaid program;

(3) the operational structure of the state medicaid program, with respect to how policy and fiscal determinations are made;

(4) the concerns and recommendations regarding the operation of the medicaid program made by other interim legislative committees, consumer advocates, health care providers, health care payers or their respective organizations;

(5) the allocation of health care costs and funding sources to avoid or eliminate unnecessary cost-shifting;

(6) the geographic distribution of health care professionals, resources and programs in the state medicaid program and of public-private partnerships to address health care access, delivery and funding issues that are problematic for both employers and employees; and

(7) the available federal, state and local sources of funding for the state medicaid program.

C. The medicaid reform committee shall solicit public input.

D. The work plan and budget shall be submitted to the New Mexico legislative council for approval. Upon approval of the work plan and budget by the council, the medicaid reform committee shall examine the statutes, constitutional provisions, regulations and court decisions governing the state medicaid program and related health care programs and services and recommend legislation or changes.

Section 4. TEMPORARY PROVISION--SUBCOMMITTEES.--

Subcommittees shall be created only by majority vote of all members appointed to the medicaid reform committee and with the prior approval of the New Mexico legislative council. A subcommittee shall be composed of at least one member from the senate and one member from the house of representatives, and at least one member of the minority party shall be a member of the subcommittee. All meetings and expenditures of a subcommittee shall be approved by the full committee in

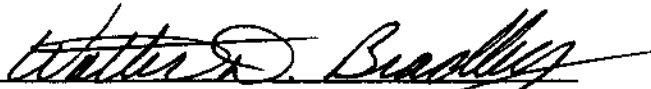
advance of such meeting or expenditure, and the approval shall be shown in the minutes of the committee.


Section 5. TEMPORARY PROVISION--REPORT.--The medicaid reform committee shall make a report of its findings and recommendations for the consideration of the legislature. The report and suggested legislation shall be made available to the New Mexico legislative council by December 15 preceding the first session of the forty-sixth legislature.


Section 6. TEMPORARY PROVISION--STAFF.--The staff for the medicaid reform committee shall be provided by the legislative council service.

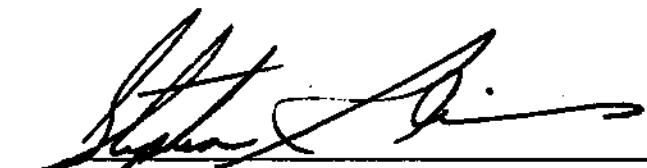
Section 7. APPROPRIATION.--Two hundred fifty thousand dollars (\$250,000) is appropriated from legislative council service cash balances to the legislative council service for expenditure in fiscal years 2002 and 2003 to pay for technical and legal assistance and for necessary equipment and supplies used in carrying out the provisions of this act and for reimbursing the per diem and mileage expenses of the committee. Any unexpended or unencumbered balance remaining at the end of fiscal year 2003 shall revert to the legislative council service cash balances. Payments from the appropriation shall be made upon vouchers signed by the director of the legislative council service or his authorized representative.

Section 8. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately. _____


Walter D. Bradley, President
Senate


Margaret Larragoite, Chief Clerk
Senate


Ben Lujan, Speaker
House of Representatives


Stephen R. Arias, Chief Clerk
House of Representatives

Approved by me this 5th day of March, 2002


Governor Gary E. Johnson
State of New Mexico

APPENDIX 12

**MEDICAID REFORM COMMITTEE AND ADVISORY GROUP
MEMBERSHIP**

Medicaid Reform Committee

Sen. Dede Feldman, co-chairwoman
Rep. James Roger Madalena, co-chairman
Sen. Ramsay L. Gorham
Rep. John A. Heaton
Sen. Allen V. Hurt
Sen. Stuart Ingle

Sen. Timothy Z. Jennings
Sen. Linda M. Lopez
Rep. Terry T. Marquardt
Rep. Danice Picraux
Rep. J. Paul Taylor
Rep. Jeannette O. Wallace

Medicaid Reform Advisory Group

Secretary of Finance and Administration Harold Field
Secretary-designate of Human Services Robin Dozier Otten
Secretary of General Services Steve Beffort (through 10/9/02)
Secretary of General Services (Acting) David Davis (10/10-12/6/02)
Arlene Brown, MD
Maralyn Budke
Jaime Estremera-Fitzgerald
Martin Hickey, MD
Jim Hinton
Nancy Koenigsberg
Ron Lujan, MD
Chet Lytle
Larry Martinez
Michael G. Miller
Kay Monaco
Samuel Montoya
Daniel D. Sandoval
Don Silva
Alfredo Vigil, MD

MEDICAID REFORM COMMITTEE

STAFF

Raúl E. Burciaga raul.burciaga@state.nm.us
Staff Attorney
Legislative Council Service - (505) 986-4600

Karen S. Wells, RN, CLNC
Medical Legal Consultant

Lisa Cacari Stone, MS, MA
WK Kellogg Doctoral Fellow in Health Policy Research

Kathleen Dexter
Legislative Council Service

Phil Lynch
Bill Draftsman
Legislative Council Service

Deb Hall, MD
Facilitator

Reese Fullerton, JD
Facilitator

APPENDIX 13

TENTATIVE AGENDA
for the
MEDICAID REFORM COMMITTEE
April 22-23, 2002
Room 322, State Capitol
Santa Fe

Monday, April 22

- 10:00 a.m. INTRODUCTIONS — WELCOME — COMMITTEE
MEMBERS — ADVISORY MEMBERS
 —Senator Dede Feldman, Co-Chair
 —Representative James Roger Madalena, Co-Chair
- 10:30 a.m. CHARGE TO THE MEDICAID REFORM COMMITTEE
 —Ben Lujan, Speaker of the House of Representatives
 —Richard M. Romero, Senate President Pro Tempore
- 11:00 a.m. HEALTH CARE AND MEDICAID — NATIONAL
TRENDS
 —Raúl E. Burciaga, Staff Attorney, Legislative
Council Service
- 12:00 noon LUNCH
- 1:30 p.m. MEDICAID 101 — MEDICAID IN NEW MEXICO
 —Rob Maruca, Director, Medical Assistance Division
- 4:00 p.m. RECESS

Tuesday, April 23

- 9:00 a.m. MEDICAID — FINANCIAL PERSPECTIVE —
HISTORICAL TRENDS —CURRENT PICTURE
 —Mark Weber, Fiscal Analyst, Legislative Finance
Committee
- 11:00 a.m. QUESTIONS — FOLLOW UP
 —Rob Maruca, Director, Medical Assistance Division
 —Mark Weber, Fiscal Analyst, Legislative Finance
Committee
- 12:00 noon LUNCH
- 1:00 p.m. GENERAL DISCUSSION
 —Committee and advisory group
 —Work plan and budget
 —Advisory group direction
- 3:00 p.m. ADJOURN

**MINUTES¹
of the
FIRST MEETING
of the
INTERIM LEGISLATIVE MEDICAID REFORM COMMITTEE**

**April 22-23, 2002
Room 322, State Capitol
Santa Fe**

Rep. James Roger Madalena, co-chair, called the first meeting of the interim legislative medicaid reform committee to order at 10:15 a.m. on Monday, April 22, in room 322 of the state capitol in Santa Fe.

PRESENT

Sen. Dede Feldman, co-chair
Rep. James Roger Madalena, co-chair
Sen. Ramsay L. Gorham
Rep. John A. Heaton (4/22)
Sen. Allen V. Hurt (4/22)
Sen. Stuart Ingle
Sen. Timothy Z. Jennings
Sen. Linda M. Lopez
Rep. Terry T. Marquardt (4/22)
Rep. Danice Picraux
Rep. J. Paul Taylor
Rep. Jeannette O. Wallace

ABSENT

Advisory

Arlene Brown (4/22)
Maralyn Budke
Jaime Estremera-Fitzgerald
Harold Field
Jim Hinton
Nancy Koenigsberg
Ron Lujan
Larry Lyons (for Martin Hickey)
Chet Lytle
Larry Martinez

¹Approved by the Medicaid Reform Committee on May 21, 2002

Michael G. Miller
Kay Monaco
Samuel Montoya
Robin Dozier Otten
Tom Rouborn (for Steve Beffort)
Daniel D. Sandoval
Don Silva
Alfredo Vigil (4/23)

Attendance dates are noted for members not present for the entire meeting.

Staff

Raúl E. Burciaga, Legislative Council Service (LCS)
Kathleen Dexter, LCS
Phil Lynch, LCS
Luce Salas, LCS
Karen Wells, LCS

Guests

The guest list is in the meeting file.

Monday, April 22

Representative Madalena opened the meeting by having the committee and staff members introduce themselves.

After welcoming comments from Senator Richard Romero, senate president pro tem, and Representative Ben Lujan, speaker of the house, members of the committee discussed the following topics and concerns:

- the state is not in an economic position to expand medicaid;
- solutions to the crisis is a shared responsibility that must be borne by everyone — from providers to pharmaceutical companies to consumers;
- free enterprise principles, such as discounts for volume purchases, are not necessarily applicable solutions to the problems plaguing our health care system;
- medicaid could face bankruptcy within 20 years and will affect other funded programs such as law enforcement and education;
- the committee must consider other studies on medicaid reform that have already been done;
- giving incentives for people to be healthy would help stem the rising cost of health care; and
- encouraging the greater use of physicians' assistants and nurse practitioners would help improve delivery of health care.

Committee Process

Sen. Feldman, co-chair, briefly discussed what the work process will be. She asked members to list what would be successful outcomes for the committee to accomplish as a way to get a handle on the issues. She also said the committee's May meeting will feature a presentation from the national conference of state legislatures (NCSL) on what other states

are doing to deal with medicaid. After that meeting, the committee may break into subcommittees, each of which will focus on a specific area. Some of the possible areas are: reimbursement, administration and eligibility and services. She also said that a link on the health policy commission's web site will allow committee members and other interested parties to keep abreast of the committee's work and share information with each other.

National Trends in Health Care and Medicaid

Raúl E. Burciaga, LCS, provided a brief overview of national trends in health care and medicaid, the largest health program in the country (a copy of his handout is in the meeting file). He said that federal and state governments are expected to spend about \$250 billion on medicaid in fiscal year 2002. Mr. Burciaga added that while two-thirds of all medicaid beneficiaries are children, two-thirds of all medicaid spending is on the elderly and disabled.

Comments from committee members included the following:

- as the number of the aged is expected to rise, the burden on medicaid will be greater; and
- the increasing rate of inflation and the number of beneficiaries may be more to blame than inefficiency in how Medicaid is administered.

Medicaid in New Mexico

Rob Maruca, director, medical assistance division (MAD), human services department (HSD), discussed medicaid's history in New Mexico (a copy of his presentation is in the meeting file). He said there are over 363,000 adults and children enrolled in the state's medicaid program through managed care or fee-for-service. He explained the process for determining an applicant's eligibility, which takes place in income support division (ISD) offices in each county. Mr. Maruca also explained that Native Americans, who have the option of using the Indian health service, are exempt from managed care unless they ask to be put in. Mr. Maruca also listed the kinds of waiver programs administered by the department of health (DOH).

Mr. Maruca outlined the savings of proposed reductions for certain programs, including:

\$5 million	market basket increases
\$12 million	personal care options
\$750,000	pharmaceuticals

Comments from committee members included the following:

- reducing the number of hours for personal care services may have a detrimental impact on consumers;
- the proposed reductions do not yield significant savings;
- cutting market basket increases will hurt nursing homes because staff will not stay to work there if they can get better pay elsewhere;

- pharmacies in the state are only marginally profitable, and lowering the reimbursement for pharmacists might further drive away pharmacists from the state; and
- small reductions in various programs might be better than drastic cuts across the board.

Kathleen Valdes, deputy director, support services, MAD, HSD, provided the committee an overview of the medicaid budget (a copy of her presentation is in the meeting file). She explained that fee-for-service costs do not include long-term care. She also said that with the federal government's changing of the way hospitals are reimbursed, there will be a decrease in cost between fiscal years 2002 and 2003. Indian health service costs for medicaid services are reimbursed 100 percent by the federal government, so there is no state money going into it.

Comments from members of the committee included the following:

- how television advertising has contributed to markedly increasing the cost and usage of pharmaceuticals; and
- the importance of getting a handle on how much a fee-for-service contractor spends on administrative costs.

Roger G. Gillespie, Jr., deputy director, program services, MAD, HSD, described the division's evaluation process for the performance of managed care organizations (MCOs) (a copy of his presentation is in the meeting file). The process includes mandatory reporting from MCOs on a variety of issues such as access and grievances and financial and quality audits. Mr. Gillespie also explained the types of waivers that allow the state to waive some federal requirements and still receive matching funds. Waivers in effect in New Mexico include home and community-based, developmental disabilities, disabled and elderly and HIV/AIDS waiver programs.

The meeting recessed at 4:10 p.m.

Tuesday, April 23

Rep. Madalena reconvened the meeting at 9:20 a.m. Sen. Feldman reminded the committee to share information via the committee's web page on the health policy commission's web site: hpc.state.nm.us/mrc.

Financial Perspective on Medicaid

Mark Weber, legislative finance committee, briefed the committee on the financial picture relating to the state's medicaid program (a copy of his presentation is in the meeting file). He explained that HSD prepares the budget projection for the program by determining how much it will cost, then figuring out how to pay for it. He said a clear-cut projection is difficult to arrive at, given the lag time in closing out each year's books due to providers' delay in billing and other factors.

Comments from members of the committee included the following:

- the value of the pre-PACE program in Albuquerque's St. Joseph's hospital, which provides daycare, medical and dental care, recreation, meals and other services to the elderly;
- decreasing the market basket increase would hurt consumers in the long run when nursing homes, for example, cannot operate satisfactorily;
- changing the definition of "medical necessity" to maintain and not necessarily to improve a patient's condition is not used as a standard in other parts of the country;
- MCOs' reimbursement rates for physicians are largely based on the rate set by HSD; and
- the state's one teaching hospital, the university of New Mexico, incurs costs associated with teaching and providing treatment to the most critically ill of patients and thus is able to qualify for a number of programs to help offset its costs.

Future Agendas

The committee requested staff to ensure the participation of the department of health, state agency on aging, the children, youth and family department and the department of finance and administration in future meetings.

Staff was also directed to have LCS provide an impartial, knowledgeable facilitator to help the committee structure its meetings productively. Various recommendations were made to use external experts from organizations including NCSL, Kaiser Commission on Medicaid and the Uninsured, Health Management Associates, Center for Budget and Policy Priorities, Center for Policy and Budget Analysis, and Mathematica Policy Research.

Comments from committee members included the following:

- the list of successful outcomes for the committee to accomplish (copies are in the meeting file);
- the committee must look at the state's financing mechanism and investigate other sources of money that can be leveraged for medicaid;
- the creation of a permanent fund for health care would be worth exploring;
- it is imperative that the state not plan the revamping of its medicaid program around what the federal government can provide because doing so would be fraught with unpredictability; and
- fixing health care and balancing the budget are very different from controlling the growth of medicaid, and the committee needs to focus on the latter.

Work Plan and Schedule

The committee discussed the merits of breaking itself up into subcommittees versus staying as a whole. Several members voiced preference for the group working as a whole for the next few months so that the whole committee can learn the same things from various experts.

Motions were made, seconded and approved for the following action items:

- that the co-chairs and staff take immediate action to seek matching funds for the committee;
- that the first day of two-day meetings be facilitated by staff; and
- that staff add an additional meeting day per month, which is to be devoted for public input, to the committee's budget.

The committee approved the following meeting dates:

May 20-21

June 24-25

July 29-30

August 26-27

September 23-24

October 17-18

November 14-15

Sen. Feldman reminded committee members to regularly check the medicaid reform committee's link on the health policy commission web site for new developments. In addition, contact information for committee members will be posted on that site.

The committee adjourned at 3:45 p.m.

**TENTATIVE AGENDA
for the
MEDICAID REFORM COMMITTEE**

**May 20-21, 2002
St. Vincent Hospital
Santa Fe**

Monday, May 20 - Southwest Conference Room

- 10:00 a.m. INTRODUCTIONS — WELCOME
 —Sen. Dede Feldman, co-chairwoman
 —Rep. James Roger Madalena, co-chairman
- 10:30 a.m. WORK PLAN & BUDGET — LEGISLATIVE COUNCIL
 CHANGES
 —Raúl Burciaga, Staff Attorney, Legislative Council Service
- 11:00 a.m. FACILITATION — INTRODUCTION — WHERE WE START
 —Deborah C. Hall, MD
 —Reese Fullerton
- 12:00 noon LUNCH (on your own)
- 1:30 p.m. FACILITATION — WHERE WE GO — OUTCOME — HOW WE
 GET THERE — PROCESS
 —Deborah C. Hall, MD
 —Reese Fullerton
- 4:30 p.m RECESS

Tuesday, May 21 - El Norte Auditorium

- 9:00 a.m. ECONOMIC DOWNTURN — IMPACT ON STATE MEDICAID
 BUDGETS — STATE RESPONSES TO BUDGET STRESSES —
 SURGE IN MEDICAID COSTS
 —Vernon K. Smith, Ph.D., Health Management Associates (HMA)
- 10:30 a.m. MEDICAID OPTIONS — STRATEGIES — RECENT PROPOSALS
 IN OTHER STATES
 —Laura Tobler, National Conference of State Legislatures (NCSL)

- 12:00 noon LUNCH (on your own)
- 1:30 p.m. SERVICES FOR ELDERLY AND DISABLED — NURSING HOME
CARE — PERSONAL CARE SERVICES — OLMSTEAD
—Donna Folkemer, NCSL
- 3:00 p.m. ROUNDTABLE DISCUSSION — PLANS FOR NEXT MEETING
—Vernon K. Smith, Ph.D., HMA
—Laura Tobler, NCSL
—Donna Folkemer, NCSL
—Medicaid Reform Committee
—Medicaid Advisory Group
- 4:30 p.m. ADJOURN

**MINUTES²
of the
SECOND MEETING
of the
MEDICAID REFORM COMMITTEE**

**May 20-21, 2002
St. Vincent Hospital
Santa Fe**

The second meeting of the Medicaid Reform Committee for the 2002 interim was called to order by Representative James Roger Madalena, co-chair, on May 20, 2002 at 10:10 a.m. in the Southwest Conference Room of St. Vincent Hospital in Santa Fe.

Present

Sen. Dede Feldman, co-chair
Rep. James Roger Madalena, co-chair
Sen. Ramsay L. Gorham
Rep. John A. Heaton
Sen. Allen V. Hurt
Sen. Stuart Ingle (5/20)
Sen. Linda M. Lopez
Rep. Terry T. Marquardt (5/21)
Rep. Danice Picraux
Rep. J. Paul Taylor
Rep. Jeannette O. Wallace (5/20)

Absent

Sen. Timothy Z. Jennings

Advisory members

Maralyn Budke
Jaime Estremera-Fitzgerald
Martin Hickey
Jim Hinton
Nancy Koenigsberg
Ron Lujan
Chet Lytle
Larry Martinez
Michael G. Miller
Kay Monaco
Samuel Montoya (5/20)
Robin Dozier Otten
Tom Rabourn (for Steve Beffort)
Don Silva

Arlene Brown
Harold Field
Daniel D. Sandoval
Alfredo Vigil

²Approved by the Medicaid Reform Committee on June 24, 2002. *(June 28, 2002)*

Staff

Raul E. Burciaga
Karen Wells
Kathleen Dexter

Facilitators

Reese Fullerton (5/20)
Deborah C. Hall

(Attendance dates are noted for those not present for the entire meeting.)

Guests

The guest list is in the meeting file.

Copies of all written testimony are in the meeting file.

Monday, May 20

The meeting opened with a welcome from Gary Buff, vice president of planning and administration for St. Vincent Hospital.

WORK PLAN, MEETING SCHEDULE AND BUDGET

Raul Burciaga explained the committee's work plan, meeting schedule and budget as approved by the Legislative Council on May 3, 2002 and noted that the committee's expenses would probably not be eligible for a federal match. He advised the committee that the New Mexico Health Policy Commission has posted certain reports on its website and that email addresses are being compiled into a listserv for members, staff and other interested parties.

FACILITATION

Senator Feldman introduced the two facilitators who have contracted to work with the committee throughout the interim — Reese Fullerton, J.D., and Deborah C. Hall, M.D. — both of whom have extensive experience in facilitation, mediation, dispute resolution and strategic planning. In guided discussion, the committee spent the day structuring its work for the interim. Appendices A, B and C to these minutes contain policies, ground rules, information requests and an agenda format adopted by the committee.

PUBLIC INPUT

Jim Jackson of the Protection and Advocacy System urged the committee to hear from health care providers and consumers regarding how the Medicaid system works and what can be improved.

The meeting was recessed at 4:32 p.m. and reconvened at 9:10 a.m. on May 21, 2002 in the El Norte Auditorium of St. Vincent Hospital.

Tuesday, May 21

The meeting opened with a review of the ground rules the committee established and a discussion of etiquette points for testimony. These points include restricting questioning to clarification rather than using questions to argue a point; focusing testimony on how the information relates to New Mexico; and giving permission to the facilitators to remind the

committee of the ground rules as necessary. Minutes from the previous meeting were read and adopted with the following corrections: on page 3, paragraph 2, line 4, strike "half" and insert "two-thirds"; and on page 3, paragraph 4, line 7, after "managed" insert "care".

ECONOMIC DOWNTURN — IMPACT ON STATE MEDICAID BUDGETS

Vernon K. Smith, Ph.D., of Health Management Associates gave a presentation on fiscal stresses faced by many states with their Medicaid programs, which serve in the aggregate about 44 million people. In a study of nearly 30 states and their annual increases in Medicaid spending versus total general fund spending, Mr. Smith showed that Medicaid spending has increased at a much greater rate (more than 11 percent projected from fiscal year 01 to 02) than general fund spending has increased (7.4 percent for the same period). At its current growth rate, Medicaid spending is projected to be 25 percent of total state spending within five years. One study shows projections for state revenues dropping by 3.8 percent in 2002 and Medicaid costs rising by 11 percent. In light of the economic downturn many states are facing, Medicaid programs are consuming a larger portion of states' revenues than can be afforded if other vital state programs are to be preserved. The main reasons reported by states for increased Medicaid expenditures are cost increases for drugs, providers and long-term care, as well as increases in enrollment.

In general questioning from the members, the following topics were discussed:

- in 2001, 50 prescription drugs accounted for 50 percent of the total increase in drug costs;
- there is a positive impact on general health as a result of the increase in prescribing drugs;
- New MexiKids is one of the most successful Medicaid outreach programs in the country;
- elderly and disabled are the fastest-growing Medicaid enrollment categories;
- states are pushing for a one-percent increase in the federal match level;
- Medicaid spending in New Mexico is somewhat under the national average at 9.6 percent of total state spending;
- supplemental Medicaid funding bills were passed nearly every year out of the past 10;
- drug advertising is a relatively new practice — while it increases consumer information it also increases drug costs to Medicaid;
- an alternative source for drug information is the internet;
- prevention programs are valuable even though the time horizon for benefits is far in the future;
- people need to change the way they access the health care system and take responsibility for their health;
- labor shortages contribute to the increase in health care costs;
- there is currently a very positive atmosphere regarding waiver applications at the Centers for Medicare and Medicaid Services (CMS);
- other states are cutting costs by instituting community-based and in-home care programs;
- two proposals for Medicare prescription drug benefits have been proposed in Congress, but chances are not good that either will succeed at this time;
- long-term care and technology growth are two additional areas where costs are rising;

- the impact of the Health Insurance Portability and Accountability Act of 1996 has been included in projections for Medicaid cost increases;
- administrative costs for the state's portion of New Mexico's Medicaid program average about three percent;
- disease management does not save money for a Medicaid program; and
- after examining the growing costs of Medicaid, 40 states chose to continue fully funding the program and got the additional money they needed from other sources.

MEDICAID OPTIONS — STRATEGIES — PROPOSALS IN OTHER STATES

Laura Tobler, health care program manager for the National Conference of State Legislatures (NCSL), gave a presentation on Health Insurance Flexibility and Accountability (HIFA) waivers available through CMS and on various proposals other states have made to meet the HIFA requirements. The main focus for HIFA waivers, which must be budget-neutral, is to provide an expedited application and review process for proposals that expand health insurance coverage to the uninsured and target a population below 200 percent of the federal poverty level. While benefits packages for optional and expansion populations may change from what a state currently offers, benefits for mandatory populations may not change, and basic primary care services must be covered for expansion populations. Cost-sharing levels can be set by each state with little restriction, and premium assistance programs can be developed so long as there is a plan to prevent crowd-out and the state monitors aggregate costs for enrollees to ensure they are not higher than in the previous program.

Current approved HIFA waivers are in place in Arizona and California, with HIFA waiver applications pending for Illinois, Michigan, Maine and New Mexico. Ms. Tobler described a non-HIFA 1115 waiver program in Utah that is being watched closely by other states because it is the first to include an annual enrollment fee and mirrors private insurance benefits by putting caps on benefits and services. Its main focus is primary care and prevention.

SERVICES FOR ELDERLY AND DISABLED — NURSING HOME CARE — PERSONAL CARE SERVICES — OLMSTEAD

Donna Folkemer of NCSL gave a presentation on Medicaid costs across all states for long-term care services. She said the main themes in long-term care today are managing costs within current programs and leveraging as many federal dollars as possible. One strategy to manage drug costs and limit drug usage is the preferred drug list, which contains only those drugs for which a drug manufacturer has agreed to provide a supplemental rebate — all others require prior authorizations. Some states are also saving money by instituting more aggressive drug utilization review programs. Most states are trying to save on nursing home costs by moving toward home- and community-based services (HCBS) programs. A new HCBS initiative is the Independence Plus waiver in which funds are allocated directly to enrollees and their families, who are then responsible for finding contract care providers. Ms. Folkemer noted that providers under this waiver are often family members and friends

who are willing to provide care to a specific individual though not willing to go into the long-term care field in general.

ROUNDTABLE DISCUSSION

During a roundtable discussion among the committee members, the advisory members and all three of the day's presenters, the following topics were discussed:

- promising programs for elderly care around the country include Programs for All-Inclusive Care for the Elderly (PACE) and consumer-directed care;
- disease management programs, such as those found in many rural federally qualified health care centers, work to identify conditions early, and some states have adopted them;
- most state *Olmstead* plans are worded in terms of broad goals, with only four states including specific benchmarks, timelines and objectives;
- there are no studies showing that HCBS is less expensive than residential care;
- the 1115 waiver template can be used to design a waiver specifically for primary care;
- all recently approved waivers at CMS were for expanding services to new populations and came about as a result of collaborations between the states and CMS;
- a new waiver trend is the single-benefit waiver, such as for family planning or pharmacy;
- CMS is encouraging states to reframe 1115 waivers as HIFA waivers;
- greater use of generic drugs can provide savings to a Medicaid program, and states have full discretion to develop provisions for generic drug purchasing;
- while rebate programs for Medicaid are in federal law, one drawback to them is that drug decisions are made based on reaching a critical sales volume rather than on prescribing the correct drug — a better system would be to drop rebate requirements and negotiate a straight discount;
- the use of a physician-directed approval and utilization review committee to look at "safe and efficacious" drugs may be more beneficial than decisions based solely on costs or rebates;
- case management is essential for the populations that access the system the most;
- the National Governors Association is pushing a proposal to move long-term care from Medicaid to Medicare, but it does not have a lot of traction at this time;
- many states have scholarship and recruitment programs to address provider shortages;
- critical access hospital programs have kept some rural hospitals open when they were in danger of closing;
- most rural clinics receive no state funding; and
- states are generally trying to maintain their current Medicaid eligibility criteria and find other ways to save money, such as cutting benefits and services.

PLANS FOR NEXT MEETING

The committee agreed on a template for future agendas that includes a blend of committee business, testimony, question-and-answer periods and public input. In the June meeting, the State Agency on Aging will discuss long-term care and elderly care, and the Department of Health and the Children, Youth and Families Department will discuss the Medicaid programs they administer. Committee staff will expand the agenda based on

recommended topics in the NCSL's *Legislator's Toolkit* and *Cost Cutting Strategies*. Additional testimony from other groups will be scheduled for subsequent meetings.

PUBLIC INPUT

David Roddy, director of the New Mexico Primary Care Association, spoke of the benefits of disease management programs, especially for diabetes patients. Gina de Blassie of St. Joseph Hospital prePACE spoke of a study on savings to be had with PACE programs. Judy Myers, director of the Governor's Committee on Concerns of the Handicapped, announced the next *Olmstead* plan meeting scheduled for June 27 and urged the committee to investigate whether acute care costs drop when in-home care is available. Michelle Lujan-Grisham, director of the State Agency on Aging, described a need for wrap-around case management that integrates services across agencies. Mary Eden of Presbyterian Salud! described a school-based health pilot project launched this year in rural areas.

Representative Picraux formally announced that an extraordinary session of the legislature would be convened at 10:00 a.m. on Friday, May 24, 2002.

The meeting adjourned at 4:30 p.m. with the following topics, questions and requests for information in the "parking lot" at the time of adjournment:

- look into systems that work — disease management, end of life systems, case management, community health centers, national standards;
- find cost data on elderly home care versus nursing home care;
- get information on the Michigan prescription drug program;
- is our life expectancy here not higher than Europe and do they prescribe at same rate;
- are there studies in prevention and the relationship between i.e. drug cost vs. hospitalization; and
- will there be a Medicare drug plan and can we see an analysis of it, looking at its impact on Medicaid?

APPENDIX A

- Ground Rules
 - < Listen respectfully.
 - < Get the job done as quickly as possible.
 - < Keep on track.
 - < Make a safe environment for discussion of any idea.
 - < Cell phones must be off or silent.
 - < No side conversations.
 - < Answer the questions posed to the best of one's ability.
 - < Use a parking lot to hold questions not immediately on topic but valuable for later discussion.
- Decision-making will be done by consensus.
- Advisory members will advise and legislators will vote.
- An alternate or proxy may advise, though not vote, and is responsible for continuity and communication between himself and the advisory member he represents.
- Brief public input will be allowed at each regular meeting and more substantial public input at the additional, non-regular meetings.
- Committee members will not knowingly disparage one another to the media.

When asked what the committee needs in order to get its job done, the following items were identified as priorities:

- data breakdowns on administrative costs by service category, enrollment by eligibility category and available federal, state and local funding sources;
- a list of programs that could either be matched with federal dollars or have their matches switched from low to high;
- data on quality outcomes and benchmarks within the state;
- a process map and a flow chart of all money through the system;
- a list of all states with statutory requirements for balanced budgets, the percentage of each state budget allocated to Medicaid and a statistical mean, mode and median on the data;
- what can small business support;
- a list of provider shortages by specialty and geographic region;
- data on increases in private insurance vs. Medicaid, including medical cost trends per year for each;
- a chart of expenditures by *service* category showing the proportion of the pie for each category and the rate of increase; and
- a chart of expenditures by *enrollment* category showing the proportion of the pie for each category and the rate of increase.

APPENDIX B

The following topics were added by the committee to its work plan (see work plan document for category descriptions).

- Category (1) current operating structure:
 - < long-term care;
 - < fragmentation of the health care system causing higher costs;
 - < cost trends in eligibility and services;
 - < administrative costs in each eligibility and service category;
 - < pharmaceutical costs;
 - < reallocate resources where certain populations are over-served;
 - < percentage of total state budget going to health care;
 - < graduated exit from eligibility; and
 - < look at consolidation of services, especially in long-term care;

- Category (2) oversight authority and activities:
 - < make quality transparent in the system;
 - < consider creating a legislative oversight committee for Medicaid system;
 - < look at the interface with other health care systems that a Medicaid recipient may also be accessing, and make the intersection of the systems work; and
 - < use binding arbitration for medical disputes;

- < Category (3) operational structure relative to policy and fiscal determinations (how do HSD and DOH decide how to spend money):
 - < Insurance Division;
 - < State Agency on Aging;
 - < Medicaid in Schools program;
 - < school-based clinics;
 - < health care providers;
 - < provider incentives for solutions; and
 - < consider alternative contracting proposals such as treating emergency rooms as urgent care centers that are reimbursed at the primary care physician rate rather than at the extraordinary rate;

- Category (4) concerns and recommendations of committees, advocates, providers and payers:
 - < liaison process between/among all agencies involved;
 - < use a focus-group approach to find out how changes would affect the population;
 - < consider other laws besides *Olmstead* that impact decisions and impose mandates;
 - < go to the next generation of managed care, including sophisticated case management; and
 - < consider alternative and nontraditional providers;

- Category (5) allocation or shifting of costs:

- < transportation;
 - < look at future cost escalation in health care and how to make Medicaid viable in light of that;
 - < look at funding of case management;
 - < look at primary care systems elsewhere, such as the Indian Health Service and tribal clinics;
 - < consider the overall effect of changes in Medicaid on the entire state economy;
 - < look at the effect of uncompensated care on the private sector; and
 - < look at third-party liability;
- Category (6) geographic distribution of providers/programs and public-private partnership mechanisms:
 - < expanding mid-levels in health care professions;
 - < consumer education on how to access the health care system;
 - < determine what the need level is now and the unmet needs in the state;
 - < use New Mexico demographics when predicting future costs;
 - < put more emphasis on prevention and personal accountability for health;
 - < study the relationship between Medicaid and SCI;
 - < encourage private sector to offer affordable health insurance to workers;
 - < expand mid-level health care programs in all state post-secondary institutions; and
 - < look at the provider shortage; and
- Category (7) federal, state and local funding sources:
 - < maximize federal matches;
 - < intergovernmental transfers with counties for federal matches; and
 - < look at county health care initiatives.

APPENDIX C

Agenda Template

Day 1

- Housekeeping
- Minutes from previous meeting
- Public Input
 - First-sign-up, first served
 - 15 minutes at beginning of day
 - 20 minutes at end of day (or more if time allows)
- Testimony
 - Presenter should use work plan categories (1-7)
 - Furnish presenter w/NM-specific info plus handouts/info from previous meetings
 - Presenter should, to extent possible, frame info and recommendations to NM situation
- Provide handouts
- Questions & Answers
 - Furnish presenter with Q's beforehand (e-mail prep through LCS staff)
 - Allow only clarification questions/comments during presentation
 - Allow more substantive questions for end of presentation or roundtable discussion

Day 2

- Housekeeping
- Data/information
 - Information requested
 - Data needs identification
- Forum for discussion
 - Brainstorming
 - Focus questions
 - General discussion
 - Expansion of information
 - Discussion groups
- Summary for moving forward
- Public input applies to Day 1 & Day 2
- Wrap up
 - Follow up
 - Tasks for staff

**TENTATIVE AGENDA
for the
MEDICAID REFORM COMMITTEE**

**June 24-25, 2002
Old Senate Chamber
Bataan Memorial Building
Santa Fe**

Monday, June 24

- 9:00 a.m. ELDERLY CARE — LONG-TERM CARE — ALTERNATIVES
—Michelle Lujan-Grisham, Director, State Agency on Aging
- 10:00 a.m. WAIVER PROGRAMS — HEALTH CARE INITIATIVES
—J. Alex Valdez, Secretary, Department of Health
- 11:00 a.m. ROUNDTABLE DISCUSSION — QUESTIONS & ANSWERS
—Michelle Lujan-Grisham
—J. Alex Valdez
—Committee and Advisory Group
- 12:00 noon LUNCH (ON YOUR OWN)
- 1:30 p.m. HOUSEKEEPING — MINUTES — PUBLIC INPUT
- 2:00 p.m. MEDICAID PROGRAMS FOR FOSTER CHILDREN AND JUVENILE
JUSTICE SYSTEM
—Deborah Hartz, Secretary, Children, Youth and Families Department
- 3:00 p.m. GUIDING PRINCIPLES
—Deb Hall
—Reese Fullerton
- 3:15 p.m. WHAT WE KNOW ABOUT MEDICAID IN NM — GAPS OR
INCONSISTENCIES IN DATA OR INFORMATION — WHAT WE KNOW
ABOUT OTHER STATES — ADDITIONAL INFORMATION NEEDED —
APPLICABILITY TO NM — ROUNDTABLE DISCUSSION
—committee and advisory group
- 4:00 p.m. PUBLIC INPUT — WRAP-UP
- 4:30 p.m. RECESS

Tuesday, June 25

- 9:00 a.m. HOUSEKEEPING — PUBLIC INPUT
- 9:30 a.m. MEDICAID BUDGET — FY 2003
—Robert Maruca, Director, Medical Assistance Division
- 9:45 a.m. STAFF UPDATE — SUMMARY & STATUS — NCSL *TOOL KIT & COST CUTTING STRATEGIES* — WHAT THE COMMITTEE NEEDS TO DO ITS WORK: DATA & INFORMATION AND PROCESS MAP
—Raúl E. Burciaga, Staff Attorney, LCS
—Karen Wells, Contractor, LCS
- 12:00 noon LUNCH (ON YOUR OWN)
- 1:30 p.m. ROUNDTABLE DISCUSSION — PLANS FOR SUBSEQUENT MEETING
— WHEN — WHERE — WHAT
- 4:00 p.m. PUBLIC INPUT
- 4:30 p.m. ADJOURN

MINUTES³
of the
THIRD MEETING
of the
MEDICAID REFORM COMMITTEE

June 24-25, 2002
Old Senate Chamber - Bataan Building
Santa Fe

The third meeting of the Medicaid Reform Committee for the 2002 interim was called to order by Representative James Roger Madalena, co-chair, on June 24, 2002 at 9:05 a.m. in the Old Senate Chamber of the Bataan Building in Santa Fe.

PRESENT

Sen. Dede Feldman, co-chair
Rep. James Roger Madalena, co-chair
Rep. John A. Heaton
Sen. Stuart Ingle (6/24)
Sen. Timothy Z. Jennings
Sen. Linda M. Lopez
Rep. Terry T. Marquardt (6/24)
Rep. J. Paul Taylor
Rep. Jeannette O. Wallace

ABSENT

Sen. Ramsay L. Gorham
Sen. Allen V. Hurt
Rep. Danice Picraux

Advisory members

Steve Beffort
Arlene Brown
Maralyn Budke
Mary Eden (proxy for Jim Hinton)
Harold Field
Martin Hickey
Jim Jackson (proxy for Nancy Koenigsberg)
Ron Lujan
Chet Lytle
Larry Martinez
Michael G. Miller
Kay Monaco
Robin Dozier Otten
Daniel D. Sandoval
Don Silva
Alfredo Vigil (6/25)

Jaime Estremera-Fitzgerald
Samuel Montoya

³Approved by the Medicaid Reform Committee on July 30, 2002.

(Attendance dates are noted for members not present for the entire meeting.)

Staff

Raul E. Burciaga
Phil Lynch
Karen Wells
Kathleen Dexter

Facilitators

Reese Fullerton
Deborah C. Hall

Guests

The guest list is in the meeting file.

Copies of all written testimony and presentation handouts are in the meeting file.

Monday, June 24

On motion duly made, seconded and adopted, the agenda for Tuesday, June 25, was amended to include a presentation on fiscal year (FY) 2003 program and administrative costs for Medicaid and the State Children's Health Insurance Program (SCHIP) by Robert Maruca, director of the Medical Assistance Division (MAD) of the Human Services Department (HSD).

ELDERLY CARE — LONG-TERM CARE — ALTERNATIVES

Michelle Lujan Grisham, director of the State Agency on Aging (SAOA), gave a presentation on the rapid growth in the population needing long-term care services and outlined possible detrimental effects of proposed spending cuts within Medicaid. Cuts in reimbursement rates would save money in the short term but create more of a provider shortage in the long term, and cuts in services or eligibility would shift pressure from Medicaid to public health facilities, county-funded programs and expensive emergency rooms. Ms. Grisham suggested the committee save money by instituting patient cost-sharing and strengthening preventive and community-based care programs as a way to keep the elderly from becoming chronically or seriously ill. She noted that the average cost to Medicaid of placing a person 60 years old or older in a nursing home (\$24,000 per year) far exceeds the cost to Medicaid of community-based care for that same person (\$4,800 per year). She also reported on a need for a care-coordination database to be used not only by citizens but also by providers as they make long-term care and referral decisions.

WAIVER PROGRAMS — HEALTH CARE INITIATIVES

Secretary of Health J. Alex Valdez gave a historical summary of the Medicaid program as it evolved to its current charter, providing health care services to an array of low-income and medically needy populations. He described the recent closings of two residential care facilities for the developmentally disabled (DD) as a positive step toward strengthening the state's community-based service network and decentralizing services beyond the Rio Grande corridor. He urged the committee to consider possible negative effects before attempting to leverage new federal funds, as the state funds used for such leverage may not necessarily go back to the same programs after the leverage. In behavioral health, Secretary Valdez said he sees a need for a comprehensive and scientifically based benefits package, and

a need for more consumer-directed care. In all health programs, he sees a critical need for workforce development to address provider shortages.

ROUNDTABLE DISCUSSION

During a roundtable discussion among the committee members, advisory members, Ms. Grisham and Mr. Valdez, the following points were covered.

- Thirty states have established "senior affairs" departments. With SAOA under HSD, New Mexico has no system for coordination of care across agencies.
- Low reimbursement rates have hampered the long-term care cottage industry.
- The focus for SAOA programs is "aging in place" — keeping the elderly in their communities as long as possible and promoting autonomy.
- Waiver programs provide more flexibility to the state than entitlement programs.
- The Medicaid waiver system is fragmented — a better approach would be to consider ways to serve the actual populations needing services.
- With the nursing home industry unstable at the moment, it is important to have a strong community-based care system in place.
- The committee should look at work done by other committees on long-term care.
- Fourteen percent of the commercial population receiving health care services uses 80 percent of the funds.
- A private-public partnership is needed in order to address the problem of unaffordable health care for low-income persons.
- Health care costs can impoverish individuals with serious medical conditions.
- Legislative appropriations given for two years rather than one might provide more stability for contract health care providers.
- The intake system for Medicaid long-term care services is used to determine eligibility for services but is not used for care coordination or needs assessment.
- None of the SAOA funds are currently used for federal matches — MAD and SAOA are working together to determine what can be matched and how, and how much might be saved from general fund expenditures.
- No data exists on the cost of unreimbursed Medicaid services being provided.
- Investment of health care and preventive services can prevent expensive chronic diseases. The Department of Health (DOH) has data on chronic disease prevention and early intervention services within the Public Health Division and will make it available to the committee.
- The Legislative Finance Committee might be able to do an analysis of the dollar amounts and programs eligible for federal matches.
- The HIV/AIDS waiver program has a comprehensive prevention agenda and supported employment programs.
- HSD is still in court on the matter of reimbursements for administrative services in the Medicaid in the Schools program.
- The DD population faces a special challenge because of limitations on how many hours a week they can work — if they move out on their own, they lose health care coverage through their parents and often do not qualify for employer-based coverage because they work part-time.

Senator Feldman directed HSD and DOH representatives to provide the committee with waiting-list figures for each of the Medicaid waiver programs. In addition, Secretary Valdez agreed to supply a breakdown of annual nursing home costs for different age groups in the DD and Intermediate Care Facility/Mentally Retarded waiver programs and a breakdown of possible matches within all waiver programs.

MINUTES — HOUSEKEEPING — PUBLIC INPUT

On motion duly made, seconded and adopted, the minutes from the May meeting of the committee were approved. The committee reviewed points from the morning's presentations that came as a surprise to some, including the lack of data and that some members see room for expansion of Medicaid programs while others see the committee's charge solely in terms of containment.

Mike Donnelly of the American Association of Retired Persons (AARP) gave a historical review of four years of AARP frustration over the lack of community-based care, a single point of entry for services, a good case management system and coordination among state agencies.

MEDICAID PROGRAMS FOR FOSTER CARE AND JUVENILE JUSTICE SYSTEM

Secretary Deborah Hartz of the Children, Youth and Families Department (CYFD) gave an overview of Medicaid programs within her department. CYFD is the largest consumer of Medicaid services for children in the state, and its Protective Services Division and Juvenile Justice Division together administered targeted case management (TCM) services to more than 11,000 children in FY 01. A recent audit of CYFD cited the department as failing to meet federal requirements for "array of services", specifically in rural areas. Ms. Hartz cited the following as special challenges her department faces:

- community-based and wrap-around services are unavailable in rural areas;
- specialized residential services are not available or providers have long waiting lists;
- timely, appropriate therapeutic placements are not always available;
- clients with multiple diagnoses have special difficulty accessing services; and
- there is no uniformity in paperwork or processes among the three Medicaid managed care organizations (MCOs).

In general discussion among the members, the following points were covered.

- While one hour of direct patient care requires more than one hour of data input and documentation, there has been a reduction in administrative overhead in the current phase of Salud! due to direct involvement between CYFD and the MCOs.
- TCM reduces paperwork, and the \$1.5 million paid for TCM from the general fund is matched three-to-one with federal money.
- There needs to be an option to revive some of the residential treatment centers that have closed, as services in such facilities qualify for federal matches not

available to state facilities such as the Youth Diagnostic and Development Center.

- Attention needs to be paid to who is making the determination of need for services. Not all referrals for residential treatment are informed decisions.
- There was no buildup of intermediate-level behavioral health services after the state's residential treatment centers closed.
- Most out-of-state placements in recent years have been youth needing treatment for sex offender issues. There are no programs for these clients in New Mexico.

Senator Feldman directed Secretary Hartz to provide the committee with cost figures on out-of-state placements and copies of CYFD's memoranda of understanding and the MAXIMUS consulting report.

GUIDING PRINCIPLES

The committee reviewed its guiding principles from previous meetings and created a synthesized list, which appears as Appendix A to these minutes.

ROUNDTABLE DISCUSSION

Raul Burciaga led a discussion of what the committee knows about the Medicaid program and what members feel they still need to know. A list of information requests from committee members during this discussion is included as Appendix B to these minutes. The following points were covered in the discussion.

- At the next meeting, the General Services Department (GSD) will provide a matrix comparing the state employees benefits package to the Medicaid package.
- The Legislative Health Subcommittee compiled information during the 2000 and 2001 interims that the Medicaid Reform Committee can use.
- The New Mexico Health Policy Commission has maps showing rural health clinics and facilities.
- Presbyterian Healthcare Services can provide a fact sheet on what improvements managed care has brought to the health care system in the past five years.
- Would care coordination really save money or is it another level of bureaucracy, and how soon would the economic impact actually be felt?

PUBLIC INPUT

David Roddy, director of the New Mexico Primary Care Association, spoke in favor of disease management programs and described difficulties in leveraging funds for federal matches.

The meeting was recessed at 4:25 p.m. and reconvened the following day.

Tuesday, June 25

Representative Madalena reconvened the meeting at 9:15 a.m.

PUBLIC INPUT

Mike Lord, president of the New Mexico Alzheimer's Association, urged the committee to continue full funding of programs for the elderly in order to avoid problems when the baby boomers age. Virginia Wilson of the National Alliance for the Mentally Ill (NAMI) noted that the needs of the psychiatrically disabled are not being seriously addressed by the committee. John Snowdon of NAMI explained a handout of typical expenses for a family of four living at 235 percent of the federal poverty level that shows an average of \$460 available per year to buy health insurance while the average health insurance cost for a family that size is \$6,000 per year.

MEDICAID BUDGET — FY 03

Robert Maruca gave a presentation on costs projected for FY 03 in the Medicaid and SCHIP programs compared to the operating budget appropriated by the legislature. Because there was a shortfall in funding for FY 02 that must be covered in FY 03, and because an additional shortfall is projected for FY 03, Mr. Maruca estimates the Medicaid and SCHIP programs will run at a combined general fund shortfall of \$22 million in the coming year. His major concerns are that the entitlement program is underfunded and suggests eligibility and benefit reductions combined with revenue increases to address the rapid growth in enrollment. He also noted that administration of the programs is underfunded and understaffed.

In general discussion among the members, the following points were made.

- The underfunding of Medicaid has impacted other state agencies as well, including GSD.
- The increase in enrollment has been in managed care, not in fee-for-service, and has ranged from 3,000 to 4,000 per month since November 2001.
- The growth in utilization of services was approximately two percent in the past 12 months, with a higher percentage in prescription drug utilization.
- The projected shortfall is two percent of the overall program budget.
- The committee needs to stay focused and make sure the private market remains viable and private insurance costs remain as low as possible.

STAFF UPDATE — DATA, INFORMATION AND PROCESS MAP

LCS staff Raul Burciaga and Karen Wells gave a presentation that included economic features of the current Medicaid program, Medicaid cost-cutting strategies suggested by the National Conference of State Legislatures (NCSL), a process map of the Medicaid system and a breakdown of issues surrounding prescription drugs. On the latter topic, Ms. Wells described several legislative options for saving money on drug purchasing, including Pharmacy Plus waivers. These waivers have a budget-neutrality requirement that can put other Medicaid programs at risk, though the state of Illinois feels its Pharmacy Plus program will pay for itself in the long run due to savings it will bring about in other long-term care areas. Another legislative option is the 340B Program, which is a federally mandated discount program that exceeds the best prices available

under the standard Medicaid rebate program. While 340B purchasing is only available to entities that qualify as federal programs, the federal Office of Pharmacy Affairs is interested in seeing states expand their 340B programs and believes there are opportunities for Medicaid to utilize 340B in purchasing prescription drugs.

In general discussion among the members, the following topics were covered.

- The current pharmacy rebate system in the private sector gives perverse incentives for drug purchasing decisions by giving exponentially greater benefits with each higher level of purchasing. It is better to make purchases based on safety, efficiency, cost and experience.
- There are big savings to be had in buying generic drugs.
- The Veterans Health Administration is an example of effective and cost-effective drug prescribing and appropriate drug utilization.
- The United States is currently the "cost-shifted nation", with less expensive versions of American drugs available in Mexico and other countries.
- There are six categories of trade in drug purchasing, and volume of purchase does not always trigger a discount.
- A stepped-therapy approach should be used in which a lower-priced drug is tried before prescribing a more expensive one within its category.
- MCOs are among those responsible for initiating Medicaid fraud investigations.
- MAD is discussing the possibility of a Native American HMO. Some issues still to be resolved are how MAD would be reimbursed for services provided at Indian Health Service facilities and whether the services currently provided would remain at a 100-percent federal matching rate.
- Medicaid enrollment procedures are much more complicated than is reflected on the process map due to management problems within the system.

Representative Madalena requested an outline of the flow of money through the Medicaid system under managed care versus the same flow under fee-for-service. Representative Taylor requested a breakdown of cost increases indicating when certain programs, such as breast and cervical screening, were implemented.

The committee identified possible roadblocks to getting their task done, which appear as Appendix C to these minutes.

ROUNDTABLE DISCUSSION

After extensive discussion on how to structure the committee's work during the remainder of the interim, the committee directed staff to develop a work plan around the three major categories set out in the NCSL cost-cutting strategies, with an emphasis on long-term viability of the health care system and on additional funding sources. A draft work plan will be sent to committee members before the next meeting for further input. In addition, staff will assess the members' availability for additional meetings for the

remainder of the interim and propose optimal dates for those meetings. The committee discussed limiting the amount of remaining time given to presenters and reserving the balance for deliberation. Proposals for presentation time to be allotted ranged from 10 to 20 percent.

PUBLIC INPUT

John Snowdon presented an additional breakdown showing the economic impact of full funding of Medicaid, including federal matches, on the state's economy. David Roddy urged the committee to address its philosophical differences and to weigh economic viability issues within the state's health care system. Bruce Evans of NAMI advocated for stronger Medicaid coverage in behavioral health and said he would prepare a handout for the committee outlining 200 recommendations regarding behavioral health compiled last year by NAMI.

The meeting adjourned at 4:35 p.m.

APPENDIX A

SYNTHESIZED GUIDING PRINCIPLES

- long-term, economically viable health care system (no negative impact on any part)
- maximum leveraging of federal dollars (reducing costs, improving system, upfront care)
- controlling costs without hurting those in need
- quality program driven by evidence and improved outcomes with input from those impacted
- reasonable co-share
- dynamics around the health care system for Native Americans

APPENDIX B

The committee requested more information on:

- maximizing Medicare dollars and what can be leveraged through Medicare;
- the commercial infrastructure, i.e., the dynamics among the commercial health care sector, Medicare and Medicaid. A firm such as Price Waterhouse could provide information on this;
- cost-shifting to uncompensated care providers;
- overlaps in the Medicaid system that can be minimized;
- a fuller explanation of impacts on direct service providers such as primary health care centers and federally qualified health centers;
- federal constraints that affect waiver programs;
- intergovernmental transfers and disproportionate share hospital payments;
- the State Coverage Initiative;
- what works and does not work within the Medicaid system as experienced by providers and consumers, especially the disabled;
- what other states are doing successfully;
- the personal care option;
- the tobacco settlement funds — what can be used for service delivery and whether funds can be matched;
- cost-shifting impacts, especially the impact of lowering SCHIP eligibility from 235 percent of poverty;
- all services, with a breakdown of which ones qualify for federal matching funds;
- HIPAA compliance for the Medicaid system;
- tribal clinics and the Indian Health Service;
- the central intake concept — the pros and cons of available triage systems;
- where the recent increases in costs have taken place, broken down by population and by service;
- private sector cost-sharing for leveraging;
- why the increase in costs for managed care services is higher than it is for fee-for-service; and
- where the increase in costs for managed care services is actually going.

APPENDIX C

The following were identified as things that would prevent the committee from getting its work done:

- inability to look at the big picture — getting bogged down by the trees;
- potential litigation;
- philosophical differences;
- problem of cost preventing the committee from thinking broadly or creatively;
- turf protection;
- money;
- lack of data;
- getting bogged down looking at the current Medicaid system rather than at where the system is going;
- failure to narrow down the volume of problems to a workable few;
- unresolved issues of how to get to a solution;
- advocacy groups that will lobby after the committee makes its final recommendations;
- legislators who disagree with the committee's final recommendations;
- inability to control federal mandates; and
- having no clear voice in federal policy.

Revised: July 26, 2002

**TENTATIVE AGENDA
for the
MEDICAID REFORM COMMITTEE**

**July 29-30, 2002
Old Senate Chamber
Bataan Memorial Building
Santa Fe**

Monday, July 29

- 9:00 a.m. HOUSEKEEPING — MINUTES — PUBLIC INPUT
- 9:30 a.m. DISABILITY COALITION PRESENTATION — ROUNDTABLE
DISCUSSION — QUESTIONS AND ANSWERS
— Doris Husted, Public Policy Director, The Arc of New Mexico
— Jim Jackson, Executive Director, Protection and Advocacy
System
— Judy Myers, Executive Director, Governor's Committee on
Concerns
of the Handicapped
— Gil Yildiz, Co-Chair, Coalition on Living Independently in the Community
- 11:30 a.m. STRATEGIES AND APPROACHES
(LCS) — Raúl E. Burciaga, Staff Attorney, Legislative Council Service
- 11:45 a.m. GUIDING PRINCIPLES
— Deb Hall, Facilitator
— Reese Fullerton, Facilitator
- 12:00 noon LUNCH (ON YOUR OWN)
- 1:30 p.m. MEDICAID MAXIMIZATION AND LOW-MATCH TO HIGH-
MATCH
— Raúl E. Burciaga
- 2:15 p.m. MEDICAID MAXIMIZATION AND LOW-MATCH TO HIGH-
MATCH ROUNDTABLE DISCUSSION — QUESTIONS AND
ANSWERS
- 4:00 p.m. PUBLIC INPUT — WRAP-UP
- 4:30 p.m. RECESS

Tuesday, July 30

- 9:00 a.m. HOUSEKEEPING — PUBLIC INPUT
- 9:30 a.m. INTERGOVERNMENTAL TRANSFERS
— Phil Lynch, Bill Draftsman, LCS
- 10:00 a.m. FINANCING MECHANISMS — DISPROPORTIONATE SHARE
— UPPER PAYMENT LIMIT
— Steve McKernan, CEO, University Hospital
- 11:00 a.m. INTERGOVERNMENTAL TRANSFERS — ROUNDTABLE
DISCUSSION — QUESTIONS AND ANSWERS
- 12:00 noon LUNCH (ON YOUR OWN)
- 1:00 p.m. PRIVATE SECTOR COST SHARING
— Karen Wells, Contractor, LCS
- 1:45 p.m. BENEFITS OVERVIEW
— Steve Beffort, Secretary, General Services Department
- 2:00 p.m. PRIVATE SECTOR COST SHARING — ROUNDTABLE
DISCUSSION — QUESTIONS AND ANSWERS
- 3:30 p.m. NEXT MEETING — FINANCING AND DELIVERY
INCENTIVES TO REDUCE/CONTAIN COSTS
— Raúl E. Burciaga
- 4:00 p.m. PUBLIC INPUT — WRAP-UP
- 4:30 p.m. ADJOURN

MINUTES*
of the
FOURTH MEETING
of the
MEDICAID REFORM COMMITTEE

July 29-30, 2002
Old Senate Chamber - Bataan Building
Santa Fe

The fourth meeting of the Medicaid Reform Committee for the 2002 interim was called to order by Senator Dede Feldman, co-chair, on July 29, 2002 at 9:10 a.m. in the Old Senate Chamber of the Bataan Building in Santa Fe.

PRESENT

Sen. Dede Feldman, co-chair
Rep. James Roger Madalena, co-chair
Sen. Ramsay L. Gorham
Rep. John A. Heaton
Sen. Allen V. Hurt
Sen. Stuart Ingle (7/30)
Sen. Timothy Z. Jennings
Sen. Linda M. Lopez
Rep. Terry T. Marquardt (7/29)
Rep. Danice Picraux
Rep. J. Paul Taylor
Rep. Jeannette O. Wallace

ABSENT

Advisory members

Adolfo Alarid (proxy for Harold Field)
Steve Beffort
Arlene Brown
Maralyn Budke
Jaime Estremera-Fitzgerald
Jim Hinton
Nancy Koenigsberg
Ron Lujan
Larry Martinez
Michael G. Miller
Kay Monaco
Samuel Montoya
Robin Dozier Otten
Richard Rolston (proxy for Martin Hickey)
Daniel D. Sandoval

Don Silva (7/29)
Alfredo Vigil (7/30)

Martin Hickey
Chet Lytle

(Attendance dates are noted for members not present for the entire meeting.)

Staff

Raul E. Burciaga
Phil Lynch
Karen Wells
Lisa Cacari-Stone
Kathleen Dexter

Facilitators

Reese Fullerton
Deborah C. Hall

Guests

The guest list is in the meeting file.

Copies of all written testimony and presentation handouts are in the meeting file.

Monday, July 29

DISABILITY COALITION PRESENTATION

On behalf of the Disability Coalition on Medicaid Reform, a presentation was given to the committee on Medicaid waiver issues by Jim Jackson, executive director of the Protection and Advocacy System; Doris Husted, public policy director of The Arc of New Mexico; Judy Myers, executive director of the Governor's Committee on Concerns of the Handicapped; and Gil Yildiz, co-chair of the Coalition on Living Independently in the Community. There are four home and community-based services (HCBS) waivers that provide services to the disabled outside of institutional settings and at a lower cost; three of these programs have waiting lists as high as triple the capacity of current enrollment and have waiting periods up to 42 months. The trend in care for the disabled has changed from institutional care to care in the community with professional control, and now to consumer-directed care, which gives a disabled person contractual control over who provides services and how. Overall, the coalition recommends that the state promote integrated HCBS; promote consumer self-direction and control of services; institute flexibility within the waiver programs and service plans; consider new financing mechanisms; hold harmless any programs whose funds are used for federal matches; refrain from instituting copays; establish a system of consumer assistance; ensure quality and accountability throughout Medicaid; and develop a new waiver to provide HCBS for the mentally ill as an alternative to psychiatric hospitalization. In addition, the coalition recommends that the state hold funding for nursing home care at its current level and expand other care options.

In a roundtable discussion, the following points were covered.

- Federal matches should be seen only as a temporary source of funding.

- When a person who receives supplemental security income (SSI) is institutionalized, those payments go directly to the institution.
- Copays are seen as a way to discourage inappropriate use of Medicaid services or as a method of cost containment.
- Managed care organizations (MCOs) under Medicaid contracts with the state are mandated to provide a certain level of behavioral health services.
- The disabled and elderly (D&E) and developmental disabilities (DD) waiver programs include funds for housing modification and the federal Department of Housing and Urban Development has independent living housing vouchers.
- The federal Fair Housing Act mandates accessibility only in housing units built since 1991. A disabled renter must pay for modifications in older units.
- Part of the difference in cost between consumer-delegated care and consumer-directed care (\$30,000 versus \$20,000 per year) is the administrative cost of the fiscal intermediary required under consumer-delegated care.
- SSI payments cannot be used for federal matches because they are federal dollars.
- HCBS for the mentally ill generally do not exist, especially in rural areas.
- The disabled can get into nursing homes fairly quickly and the eligibility date is retroactive, while a determination of eligibility for in-home services can take up to 60 days and is not retroactive.
- By making an amendment to the D&E waiver, services can be extended to those with brain injuries. Currently, \$1.8 million is disbursed annually from the Brain Injury Services Fund to this population.
- The Human Services Department (HSD) is working with the Interagency Committee on Long-term Care to develop a global waiver.
- The waiver application process should be expedited.
- The state offers tax credits for building casinos and racetracks but not for modifying housing for handicapped accessibility.
- The attendant care program in the Children, Youth and Families Department (CYFD) still exists, but eligibility has been tightened and the program is now being used to provide emergency care to people needing protective services.

STRATEGIES AND APPROACHES

Raul Burciaga outlined the committee's schedule through the remainder of the 2002 interim, and the committee adopted the following additional meeting dates, locations and topics: September 12 (Albuquerque), Native American health issues; October 9-10 (Las Cruces), border and rural health issues; and December 5-6 (Santa Fe), proposed legislation.

MEDICAID MAXIMIZATION AND LOW-MATCH TO HIGH-MATCH

Raul Burciaga gave a presentation on maximizing Medicaid in order to limit state general fund expenditures and on reclassifying Medicaid services to qualify for higher federal matches. He identified a range of services that may qualify for a federal medical assistance percentage (FMAP) reimbursement rate at or greater than 75 percent. He noted that while the Centers for Medicare and Medicaid Services (CMS) allows 100 percent FMAP only on services to Native Americans that are provided at facilities owned or leased by the Indian Health Service (IHS) or a tribe, it could be argued that the statutory

phrasing "services received through an IHS facility" includes services provided by referral through an IHS facility. The primary advantages to Medicaid maximization are financial considerations, taking some of the burden off the state general fund and shifting it to the federal government without reducing eligibility or services. Potential disadvantages include transition and implementation costs, loss of funding to programs serving non-Medicaid populations and creation of new constituencies that would demand increased state funding for the program in the future.

In general discussion among members, the following points were covered.

- Services can only be expanded under the current Medicaid program if there is an expansion into new populations.
- With the higher FMAP to take effect in October, the state will see a \$13 million increase that has already been taken into consideration for projected costs. In addition, the United States Senate has considered an additional 1.5 percent increase in the FMAP for 18 months for certain states.
- The committee needs to carefully consider the long-term impacts and future costs of expansions and entitlements.
- Cuts in services will have a disproportionate impact on rural areas of the state.
- Use of funds from programs serving non-Medicaid populations for a federal match might mean the ultimate loss of those funds and programs.
- The federal government is and has been receptive to waiver options but may not be as favorable in the future.
- The committee needs to concentrate on maximizing the current program and stay away from expanding into new populations and new costs as this would affect other departments' budgets in state government.
- Paperwork problems within the Medicaid program need to be addressed and fixed.
- Medicaid enrollment through Department of Health (DOH) programs and services is handled and paid for primarily by DOH because HSD does not have a budget for this. DOH personnel will look into what it would take to move this function to HSD. A simplification of this process would free up money for patient care.

The committee directed Mr. Burciaga to include the Legislative Council Service, HSD, CYFD, CMS and DOH in his investigation into what programs and services can or cannot be matched or have their matches increased and to develop a framework of questions so that each agency responds to the same inquiry. Topics for this inquiry include impacts on the current system; obstacles; what "new" would look like; how many people would be included and covered, with cost breakdowns based on maintaining the current enrollment numbers versus expanding the enrollment; what services would be required; the impact on rural areas; and state and federal regulations that would affect maximization efforts. Advisory group member Larry Martinez and public member Jim Jackson agreed to work with Mr. Burciaga on this effort. Mr. Burciaga was also directed to pursue, through the attorney general's office, the question of 100 percent FMAP for contract services provided under IHS referral.

The committee and members of the public established working groups to gather information on topics outlined in cost-cutting strategies developed by the National Conference of State Legislatures (NCSL). These working groups appear as Appendix A to these minutes.

Committee staff was directed to transmit minutes from committee meetings to Senator Jeff Bingaman and to invite him to make a presentation at a future meeting.

PUBLIC INPUT FOR JULY 29

Thomas Pinkney told the committee it is very important for people with disabilities to lead independent lives and that there is a great deal of red tape in arranging for services. Polly Arango presented a list of recommendations from Family Voices of New Mexico on the topics of potential funding streams for Medicaid, cost efficiencies, copays, the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program and consumer involvement. Mary White of Go Fors, Inc., described her grant-based agency's array of non-Medicaid-reimbursable transportation services. Andy Curry of the San Juan Center for Independence pointed out that: not all people on waivers are on them permanently; many people want to keep their disabled family members at home, and retroactive eligibility and payments for in-home services would be a great help; many people are under pressure to sell their assets in order to qualify for Medicaid; and there is a need to streamline the waiver programs and the system for handling medical information. Pauline Montoya, also of the San Juan Center for Independence, spoke in favor of flexibility rather than the current system of a set number of service hours per month for a disabled person. Stevie Bass of Taos spoke in favor of consumer-directed care over consumer-delegated care and of the difficulties she has faced trying to get her adult autistic daughter enrolled in the personal care option and DD waiver programs before she turns 21. Rebecca Shuman of The Arc of New Mexico reported on efforts to make SSI payments self-directed and also described a successful Robert Wood Johnson Foundation pilot project on consumer-directed care conducted in 19 states. Randy Martinez described his positive experiences on the personal care option, which has allowed him to be employed and has bolstered his self-esteem. Karl McKibben of People First of Albuquerque spoke in favor of self-directed care. Michael Allen spoke in favor of developing self-determination tools for the DD population and told of his adult child daughter losing custody of her own child in part due to a lack of support services for the disabled. Rachel O'Connor of the Brain Injury Association of New Mexico explained revenue sources for and disbursements from the Brain Injury Services Fund and spoke in favor of a brain injury waiver. Susan Lewis told of her 10 years in a hospital and nursing home following an automobile accident and defended the right of the disabled to choose whether to live in an institution or in the community. John Snowdon of the National Alliance for the Mentally Ill spoke about the state's severe shortage of psychiatrists, especially child psychiatrists, who treat Medicaid clients. Mark Johnson of El Mirador gave details on intermediate care facilities for the mentally retarded. Anna Hatanaka of the Association of Developmental Disabilities Community Providers noted that plans of care for the disabled are developed by teams and are reviewed and updated often; it was DOH that closed state facilities for the disabled, not the court; and every dollar spent on early intervention saves seven dollars in the long run. David Roddy of the New Mexico Primary Care Association spoke about the danger to primary care clinics of diverting state primary care funds to expand or sustain Medicaid

coverage. Jim Schumaker of Behavioral Health Services spoke in favor of an additional waiver for the mentally ill as there is currently no funding for employment services for this population. Doris Dennison spoke of her experiences on the personal care option and that it has benefited her greatly.

The meeting was recessed at 4:40 p.m. and reconvened the following day.

Tuesday, July 30

Representative Madalena reconvened the meeting at 9:15 a.m.

HOUSEKEEPING — MINUTES

Raul Burciaga reviewed the meeting dates chosen by the committee and the working groups as formed the day before. Deb Hall reviewed the information requests made by the committee, which appear as Appendix B to these minutes. On motion duly made, seconded and adopted, the minutes from the June meeting of the committee were approved.

INTERGOVERNMENTAL TRANSFERS

Phil Lynch answered questions from the committee on intergovernmental transfers and outlined the taxation status of health insurance in the state. Currently, gross receipts tax is not imposed on private health insurance; however, a premium tax is a consideration for health insurance, including managed care contracts for Medicaid, as a way to generate state funds to be used for federal matches. How the collected tax revenues would be allocated between state and counties is still to be considered. The State Coverage Initiative (SCI) steering committee has information on the potential impact of such a tax and will share it with the committee.

In general discussion among members, the following points were covered.

- Sole community provider hospital funds are not equitably distributed statewide. Counties in other states are using these funds as matches for federal dollars.
- Some counties are hesitant to share their funds, but might be more willing to do so if they knew it could mean a three-to-one match.
- Funds used for programs serving non-Medicaid clients have not yet been used for matches because the federal money gained may not necessarily go back to the same programs.
- One difficulty in using county funds for matches is that CMS requires that all the money return to the county for patient care. One possibility is to run the money through the county hospital through an agreement between county and hospital.

FINANCING MECHANISMS

Steve McKernan, chief executive officer of University of New Mexico Hospital (UNMH), gave a presentation explaining various financing mechanisms used by UNMH to cover the uncompensated care provided by the hospital to indigent and non-Medicaid

clients. Disproportionate share (DSH) payments are federal money paid to hospitals that provide care for a disproportionate number of indigent and extreme medically needy clients. DSH payments have been capped, with states that applied to the program prior to 1991 receiving a larger reimbursement percentage than those states that applied later. New Mexico receives one percent reimbursement, though a bill backed by Senator Jeff Bingaman to increase that reimbursement to three percent has recently passed the United States House of Representatives and has moved to the Senate. Some states receive as much as 15 percent. UNMH is also financially constrained by the upper payment limit (UPL) provision that limits the reimbursement under Medicaid for any given service to the amount that would have been paid for that same service under Medicare. Overall, UNMH's projected margin for fiscal year (FY) 02 is one percent, up from an operating loss of three percent in FY 99, and this operating margin is too tight to allow UNMH to develop or expand programs.

In general discussion among members, the following points were covered.

- If UNMH's DSH payment money is used for a federal match, it comes back to the state in general and cannot be directed by UNMH to specific programs.
- UNMH is the only hospital in the state that can do intergovernmental transfers and is currently maxed out on funds available for transfers.
- Seventy-five percent of DSH funds coming to New Mexico go to UNMH — the balance is distributed to other hospitals in the state.
- New Mexico should consider suing the federal government over the disproportionate sharing of DSH payments among states. A suit was filed by Minnesota over a similar issue involving Medicare and FICA taxes.
- Rural counties around New Mexico should consider suing the state over the disproportionate sharing of DSH payments among counties.
- There need to be incentives, such as tax credits for the purchase of private health insurance, that keep the health insurance industry healthy.
- There need to be limits on annual increases in health insurance premiums.
- If the state or any of its agencies files suit, litigation costs are paid out of the general fund unless such costs are in the agency's operating budget.
- If an indigent patient from outside Bernalillo County is referred to UNMH for services unavailable in the home county, those services are provided free of charge — if the services are available in the home county, UNMH requests payment out of the county's indigent fund, though payment is not always received.
- The burden of uncompensated care could be shifted from the state general fund to federal funds if a waiver is created that covers the non-Medicaid population.
- It could be possible for UNM to enter into a managed care contract with the state.

On motion duly made, seconded and adopted, the committee directed Raul Burciaga to work with HSD to draft a letter to the New Mexico congressional delegation in favor of an increase in the DSH payment reimbursement percentage. On an additional motion duly made, seconded and adopted, the committee decided to send a letter to CMS supporting the reinstatement of the "150 percent rule" for DSH payments.

MINNESOTA FICA SUIT

Don Trigg of the attorney general's office reported that New Mexico was a party to the suit filed by Minnesota regarding fixed FICA taxes versus variable Medicare fee schedules. The court ruled that this situation does not violate the United States Constitution. Mr. Trigg feels that a suit regarding disproportionate sharing of DSH payments would get a similar ruling. He did not recommend that the state join in a recent petition to Congress regarding fair and equitable distribution within Medicare and Medicaid. However, New Mexico is part of a multistate working group on a possible prescription drug case.

PRIVATE SECTOR COST-SHARING

Karen Wells gave a presentation on the pros and cons of instituting private sector cost-sharing in Medicaid as a way to contain costs and increase revenue. Cost-sharing measures include instituting premiums, deductibles, copayments and coinsurance, with costs recovered from individuals, families or employers. Other options include expanding the Health Insurance Premium Payment (HIPP) program, in which Medicaid pays private insurance premiums for certain eligible individuals, and implementing various waivers for expansion populations such as those to be covered by SCI.

In general discussion among members, the following points were covered.

- If the HIPP program is reinstated, the state should enroll the least healthy eligible individuals and leave the healthiest ones in Medicaid to keep costs down.
- Limits and guidelines for copays need to be addressed at the federal level.
- Copays work for the chronically well but hurt the chronically ill.

BENEFITS OVERVIEW

Steve Beffort, secretary of general services, presented a comparison of the Medicaid benefits plan and the benefits plan for state employees. Demographics in the two programs differ substantially in that the average age of a state employee is 42 years old and the average age of a Medicaid recipient (excluding those on SSI) is 10.8 years old. In addition, Medicaid serves populations that are in poverty or are disabled, whereas the state plan covers working individuals. While Medicaid has no copays or coinsurance, the state benefits plan has both, and Medicaid is funded solely from public money while state employees pay 38 percent of the cost of their premiums. The overall average monthly premium for enrollees in managed care under both plans (excluding those on SSI) is nearly identical at just over \$217.

In general discussion among the members, the following points were covered.

- The average annual salary for state employees is low enough that many children of these employees qualify for the State Children's Health Insurance Plan

(SCHIP), which is free. The loss of this young and primarily healthy group can have an adverse effect on the private insurance pool.

- The average age in the state plan went up when SCHIP began — while this may have had a negative impact in some programs, it may have been positive overall.
- There will probably be no major migration from the state plan to SCHIP in the future as most of those eligible have already enrolled — the bubble is past.
- Mercer Human Resource Consulting, which compiled the benefits plan comparison, provides no further services to the state except actuarial services for the Medical Assistance Division (MAD) of HSD.
- The committee needs to consider ways to merge the Medicaid and state employee plans, perhaps through a waiver, to help the low-income working population.
- Medicaid is, by design, not a commercially viable plan, and the committee needs to look for ways to reasonably share costs with recipients.
- Private insurance plans need to be supported.
- It is deceptive to refer to 235 percent of the federal poverty level as a "high" income level — it comes to \$40,000 for a family of four.
- There is a group within MAD that works to recover uncollected third-party payments.
- Copays are often absorbed by providers. It can cost a provider \$18 in administrative costs to collect an unpaid \$.50 copay. Instituting copays would not generate enough savings to the state general fund to outweigh the detrimental impact on providers who absorb the cost.
- As a result of the *Southerland v. White* suit, 10 percent of money awarded to a Medicaid enrollee in a personal injury case goes to Medicaid. The major opposition to raising this percentage comes from the Association of Trial Lawyers of America.
- Discretionary income does exist in the Medicaid population and there needs to be an expectation that one pays to access services.
- Copays should not penalize people for seeking preventive care.
- Fifty to 60 percent of people in the emergency room do not need emergency care. A higher copay for emergency services could cut down on this.
- Partnerships between hospitals and primary care clinics could make it possible for clinics to be open in off hours.
- Doctors need to be trained to refer non-emergency cases to an urgent care clinic rather than the emergency room.
- Families go to emergency rooms because it is the only place they can get care when they need it. The backlogs in care and access difficulties are often in more populated areas.
- The medical legal environment works against doctors.
- Some of the state's health care costs are a direct result of there being no laws on certain preventive issues, such as helmet and trigger lock laws.
- The shortage of primary care can be addressed by increasing the number of mid-level health care providers.

PUBLIC INPUT FOR JULY 30

Linda Sechovec of the New Mexico Health Care Association told the committee she is available as a resource. Jim Jackson urged the committee to look at what Medicaid-reimbursable services are being provided under the Bernalillo County mill levy and use those funds for matches. David Roddy said it could be to the benefit of all hospitals in the state if they work together.

The meeting was adjourned at 4:15 p.m.

APPENDIX A

Working groups by topic (assigned staff noted in parentheses):

1. & 2. MEDICAID MAXIMIZATION & LOW-MATCH TO HIGH-MATCH (Raul Burciaga)

Dan Harris	representatives from	Cathi Valdes
Rep. Heaton	DOH, HSD, CYFD,	
Jim Jackson	SAOA & CMS	
Larry Martinez		

3. INTERGOVERNMENTAL TRANSFERS (Phil Lynch)

Michael Aragon	Rep. Madalena	David Roddy
Cecilia Contreras	Steve McKernan	Richard Rolston
Rep. Heaton	Michael Miller	Rep. Taylor
Suzanne Kotkin-Jaszi	Samuel Montoya	Rep. Wallace

4. PRIVATE SECTOR COST SHARING (Karen Wells)

Rep. Heaton
Ellen Pinnes

5. RECONFIGURING THE LONG-TERM CARE DELIVERY SYSTEM (Lisa Cacari-Stone)

Roger Gillespie	Mark Johnson	Dan Sandoval
Michelle Lujan Grisham	Rachel O'Connor	Rep. Taylor
Anna Hatanaka	Ellen Pinnes	Sadi Trujillo
Doris Husted	Christina Rutland	

6. PHARMACY COST CONTAINMENT STRATEGIES (Karen Wells)

Ross Becker	Jaime Estremera-	Karla Finnell
Charles Boatright	Fitzgerald	Roger Gillespie
Mary Eden	Sen. Feldman	Rep. Picraux

7. RATE ADJUSTMENT (Raul Burciaga)

Anthony Barela	Anna Hatanaka	Michael Miller
Anna Chavez	Sen. Jennings	Kay Monaco
Georgia Cleverley	Sharon Jones	

8. MANAGING HEALTH CARE BETTER (Lisa Cacari-Stone)

Bob Beardsley	Jaime Estremera-	Gloria Miera
Charles Boatright	Fitzgerald	Kay Monaco
Arlene Brown	Rep. Heaton	David Roddy
Mary Eden	Sharon Jones	

9. EXPANDING MANAGED CARE (Karen Wells)

Marlene Baca	Ross Becker	Steve Beffort
--------------	-------------	---------------

Karla Finnell
Roger Gillespie
Rep. Heaton

Doris Husted
Nancy Koenigsberg
Michael Miller

Mark Padilla
Rebecca Shuman
Deb Stolk

10. SELECTIVE CONTRACTING (Raul Burciaga)

Marlene Baca
Cynthia Bowman
Georgia Cleverley
Sen. Feldman
Rep. Heaton

Tom Horan
Susan Loubet
Larry Martinez
Kay Monaco

Samuel Montoya
Mark Padilla
Rep. Picraux
David Roddy

11. NEW FUNDING SOURCES (Karen Wells)

Marlene Baca
Sen. Feldman
Tom Horan
Larry Martinez

Kay Monaco
Samuel Montoya
(pending)
Rachel O'Connor

Rep. Picraux
David Roddy
Cathi Valdes
Silvija Widmer

12. LONG-TERM VIABILITY OF THE HEALTH CARE SYSTEM

The committee determined that this topic would be addressed by all working groups and by the committee as a whole.

13. REVIEW OF ELIGIBILITY AND SERVICES (Lisa Cacari-Stone)

Marlene Baca
Bob Beardsley
Charles Boatright

Georgia Cleverley
Jim Jackson
Ruth Hoffman

Susan Loubet
Ellen Pinnes
Rebecca Shuman

14. REVIEW OF STATUTES (Raul Burciaga)

John King
Nancy Koenigsberg

Ellen Pinnes
Marty Rosenblatt

APPENDIX B

TASKS AND INFORMATION REQUESTS

The Disability Coalition on Medicaid Reform agreed to provide the committee with cost estimates on what a "perfect world" of programs for the disabled would look like.

Kay Monaco requested the Ganz study on Medicaid benefits.

Representative Heaton asked for an analysis of potential state savings due to the changed definition of "homebound status" under Medicare.

Senator Feldman requested models from other states and the names of consultants working with other states.

Secretary Beffort asked for a total number of people receiving state-funded non-Medicaid health services and what percentage of the total state population is receiving subsidized health care.

Senator Feldman requested that the Legislative Finance Committee (LFC) assist committee staff in coming up with a projection of revenue if a gross receipts tax is imposed on for-profit hospitals in the state; look at a similar revenue projection from imposition of a premium tax; and review all bills that have either been generated by or written for the LFC regarding indigent funds and their transfer with Medicaid. The following people agreed to work on this with Raul Burciaga:

Cecilia Contreras

Rep. Heaton

Suzanne Kotkin-Jaszi

Larry Martinez

Steve McKernan

Michael Miller

Samuel Montoya

Rep. Picraux

David Roddy

Richard Rolston

Rep. Taylor

Rep. Wallace

Jaime Estremera-Fitzgerald requested that Steve McKernan submit possible waiver scenarios for covering unserved populations such as is done through UNM Care.

Senator Feldman requested that Don Trigg provide information on other lawsuits concerning health care that New Mexico might join.

Representative Heaton requested a breakdown of copays charged for child health care services in SCHIP and Salud!

Jim Hinton requested from Secretary Beffort the total number of kids eligible to move from the state employees plan to SCHIP.

Senator Lopez requested that the studies done by Kathy Ganz and Bill Wiese for the Legislative Health Subcommittee be made available to the committee.

Senator Jennings requested that Secretary Beffort do a comparison that includes the Retiree Health Care Authority plan. (This is included in the Ganz and Wiese study requested above.)

Representative Taylor requested a report done on copays in SCHIP by the New Mexico Pediatric Society.

Deb Hall and Reese Fullerton agreed to formulate a template for use by the working groups.

Maralyn Budke agreed to ask Larry Gage for his assistance on DSH and UPL issues.

Senator Feldman requested that HSD do a calculation and estimate on modes of administering copay collection.

Senator Feldman requested that the General Services Department give figures on the actual number of people who have dropped off the state employees insurance plan and gone on Medicaid.

Secretary-designate Otten requested the gap analysis report on behavioral health from DOH.

Larry Martinez requested data from MAD or the attorney general on Medicaid fraud.

**TENTATIVE AGENDA
for the
MEDICAID REFORM COMMITTEE**

**August 26-27, 2002
West Ballroom, Corbett Center
New Mexico State University
Las Cruces**

Monday, August 26

- 9:00 a.m. WELCOME
—Jay Gogue, President, NMSU (or)
—William Flores, Provost, NMSU
- 9:15 a.m. HOUSEKEEPING — MINUTES — PUBLIC INPUT
- 9:45 a.m. COMMUNITY PROVIDERS — MEDICAID ISSUES
—Catherine Torres, MD
—Silvia Sierra, Dona Ana County Director of Human Resource
Programs
—Melanie Goodman, Child and Maternal Health Council
—MaryAnn Aelmans Digman, CEO, Memorial Medical Center
—John Myers, Social Worker
—Ron Gurley, President, National Alliance for the Mentally Ill, and
Chairman, Dona Ana County Health Council
- 11:45 a.m. LUNCH (ON YOUR OWN)
- 1:15 p.m. INFORMATION REQUESTS FROM PREVIOUS MEETING —
STATUS
—Raúl E. Burciaga, Legislative Council Service (LCS)
- 2:00 p.m. RECONFIGURING THE LONG-TERM CARE DELIVERY
SYSTEM — PRESENTATION — ROUNDTABLE DISCUSSION
— QUESTIONS AND ANSWERS
—Lisa Cacari Stone, LCS
- 4:00 p.m. PUBLIC INPUT — WRAP-UP
- 4:30 p.m. RECESS

Tuesday, August 27

- 9:00 a.m. HOUSEKEEPING — PUBLIC INPUT
- 9:30 a.m. PHARMACY COST CONTAINMENT STRATEGIES —
PRESENTATION — ROUNDTABLE DISCUSSION —
QUESTIONS AND ANSWERS
—Karen Wells, LCS
- 11:30 a.m. LUNCH (ON YOUR OWN)
- 1:00 p.m. RATE ADJUSTMENT — PRESENTATION — ROUNDTABLE
DISCUSSION — QUESTIONS AND ANSWERS
—Raúl E. Burciaga, LCS
- 3:00 p.m. OUTSTANDING ISSUES — RECAP OF INFORMATION
NEEDS
REQUESTS
—Facilitators and LCS staff
- 3:30 p.m. PUBLIC INPUT — WRAP-UP
- 4:00 p.m. ADJOURN

AMENDED MINUTES*
of the
FIFTH MEETING
of the
MEDICAID REFORM COMMITTEE

August 26-27, 2002
Corbett Center - New Mexico State University
Las Cruces

The fifth meeting of the Medicaid Reform Committee for the 2002 interim was called to order by Representative James Roger Madalena, co-chair, on August 26, 2002 at 9:15 a.m. in the west ballroom of the Corbett Center at New Mexico State University in Las Cruces.

PRESENT

Sen. Dede Feldman, co-chair
Rep. James Roger Madalena, co-chair
Rep. John A. Heaton
Sen. Stuart Ingle
Sen. Timothy Z. Jennings
Sen. Linda M. Lopez
Rep. Terry T. Marquardt (8/26)
Rep. Danice Picraux
Rep. J. Paul Taylor
Rep. Jeannette O. Wallace

ABSENT

Sen. Ramsay L. Gorham
Sen. Allen V. Hurt

Advisory members

Steve Beffort
Arlene Brown
Mary Eden (proxy for Jim Hinton)
Jaime Estremera-Fitzgerald
Martin Hickey
Bill Jordan (proxy for Kay Monaco)
Nancy Koenigsberg
Ron Lujan
Larry Martinez
Steve McKernan (proxy for Maralyn Budke)
Michael G. Miller
Samuel Montoya
Robin Dozier Otten
Daniel D. Sandoval

Harold Field
Chet Lytle
Don Silva
Alfredo Vigil

**Approved as amended on September 24, 2002.*

(Attendance dates are noted for members not present for the entire meeting.)

Staff

Raul E. Burciaga
Karen Wells
Lisa Cacari Stone
Larry Matlock
Kathleen Dexter

Facilitators

Reese Fullerton
Deborah C. Hall

Guests

The guest list is in the meeting file.

Copies of written testimony and presentation handouts are in the meeting file. Data and information requests from the meeting are listed in Appendix A to these minutes.

Monday, August 26

WELCOME — HOUSEKEEPING — MINUTES

Dr. Jay Gogue, president of New Mexico State University, welcomed the committee to Las Cruces and gave background information on the school. Upon a motion duly made, seconded and adopted, the minutes from the July meeting of the committee were approved.

COMMUNITY PROVIDERS — MEDICAID ISSUES

A group of community providers working in Dona Ana County (DAC) gave presentations on the current state of health care programs in south central New Mexico and how changes in Medicaid would negatively affect residents of the region. Silvia Sierra, DAC director of human resource programs, reported that 24 percent of DAC residents are enrolled in Medicaid compared to 18 percent of the state's total population, with children comprising 72 percent of the county's enrollees compared to 21 percent statewide. She urged the committee to increase funding for the Promotora and Border Vision Fronteriza programs as these have been successful in educating the area's non-English-speaking population on health matters and Medicaid enrollment. She also encouraged the committee to consider designing waivers specific to DAC and border region needs. MaryAnn Aelmans-Digman, president and CEO of Memorial Medical Center, Inc. (MMCI), reported that MMCI had been the area's sole community provider hospital until this year. With the opening of a new, for-profit hospital in Las Cruces, MMCI is faced with the possibility that it will lose its private-sector clientele and be overburdened with indigent and uninsured patients. Catherine Torres, a local pediatrician, voiced concern that cuts in Medicaid could lead to a drop in the immunization rate for children, which is up to 98 percent following successful outreach. Melanie Goodman of the Maternal and Child Health Council (MCHC) reported that while 50 percent of the county's population lives outside Las Cruces, 90 percent of the health care providers are within the city limits. MCHC focus groups have identified lack of transportation, cost of care and a perception that culturally and linguistically appropriate services are not available as the region's major barriers to accessing health care services. John Myers, chair of the DAC Health Care Task Force, and Ron Gurley, president of the National

Association of the Mentally Ill (NAMI) New Mexico, urged the committee to read the gap analysis for a portrait of the critical shortage of services and service providers for the mentally ill. While 58 percent of the psychiatrists licensed to practice in New Mexico live out of state and do not necessarily practice here, their presence on the licensure rolls prevents the state from qualifying for certain loan-payoff-for-service programs that would attract more providers to the state. Mr. Gurley also cautioned the committee against making any cuts in Medicaid that would reduce the number or availability of antipsychotic drugs.

In general discussion among the members and advisory group, the following points were covered.

- A statutory provision in the state's Medicaid program protects MMCI's status as sole community provider hospital for 12 months after the new hospital opens.
- Certain physician fees or services that are Medicaid-reimbursable in areas covered by Presbyterian and Lovelace/Cigna are not reimbursed in Cimarron's service area.
- The Promotora program has been a very effective Medicaid outreach. Training for this program should remain bilingual, and an effective cross-training scenario would be to involve local health clinic and congressional staff as well.
- MMCI has a grant-funded program sending a mobile unit and pediatricians into rural areas to provide care. While mid-level staff would cost less in this program, most visits require experienced physicians.
- The events of September 11, 2001 put the J1 visa program on hold; physicians from other countries are not able to enter the country to fill vacant health care positions.
- The opening of a second hospital in a community can cause health care costs to rise due to duplication of equipment, services and personnel.
- Many immigrant parents resist enrolling their children in the State Children's Health Insurance Program out of fear of being deported.
- Communities need to be urged to set up school-based clinics for child health care.
- Possible ways to cut costs in Medicaid include streamlining paperwork and trimming administrative and indirect costs within the Salud! contracts.
- DAC would be willing to put up its indigent funds for a federal match if 100 percent of the money would go back to the county.

Summarized recommendations from this discussion included cutting indirect costs in Medicaid; promoting and fully funding the Promotora program; increasing the state funds put up for federal matches; creating a single formulary for all Medicaid contracts; and delineating waivers tailored to the needs of specific areas and populations. Committee members identified the following topics for future discussion.

- What happens to sole community provider funds when a new hospital opens?
- What is considered "medically necessary"?

- What health care needs are common to all areas of the state and what needs are community-specific?
- Where can cuts be made, rather than efficiency measures adopted, in the system?
- Does the state still have a choice between managed care and fee-for-service?
- What is each county doing with its indigent funds and can they be used for federal matches?
- Will for-profit hospitals concentrate on providing services that make money and leave the not-for-profit hospitals to provide the services that lose money?

On motion duly made, seconded and adopted, the committee directed staff to draft a letter to the New Mexico congressional delegation supporting a reinstatement of the J1 visa program.

RECONFIGURING THE LONG-TERM CARE DELIVERY SYSTEM

Lisa Cacari Stone summarized the work and findings of the Reconfiguring the Long-term Care (LTC) Delivery System work group. The group found that New Mexico already has an underdeveloped LTC delivery system, and it proposes that increased efficiency, rather than cuts, be the focus of reform as this could lead to lower costs in the long run. Options for consideration include expanding the Program of All-inclusive Care for the Elderly (PACE); supporting family care giving; reducing or eliminating the institutional bias in publicly funded care programs; increasing community-based programs; expanding self-directed care options; investing in ancillary services; increasing adult care in rural areas; expanding public transport and housing availability for seniors and the disabled; investing in recruitment and retention programs for home health care providers; conducting a long-term services availability survey; and setting a time frame for submission of the 1115 global funding waiver with an anticipated implementation date.

In a roundtable discussion among committee, advisory and working group members, the following points were covered.

- The growth in LTC costs in the past several years needs to be reviewed in the context of the parallel growth in population.
- One study has shown that there are five communities in New Mexico where a PACE program would function well. Another study has shown that PACE would not work in rural areas if it is the only LTC program available.
- A study funded by the Robert Wood Johnson Foundation found that improvements in state data systems are essential if state legislators are to make informed cost comparisons within Medicaid programs.
- The state should consider a longer look-back period in asset eligibility standards.
- The Department of Health has implemented resource allotments based on fiscal caps rather than unit caps, allowing for more flexibility and greater choice.
- It could be more immediately cost-effective to support the Promotora program than to implement a loan forgiveness program for psychiatrists who are not

- going to stay in the state to practice over the long term. Some states tie their loan forgiveness programs to willingness to treat Medicaid patients.
- Retention is a major problem; the average length of stay for a long-term caregiver is six months.
 - The state should consider a tax credit for purchasing LTC insurance.
 - An additional option is consolidating all LTC services and making structural changes in state government to accommodate this.
 - If a global waiver is implemented, does the state actually have the money to serve all the people who need LTC services?

PUBLIC INPUT FOR AUGUST 26

William Strouse of the New Mexico Human Needs Coordinating Council spoke in favor of maintaining current Medicaid eligibility standards, stabilizing health care delivery in the state and gathering as much public input as possible. Maureen Gant of Tresco, Inc., spoke of the significant positive impact the Developmental Disabilities (DD) Waiver has had on the DD population and suggested that the committee revisit a vetoed bill from the past that would have cut costs in Medicaid and addressed the provider shortage by allowing for certified medication aides. Diane Brandt of the Southwest Counseling Center spoke in favor of maintaining reimbursement for psychosocial rehabilitation, which is a cost-effective program of behavioral health services. Terry Maese, Tara Sheridan and Craig Brandt, members of the public who are receiving behavioral health services, urged the committee not to cut Medicaid funding for such services. Priscilla Salinas spoke of how the DD Waiver has helped fill the gap between what services are available under her private insurance and what her child needs. Judy Myers, director of the Governor's Committee on Concerns of the Handicapped, described a need for the state to acknowledge other disabilities beyond those covered under the DD Waiver and spoke in favor of allowing spouses to be hired as in-home care providers. Jim Jackson, director of the Protection and Advocacy System, reminded the committee that the *Olmstead* decision is an interpretation of the Americans with Disabilities Act and not an act in itself; spoke in favor of a centralized intake system; and pointed out that the asset eligibility standard is stricter for the personal care option than it is for institutional care, speaking in favor of eliminating this disparity.

The meeting was recessed at 4:30 p.m. and was reconvened the following day at 9:20 a.m.

Tuesday, August 27

PHARMACY COST CONTAINMENT STRATEGIES

Karen Wells gave a presentation outlining pharmacy cost containment options within Medicaid. Certain options are currently under development by the Human Services Department (HSD), such as establishing a pharmacy and therapeutics committee, instituting a prior authorization system, enhancing drug utilization reviews, establishing a preferred drug list, negotiating supplemental rebates, initiating new maximum allowable

cost drug pricing lists and reducing dispensing fees. Additional options to consider include mandating the use of generics, carving out pharmacy services from managed care contracts, increasing the use of the federal 340b program, creating a Pharmacy Plus Waiver, requiring disclosure on the part of pharmaceutical detailers, expanding bulk purchasing programs, requiring cost sharing or copayments, establishing a uniform preferred drug list across managed care contracts, placing an annual cap on prescription drug benefits, requiring re-use of unit dose packaged drugs, hiring a counter detailer, promoting therapeutic alternatives, implementing disease management programs and promoting step therapy.

In a roundtable discussion among committee and advisory members, the following points were covered.

- If generics are required, it is important not to limit the use of drugs for catastrophic cases.
- One drawback to step therapy is that a patient must begin the entire step therapy process over again if he changes health care plans.
- Other states could partner with New Mexico to hire a counter detailer.
- There are North American Free Trade Agreement (NAFTA) and antitrust issues that limit the possibility of New Mexico buying prescription drugs for its Medicaid program in Mexico or Canada.
- Use of prescription drugs does reduce health care costs in other areas.
- Prescription drug rebates are based in part on a drug's favorable placement on a managed care organization's (MCO's) formulary.
- The carve-out for prescription drugs in the state employee benefits package has been successful, and the state gets about eight percent back in rebates.
- Before doing a carve-out for prescription drugs from the MCO contracts, the state must consider what entity would assume the risk for managing the expense.
- There needs to be transparency in prescription drug pricing schedules to ensure that Medicaid programs are getting the lowest price.
- If a clear chain of custody can be established, reimportation of drugs could work.
- Contracts for pharmacy benefit managers need to be examined to see how they are making their money.
- Prescription drugs cost less in Mexico because there are no liability standards.
- People react differently to different drugs, including brand name versus generic. A tiered copay system would give patients a choice.
- A pharmaceutical and therapeutics committee is the appropriate body for making drug choices for the state's formulary.
- Eliminating brand name drugs would eliminate the rebate revenue.
- A carve-out for prescription drugs would reduce the MCOs' ability to manage care effectively and provide disease management services if pharmaceutical data is not submitted to the MCOs quickly by the pharmacy benefit manager. It would also affect the discount level for the populations remaining with the MCOs.

- The state should consider combining the Medicaid and Interagency Benefits Advisory Committee populations for more effective bulk purchasing.
- The burden placed on the chronically ill by copays is limited by federal law tying copays to a percentage of a person's income.
- The UNM Cares program at the University of New Mexico hospital has had some success with its tiered copay system.
- A copay system could be designed with three tiers based on generic, medically necessary and patient-preferred brand.

The committee approved Karen Wells' suggestion that a final discussion of prescription drugs be postponed until after the special hearing on this topic to be hosted by the Legislative Health and Human Services Committee late in September.

RATE ADJUSTMENTS

Raul Burciaga gave a presentation on reimbursement rates in Medicaid and four options for rate adjustments, including freezing or reducing provider rates; freezing or reducing MCO rates; adjusting case mix, risk and payment methodology; and reducing rates and reinvesting a percentage of the savings in public, primary and preventive care programs. A fifth option, added during the ensuing discussion, is to invest an additional \$125 million in the Medicaid program to be used for a three-to-one federal match.

In discussing the options, the committee and advisory members covered the following points.

- Rates should not be cut in a way that would drive providers out of the state and reduce access to care.
- While New Mexico's Medicaid program reimburses at 95 percent of the Medicare rate for services, the Medicare rate set for New Mexico is considerably lower than that set for neighboring states.
- HSD has already looked into the possibility of cutting reimbursement rates and has decided against recommending it.
- Cutting rates will not affect rural areas because providers are already scarce.
- The committee needs to use a fee-for-service equivalency to look at the actual costs and provider rates under managed care.
- Before managed care was implemented for Medicaid, administrative costs were approximately six percent of the total budget. Administrative expenses are not separated out in current MCO contracts and would be difficult to track because they can be moved around and charged in hidden ways. One major public concern is lack of information on administrative costs in corporations in general and on what dividends are being paid to shareholders.
- The committee should consider a universal health care system.
- Reimbursement rates are impacted by enrollment and eligibility requirements.
- More emphasis needs to be put on preventive care as provided through the public health system, the Medicaid in the Schools program and school-based clinics.

OUTSTANDING ISSUES — RECAP OF INFORMATION REQUESTS

Raul Burciaga reported that all outstanding information requests are being allocated by topic to the appropriate work groups. He reminded the committee that its September 12 meeting will be devoted entirely to Native American health care issues specific to Medicaid.

PUBLIC INPUT FOR AUGUST 27

Gerald Carson described the benefits of LTC insurance as a way to shift costs away from Medicaid. Michelle Lujan Grisham, director of the State Agency on Aging, called for a clarification of who can supply in-home care and for detailed eligibility numbers in the personal care option, and suggested using decommissioned military housing units for the elderly. Catherine Benavidez Clayton, executive director of the Epilepsy Foundation of Colorado, noted that New Mexico does not have an epilepsy foundation and that there are innovative drug treatments that should be included in the Medicaid preferred drug list. Jim Jackson presented results from a study on pharmaceutical companies comparing the percentage of revenue spent in 2001 on advertising versus the percentage spent on research and development, with figures on the top five compensation packages for pharmaceutical executives. Nicole Gurley, past president of NAMI-DAC, spoke against restricting or eliminating brand name psychotropic medications and against requiring step therapy for the mentally ill. Guadalupe Hernandez, whose personal care hours were recently cut from 256 hours per month to 150 hours, asked the committee to please investigate his case and others in which hours have been cut for no discernible reason. B.J. Hall of Coordinated Care Corporation reported that several of her company's personal care option clients have had their service hours cut recently and that nearly 50 percent of these cuts have been based on erroneous client assessments. Lila Roberts, also of Coordinated Care Corporation, cautioned the committee regarding the move toward self-directed care, saying this can be a bad situation for the frail elderly who are easily exploited. Ellen Pinnes of the Disability Coalition on Medicaid Reform described data showing that the MCOs have made money on their Medicaid contracts and lost money on the commercial side; spoke in favor of making consumer-directed care available for those who qualify and keeping those who need agency help under a consumer-delegated system; and described copays and annual caps on prescription drug benefits as being burdens on the chronically ill. Doug Kocham, a Medicaid recipient, said he is grateful that Medicaid was available to him when he had no insurance and needed surgery and post-surgical assistance. Bobbi Sanchez spoke against combining all clients who are chronically ill into one population and said consumers need more information on directed versus delegated care options. Jim Parker of the Governor's Committee on Concerns of the Handicapped spoke in favor of directed care options. Randy Martinez spoke in favor of the personal care option waiver and urged the committee not to make hasty decisions as it tries to save money. Sharon Jones of Cimarron Health Plan and *Mary Eden of Presbyterian Health Plan* refuted a comment made earlier regarding MCO administrative costs being billed in hidden ways and said this is not the case with Cimarron or *Presbyterian*. **

The meeting was adjourned at 4:30 p.m.

***Italics reflect amendments made to these minutes on September 24, 2002.*

APPENDIX A

TASKS AND INFORMATION REQUESTS

Ron Gurley will provide a delineated list of possible waivers for the mentally ill.

Mary Eden said she would provide data on costs in Presbyterian's Salud! program.

Michelle Lujan Grisham said she would provide an explanation of and the formula used for asset eligibility standards and the three-year look-back period.

On the reconfiguring LTC options, the following information was requested:

- Family care givers: need to find out how many people are getting paid now under the personal care option and whether those people provided the same care before they were being paid
- Nursing homes: need real figures on cost of care, as the numbers come out differently from different sources
- Self-directed services: need to identify what service delivery models need to be implemented in the system in order for self-directed care to work
- Adult care in rural areas: need data on how the current resources are being used and need to define "rural"
- Expanding public transportation and affordable housing: need to look at the two issues separately
- Recruitment and retention/workforce development: need data on shortages in various health care professions
- Available long-term care services: update the study done two years ago

Secretary Otten offered to bring the time frame for the 1115 global waiver.

Senator Feldman requested data on fee-for-service prescription drug costs.

Secretary Otten requested more MCO data from Larry Georgiopoulos, specifically a savings breakdown on state, federal and mixed funds.

Martin Hickey requested information on what percentage of a managed care program uses the largest percentage of prescription drug dollars.

Representative Taylor requested discernible information on profits from pharmacies and how much of a burden would be placed on pharmacies under proposed changes.

Senator Ingle asked Karen Wells to provide information on states that have liability limits on prescription drugs.

Senator Feldman requested data on how much a switch to generics would save and whether the state is already relying heavily on them.

Representative Taylor requested an estimate of possible savings from a prescription drug carve-out.

Martin Hickey requested an analysis of a prescription drug carve-out and the possibility of a pharmacy benefit manager arrangement in combination with other states.

Senator Feldman requested data from Florida and Michigan on their prescription drug carve-outs, as well as an estimate of how much more expertise and staff would be needed in HSD to administer this.

Senator Feldman requested information on the business practices of pharmacy benefit managers.

Representative Picraux requested information from other states on bulk purchasing practices.

Larry Martinez requested information on what populations are exempt from copays.

Representative Taylor suggested that the pharmacy cost containment working group get more information on re-use of packaged drugs and the rules for and practical limitations of doing this.

Dr. Brown requested information on how provider reimbursement rates in New Mexico compare with those in other states.

Dr. Hickey requested data on what it would cost the state if providers were reimbursed at 125 percent of the Medicare rate across the board in managed care.

Representative Heaton and Jaime Estremera-Fitzgerald requested research to defend a decision not to cut reimbursement rates.

Representative Heaton requested information on the impact in other states that have cut reimbursement rates.

Dr. Hickey requested information on the indexing effect of the variable Medicare rates.

Mary Eden offered, on behalf of the three MCO contractors, to send cost data to HSD or a third party to be aggregated and to make it available to the committee.

Roger Gillespie agreed to investigate, through Blue Cross Blue Shield, the reason the personal care hours for Guadalupe Hernandez were reduced from 256 to 150.

Revised: September 9, 2002

**TENTATIVE AGENDA
for the
MEDICAID REFORM COMMITTEE**

**September 12, 2002
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque**

- 9:00 a.m. CALL TO ORDER — HOUSEKEEPING — PUBLIC INPUT
- 9:15 a.m. TRIBAL HEALTHCARE ALLIANCE
—Joe Moquino, Acting CEO, New Mexico Tribal Healthcare Alliance
- 10:00 a.m. IHS — MEDICAID ISSUES
—Joe Moquino
—Anslem Roanhorse, Third Party Coordinator, Navajo Area IHS
—Ron Wood, Executive Officer, Navajo Area IHS
—Floyd Thompson, CEO, Gallup Indian Medical Center
- 10:45 a.m. ROUNDTABLE DISCUSSION
- 11:30 a.m. LUNCH (ON YOUR OWN)
- 12:30 p.m. 100 PERCENT FEDERAL MATCH
—Raúl E. Burciaga, Legislative Council Service
- 1:15 p.m. PUEBLO AND TRIBAL ISSUES WITH MEDICAID
—Roz Chapela, Department Director, Navajo Division of Health
—Taylor McKenzie, MD, Navajo Nation Vice President
—Colleen Whitehead, Director of Health and Human Services, Pueblo of
Jemez
—Additional Presenters TBA
- 2:00 p.m. ROUNDTABLE DISCUSSION
- 3:00 p.m. PUBLIC INPUT
- 3:15 p.m. ADJOURN

MINUTES*
of the
SIXTH MEETING
of the
MEDICAID REFORM COMMITTEE

September 12, 2002
Indian Pueblo Cultural Center
Albuquerque

The sixth meeting of the Medicaid Reform Committee for the 2002 interim was called to order by Representative James Roger Madalena, co-chair, on September 12, 2002 at 9:20 a.m. in the special events building of the Indian Pueblo Cultural Center in Albuquerque.

PRESENT

Sen. Dede Feldman, co-chair
Rep. James Roger Madalena, co-chair
Sen. Timothy Z. Jennings
Sen. Linda M. Lopez
Rep. Danice Picraux
Rep. Jeannette O. Wallace

ABSENT

Sen. Ramsay L. Gorham
Rep. John A. Heaton
Sen. Allen V. Hurt
Sen. Stuart Ingle
Rep. Terry T. Marquardt
Rep. J. Paul Taylor

Advisory members

Jim Hinton
Nancy Koenigsberg
Ron Lujan
Chet Lytle
Larry Martinez
Steve McKernan (proxy for Maralyn Budke)
Samuel Montoya
Tom Rabourn (proxy for Steve Beffort)
Daniel D. Sandoval
Vahid Staples (proxy for Harold Field)
Cathi Valdes (proxy for Robin Otten)

Arlene Brown
Jaime Estremera-Fitzgerald
Martin Hickey
Michael G. Miller
Kay Monaco
Don Silva
Alfredo Vigil

Staff

Raul E. Burciaga
Karen Wells
Lisa Cacari Stone
Kathleen Dexter

Facilitators

Reese Fullerton
Deborah C. Hall

Guests

The guest list is in the meeting file.

Copies of written testimony and presentation handouts are in the meeting file. Data and information requests from the meeting are listed in Appendix A to these minutes.

TRIBAL HEALTH CARE ALLIANCE

Joe Moquino, acting CEO of the New Mexico Tribal Health Care Alliance (THCA), and Dr. Siu G. Wong, also of THCA, updated the committee on the alliance's progress toward contracting with the state as a managed care organization (MCO) for Medicaid-eligible Native Americans in the state. The alliance is a consortium of 23 tribes, including representation for urban Indians, and its target population is the approximately 36,000 Native Americans who have opted out of Salud! managed care. The alliance has contracted with Evercare to provide third-party administration and, as of August, has received its certificate of authority from the Insurance Division of the Public Regulation Commission. While the alliance plans to use a capitated system, it will conduct quarterly reviews to determine the optimal mix of capitated versus fee-for-service reimbursement as it integrates its structure with that of the Indian Health Service (IHS). Its contract with the state will be competitive with the rates charged by the other MCOs.

In general discussion among the committee and advisory members, the following points were covered.

- The behavioral health component of the alliance will use the mental health providers currently contracted by IHS or the Salud! MCOs. Behavioral health services will be integrated within the system and will not require a referral.
- It is important for the alliance to establish positive working relationships with area hospitals in order to avoid cost-shifting.
- The Medical Assistance Division (MAD) of the Human Services Department (HSD) is recommending that the \$65.00 supplemental funding paid to the current Salud! MCOs for each Native American enrollee not be paid to the alliance.

IHS — MEDICAID ISSUES

Anslem Roanhorse, third-party coordinator for the Navajo Area IHS, Ron Wood, executive officer of the Navajo Area IHS, and Floyd Thompson, CEO of the Gallup Indian Medical Center, joined Mr. Moquino for a presentation and discussion of issues between the IHS system and Medicaid. As federal funding for IHS has leveled off in recent years, the system has become increasingly dependent on third-party revenues, including Medicaid payments. While certain aspects of New Mexico's Medicaid managed care system were initially problematic for the Navajo Area IHS, notably the processing of claims and reimbursements by third-party administrators, Mr. Roanhorse said that there

has been improvement in recent years. He also cited the opt-in policy, increased outreach and patient education, a formal communication protocol and a tribal consultation protocol as signs of progress. Mr. Roanhorse urged the committee to fully involve tribes and IHS in any state health reform initiatives; continue the fee-for-service structure and opt-in policy; maintain the 100 percent federal funding pass-through for covered services; maintain the current eligibility requirements; and improve access to services in rural areas.

In general discussion among the committee and advisory members, the following points were covered.

- The committee must keep in mind the impact of changes in the Medicaid system on providers and avoid interruptions in cash flow that can devastate a clinic.
- Medicaid-eligible Native Americans in New Mexico will soon have five choices for health care: the three Salud! MCO contractors, the THCA and IHS. Some Native Americans strongly prefer IHS for reasons of familiarity and wanting to avoid the stigma of being enrolled in Medicaid.
- Some providers do not like contracting under a fee-for-service system because payments are low.
- Federal funding for IHS will probably be flat for the next several years.
- The Bush administration is considering a reduction in IHS funding to offset third-party revenues.
- IHS saves the state \$10 million annually by providing 100 percent federally funded care to Native Americans who qualify for, but did not opt in to, Salud!.

100 PERCENT FEDERAL MATCH

Raul Burciaga outlined programs and services that qualify for 100 percent federal medical assistance percentage (FMAP). While federal law states that services received *through* an IHS facility qualify for 100 percent reimbursement, the Centers for Medicare and Medicaid Services (CMS) interprets the law to mean 100 percent match is provided only for services rendered *in* an IHS facility; any services rendered by referral *through* IHS but provided in a non-IHS facility qualify only for the regular FMAP reimbursement, currently set at approximately 75 percent. The State Medicaid Directors Association and the National Governors Association have mounted an ongoing, though unsuccessful, effort to change this interpretation of the law, and CMS continues to narrow its definition of services qualifying for 100 percent reimbursement. Given federal budget constraints, it may be at least five years before any change in the CMS policy is possible.

In general discussion among committee and advisory members, the following points were covered.

- The gap between when services are received and when enrollment is verified, as well as paperwork problems between hospitals, IHS and Medicaid, results in uncompensated care.

- Most Navajo health facilities are funded at only 45 to 61 percent of need.
- It is in the state's interest to enroll as many Native Americans as possible in Medicaid and then send them to IHS facilities for health care.
- The Salud! MCOs do a semiannual reconciliation on the supplemental funding paid for Native American enrollees, and overpayments are returned to HSD.

PUEBLO AND TRIBAL ISSUES WITH MEDICAID

Taylor McKenzie, MD, Navajo Nation vice president, Robert Nakai, director of the Navajo Division of Health, Gregory T. Ortiz, first lieutenant governor of the Pueblo of Acoma, Colleen Whitehead, director of health and human services for the Pueblo of Jemez, Maura Stone, director of special education for the Zuni Public Schools, and Eldred Bowekaty, also of the Zuni Public Schools, spoke of tribal and pueblo issues with the Medicaid program. Dr. McKenzie reported that the Navajo Nation opposes the Salud! program; wants a subcommittee of the Medicaid Reform Committee (MRC) to meet with tribal representatives to receive their input; and will review the final recommendation of the MRC and take a stand on it. Ms. Whitehead noted that the Pueblo of Jemez, which has tribally directed, operated and controlled health care facilities and programs, faces problems with inconsistencies between IHS offices; infrastructure needs, including staff; eligibility determinations; duplication of services between Medicaid and Medicare; and ancillary services that would improve access to services, such as transportation. She also expressed disappointment that tribal representation in the Medicaid reform process is low and called for an oversight committee to monitor and develop a tribal-state health care partnership. Maura Stone requested that the MRC support her school district in its pursuit of an audit of MAD's management of the Medicaid in the Schools program. Mr. Ortiz requested notification of all MRC meetings so that tribes can make their concerns known.

PUBLIC INPUT

Jana Gunnell of the McKinley Community Health Alliance spoke of the problems of poverty and lack of access to health care in McKinley County, and urged the committee not to relieve the state's budget problems by cutting services to this already-underserved area. Jim Parker of the Governor's Committee on Concerns of the Handicapped spoke in favor of having Medicaid dollars follow and be controlled by the recipient. Alvin Rafelito of the Pine Hill Health Center cited lack of providers, lack of transportation and changes in paperwork requirements as major barriers to accessing care in his region and urged the committee to focus on reforming the system in progressive and positive ways. Emmett Francis of the Albuquerque Metropolitan Native American Coalition reported that funding for IHS services in urban areas is being reduced because of contracting by tribes to set up local "638" facilities.

The meeting was adjourned at 3:30 p.m.

APPENDIX A

DATA AND INFORMATION REQUESTS

Dr. Wong said the CFO for the THCA would submit a written response to Raul Burciaga detailing the funding sources and asset reserve for the alliance.

Senator Jennings requested data on how IHS is funded.

Senator Feldman requested information on how the Turtle Care program is capturing 100 percent federal funding for enrollees, as well as the HSD perspective on this.

**TENTATIVE AGENDA
for the
MEDICAID REFORM COMMITTEE**

**September 23-24, 2002
Old Senate Chamber
Bataan Memorial Building
Santa Fe**

Monday, September 23

- 9:00 a.m. WELCOME
- 9:30 a.m. REVIEW AND WRAP-UP OF STRATEGIES 4, 5 AND 7: PRIVATE SECTOR COST SHARING — RECONFIGURING LONG-TERM CARE DELIVERY SYSTEM — RATE ADJUSTMENT
—Karen Wells, Legislative Council Service (LCS)
—Lisa Cacari-Stone, LCS
—Raúl E. Burciaga, LCS
- 11:15 a.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS
- 12:00 noon LUNCH (ON YOUR OWN)
- 1:30 p.m. MEDICAID MANAGED CARE ORGANIZATIONS — FINANCIAL REPORTING
—Representative from Lovelace Health Plan
—Representative from Presbyterian Health Plan
—Representative from Cimarron Health Plan
- 2:30 p.m. MEDICAID MONITORING AND OVERSIGHT
—Rob Maruca, Director, Medical Assistance Division
- 3:00 p.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS
- 4:00 p.m. PUBLIC INPUT
- 4:30 p.m. RECESS

Tuesday, September 24

- 9:00 a.m. STRATEGIES 8, 9 AND 10: MANAGING HEALTH CARE BETTER — EXPANDING MANAGED CARE — SELECTIVE CONTRACTING
—Karen Wells, LCS
—Lisa Cacari-Stone, LCS
—Raúl E. Burciaga, LCS

10:30 a.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

12:00 noon LUNCH (ON YOUR OWN)

1:30 p.m. PRESENTATION — TBA

2:30 p.m. PRIORITIZATION ON STRATEGIES 4, 5, 7, 8, 9, 10
 —LCS staff
 —Committee and advisory members

3:30 p.m. PUBLIC INPUT — MEETING WRAP-UP

4:00 p.m. ADJOURN

**MINUTES
of the
SEVENTH MEETING
of the
MEDICAID REFORM COMMITTEE**

**September 23-24, 2002
Old Senate Chamber - Bataan Building
Santa Fe**

The seventh meeting of the Medicaid Reform Committee for the 2002 interim was called to order by Representative James Roger Madalena, co-chair, on September 23, 2002 at 9:20 a.m. in the Old Senate Chamber of the Bataan Building in Santa Fe.

PRESENT

Sen. Dede Feldman, co-chair
Rep. James Roger Madalena, co-chair
Sen. Ramsay L. Gorham
Sen. Allen V. Hurt
Sen. Stuart Ingle (9/24)
Sen. Timothy Z. Jennings
Sen. Linda M. Lopez
Rep. Danice Picraux
Rep. J. Paul Taylor
Rep. Jeannette O. Wallace (9/23)

ABSENT

Rep. John A. Heaton
Rep. Terry T. Marquardt

Advisory members

Adolfo Alarid (proxy for Harold Field)
Arlene Brown
Jaime Estremera-Fitzgerald
Jim Hinton
Nancy Koenigsberg
Ron Lujan
Chet Lytle
Larry Martinez
Steve McKernan (proxy for Maralyn Budke)
Michael G. Miller
Kay Monaco
Robin Dozier Otten
Tom Rabourn (proxy for Steve Beffort)
Daniel D. Sandoval
Jeannette Velarde (proxy for Martin Hickey)

Samuel Montoya
Don Silva
Alfredo Vigil

(Attendance dates are noted for members not present for the entire meeting.)

Staff

Raul E. Burciaga
Karen Wells
Lisa Cacari Stone
Kathleen Dexter

Facilitators

Reese Fullerton
Deborah C. Hall

Guests

The guest list is in the meeting file.

Copies of all written testimony and presentation handouts are in the meeting file. All data and information requests from the meeting are listed in Appendix A to these minutes. A summary of strategies to date is included as Appendix B.

REVIEW AND WRAP-UP OF STRATEGIES 4, 5 AND 7

Karen Wells led a wrap-up discussion on private sector cost-sharing options. The following points were addressed in the discussion.

- Unless a waiver is requested, certain populations are exempt from copays.
- While copays do modify utilization behavior in the insured population, they might not have the same effect on Medicaid recipients, who would still seek services even if they cannot make the copay.
- Data from other states do not show that copays save money in Medicaid.
- The insurance system is failing because it is being asked to do too much while the individual is being asked to do too little.
- Since small providers are hurt most by unpaid copays, the committee needs to look first at imposing or raising copays on institutions. Increased copays on emergency room (ER) visits might encourage people to go to less expensive urgent and primary care centers. However, ERs are becoming the de facto safety net due to lack of access to primary care services.
- Those who are being responsible about paying for their own health care and insurance are being punished by those who are abusing the system.
- The UNM Care program imposes \$5.00 to \$15.00 copays, and data shows no decrease in utilization.
- There are some copays in the State Children's Health Insurance Program (SCHIP).
- The Human Services Department (HSD) has submitted a request to the Centers for Medicare and Medicaid Services (CMS) that higher copays be allowed.
- The state needs to invest in and support the primary care system, which must have the capacity and capability to operate after business hours. Strengthening the education and certification system for physicians' assistants and certified nurse practitioners is one way to address this situation.

- The original intent with SCHIP was that parents with private health insurance would not enroll their children in the program. This limitation was dropped, as was the 12-month crowd-out provision after a ruling from CMS. However, a six-month crowd-out provision will soon be imposed.

Lisa Cacari Stone led a discussion summarizing options for reconfiguring the long-term care (LTC) delivery system. She noted for the record the following changes to be made to the "Reconfiguring Long-term Care" policy brief presented to the committee at its August 26-27 meeting.

- On page 2, bullet 1 should read "Replacing institutional care with home and community based services (HCBS) does not automatically translate into reduced Medicaid spending if the system is not fully developed" instead of "Replacing HCBS with institutional care does not automatically translate into reduced Medicaid spending if the system is not fully developed".
- On page 7, under "Findings from the Data", add the clarification that "New Mexico was included among the 50 states in a survey conducted by the Robert Wood Johnson Foundation that found that state data is not adequate to support health reform or monitor systems change due to barriers such as funding issues, lack of comparability across data sets, and the reluctance of providers and insurers to submit required data".

The following points were addressed in the discussion on the LTC delivery system.

- HSD will resubmit its proposal to CMS for a global funding waiver (GFW) in the next 60 days. One possibility is to obtain private grant funding for a limited pilot project before expanding the GFW to the whole state. While the GFW would serve more people than are currently served, it would not save the state any money or eliminate the waiting list because the eligible population is growing rapidly.
- The structure of LTC services delivery within the state needs to be reconsidered and merged into one department. More than 30 states have combined adult and Medicaid LTC services into one department and are spending less due to a move away from institutional care.
- While certain waivers have been developed as a result of legislative requests, it is HSD, not the legislature, that designs them and submits applications to CMS.
- Some states are considering Program of All-inclusive Care (PACE) programs for the developmentally disabled (DD) and children. The PACE Association is also considering PACE models for rural areas. Rural PACE would be more expensive than urban PACE, though less expensive than nursing home care.
- The state needs to ask for at least a four-year post-graduation commitment to practice in New Mexico from doctors, physicians' assistants and certified nurse practitioners participating in a loan payoff program.

Ms. Cacari Stone recommended that representatives from the Department of Health (DOH), the State Agency on Aging (SAoA), HSD and the Children, Youth and Families Department (CYFD) meet as a group to compare their respective data and cost analyses on LTC services, then give a report to the committee at an upcoming meeting.

Raul Burciaga led a discussion on options for rate adjustments to providers and MCOs, with the following corrections made to slide eight of his presentation: "1% - \$5M GF, 2% - \$10M GF, 3% - \$20M GF". The following points were addressed during the discussion.

- The decline in enrollment figures from July to August 2002 is because retroactive eligibility figures are not included and because of a seasonal drop.
- As of October 2001, HSD stopped its SCHIP outreach efforts, though the Covering Kids outreach done by the MCOs is ongoing.

MEDICAID MANAGED CARE ORGANIZATIONS — FINANCIAL REPORTING

Garrey Carruthers of Cimarron Health Plan, Jeannette Velarde, MD, of Lovelace Health Plan and David Scrase, MD, of Presbyterian Health Plan gave presentations on costs for Medicaid services within the MCOs and in the fee-for-service (FFS) sector. Certain factors were cited to explain the rising cost of health care premiums, including general inflation; advances in drugs and medical technology; rising provider rates; government mandates and regulations; increased consumer demand; litigation and risk management; and fraud and abuse. Dr. Scrase noted that New Mexico is caught in an unhealthy cycle in which uninsured residents are unable to pay for their health care; the provider or hospital raises its rates to cover the uncompensated care it provides for this population; the increased rates are passed on to insurance companies, who pass them on as premium increases; more residents drop their health insurance; and the population of those who are uninsured grows. Mr. Carruthers suggested saving money in Medicaid by limiting benefits rather than eligibility and by narrowing the definition of "medically necessary" services. As examples, he proposed limits in vision benefits, adult dental services, non-emergency transportation and occupational and speech therapies.

In general discussion among committee and advisory members, the following points were covered.

- It might be possible for the state to save money by moving services for dual Medicare/Medicaid eligibles, the Medicaid in the Schools (MITS) program and case management for early intervention and protective services into managed care.
- There has been a steady five percent annual decline in enrollees in private insurance for the past four years in New Mexico. Each \$1.00 increase in commercial insurance premiums accounts for approximately 600 people either dropping, or having their employers drop, health insurance coverage.
- It currently costs an MCO approximately \$1.4 million to be certified by the National Committee for Quality Assurance (NCQA), one of several

certifications required by the state. Eliminating redundant certifications would save money.

- The definition of "medically necessary" was expanded to address the needs of the chronically ill, including the chronically mentally ill. It does not take away a doctor's discretion and should remain as is.
- There is no increase in paperwork for providers if copays are increased. However, there is a huge difference between collecting an \$18.00 copay with that amount of paperwork as opposed to the \$.50 copay mandated by CMS in certain cases.
- Presbyterian is willing to give the state a dollar-for-dollar drop in capitation rates to match drops in benefits, excluding calculations for copay increases.
- The elimination of the 12-month crowd-out provision for SCHIP enrollment, in combination with an increase in private insurance premiums, explains some of the drop in private insurance enrollment.
- The state pays more for insuring children of state employees than it does if the same children are enrolled in SCHIP, in which state money qualifies for a federal match.
- During the past year, twice as many state employees dropped health care coverage and moved at least one family member to Medicaid as in previous years. Exit interviews would help determine how much of this drop is explained by leaving employment, losing employment or other factors.
- State funds could be leveraged more effectively by expanding Medicaid behavioral health (BH) services.

The MCO representatives were asked to return the following day to finish the discussion.

MEDICAID MONITORING AND OVERSIGHT

Deborah Stolk, chief of the Contracts Administration Bureau, Medical Assistance Division (MAD), HSD, and Martin Rosenblatt, chief of the Quality Assurance Bureau, MAD, outlined the monitoring and oversight conducted by their bureaus with respect to Salud! contracts, as well as the numerous reports required of the MCOs. Mr. Rosenblatt spoke in favor of retaining the requirement that an MCO receive IPRO certification in addition to the NCQA certification, since the latter looks only at whether policies are in place while the IPRO looks at whether those policies are actually working.

PUBLIC INPUT FOR SEPTEMBER 23

Ellen Pinnes presented recommendations on behalf of the Disability Coalition on Medicaid Reform (DCMR) regarding LTC options, and noted that if half of the recipients of personal care option services were moved from an agency-directed to a self-directed model, the state could save approximately \$10 million. Doris Husted presented a position statement from the Children's Advisory Task Force concerning the negative impact and crisis situation that the state's nursing shortage has created for children who require skilled nursing care under the Medically Fragile Waiver. Ramona Flores-Lopez of DOH urged the committee to be creative in addressing the provider shortage and spoke in favor of creating a single agency to coordinate LTC services over the entire life spectrum. Doris

Husted spoke against using a PACE model for the DD population as this would segregate them; stated that the MCOs have not been providing early intervention services for children at risk for DD; and warned of potential negative impacts on overall health if dental services are cut for the adult DD population. Michelle Lujan Grisham, director of SAoA, recommended that the committee find currently unmatched funds anywhere possible and invest them in LTC programs; stated that there is nowhere to discharge elderly people as they leave ERs; noted that self-directed care is not the only solution for LTC; and spoke in favor of creating an LTC department for the state. Jim Jackson of the Protection and Advocacy System noted that insurance premiums are not rising \$1.00 per month but rather \$30.00 to \$40.00 per month per employee; explained that the FFS program serves the least healthy populations while the managed care enrollees tend to be the healthiest; reminded the committee that the DCMR made recommendations at a previous meeting on how to save money in Medicaid; and suggested that the MCOs get together with the benefits work group to discuss cutting benefits. Ellen Pinnes presented statistics on the negative impact of copays; described transportation services as essential for the Medicaid population; and mentioned a study that found that while \$2 million could be saved by instituting copays, the additional cost of administering them may eliminate the savings. David Roddy of the New Mexico Primary Care Association stated that copays would essentially be a reduction in provider reimbursements and that raising copays for ER visits would not discourage use because that is all that is available in some cases.

The meeting was recessed at 4:50 p.m. and reconvened the next day at 9:40 a.m.

Tuesday, September 24

PROCESS MAP — REVIEW AND WRAP-UP OF STRATEGIES 8, 9 AND 10

Karen Wells presented a process map for the Medicaid program detailing enrollment, service delivery, payment for services and oversight and monitoring procedures; a breakdown of federal matches within all Medicaid programs; and a relationship map of all entities involved in Medicaid. As an addition to her outlines, it was noted that each MCO has a fraud and abuse program as part of its oversight and monitoring efforts.

Lisa Cacari Stone summarized options for managing care better, including case management, disease management, primary care case management (PCCM) and investing in community efforts such as the Promotora program. She proposed that the state apply for a grant to conduct a PCCM pilot project for a limited population in a limited area of the state, to be reviewed after a few years and possibly expanded statewide. Karen Wells summarized options for expanding managed care, including instituting PCCM for the current FFS population, expanding managed care to include new populations and expanding services covered. She noted that the Primary Care Network (PCN), a PCCM project in the early 1990s, paid providers \$2.00 per member per month for care coordination. Raul Burciaga summarized options for selective contracting, including using a PCCM model for care; selectively contracting for monitoring and oversight

activities; and consolidating claims processing across all MCOs. He reported that Medicare administrative expenses run at just under two percent, while Medicaid administrative expenses range from nine to 11 percent. He also noted that Medicaid costs cannot be controlled if the behavior of providers (prescribing and procedures) and patients (diet and activity) does not change.

In general discussion among committee and advisory members, the following points were covered.

- Costs for preventive care and provider education are included in the administrative expenses for the MCOs.
- The study showing positive outcomes for the PCN is flawed. The PCN had a high "confusion factor" when it was first implemented and this resulted in billing problems for providers such as UNM Hospital, which was not always paid for services it provided. Positive developments from the PCN included strengthened relationships between patients and their primary care physicians, higher patient satisfaction levels and an increased understanding among Native Americans of how to access the health care system.
- Managed care is not an overall solution; it has been good for family practice physicians but has driven other doctors out of the state. It is time to assess whether it is still appropriate or if some other system should be implemented.
- A national initiative called Healthy People 2010 is looking at case management within the managed care system as well as in each provider's office.
- The best case management is done at the community level. A strong primary care system partnering with community programs and the MCOs could be the best way to manage the FFS population.
- The real issue facing the state is to provide basic health care to everyone. There is a huge population who work hard and have no access to health insurance because their employers do not offer it and they cannot afford it themselves. Basic primary care for all residents is cost-effective and would end cost-shifting.
- The state needs to have control over the cost of Medicaid but does not at this time. A tax increase cannot be imposed to cover the increased costs of Medicaid.
- Consolidated claims processing would let the state manage the system better.
- If the benefits package for Medicaid recipients is cut, there should be a corresponding cut in the benefits to the MCOs. If an MCO's capitation rate includes services it does not provide, the money should go back to the state.
- One of the ethical issues for doctors is that they are required to provide certain care, yet under managed care, a doctor's decision-making process is compromised.
- It seems that once a program begins to work effectively and people begin to understand and access the health care system, the program either ends or changes.
- DOH should be doing more primary care and immunization.

- The case management payments in the MCO contracts should be removed and given to providers, as they are the ones actually doing case management. Offsite case management is not as effective as that done by a provider.
- Disease management and case management work well in the UNM Care program.
- The state is not eligible for 340b pricing on prescription drugs because it is not a 340b entity.
- The unit of production in health care is currently the patient encounter. The system should be changed to an evidence-based model that rewards a provider for restoring a patient to a baseline level of health.
- There are disparities between data on costs depending on the source, including the MCO financial data. The committee needs to be cautious about figures projecting cost savings and understand that some reflect cost avoidance rather than savings.
- Copays and community programs represent ways to promote wellness. Every dollar invested in wellness can bring about \$3.00 in savings. The state should consider tax rebates for healthy lifestyle choices such as not using tobacco.
- The State Coverage Initiative (SCI) will offer health insurance to a segment of the low-income working population with a mixture of federal, state and private funds.

MANAGED CARE ORGANIZATIONS, CONTINUED

The following points were covered in the discussion with MCO representatives continued from the previous day.

- The MCOs are looking at streamlining and reducing administrative burden in areas such as claims submission, prior authorizations, referrals and credentialing. The New Mexico Health Policy Commission has a task force looking into the credentialing process and will report its findings in October.
- Complying with the Health Insurance Portability and Accountability Act (HIPAA) has been expensive, but it will increase efficiency in the long run.
- Cost-shifting is economic discrimination against men since Medicaid is primarily for women and children. If insurance premiums go any higher, the state will be killing its golden goose. SCI will mitigate some of the cost-shifting.
- The case management done by MCOs does not replace or take away from what a provider does.
- It is five times more expensive for an MCO to process a paper claim than an electronic one. MCOs are reluctant to consolidate the claims processing system because they would lose access to the data they use for managing care.
- MITS sites might be incorporated into managed care.
- All discharges from inpatient mental health stays receive case management. However, there is sometimes a five-day delay after discharge, which can be a problem if medications are involved.
- The change in the definition of medical necessity was a move to restore access to services that were covered but not necessarily available or accessible.

- The capitation rate for MCOs covers services that must be contracted out, such as BH services. MCOs assume the risk for contracted services and sometimes operate at a loss, and that money is not reimbursed to them by the state.
- If pharmacy were carved out from the Salud! contracts, the state would not get the same rebates on purchasing and the MCOs would have a problem managing care.

PRIORITIZATION ON STRATEGIES 4, 5, 7, 8, 9 AND 10

The committee prioritized the strategies they had discussed to date, and their decisions appear as Appendix B to these minutes.

On motion duly made, seconded and approved, the minutes of the August 26-27 and September 12 meetings were adopted, with the August 26-27 minutes amended as follows: on page 8, first paragraph, final sentence, the phrase "and Mary Eden of Presbyterian Health Plan" shall be inserted after the phrase "Cimarron Health Plan", and the phrase "or Presbyterian" shall be inserted after the phrase "the case with Cimarron".

PUBLIC INPUT FOR SEPTEMBER 24

Cecelia Contreras of the Chaves County Indigent Health Care Affiliate urged the committee to remember indigent health care needs and mentioned that the only primary care provider in Chaves County has not taken new clients in a year. Doris Husted noted that the case management and service coordination provided to the waiver populations does make a difference in utilization patterns. David Roddy spoke in favor of PCCM, saying this model has a better chance of succeeding now that the state has experience with managed care; and noted that Lovelace/Cigna does the most case management of all the MCOs and also has the highest profit margin. Jim Jackson refuted a comment made earlier in the meeting that advocacy groups were responsible for the current BH system, saying the groups had joined with DOH and CYFD to recommend carving BH services out of the MCO contracts due to a lack of experience with BH on the part of the MCOs. David Roddy spoke of a need for cooperation between MCOs and primary care providers in order for case management to be effective, and also noted that disease management can help reduce the number of hospitalization days for clients.

The meeting was adjourned at 5:00 p.m.

APPENDIX A

DATA AND INFORMATION REQUESTS

Tom Rabourn said he would provide data from the state employees insurance program on how cost-sharing does modify utilization behavior.

Larry Martinez requested information on what populations and services can have copays versus those that require a waiver. Karen Wells pointed out that this information was supplied to the committee at a previous meeting and that the committee was not in favor of a waiver for copays when HSD reported it might generate only \$2 million in savings.

Jaime Estremera-Fitzgerald requested information on the copay system recently put into place in Missouri as well as data on the effect of copays on utilization in the SCHIP population.

Karen Wells said she would supply information on copays and waivers in other states for populations greater than 185 percent of the federal poverty level.

Larry Martinez requested information on how increased copays would impact MCO contracts.

Secretary Otten requested cost savings data on the options listed in the LTC options, with projections in demographic changes. Lisa Cacari Stone said she has an NCSL document addressing this.

Senator Feldman requested cost comparison data on serving the nursing home population versus the population receiving home and community-based services. Senator Gorham expanded this request to include those on the personal care option, comparing costs for those with the same level of need across the three groups.

Senator Hurt requested data on the possible fiscal impact to Medicaid if malpractice suits went to binding arbitration rather than to a jury trial, or if there were a "loser pays" tort system.

Cathi Valdes said she would supply figures on the average number of retroactive Medicaid eligibility determinations per month.

Secretary Otten said she would supply information on how much HSD spent on advertising for SCHIP outreach.

Dr. Scrase said he would provide estimates on the average length of stay in residential treatment centers before and after the change in the medically necessary definition.

Garrey Carruthers said he would supply data on savings to be had if non-emergency transportation services were dropped from Medicaid.

Senator Hurt requested that the MCOs compile a list of expendable reports and redundant quality certifications, and Senator Feldman requested that HSD be involved in compiling this list.

Senator Hurt requested that the MCOs compile a list of FFS services that could be moved to managed care.

Dr. Brown requested a list of optional versus mandatory Medicaid services. (This was supplied to the committee on September 24.)

Senator Feldman requested exit interview data on why people are dropping private insurance and moving onto Medicaid.

Jaime Estremera-Fitzgerald requested information on what geographic areas are served by what MCOs, specifics on how case management is handled in each MCO and information on partnering capabilities for community case management.

Secretary Otten requested a list of FFS services provided by the MCOs and how much money is involved before considering managed care for the FFS population. Cathi Valdes said she will update a report she has on these figures and make it available.

APPENDIX B

STRATEGY SUMMARY TO DATE

Rate Adjustments

Keep these options on the table:

- freeze or cut provider rates
- freeze or cut MCO rates

Cost Sharing

Keep these options on the table:

- increase copays in institutions (ERs, urgent care)
- increase copays for higher poverty levels

Reconfiguring Long-term Care

Keep these options on the table:

- self-directed care
- personal care option
- PACE
- global waiver
- HCBS waiver
- increase nursing facility capacity
- improve infrastructure and support
- LTC insurance
- consolidation of LTC services into one agency
- move LTC out of Medicaid into Medicare

Managing Care Better

Keep these options on the table:

- disease management
- case management
- PCCM for targeted populations
- primary pharmacy for FFS populations
- FFS into managed care
- selective contracting for consolidated claims systems (or "encouraging electronic warehouse")
- uniform electronic filing standard
- consider MCO model for urban areas, non-MCO model in rural areas

**TENTATIVE AGENDA
for the
MEDICAID REFORM COMMITTEE**

**October 9-10, 2002
New Mexico Farm and Ranch Heritage Museum
Las Cruces**

Wednesday, October 9

- 9:00 a.m. WELCOME
- 9:15 a.m. HOUSEKEEPING — MINUTES — PUBLIC INPUT
- 9:30 a.m. BORDER HEALTH CARE ISSUES
—John Myers, Chairman, Border Health Council
—Alice Salcido, Border Health Office, Maternal Child Health
Planner
—Dan Reyna, Director, Border Health Office
- 10:30 a.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS
- 11:30 a.m. LUNCH (ON YOUR OWN)
- 1:00 p.m. SCHOOL-BASED HEALTH CARE
—Susan Gowing, President, NM Assembly on School-Based
Health Care
- 1:30 p.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS
- 2:00 p.m. MEDICAID REFORM AND COST-CUTTING EFFORTS —
MEDICAID PROGRAM — ACTUAL AND PROJECTED COSTS
—Raúl E. Burciaga, Legislative Council Service
- 2:30 p.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS
- 3:00 p.m. PUBLIC INPUT — WRAP-UP
- 3:30 p.m. RECESS

Thursday, October 10

- 9:00 a.m. HOUSEKEEPING — PUBLIC INPUT
- 9:30 a.m. RURAL HEALTH CARE ISSUES
—Frank Crespín, Medical Director, La Clinica de Familia
—David Roddy, Executive Director, NM Primary Care Association

—Other Presenters, TBA

10:30 a.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

11:30 a.m. LUNCH (ON YOUR OWN)

1:00 p.m. HOME-BASED MODEL FOR RESIDENTIAL
DEVELOPMENTAL DISABILITIES WAIVER PROGRAM
—Chris Hopper, President/CEO, Grace Requires Understanding,
Inc.
—Maria Marquez, Home-Based Provider, Service Coordinator
—Belva Geronimo, Home-Based Service Recipient

1:45 p.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

2:30 p.m. WRAP-UP — PUBLIC INPUT

3:00 p.m. ADJOURN

**MINUTES
of the
EIGHTH MEETING
of the
MEDICAID REFORM COMMITTEE**

**October 9-10, 2002
New Mexico Farm and Ranch Heritage Museum
Las Cruces**

The eighth meeting of the Medicaid Reform Committee (MRC) for the 2002 interim was called to order by Senator Dede Feldman, co-chair, on October 9, 2002 at 9:30 a.m. at the New Mexico Farm and Ranch Heritage Museum in Las Cruces.

PRESENT

Sen. Dede Feldman, co-chair
Rep. James Roger Madalena, co-chair
(10/10)
Sen. Ramsay L. Gorham
Rep. John A. Heaton
Sen. Timothy Z. Jennings
Rep. Terry T. Marquardt (10/9)
Rep. J. Paul Taylor

ABSENT

Sen. Allen V. Hurt
Sen. Stuart Ingle
Sen. Linda M. Lopez
Rep. Danice Picraux
Rep. Jeannette O. Wallace

Advisory members

Carla Chavez (proxy for Kay Monaco)
Mary Eden (proxy for Jim Hinton)
Jaime Estremera-Fitzgerald
Roger Gillespie (proxy for Robin Dozier
Otten)
Nancy Koenigsberg
Michael G. Miller
Samuel Montoya
Jeannette Velarde (proxy for Martin
Hickey)
Alfredo Vigil

Steve Beffort
Arlene Brown
Maralyn Budke
Harold Field
Ron Lujan
Chet Lytle
Larry Martinez
Daniel D. Sandoval
Don Silva

(Attendance dates are noted for members not present for the entire meeting.)

Staff

Raul E. Burciaga
Karen Wells
Lisa Cacari Stone
Kathleen Dexter

Facilitators

Reese Fullerton
Deborah C. Hall

Guests

The guest list is in the meeting file.

Copies of all written testimony and presentation handouts are in the meeting file. All data and information requests from the meeting are listed in Appendix A to these minutes. All points put forth for consideration as final recommendations of the committee appear as Appendix B to these minutes.

Wednesday, October 9

BORDER HEALTH CARE ISSUES

John Myers, chairman of the Border Health Council, Alice Salcido, maternal child health planner for the Border Health Office, and Dan Reyna, director of the Border Health Office, gave a presentation on Medicaid issues in the border region of the state. The Border Health Council held three community forums in July, during which participants raised concerns regarding implementation, education, operation and navigation in Medicaid. The council cited issues regarding the complexity of the program due to the use of multiple managed care organizations (MCOs); the program's emphasis on cost containment and profit rather than on continuum of care; the lack of an integrated and comprehensive health care system; the lack of special allowances for rural and border areas; and costly paperwork requirements. One successful outreach program in the border area has been Border Vision Fronteriza (BVF), which helps residents navigate Medicaid through the use of community health advisors, or promotoras. BVF has consistently enrolled more than five times the number of targeted enrollees per year since the program's inception in January 2000, and it is being used as a model for other states. One obstacle to Medicaid enrollment is the erroneous perception that an immigrant parent jeopardizes his immigrant status and may be deported if he enrolls his eligible child. Another obstacle is the requirement that an enrollee have a social security number, which in turn requires either a birth certificate or application; delays in obtaining these cause delays in Medicaid enrollment. The federal Immigration and Naturalization Service is conducting community education and outreach on both these issues to facilitate enrollment. In addition to advocating for such education and outreach measures, the Border Health Office also recommends an increase in the number of in-hospital eligibility workers and a stronger effort to recoup Medicaid "Category 85" reimbursements for providing emergency services to certain undocumented aliens.

In a roundtable discussion among the committee members, advisory members and presenters, the following points were covered.

- The key to getting Category 85 reimbursements is to have more in-hospital eligibility workers and promotoras who establish eligibility before a patient is discharged.

- One study shows that increased support services such as promotora programs reduce emergency room use.
- A recent survey of border county hospitals shows that emergency medical services provided to undocumented aliens accounts for 25 percent of uncompensated care.
- Per the U.S. Constitution, any child born in the U.S. is granted automatic citizenship regardless of the citizenship or residency status of the parents. While Medicaid has both a citizenship and a residency requirement, Department of Health (DOH) programs do not have a citizenship requirement for prevention programs.
- The state cannot afford to be enrolling children of Mexican citizens in Medicaid.
- Without the cash-paying Mexican citizens receiving health care services, one hospital in the border area would have closed by now.
- The population that pays a lot of taxes but earns too much money to qualify for state health care programs needs to be taken into consideration.

SCHOOL-BASED HEALTH CARE

Susan Gowing, president of the New Mexico Assembly on School-based Health Care (NMASHC), gave a presentation on school-based health clinics (SBHCs), which provide an array of health services on school grounds. A breakdown of visits to SBHCs nationwide shows the following:

<u>Reason</u>	<u>Percent of total annual visits</u>
Mental health/substance abuse	34
Acute illness	25
Reproductive health	8
General medical examinations	8
Injuries	6
Other	balance.

The first SBHC opened in 1971; since that time, clinics have been established in 45 states, with 17 clinics operating in New Mexico in 2000. Studies have shown that teens who have access to health care at school have fewer after-hour emergency room visits, a lower incidence of pregnancy and fewer absences than teens without access to such care. Ten of these clinics have closed recently due to shortage of funds, however, and the NMASHC recommends that funds be increased for the SBHCs by requiring that MCOs reimburse the clinics for services provided to Medicaid enrollees and by using the general fund dollars spent by the DOH's Office of School Health for a federal match. The NMASHC also recommends that these clinics provide more comprehensive services to teens and that each have a core of five employees.

In general discussion among the committee and advisory members, the following points were covered.

- There are great savings to be had by strengthening SBHCs because of the pregnancy prevention statistics and because health issues, both mental and physical, are tied to the dropout rate.
- In many small communities in the state, an SBHC is the only confidential health care available to teens.
- The MCOs support the SBHCs; however, an SBHC cannot be reimbursed by an MCO for services to Medicaid enrollees unless it meets National Council for Quality Assurance accreditation, agrees to notify an enrollee's primary care physician when services are provided and has an appropriate billing system. A Robert Wood Johnson Foundation grant project allows certain SBHCs to bill for services through fiscal agents.
- A teenager cannot be put on psychoactive medication through an SBHC without parental notification.
- Thirty percent of the SBHCs are sponsored administratively by local hospitals. Those administrative expenses might qualify for a federal match.

MEDICAID REFORM AND COST-CUTTING EFFORTS — MEDICAID PROGRAM ACTUAL AND PROJECTED COSTS

Raul Burciaga reported on actual and projected costs for the Medicaid program for fiscal years (FYs) 2000 through 2004. While the Medicaid program showed an \$11.9 million surplus in FY01, there is a projected cumulative shortfall of \$38.1 million through FY03. In combination with the projected cost for the program in FY04, the additional general fund dollars needed to administer the program in FY04 and cover the cumulative shortfall from previous years is \$453.4 million. An \$82 million increase is projected for FY04 over the FY03 Medicaid budget appropriation. Enrollment figures for FY03 project a growth rate of 8.35 percent, with nearly all the growth in the Temporary Assistance for Needy Families, or TANF, eligibility category.

In general discussion among the committee and advisory members, the following points were covered.

- The State Coverage Initiative (SCI), which is projected to insure 8,000 adults, may be in direct competition with Medicaid for funding.
- The Human Services Department (HSD) will not pursue renegotiation of the MCO contracts until after the MRC makes its final recommendations.

PUBLIC INPUT FOR OCTOBER 9

Anna Otero Hatanaka, executive director of the Association of Developmental Disabilities Community Providers, expressed disappointment that HSD has pursued cutting the reimbursement rates to intermediate care facilities for the mentally retarded (ICF/MRs) but has not pursued cutting the rates paid to MCOs. Ms. Hatanaka and Maureen Gant of Tresco, Inc., noted that public hearings are important when programs are

being implemented, but that they do not feel that serious attention is paid to the public commentary made in those meetings.

The meeting was recessed at 4:00 p.m. and reconvened the next day at 9:15 a.m.

Thursday, October 10

RURAL HEALTH CARE ISSUES

Frank Crespín, medical director for La Clínica de Familia, and David Roddy, executive director of the New Mexico Primary Care Association, gave a presentation on New Mexico's rural primary health care network. Currently, New Mexico provides approximately \$12 million annually to support its rural clinics, with more than \$36 million per year provided by the federal government. The state money for these clinics — referred to as Rural Primary Healthcare Act (RPHCA) funds — is one source of "unmatched" funds being considered by the MRC for use in leveraging additional federal money for health care. Mr. Roddy pointed out, however, that RPHCA funds should not be considered unmatched as they are a critical element in what the federal Department of Health and Human Services considers a federal, state, local and community partnership. Removing any of the state RPHCA funds from this formula would weaken an already underfunded health care network.

In general discussion among committee and advisory members, the following points were covered.

- By improving accessibility of rural clinics and strengthening programs that use community health advisors, the state could save money by lowering the incidence of ER visits.
- Disease management should be done within a continuum of care system; however, it is not clear if such management is the best use of a physician's time.
- It is critical that rural clinics be held harmless in any redirection of RPHCA funds, as these clinics operate on very tight budgets.
- The MCOs are in favor of, and willing to participate in, disease management.
- SCI would be a help to rural clinics, though the primary positive impact would be in urban areas because that is where the jobs are.
- Utah has a waiver for primary care services only, and the program uses income as the eligibility criterion.
- Rural clinics receive cost-based reimbursement only on 37 percent of their patients.

HOME-BASED MODEL FOR RESIDENTIAL DEVELOPMENTAL DISABILITIES WAIVER PROGRAM

Chris Hopper, president and CEO of Grace Requires Understanding, Inc., Maria Marquez, home-based services provider and service coordinator, and Belva Geronimo, a recipient of home-based services, gave a presentation on the merits of providing in-home care for the developmentally disabled, as well as on some difficulties they have faced with certain DOH personnel. Scott Doan of DOH responded to their concerns, outlining the appeal process in place. Doris Husted of the ARC of New Mexico stated that her organization is not opposed to home-based services but feels that institutional treatment needs to be available for individuals who require that level of care.

PUBLIC INPUT FOR OCTOBER 10

Bobbi Jo Sanchez described DOH as being in a difficult situation at times regarding in-home care patients because the department is not always given the treatment information it needs.

The committee adjourned at 2:50 p.m.

APPENDIX A

DATA AND INFORMATION REQUESTS

Roger Gillespie said he would bring copies of the regulation regarding citizenship and residency requirements for Medicaid eligibility to the next meeting.

Roger Gillespie said he would bring information on the match level for Category 85 reimbursements to the next meeting.

Samuel Montoya said he would bring copies of a report done in 2002 on the relationship between county indigent funds and hospitals, showing that the funds are paying for services that could be paid by Category 85 reimbursements.

Mary Eden said she would supply a list of MCO-reimbursable services in SBHCs.

Roger Gillespie said he would get information on whether cash reserve funds could be used to pay down the Medicaid shortfall.

Senator Feldman requested information on HSD's current recommendation for MCO contract renegotiations and how HSD plans to come up with the funds to cover the \$45 million shortfall in its funding for FY03.

Raul Burciaga offered to do a presentation at a future meeting on the SCI program and its funding.

Representative Taylor requested that pros and cons be presented with each option to be considered by the committee at its final meeting, as well as some note identifying those options that are the most applicable to Medicaid.

Senator Feldman requested information on what effect an increase in the FMAP would have on new revenue streams.

Senator Feldman asked Roger Gillespie to get information on when the new rate cuts to ICF/MRs go into effect.

Senator Feldman directed David Roddy to work with committee staff and representatives from the MCOs to estimate the cost of implementing a disease management pilot project centered on three chronic diseases.

Representative Heaton requested that HSD look into the possibility of writing a waiver to allow RPHCA funds that are used by the state for a federal match to be returned 100 percent to the clinics.

Representative Taylor requested that David Roddy provide a breakdown of how rural clinics are paid and what populations are served by them, specifically within the immigrant populations.

David Roddy said he would present two recommendations regarding RPHCA funds; a clear description of the current match situation for rural clinic funding; cost projections for disease management programs; a breakdown of rural clinics by service area rather than by county; and an explanation of how expanding Medicaid might decrease funding to rural clinics.

David Roddy said he would investigate whether it is possible for a facility to be both an FQHC and a 638 facility.

Jaime Estremera-Fitzgerald requested that staff find out if the new director of the Indian Health Service (IHS) is looking for ways for IHS facilities to partner with FQHCs.

APPENDIX B

RECOMMENDATIONS

The following points were put forth as recommendations for the committee to endorse:

- pursue Category 85 reimbursements more diligently to take the burden off county indigent funds;
- match those county indigent funds that are currently unmatched and write a waiver that would allow 100 percent of those funds to return to the counties; and
- require that all rural clinics in the state become certified as federally qualified health clinics and, therefore, eligible for cost-based reimbursement.

**TENTATIVE AGENDA
for the
MEDICAID REFORM COMMITTEE**

**October 17-18, 2002
Old Senate Chamber, Bataan Memorial Building
Santa Fe**

Thursday, October 17

- 9:00 a.m. WELCOME — HOUSEKEEPING — MINUTES
- 9:30 a.m. LONG-TERM HEALTH CARE ISSUES
—Linda Sechovec, Executive Director, NM Health Care
Association
- 10:15 a.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS
- 11:00 a.m. FROM STRATEGIES AND OPTIONS TO FINDINGS AND
RECOMMENDATIONS — PROCESS FOR REMAINDER OF
MEETINGS
—Senator Dede Feldman, Co-chair
—Representative James Roger Madalena, Co-chair
—Raúl E. Burciaga, Legislative Council Service (LCS)
- 11:30 a.m. PUBLIC INPUT
- 11:45 a.m. LUNCH (ON YOUR OWN)
- 1:15 p.m. ELIGIBILITY AND SERVICES
—Lisa Cacari-Stone, LCS
- 2:00 p.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS
- 4:00 p.m. PUBLIC INPUT
- 4:30 p.m. RECESS

Friday, October 18

9:00 a.m. HOUSEKEEPING

9:30 a.m. INTERGOVERNMENTAL TRANSFERS — NEW FUNDING SOURCES — MAXIMIZATION AND HIGHER MATCH
—Phil Lynch, LCS
—Karen Wells, LCS
—Raúl E. Burciaga, LCS

10:30 a.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

11:45 a.m. PUBLIC INPUT

12:00 noon LUNCH (ON YOUR OWN)

1:30 p.m. NON-EMERGENCY TRANSPORTATION SERVICES
—Ron Brooks, Management Associate, ATC/Vancom
—Leora Jaeger, Principal, LJS Consulting, Inc.
—Phil Rios, Director, Sandoval County Community Services

Division

2:00 p.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

2:30 p.m. STATUTES AND REGULATIONS — MEDICAID FRAUD
—Raúl E. Burciaga, LCS

3:00 p.m. ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

4:00 p.m. WRAP-UP — PUBLIC INPUT

4:30 p.m. ADJOURN

**MINUTES
of the
NINTH MEETING
of the
MEDICAID REFORM COMMITTEE**

**October 17-18, 2002
Old Senate Chamber, Bataan Memorial Building
Santa Fe**

The ninth meeting of the Medicaid Reform Committee for the 2002 interim was called to order by Representative James Roger Madalena, co-chair, on October 17, 2002 at 9:15 a.m. in the Old Senate Chamber of the Bataan Building in Santa Fe.

PRESENT

Sen. Dede Feldman, co-chair
Rep. James Roger Madalena, co-chair
Sen. Ramsay L. Gorham
Rep. John A. Heaton
Sen. Allen V. Hurt
Sen. Linda M. Lopez
Rep. Terry T. Marquardt
Rep. Danice Picraux
Rep. J. Paul Taylor
Rep. Jeannette O. Wallace

ABSENT

Sen. Stuart Ingle
Sen. Timothy Z. Jennings

Advisory members

Adolfo Alarid (proxy for Harold Field)
Maralyn Budke
David Davis (Tom Rabourn)
Jaime Estremera-Fitzgerald
Martin Hickey
Jim Hinton
Nancy Koenigsberg
Chet Lytle
Larry Martinez
Michael G. Miller
Kay Monaco
Robin Dozier Otten
Daniel D. Sandoval
Don Silva
Tasia Young (proxy for Samuel Montoya) (10/18)

Arlene Brown
Ron Lujan
Alfredo Vigil

(Attendance dates are noted for members not present for the entire meeting.)

Staff

Raul E. Burciaga

Phil Lynch
Karen Wells
Lisa Cacari Stone
Larry Matlock

Facilitators
Reese Fullerton
Deborah C. Hall

Guests

The guest list is in the meeting file.

Thursday, October 17

LONG-TERM HEALTH CARE ISSUES

Linda Sechovec, executive director of the New Mexico Health Care Association, presented information about long-term care in New Mexico regarding nursing facilities, residential care facilities and intermediate care facilities for the mentally retarded (ICF/MR) licensed settings. Ms. Sechovec furnished information regarding the number and types of facilities, the financing by payer type and the average costs for the types of providers. Ms. Sechovec also provided information regarding the clients served by the providers with breakdowns by age and medical condition. Ms. Sechovec provided the committee with information on the financing and financial stress of nursing facilities, particularly as they relate to Medicaid funding. According to a study by the Lewin Group, "If states experience a Medicaid rate freeze on top of the pending Medicare cuts, 61 percent of facilities nationwide could experience financial instability". Ms. Sechovec discussed the interconnectedness between Medicare and Medicaid funding of nursing facilities and the impact of nursing shortages. Finally, Ms. Sechovec provided the committee with various cost savings ideas as outlined in her handouts.

ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

In general discussion among the members, the following topics were covered.

- Personal care options may provide opportunity for non-specialized caregivers to provide assistance for these patients; perhaps there is an opportunity to use such caregivers in nursing facilities.
- Nursing facilities have lost cooks and housekeepers to casino employment opportunities.
- The state should eliminate two peer groupings so that high-cost state facilities are subject to cost ceilings. State facilities often have higher costs because of greater staffing requirements and the facilities' function as a safety net provider (i.e., the "poorest of the poor").
- Hospice provides care for patients determined by a physician to be terminally ill with an expectation of death within 180 days. However, the average program is 18 days, indicating late referrals to the hospice program.
- Medicare pays for hospice care and that may provide some cost savings if there is an effort to ensure that those qualified beneficiaries are receiving hospice services through Medicare rather than Medicaid.

- There are numerous medical conditions, including incontinence, chronic obstructive pulmonary disease and smoking, that are the most frequent for nursing facility admission. The lack of a spouse is often the main reason.
- There are a number of people admitted based on behavioral and mental health needs, many of whom are in state facilities, e.g., Alzheimer's patients.
- Cash-counseling may be another method of providing assistance to the aged and disabled, but New Mexico opted to go with a consumer-directed or consumer-delegated personal care option.
- There is some concern that families with resources are impoverishing their elderly parents or other elderly family members to get the state to pay for care; perhaps eligibility and resource criteria should be tightened.

FROM STRATEGIES AND OPTIONS TO FINDINGS AND RECOMMENDATIONS — PROCESS FOR REMAINDER OF MEETINGS

Raul Burciaga indicated that the committee's work has, in some ways, only just begun. The options will be summarized and presented to the committee in November for consideration and recommendation. The committee will be provided with one option per page with respective descriptions, pros, cons, program impacts and fiscal impacts.

Senator Feldman indicated that one of the initial recommendations is for the committee to use facilitators. She stated that the facilitators, Deb Hall and Reese Fullerton, have been very helpful, and she offered her thanks on behalf of the committee. Senator Feldman advised the committee that the facilitators' role would be even more important at the next meeting to ensure that the committee gets through all proposed options.

ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

In general discussion among the members, the following topics were covered.

- The committee must be in a position to broker a solution that offers "the best to the most".
- Position papers from committee members or the public will be made available to all members of the committee as well as to the general public. However, the committee has not had the time to accommodate all requests for oral presentations.
- Voting on the proposed options will be limited to the legislators, but the advisory members will have an opportunity to present their views and preferences.

ELIGIBILITY AND SERVICES

Lisa Cacari Stone provided the committee with information on eligibility and benefits in the New Mexico Medicaid program. Ms. Cacari Stone reviewed the federal mandatory and optional eligibility and benefits information, as well as an updated comparison chart that included benefit packages under Medicaid, the state employees plan, UNM Care, the Minimum Health Care Protection Act and the State Coverage Initiative waiver. Ms. Cacari Stone discussed some of the eligibility and benefits cuts that

other states have undertaken in an effort to contain Medicaid costs. She also presented socio-economic and demographic information as it relates to key health care coverage indicators in New Mexico.

ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

In general discussion among the members, the following topics were covered.

- Committee members had various questions regarding the different eligibility categories and the percentage of the federal poverty level (FPL) under which they are covered.
- The number of children covered under Medicaid or SCHIP has increased by nine percent.
- the number of Medicaid enrollees will change (probably increase) because of retroactive eligibility.
- The Human Services Department (HSD) outreach on SCHIP has been significantly reduced because any expansion would greatly impact the budget projections. There are, however, other outreach initiatives that the managed care organizations (MCOs) and advocacy groups continue to use.
- An updated benefit plan matrix that had been developed by Kathy Ganz for the Legislative Health Subcommittee, particularly as it related to the proposed SCI waiver benefit plan, was reviewed and discussed.
- Some of the pros and cons of cost-sharing initiatives, i.e. premiums and copayments, were discussed, including what is or is not permissible under federal law.
- Children may be covered under Medicaid if their household income is at or below 235 percent FPL. There were some suggestions that perhaps this eligibility level could be scaled back, while others indicated that some states cover children in households up to 300 percent or 350 percent FPL.
- Some people around the state are technically considered uninsured but they have access to and are covered by safety net programs such as UNM Care.
- The committee received copies of letters from Secretary Otten to the legislature dated December 2001 and January 2002 that provided some opportunities for Medicaid cost-cutting based on optional eligibility categories and benefits.
- The federal approval of the SCI request was contingent on ensuring that New Mexico did not reduce or eliminate the children in households between 185 percent and 235 percent FPL currently served under SCHIP funding.
- Suggestions were made to set up eligibility on a month-to-month or once-every-three- months basis, but various comments indicated that the administrative burden of doing that and the impact on providers were more problematic than staying with a one-year eligibility cycle.
- The committee discussed the status on MCO contract negotiations and whether there were any significant changes being proposed or considered. If the committee makes any recommendations on benefits or eligibility cuts, HSD will review the costs actuarially and renegotiate. HSD's expectation is to have

the contracts negotiated and signed by December 31, 2002 based on the direction in Senate Bill 1 from the special session on the budget. There was considerable discussion on the timing and potential struggle between the committee's recommendations and the HSD/MCO negotiations.

- The facilitators reminded the members to request whatever additional information they need to consider any changes to eligibility and benefits levels.

PUBLIC INPUT FOR OCTOBER 17

None

The committee recessed at 4:30 p.m. and reconvened at 9:12 a.m. the following day.

Friday, October 18

HOUSEKEEPING

David Davis, the new secretary of the General Services Department, introduced himself. He replaces former Secretary Steve Beffort on the committee.

The committee briefly discussed the Medicaid enrollment process.

INTERGOVERNMENTAL TRANSFERS — NEW FUNDING SOURCES — MAXIMIZATION AND HIGHER MATCH

Karen Wells and Phil Lynch presented the committee with information regarding new funding initiatives and greater match opportunities to address the Medicaid shortfall. Ms. Wells and Mr. Lynch provided a summary of various options, one per page, that described the funding initiatives and provided pros, cons and some estimated fiscal impact information. The initiatives included use of county indigent funds, removal of premium tax exemptions, increase of premium tax, payment methodology revisions for certain clinics, increases in the cigarette tax and the alcohol excise tax, revisions to the gross receipts taxes applicable to nonprofit and for-profit hospitals, use of tobacco settlement funds and other funding initiatives. The presentation included some initial projections on the increased funding that the initiatives would provide.

ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

In general discussion among the members, the following topics were covered.

- The use of county indigent funds creates a problem for counties if that funding stream is not returned to the counties in at least the same amount as what was provided. Similarly, any delay in getting the money back to the counties could impact the coverage of indigent health care claims. While a waiver may be necessary, it would more than likely require some expansion of the eligibility criteria to cover those individuals served through county indigent funding. The mechanics of such a proposal are very complicated and need further discussion and review among the counties and HSD.

- The initial exemption of the MCOs from paying the premium tax was not the legislature's intent, it was an oversight. Other states have done this and staff discussions with the federal Centers for Medicare and Medicaid services, or CMS, indicate this is not problematic since it applies to all MCOs.
- The removal of the exemption makes sense, but an increase in the premium tax would drive up costs for commercial lines of business and for health care in general.
- A mandate to have employers provide health insurance, or the assessment of a payroll tax if it is not provided, is counterproductive. The private sector needs creative mechanisms to get more people covered; mandates would not do that and may, in fact, cost jobs.
- A decrease in the number of people covered under commercial insurance could produce a corresponding increase in the number enrolled in Medicaid, adding to the state's fiscal burden.
- HSD will work with the New Mexico Primary Care Association to determine what alternative payment methodology for federally qualified health clinics, or FQHCs, is available.
- The committee should not assume that the proceeds from the sale of the Los Alamos Medical Center will automatically go to the Con Alma Foundation.
- There was some general agreement on the increase in cigarette taxes but some concern about the diminishing returns, particularly if cigarettes are available through tribal outlets.
- Hospitals are already fiscally strapped, and repealing the 50 percent gross receipts tax exemption on for-profit hospitals or imposing it on nonprofit hospitals would put them in a precarious situation.
- There may be a way to hold the hospitals harmless, i.e. match the taxed funds and revert the initial money back to the hospitals. Nonetheless, considerable research would be required to determine if and how this could be done.
- Two and one-half days of unpaid leave for state employees to help the budget and Medicaid shortfall was removed from consideration.
- Land grant and miners hospital funding would require constitutional amendment or federal action, which makes those options not feasible.
- An increase in the excise tax on alcohol may help to defray some of the costs associated with alcohol abuse and associated illnesses and injuries.
- Earmarking is generally objectionable for a number of reasons, primarily because it limits the flexibility of the standing legislative finance and appropriations committees, as well as the legislature itself.

PUBLIC INPUT

Karla Fennel, assistant director with the New Mexico Primary Care Association, indicated that the proposal regarding alternative funding methodology for certain clinics is solid but may need some refinement. She will work with staff and the Medical Assistance Division (MAD) on the information.

Steve Shepherd, county health division director, county indigent funds, indicated that timeliness is a concern on the use of indigent funds since they are not drawing

interest. Also, the counties are concerned with any loss in the flexibility of administering the program funds.

Dan Weaks, New Mexico Hospital and Health Systems Association, advised the committee to proceed carefully on how the premium tax is structured, particularly if there are any "downstream" transactions that may be subject to taxation.

NON-EMERGENCY TRANSPORTATION SERVICES

Ron Brooks, management associate with ATC/Vancom, Leora Jaeger, principal, LJS Consulting, Inc., and Phil Rios, director of the Sandoval County Community Services Division, presented the committee with information on non-emergency Medicaid transportation services. Federal law states that "the Medicaid agency will ensure necessary transportation for recipients to and from providers". The presenters provided financial information on non-emergency transportation and on three different transportation models — capitated, administrative managers and brokerage—used throughout the country. They indicated that in some cases, simple bus passes are as effective and are significantly less expensive. The presenters discussed the Sandoval County Transportation Coordination Study due to be completed in 2003. Specifically, they requested that the committee direct MAD to provide Sandoval County with technical assistance and access to detailed Medicaid transportation data, identify funds to expand the Sandoval study and review the project findings to consider a demonstration project.

ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

In general discussion among the members, the following topics were covered:

- Including non-emergency transportation as part of the MCO's per member per month rate may not be cost-effective. MCOs are in the business of health care, not transportation.
- There are entities whose focus is on cost-effective non-emergency transportation, and the committee should consider recommendations to carve that function out of the MCOs' rates.
- Medicaid should proceed cautiously with any changes. Rural and urban transportation requirements are different, and this impacts transportation resources and needs.
- There is a need to determine whether complaints about transportation include differences between what the three MCOs provide, i.e. inconsistencies that HSD/MAD should address.
- If transportation costs make up one to two percent of the MCOs' respective budgets, the problems may not be very apparent to them since their focus is on providing health care. Perhaps it is best to consider a carveout.
- Transportation issues were also problematic before managed care, e.g. Medicaid clients had to obtain a provider number in order to have costs reimbursed.

- Transportation has consistently been an issue with the Legislative Health and Human Services Committee because so many areas lack taxis, buses and other transportation resources. A demonstration pilot may be in order to determine the best use of resources and potential cost savings.

STATUTES AND REGULATIONS — MEDICAID FRAUD

Mr. Burciaga provided a brief overview of the numerous statutes and regulations that govern the Medicaid program. He also presented to the committee copies of the *New Mexico Medicaid Fraud Control Unit's Annual Report*. The fraud unit is part of the New Mexico Attorney General's Office (AGO). Federal law requires a Medicaid fraud unit that is not administratively attached to the Medicaid agency.

ROUNDTABLE DISCUSSION — QUESTIONS AND ANSWERS

In general discussion among the members, the following topics were covered.

- Coordination between HSD and the AGO has improved recently, but there appears to be more opportunity for closer coordination to address fraud and abuse.
- Training staff in the fraud unit has been a priority, but the AGO's budget is limited.
- Fraud involves intent, i.e. state of mind, which has a higher burden of proof than simply abuse.
- The AGO would prefer to see more than just the obvious cases, it is interested in reviewing the "marginal" cases as well.
- There is concern that MCOs may not pursue some overpayments if the cost of recoupment exceeds the recoupment itself, i.e. it does not make "business sense".
- MCO referrals are not limited to specific cases, they also include "suspicious activity".
- While there are still some coordination problems among the MCOs, HSD and the AGO, enhancements to system edits provide a more sophisticated approach to identifying suspicious or problematic activity.

PUBLIC INPUT FOR OCTOBER 18

Brenda Crocker, caregiver, stated that Medicaid is very important to her family. Without it, she suspects she would have lost both of her daughters, who have had seven surgeries between them. She indicated that transportation is critical to her ability to get her daughters the care they require because of their special needs. She has reported what she suspects as fraudulent activity on the part of some providers and is appreciative of the committee's efforts to ensure that this is addressed.

Mike Newman, a survivor of a brain injury accident in 1985 and a member of the Brain Injury Advisory Council, indicated his support for case management programs and life skills training. He supports language that would include brain injury services under the Section 1115 global funding waiver.

The committee adjourned at 3:54 p.m.

**TENTATIVE AGENDA
for the
MEDICAID REFORM COMMITTEE**

**November 13-15, 2002
Santa Fe Community College
Santa Fe**

Wednesday, November 13

- 9:00 a.m. WELCOME — HOUSEKEEPING — PROCESS OVERVIEW
Senator Dede Feldman, Co-chair
Representative James Roger Madalena, Co-chair
Raul E. Burciaga, Staff Attorney, Legislative Council Service

(LCS) Deborah Hall, Facilitator
Reese Fullerton, Facilitator
- 9:30 a.m. REVIEW AND RANKING OF OPTIONS
- PROGRAM CHANGE OPTIONS
- Pharmacy cost containment
 - Managing Health Care Better
 - Primary Care Case Management
 - Long-Term Care
- PROGRAM LIMITATION OPTIONS
- Cost sharing
 - Eligibility and benefits
- PROGRAM FUNDING OPTIONS
- Maximization and matching
 - Earmarking
 - Intergovernmental transfers
 - New funding sources
- 11:45 a.m. PUBLIC INPUT
- 12:00 noon LUNCH (ON YOUR OWN)
- 1:30 p.m. REVIEW AND RANKING OF OPTIONS (continued)
- 4:30 p.m. PUBLIC INPUT
- 4:45 p.m. RECESS

Thursday, November 14

9:00 a.m. REVIEW AND RANKING OF OPTIONS (continued)

11:45 a.m. PUBLIC INPUT

12:00 noon LUNCH (ON YOUR OWN)

1:30 p.m. REVIEW AND RANKING OF OPTIONS (continued)

4:30 p.m. PUBLIC INPUT

4:45 p.m. RECESS

Friday, November 15

9:00 a.m. HOUSEKEEPING—MINUTES—REVIEW OF RANKING
OUTCOMES

9:15 a.m. PUBLIC INPUT

9:30 a.m. LEGISLATIVE VOTING ON OPTIONS

11:30 a.m. REVIEW OF VOTING OUTCOMES

12:00 noon LUNCH (ON YOUR OWN)

1:30 p.m. NEXT STEPS FOR FINDINGS AND RECOMMENDATIONS—
LEGISLATIVE INITIATIVE CONSIDERATIONS

3:30 p.m. ADJOURN

**MINUTES
of the
TENTH MEETING
of the
MEDICAID REFORM COMMITTEE**

**November 13-15, 2002
Santa Fe Community College Board Room
Santa Fe**

The tenth meeting of the Medicaid Reform Committee for the 2002 interim was called to order by Representative James Roger Madalena, co-chair, on November 13, 2002 at 9:15 a.m. in the board room of the Santa Fe Community College in Santa Fe.

PRESENT

Sen. Dede Feldman, co-chair
Rep. James Roger Madalena, co-chair
Sen. Ramsay L. Gorham
Rep. John A. Heaton
Sen. Allen V. Hurt
Sen. Stuart Ingle
Sen. Timothy Z. Jennings
Sen. Linda M. Lopez
Rep. Terry T. Marquardt (11/15)
Rep. Danice Picraux
Rep. J. Paul Taylor
Rep. Jeannette O. Wallace (11/15)

ABSENT

Advisory members

Arlene Brown
Maralyn Budke
Jaime Estremera-Fitzgerald
Jim Hinton
Nancy Koenigsberg
Ron Lujan
Chet Lytle
Larry Martinez
Michael G. Miller
Kay Monaco
Samuel Montoya (11/13)
Robin Dozier Otten
Tom Rouborn (proxy for David Davis)
Daniel D. Sandoval
Don Silva (11/13-14)

Harold Field

Jeannette Velarde (proxy for Martin Hickey)
Alfredo Vigil
Tasia Young (proxy for Samuel Montoya on 11/14-15)

(Attendance dates are noted for members not present for the entire meeting.)

Staff

Raul E. Burciaga
Phil Lynch
Karen Wells
Lisa Cacari Stone
Larry Matlock
Kathleen Dexter

Facilitators

Reese Fullerton
Deborah C. Hall

Guests

The guest list is in the meeting file.

Wednesday and Thursday, November 13-14

REVIEW AND RANKING OF OPTIONS

The committee and advisory members spent the first two days of the meeting discussing and ranking each of the 90-plus options, which were divided into the broad categories of program changes, program limitations and funding sources. All options were ranked on a scale from 1 (strongly oppose) to 5 (strongly in favor), with the statistical mean and median score computed for each.

Meeting handouts included, for each option, a description, pros and cons, program impact and fiscal impact, plus an appendix with reference information. Copies of the handouts are in the meeting file. The committee's ranking is attached.

PUBLIC INPUT FOR NOVEMBER 13-14

Richard deAngelo, a pharmacist speaking on behalf of the New Mexico Society of Pharmacists, noted that pharmaceuticals are appropriate treatment; spoke in favor of leaving pharmacy benefits within the MCO contracts for more effective disease management; and urged the committee to base any preferred drug list on safety and efficacy rather than on cost. Susan Lewis, Sherri Watson, Gilbert John, Alice Ellison, Ken Collins, Laurie Soles, Rosie Wolf, LaDonna Jennings, Dr. Susan Brown and Rufus Begay, all of the Save Our Services campaign, addressed the committee in general and Robert Maruca in particular regarding recent cuts that have been made in their personal care option hours. Mr. Maruca agreed to meet with the group the following week to discuss the matter in detail. Nancy Koenigsberg noted that any alteration in hours under the personal care option can be appealed and that the policies governing the appeal process will be reviewed next spring. Larry Maestas of Project Succeed spoke on behalf of the working disabled, urging the committee to keep in mind that many disabled citizens are

willing and able to work, and that programs such as the personal care option make this possible. David Roddy of the New Mexico Primary Care Association noted that other states are using alternative methods to receive higher reimbursements from the federal government than New Mexico receives for federally qualified health centers, and he spoke against the option of increasing the premium tax on MCOs. Jerry Berger of ACC Consultants, Inc., spoke against cuts in adult dental services, saying this would negatively affect nearly 5,000 New Mexico residents.

The committee recessed at 4:55 p.m. on November 13. It reconvened at 9:20 a.m. and recessed at 4:20 p.m. on November 14.

Friday, November 15

The committee reconvened at 9:40 a.m. Committee staff presented a spreadsheet of the final ranking for all options considered during the previous two days, sorted by mean score. The spreadsheet appears as Appendix A to these minutes. On motion duly made, seconded and approved, the committee decided to vote on all options receiving a mean score of 2.5 or higher, plus only seven of the options with a score lower than 2.5. All other options were eliminated from consideration.

LEGISLATIVE VOTING ON OPTIONS

Committee members voted on each remaining option, and those options receiving a positive vote will be included in the committee's recommendations to the legislature. Each option and its vote is listed in Appendix B to these minutes.

PUBLIC INPUT FOR NOVEMBER 15


Linda Pryor of Pfizer spoke in favor of a study to see if there are savings to be had in a carveout of pharmacy benefits, though she said the MCOs have managed pharmacy benefits well. Larry Georgiopoulos of Presbyterian Health Services urged the committee to keep pharmacy benefits within the MCO contracts in order to better manage costs and the clinical aspects of pharmaceutical use.

The committee adjourned at 3:30 p.m.

APPENDIX A**OPTIONS
RANKED BY MEAN SCORE**

OPTION	DESCRIPTION	MEAN
F05	Increase % of tobacco settlement fund to Mcd	4.88
F01	Match health-related SGF for Mcd-elig expenses	4.74
F09	Apply premium tax to Mcd MCO PMPM pmt	4.73
C06	DOH, MCOs, HSD pilot - expand promotores	4.68
F12	Impose excise tax on alcohol	4.59
F13	Increase cig tax by \$0.60/pack - earmark Mcd	4.54
C14	PCO awareness of consumer-directed	4.46
F02	Maximize use of IHS/tribal for 100% FMAP	4.41
L03B	Impose copay for drugs not PDL	4.36
N04	Match SGF \$ w/waivers for SGF-served pop's	4.36
C07D	DM pilot for FFS	4.33
C02	Maximize use of 340B pgm	4.33
C07C	Ensure case-mgmt is core medical svc	4.32
N05	Change lookback from 3 to 5 years	4.30
L07.4	Explore waivers for innovative benefit packages	4.29
F06A	Estab alternative pmt methodology for FQHCs	4.29
C12	Global funding waiver	4.23
C09	Pilot: PCCM for FFS sub-population	4.22
C07A	Require MCOs to strengthen DM pgms	4.22
C19	Provide tax credits for LTC insurance purchase	4.17
C07B	Replaced w/C07D	4.14
C17	Expansion of PACE	4.09
F06B	Reimburse clinics for Mcd outreach/enrollment	4.04
C21	Strengthen fraud/abuse efforts and coordination	3.96
C01B	Require uniform PDL for Mcd and other pgms	3.83
C03C	Direct HSD to study phmcy carve out	3.77
C08	Study: replace MCO w/PCCM	3.74

APPENDIX A**OPTIONS
RANKED BY MEAN SCORE**

C10C	Analysis on transport models	3.68
C01A	Require uniform PDL for FFS and Salud	3.63
C06B	Expand promotores as part of PCCM for FFS	3.58
N03	Reverse HSD MAAC initiative re Rx	3.55
L06.2I	PCP gatekeeper for svcs by other practitioners	3.55
C18A	LTC consolidation adults only	3.50
C18B	LTC consolidation adult and children	3.44
L06.3J	Limit eyeglasses exam/2 yrs and cap refill	3.35
F08	Request waiver - indigent fund for Mcd use/HH	3.31
C13	Study: PCO C/B analysis direct vs. delegate	3.25
C05B	Establish drug purchasing cooperative AG	3.24
C20	Pilot 1115 waiver for behavioral health	3.17
C11	Consolidation of info systems	3.13
C03A	Carve out phmcy from Salud	3.08
C10A	Carve out non-emgcy transport w/brokerage	3.04
C05A	Establish drug purchasing cooperative	2.88
L03	Impose tiered co-pmts on high-cost Rx	2.82
C10B	State administered transport model	2.78
F04B	Earmark % of gaming revenues	2.63
L04	Impose \$5 copay on office visits and Rx	2.52
		
F04A	Earmark % of severance tax perm fund for Mcd	2.46
C16A	Control growth of NF beds thru formal process	2.46
L02	Impose co-pays on ER svcs	2.45
L01	Impose premium on certain Mcd beneficiaries	2.32
C04	Provide MCOs w/greater flex to manage phmcy	2.29
L05A	Reduce MCO PMPM pmts by 0.5% - 1.0%	2.26
L06.2E	Reduce optional other practitioner svcs	2.22

APPENDIX A**OPTIONS
RANKED BY MEAN SCORE**

L06.2F	Reduce optional D&E waiver svcs	2.05
L06.3G	Reduce dental by 10%	1.96
N06	Add'l 1/16 grt for county indigent claims fund	1.91
L06.1F	Reduce by 10% optional Rx svcs	1.91
L06.1D	Reduce by 10% optional inst'l care svcs	1.91
C03B	Carve out phmcy from Salud but MCOs manage	1.85
L06.2H	Reduce optional medical supply svcs	1.83
L06.1E	Reduce by 10% optional PCO svcs	1.82
F11	Increase premium tax on health insurance to 4%	1.82
F10	Repeal/impose GRT on hospitals	1.74
L06.2G	Reduce optional ICF/MR waiver svcs	1.70
F07	Double amt for cnty-supp'd Mcd fund - add'l 1/16	1.69
L06.2D	Eliminate optional medical supply svcs	1.67
L06.3F	Reduce case mgmt by 10%	1.65
L06.3C	Eliminate optional pre-PACE svcs	1.63
L05B	Reduce FFS provider pmnts by 0.5% - 1.0%	1.61
L06.3E	Reduce eyeglass covg to commercial plan level	1.54
L06.3B	Eliminate optional dental svcs for adults	1.54
L06.3H	Reduce pre-PACE by 10%	1.50
L07.2A	Reduce children's elig to 200% FPL	1.44
L06.3A	Eliminate optional case mgmt svcs	1.33
L07.3A	Reduce elig aged/blind/disabled to 200% SSI	1.25
L06.2A	Eliminate optional other practitioner svcs	1.16
L07.1D	Eliminate working disabled	1.13
L07.1	Eliminate presumptive elig for children	1.13
L06.3D	Elim breast/cervical cancer omitted	1.13
L06.2C	Eliminate optional ICF/MR svcs	1.13
L06.2B	Eliminate optional D&E waiver svcs	1.13

APPENDIX A**OPTIONS
RANKED BY MEAN SCORE**

L06.1B	Eliminate optional PCO svcs	1.13
L07.2C	Reduce children's elig to 150% FPL	1.09
L07.1C	Eliminate SCHIP 185-235% FPL	1.09
L07.1B	Eliminate children 133-185% FPL	1.09
L07.2B	Reduce children's elig to 167.5% FPL	1.09
L06.1A	Eliminate optional institutional care svcs	1.08
L06.1C	Eliminate optional Rx svcs	1.04
L07.3B	Reduce to SSI level (73%)	1.00

APPENDIX B

FINAL VOTES ON OPTIONS

OPTION	DESCRIPTION	MEAN	PASS VOTE
C01A	Require a uniform, preferred drug list for FFS and Salud!	3.63	DP U
C01B	Require a uniform, preferred drug list for Medicaid, IBAC, DOH and other potential purchasers.	3.83	DP U
C02	Maximize the use of the federal 340B discount drug program.	4.33	DP U
C03A	Carve out pharmacy from Salud!	3.08	DNP 4-8
C03B	Carve out pharmacy from PMPM rate, but pay MCOs to manage the benefit and coordinate care.	1.85	DNP U
C03C	Direct HSD to conduct a cost-benefit analysis on the carveout of pharmacy from Salud!	3.77	DP 8-1
C04	Provide greater flexibility to MCOs in management of the pharmacy benefit; allow MCOs to manage the benefit similar to the commercial market.	2.29	S
C05A	Establish a prescription drug purchasing cooperative to combine the buying power of Medicaid, IBAC, DOH, VA, Corrections and other potential purchasers; consolidate contract administration and negotiation under one state agency.	2.88	DP U
C05B	Establish drug purchasing cooperative or refer to the attorney general.	3.24	S
C06B	In collaboration with DOH, HSD and the MCOs, implement a pilot program with FFS and Salud! expanding the use of promotores/community health representatives utilizing findings from existing programs in the northwest, border areas and northern New Mexico.	3.58	DP U
C07A	Require MCOs to strengthen disease management programs and coordinate more closely with PCPs through incentives for participation and service to underserved areas.	4.22	DP U
C07C	Ensure case management is a core medical service provided within the disease management programs for FFS and Salud!	4.32	DP U

C07D	Utilize a disease management firm to design a pilot program for FFS by using key health status indicators and accountability for clinical benefits and cost savings.	4.33	DP U
C08	Direct HSD to conduct a comprehensive feasibility study and cost-benefit analysis on the replacement of the current managed care model with a statewide PCCM model with options.	3.74	DP U
C09	Apply for grant from the Agency on Health Care Research and Quality (Center for Primary Care Research) to implement a pilot/demonstration project for PCCM model for FFS population or sub-population to ensure medical and utilization review.	4.22	DP U
C10A	Carve out and manage non-emergency transportation from Salud! and manage FFS through a brokerage model.	3.04	DNP 3-7
C10B	Carve out and manage non-emergency transportation from Salud! and manage FFS through a state-administered model.	2.78	DNP U
C10C	Conduct a cost-effectiveness analysis of non-emergency transportation comparing brokerage model vs. state-managed model.	3.68	DP U
C10D	Conduct a pilot in a rural and an urban area for non-emergency transportation carveout in FFS only.		DP U
C11	Consolidate information system for managed care and FFS to provide all claims processing, reimbursement, data repository and real-time, online reporting capability while maintaining integrity and security for respective users.	3.13	DNP 5-7
C12	HSD to develop and submit 1115 Global Funding Waiver (GFW) and include preliminary cost-effectiveness estimates of GFW by January 2003.	4.23	DP U
C13	Conduct a cost-benefit analysis of the personal care option sampling a sub-population of consumer-directed vs. consumer-delegated care with evaluation of various factors.	3.25	DP U
C14	Continue the personal care option with increased consumer awareness of consumer-directed services as a choice in addition to consumer-delegated (agency-directed) services.	4.46	DP U
C17	Expand Program of All-Inclusive Care for the Elderly (PACE) in urban areas of the state beyond current 187 consumers in Albuquerque (e.g., Las Cruces, Roswell or Santa Fe).	4.09	DP 7-3

C18B	Consolidate long-term care services provided by DOH, CYFD, HSD 3.44 and SAoA under one agency for all services from birth to death (including LTC Link development).		DP U
C19	Amend the tax code to allow individuals tax credits for purchasing 4.17 and maintaining long-term care insurance.		DP U
C20	Develop a pilot Medicaid behavioral health waiver under an 1115 3.17 research and demonstration waiver for 100 recipients with severe and persistent mental illness and a co-occurring addiction disorder in Dona Ana County.		DNP 6-6
C21	Strengthen fraud and abuse detection, reporting and recovery.	3.96	DP 9-3
F01	Match state general fund dollars allocated for health-care-related 4.74 programs or services in other state agencies that are reimbursable under Medicaid.		DP U
F02	Maximize the 100% federal match available for services rendered to 4.41 Native Americans in Indian Health Service or tribally operated facilities (limited referrals, IHS facilities as PCPs, working with CMS, NM congressional delegation and other states).		DP U
F04A	Earmark a percentage of the distribution of the severance tax 2.46 permanent fund for Medicaid; include a sunset provision.		S
F04B	Earmark a percentage of gaming revenues for Medicaid.	2.63	DP 8-3
F05	Increase percentage of tobacco settlement funds dedicated to 4.88 Medicaid support.		DP U
F06A	Establish an alternative payment methodology for FQHCs that will 4.29 allow true reimbursement of 100% of costs.		DP U
F06B	Reimburse primary care clinics for Medicaid outreach and 4.04 enrollment activities.		DP U
F08	Use county medical indigent funds to obtain Medicaid match; 3.31 direct HSD to work with counties to apply for a waiver to permit redistribution of funds back to counties.		DP 8-4
F09	Require application of premium tax on Medicaid MCO PMPM 4.73 payments.		DP U

F12	Impose an excise tax on alcohol sales; earmark funds for a combination of Medicaid funding and the development of a statewide trauma system.	4.59	DP 7-4
F13	Increase cigarette tax by \$0.60 per pack earmarked (in whole or in part, with or without sunset clause) for the Medicaid program.	4.54	DP 7-4
L01	Impose a monthly premium on selected Medicaid beneficiaries.	2.32	DP 10-2
L02	Impose co-payment on ER services unless patient is admitted as a result of ER evaluation.	2.45	DP 8-4
L03	Impose tiered co-payments on higher-cost prescription drugs to provide incentives for greater use of generic drugs when there is a generic or lower-cost equivalent available.	2.82	DP 8-3
L03B	Impose co-payments for drugs not on the preferred drug list.	4.36	DP U
L04	Impose a tiered copay on office visits and prescription drugs for Medicaid beneficiaries at or above 133% of the federal poverty level with the provider held harmless.	2.52	DNP 6-6
L05A	Reduce Medicaid Salud! MCO PMPM payments by 0.5% - 1.0%.	2.26	S
L06.2E	Reduce optional other practitioner services.	2.22	S
L06.2F	Reduce optional disabled and elderly waiver services.	2.05	S
L06.2I	PCP gatekeeper for services by other practitioners.	3.55	DNP 2-5
L06.2Ia	PCP gatekeeper for services by other practitioners being in collaboration with and communication to the PCP with the exception of self-referral services.		DP U
L06.3J	Reduce optional eyeglass services to commercial plan level (e.g., one exam every two years with cap on eyeglass refills).	3.35	DP 7-5
L07.4	Explore waivers for innovative reduced benefit packages.	4.29	DP U
N01	WITHDRAWN		
N02	An outside firm to conduct an analysis of how pharmaceuticals are being used, what trends exist and possible cost savings.		DP U

N03	Direct HSD to reverse its policy that took away incentives for 3.55 pharmacists to use generic prescription drugs.	DP U
N04	Apply for waivers for populations served by other agencies' 4.36 programs or services that are currently state general funds only to enable Medicaid match.	DP U
N05	Change lookback period (assets) from 3 to 5 years if permissible by 4.30 federal law.	DP U

GLOSSARY

CMS - Centers for Medicare and Medicaid Services
 CYFD - Children, Youth and Families Department
 DOH - Department of Health
 FFS - fee-for-service
 FQHC - federally qualified health center
 HSD - Human Services Department
 IBAC - Interagency Benefits Advisory Committee
 MCO - managed care organization
 PCCM - primary care case management
 PCP - primary care provider
 PMPM - per member per month
 SAoA - State Agency on Aging
 VA - Veterans Health Administration

**TENTATIVE AGENDA
for the
MEDICAID REFORM COMMITTEE**

**December 6, 2002
Room 322, State Capitol**

Friday, December 6

- 9:00 a.m. WELCOME — HOUSEKEEPING — MINUTES
- 9:30 a.m. MEDICAID REFORM COMMITTEE OPTIONS — FINDINGS
AND RECOMMENDATIONS
—Raúl E. Burciaga, Staff Attorney, Legislative Council Service
- 10:00 a.m. DISCUSSION OF APPROVED ITEMS FROM LAST MEETING:
RECOMMENDATIONS FOR LEGISLATION, REGULATION,
CONTRACT NEGOTIATION, PILOT PROJECTS, STUDIES
AND OTHER INITIATIVES
—Legislators
- 11:30 a.m. LUNCH (ON YOUR OWN)
- 12:30 p.m. DISCUSSION OF APPROVED ITEMS FROM LAST MEETING
(CONTINUED)
—Legislators
- 1:30 p.m. WHERE DO WE GO FROM HERE WITH THESE
RECOMMENDATIONS? — COMMENTS AND
PERSPECTIVES
—Advisory members
- 2:30 p.m. PUBLIC INPUT — WRAP-UP
- 3:00 p.m. ADJOURN

**MINUTES
of the
ELEVENTH MEETING
of the
MEDICAID REFORM COMMITTEE**

**December 6, 2002
Room 322 - State Capitol**

The eleventh meeting of the Medicaid Reform Committee for the 2002 interim was called to order by Representative James Roger Madalena, co-chair, on December 6, 2002 at 9:20 a.m. in Room 322 of the State Capitol.

PRESENT

Sen. Dede Feldman, co-chair
Rep. James Roger Madalena, co-chair
Rep. John A. Heaton
Sen. Allen V. Hurt
Sen. Stuart Ingle
Sen. Timothy Z. Jennings
Sen. Linda M. Lopez
Rep. Terry T. Marquardt
Rep. Danice Picraux
Rep. J. Paul Taylor
Rep. Jeannette O. Wallace

ABSENT

Sen. Ramsay L. Gorham

Advisory members

Arlene Brown
David Davis
Jaime Estremera-Fitzgerald
Martin Hickey
Jim Hinton
Bill Jordan (proxy for Kay Monaco)
Nancy Koenigsberg
Chet Lytle
Larry Martinez
Michael G. Miller
Robin Dozier Otten
Daniel D. Sandoval
Tasia Young (proxy for Samuel Montoya)

Maralyn Budke
Harold Field
Ron Lujan
Don Silva
Alfredo Vigil

Staff

Raul E. Burciaga
Karen Wells

Lisa Cacari Stone
Kathleen Dexter

Facilitators

Reese Fullerton
Deborah C. Hall

Guests

The guest list is in the meeting file.

Copies of all handouts and written testimony are included in the meeting file.

HOUSEKEEPING — MINUTES

Upon motions duly made, seconded and adopted, the minutes of the meetings from September 23-24, October 9-10 and November 13-15 were approved as submitted.

OPTIONS — FINDINGS AND RECOMMENDATIONS — DISCUSSION OF APPROVED ITEMS — RECOMMENDATIONS FOR LEGISLATION

Raul Burciaga summarized the work of the committee during the 2002 interim, which included 20 days of meetings and more than 35 presentations. He presented two matrices — one outlining all the options considered by the committee at its previous meeting and a second showing the options that the committee voted to include in its final recommendations to the legislature. The options to be forwarded to the legislature include 24 that suggest program changes, 10 that call for studies or analyses, four that involve tax changes and three that earmark funds for Medicaid. The committee debated the merits of presenting one omnibus bill to the legislature as opposed to breaking the options into several bills grouped by topic, and decided in the end to present multiple bills.

Earmarking Options

On a motion duly made, seconded and adopted by a vote of seven in favor and three against, the committee voted to submit:

- a bill recommending that additional general fund revenue from the gaming revenues be earmarked for the Medicaid program; and
- a bill recommending that additional general fund revenue from the tobacco settlement revenue be earmarked for the Medicaid program.

On a motion duly made, seconded and adopted without objection, the committee voted to:

- move the option involving county indigent funds out of the earmarking category and into the studies category; and
- restate the same option to call for a study, to be conducted in cooperation with the counties, on developing a waiver to hold counties harmless if county indigent funds are used for federal matches.

Tax Options

On motions duly made, seconded and adopted without objection, the committee voted to propose separate bills on each of the four options involving tax changes, with the following committee members agreeing to carry the following bills:

- Senator Jennings and Senator Ingle to carry a bill removing the exemption from the premium tax for managed care organizations;
- Senator Hurt to carry a bill imposing an excise tax on alcohol sales and earmarking those funds for a combination of Medicaid funding and the development of a statewide trauma system (also endorsed by the Legislative Health and Human Services Committee (HHS));
- Representative Taylor, Representative Picraux, Senator Feldman and Senator Hurt to carry a bill increasing the tax on cigarettes by \$0.60 per pack and earmarking the funds for Medicaid (also endorsed by the Tobacco Settlement Revenue Oversight Committee); and
- Representative Heaton and Senator Lopez to carry a bill allowing a tax credit for the purchase of long-term care insurance.

Studies and Analyses Options

On a motion duly made, seconded and adopted without objection, the committee voted to combine all options involving studies and analyses into one bill, to be carried by Senator Lopez and Representative Picraux, that includes language:

- requiring the Human Services Department (HSD) to work with other agencies, such as the New Mexico Health Policy Commission, to study the proposed topics; and
- authorizing HSD to seek private funding for the studies.

It was noted that general fund expenditures for staff conducting these studies qualify for a 50 percent federal match and that private funds used for the same expenses may qualify for a match as well.

Program Changes Options

On motions duly made, seconded and adopted without objection, the committee voted to:

- include a recommendation to create a long-term services department in its omnibus bill on program changes, as well as endorse a bill from HHS on the same topic;
- endorse all HHS bills on pharmacy issues; and
- place all options concerning program changes in one omnibus bill, with amended language:
 - < regarding adult vision benefits, allowing an eye exam annually and eyeglasses every two years; and
 - < regarding copays on emergency room visits, ensuring that hospitals be held harmless.

Additional Option

On motion duly made, seconded, amended and rejected by a vote of three in favor and seven against, the committee voted against suggesting that the percentage of the state budget allocated to Medicaid be frozen at its current level for the next two (amended from three) years. Senator Feldman requested the assistance of the advisory members as the bills are presented to the legislature and debated. Various advisory members offered their assistance and thanked and praised the committee for its work.

PUBLIC INPUT FOR DECEMBER 6

Ron Gurley of the National Association of the Mentally Ill-New Mexico urged the committee to carve out behavioral health services from the managed care contracts. Richard Montoya, executive director of the New Mexico Optometric Association, spoke against any cuts in the vision benefits under Medicaid. Dale Alverson, MD, from the University of New Mexico Center for Telehealth spoke of the cost savings and improved health outcomes that are possible if telehealth is integrated into Medicaid. Andy Curry of the San Juan Center for Independence spoke in favor of the personal care option and urged the committee not to put it under managed care. David Roddy of the New Mexico Primary Care Association thanked the committee for including substantive public input throughout the interim.

The committee adjourned at 3:40 p.m.

APPENDIX 14

2002 PROPOSED⁴
WORK PLAN, MEETING SCHEDULE AND BUDGET
for the
MEDICAID REFORM COMMITTEE

The Medicaid Reform Committee was created by Senate Bill 379 (Chapter 96), Forty-fifth Legislature, Second Session, 2002.

Membership

Medicaid Reform Committee

Sen. Dede Feldman, co-chairwoman (D)
Rep. James Roger Madalena, co-chairman (D)
Sen. Ramsay L. Gorham (R)
Rep. John A. Heaton (D)
Sen. Allen V. Hurt (R)
Sen. Stuart Ingle (R)

Sen. Timothy Z. Jennings (D)
Sen. Linda M. Lopez (D)
Rep. Terry T. Marquardt (R)
Rep. Danice Picraux (D)
Rep. J. Paul Taylor (D)
Rep. Jeannette O. Wallace (R)

Medicaid Advisory Group

Steve Beffort
Arlene Brown, MD
Maralyn Budke
Jaime Estremera-Fitzgerald
Harold Field
Martin Hickey, MD
Jim Hinton
Nancy Koenigsberg
Ron Lujan, MD

Chet Lytle
Larry Martinez
Michael G. Miller
Kay Monaco
Samuel Montoya
Robin Dozier Otten
Daniel D. Sandoval
Don Silva
Alfredo Vigil, MD

Work Plan

The Medicaid Reform Committee proposes to address the reform of the Medicaid program as stated in SB 379 (Ch. 96): The "medicaid reform committee shall take into consideration current resources and projected needs for the state medicaid program's services, delivery, funding and policy." As set out in Chapter 96, Laws 2002, the committee plans to review:

(1) the current operating structure of the medicaid programs in New Mexico;"

- *eligibility categories and associated services*
- *SCHIP, Salud!, fee-for-service, waiver programs*

⁴Approved by the Legislative Council on May 3, 2002.

"(2) the level of oversight authority necessary for the medicaid-related divisions of the human services department and health care payer and provider contractors under the medicaid program;"

- *coordination between the Income Support Division and Medical Assistance Division of the Human Services Department (HSD)*
- *performance standards and reports required by HSD from all contractors involved in the administration of the Medicaid programs*
- *reporting requirements with the Centers for Medicare and Medicaid Services (CMS - formerly HCFA)*

"(3) the operational structure of the state medicaid program, with respect to how policy and fiscal determinations are made;"

- *coordination between HSD and the Department of Health (DOH), the Children, Youth and Families Department (CYFD), the Attorney General's Medicaid Fraud Unit, the Department of Finance and Administration (DFA), the Legislative Finance Committee (LFC), the Health Policy Commission (HPC), the Border Health Office and other agencies*
- *HSD oversight of its Medicaid contracts with respect to policy and fiscal issues*

"(4) the concerns and recommendations regarding the operation of the medicaid program made by other interim legislative committees, consumer advocates, health care providers, health care payers or their respective organizations;"

- *HSD responses or corrective action plans to CMS' concerns regarding mental and behavioral health, LFC's concerns regarding administrative costs, grievance and appeal issues, health care resource shortages, and Indian Health Service (IHS) reimbursement methodology*

"(5) the allocation of health care costs and funding sources to avoid or eliminate unnecessary cost-shifting;"

- *HSD examination of cost reports and contractor budgets and costs*
- *appropriateness of cost-shifting*

"(6) the geographic distribution of health care professionals, resources and programs in the state medicaid program and of public-private partnerships to address health care access, delivery and funding issues that are problematic for both employers and employees; and"

- *providers*
- *Native American managed care organization or other initiatives*
- *alternative coverage mechanisms*
- *rural health care*
- *border health care*

"(7) the available federal, state and local sources of funding for the state medicaid program."

Meeting Schedule

The Medicaid Reform Committee held its organizational meeting on April 22-23, 2002. The committee proposes the following meeting dates and locations:

May 20-21	Santa Fe
June 24-25	Santa Fe
July 29-30	Santa Fe
August 26-27	Las Cruces
September 23-24	Santa Fe
October 17-18	Santa Fe
November 13-14-15	Santa Fe

Additionally, the committee proposes six optional meetings for the purposes of public input or subcommittee/subgroup working meetings:

June	Santa Fe
July	Gallup*
August	Roswell*
September (2-days)	Santa Fe
October	Las Cruces*

* Meetings for public input outside of Santa Fe could be assigned to a subcommittee or subgroup and the entire committee and advisory group would not be required to attend.

Budget

See attached

Proposed budget for payment of legislative and advisory members:

Seven 2-day meetings and one 3-day meeting:	\$50,158.76
April 22-23	Santa Fe
May 20 -21	Santa Fe
June 24-25	Santa Fe
July 29-30	Santa Fe
August 26-27	Las Cruces
September 23-24	Santa Fe
October 17-18	Santa Fe
November 13-14-15	Santa Fe

Proposed budget for payment of legislative and advisory members:

*Six optional meetings:	\$23,959.73
June	Santa Fe
July	Gallup
August	Roswell
September (2 days)	Santa Fe
October	Las Cruces

Total for meetings: \$74,118.49

Facilitation \$20,000
\$125/hr x 8 hours x 15 days = \$15,000 (facilitation estimate)
\$100/hr x 5 hours x 10 days = \$5,000 (preparation, reports estimate)

Expert testimony (e.g.) \$51,000
National Conference of State Legislatures
Kaiser Commission on Medicaid and the Uninsured

Health Management Associates
Center for Budget & Policy Priorities
Center for Policy & Budget Analysis
Mathematica Policy Research
(\$2,000/day + \$1,000/expenses) x 17 days (estimate)

Contract staff \$45,000
\$15,000 x 3 (estimate)

Actuarial analysis & projections \$150,000
\$50,000 x 3 Medicaid elig/svcs scenarios (estimate)

GRAND TOTAL \$340,118

This budget proposal assumes a determination by CMS that some of the committee's expenditures can be supplemented with federal matching funds. If not, the amounts for facilitation, expert testimony, contract staff, and actuarial analysis & projections can be reduced by \$90,000 to correspond with the \$250,000 appropriation.

APPENDIX 15

OPTION C1

Require a uniform, preferred drug list for:

- A. FFS and Salud!; or
- B. Medicaid, IBAC, DOH and other potential purchasers.

CATEGORY

Program Changes

STRATEGY

Pharmacy Cost Containment

PROS

1. Providers and patients are less subject to changes and inconsistencies arising from multiple lists.
2. Increases the potential for negotiation of more substantial discounts and rebates.
3. Unifies and simplifies what is now a fragmented system.
4. The state is already developing a preferred drug list and prior authorization process for the FFS population in Medicaid.

CONS

1. MCOs would have to maintain separate formularies for Medicaid (or Medicaid and IBAC) and their other commercial populations.
2. MCOs' ability to negotiate discounts and rebates for their commercial populations could be affected.
3. Providers would still have to deal with multiple formularies unless others adopted the same list.
4. Would require renegotiation of Express Scripts contract, if IBAC included.
5. Limits current flexibility that DOH has to purchase drugs at variable discounts based on the specific program provided.

PROGRAM IMPACT

1. Assures more continuity of care and consistency of drugs for Medicaid beneficiaries.
2. The state would assume a more substantial role in negotiating discounts.
3. Close coordination and cooperation would be required between departments of state government and other purchasers.

FISCAL IMPACT

1. The HSD estimates savings for the FFS population of \$7 million by implementing the supplemental rebate program; extending the program to the Salud! populations and other populations, could generate significant additional savings
2. Other states are projecting substantial savings with similar approaches:
 - FL: rebates went from 19% to 25%;
 - ME: anticipates \$10 million savings; and
 - MI: expects to save \$42 million in the first year of operation.
3. Savings in providers' offices could be significant if program was widespread.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C01A	Require a uniform, preferred drug list for fee-for-service (FFS) and Salud! (managed care)	3.63	DP	U	Pharmacy
C01B	Require a uniform, preferred drug list for Medicaid, the Interagency Benefits Advisory Committee (IBAC - retiree, state employee and teachers health insurance plans), Department of Health (DOH) and other potential purchasers	3.83	DP	U	Pharmacy

OPTION C2

Maximize the use of the federal 340b discount drug program:

- A. require and assist all eligible entities to enroll in the program;
- B. establish mechanisms for eligible entities to bill Medicaid at acquisition cost for drugs purchased at the 340b price, and for exclusion of those drugs from the Medicaid rebate program; and
- C. explore all other avenues to maximize 340b, to include participation in demonstration projects, disease/case management programs, contracting among eligible entities and bulk purchasing.

CATEGORY

Program Changes

STRATEGY

Pharmacy Cost Containment

PROS

1. Outpatient prescription drugs purchased at 340b prices are significantly less expensive than the Medicaid “best price”.
2. NM has many eligible entities that are not enrolled, including potentially several hospitals, school based health centers, tribal clinics, urban tribal clinics, migrant clinics, homeless clinics and black lung clinics (one estimate projects 7 eligible hospitals, including Presbyterian and Lovelace).
3. By assisting with enrollment, the Medicaid program can lower pharmacy costs.
4. Enrollment potentially saves the eligible entity money, especially hospitals; one recent study estimates an average savings of \$2 million per hospital per year (Von Oehson).
5. Billing of acquisition cost and exclusion from the rebate program are requirements of the program.
6. The cost to the Medicaid program to pay 340b prices is less than the net cost of the rebate program.
7. The federal Office of Pharmacy Assistance (OPA) is promoting creative demonstration projects to maximize the use of 340b, including purchasing cooperatives, contracts with multi-pharmacy services and clinical pharmacy projects.
8. Some clinical models, like disease management projects, improve health outcomes for patients and strengthen relationships between network providers.

CONS

1. FQHCs that participate could lose money when dispensing 340b purchased drugs to non-Medicaid people.
2. Local pharmacies could lose some business if they are not contracted with eligible 340b entities; additionally, requirements for pharmacies to participate are burdensome.
3. There may be administrative barriers to establishing appropriate and necessary contractual relationships.
4. Cooperation and coordination between multiple parties would be needed to design and implement demonstration projects.
5. Could be inconvenient or difficult for patients, if they were required or encouraged to use 340b entities for primary care.
6. Could limit patient choice of provider.
7. Would serve a limited FFS population if Salud! population not included.

PROGRAM IMPACT

1. More non-Medicaid patients benefit from lower prescription drug prices.
2. Administrative changes needed to create, implement and monitor billing process.
3. Evaluation would be imperative to compare 340b prices to supplemental rebate prices.

FISCAL IMPACT

1. Estimated potential savings to Medicaid of \$300,000/hospital/year, or \$2.1 million total.
2. Saves approximately 11.5% in purchase price (national average) on the volume of drugs sold/dispensed by covered entities.
3. OPA grants are available for \$50,000 to \$100,000.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C02	Maximize the use of the federal 340B discount drug program	4.33	DP	U	Pharmacy

OPTION C3

Carve out pharmacy from Salud!:

- A. carve out entire pharmacy benefit; or
- B. carve out pharmacy from PMPM rate, but pay MCOs to manage the benefit and coordinate care.

CATEGORY

Program Change

STRATEGY

Pharmacy Cost Containment

PROS

1. The state can get better discounts using Medicaid and supplemental rebates (Lewin Group).
2. The state's discounts are potentially increased with higher volume and a uniform preferred drug list.
3. The state is already establishing mechanisms for a pharmacy and therapeutics committee, enhanced drug utilization review and a preferred drug list; may contract with a pharmacy benefit manager (PBM).
4. A carveout could streamline and unify administration of the pharmacy benefit.
5. More states are moving in this direction; in a recent survey, 10 of 33 states excluded all drugs from capitated plans.
6. Prescription drugs could be partially carved out, to benefit from the rebate advantage, but allow the MCOs to manage the benefit.

CONS

1. A full carveout disrupts the MCOs ability to conduct disease management and care coordination, and eliminates the incentive for utilization management activities.
2. Substantial increases in HSD staff and expertise would be necessary.
3. The MCOs' ability to negotiate discounts and rebates for their commercial population would be harmed; senior members' costs for prescriptions could increase by as much as 33% (MCO estimate).
4. Costs could go up if HSD management of the benefit is not sufficiently aggressive.
5. A contract with a PBM is not risk based and may contain hidden costs.
6. Data could be more difficult to obtain from PBMs than from MCOs.

PROGRAM IMPACT

1. Full carveout would require substantially more staff, expertise and an enhanced information system.
2. If a PBM is used to manage the benefit, strict contract requirements would be necessary to ensure transparency of pricing and responsiveness.
3. Partial carveout requires increased coordination and cooperation between HSD and MCOs and renegotiation of the MCO contracts.

FISCAL IMPACT

1. One national study (Lewin Group) shows:
 - A) FFS Medicaid unit acquisition cost 12% below MCOs for the same population (with rebates);
 - B) cost per script, usage rates and cost PMPM is better managed by MCOs.
2. State data is not comparable as populations served are significantly different and data is reported differently.
3. Other states are projecting substantial savings with similar approaches:
 - FL: rebates went from 19% to 25%;
 - ME: anticipates \$10 million savings; and
 - MI: expects to save \$42 million in the first year of operation.
4. Additional administrative fees (to MCOs for a partial carveout) and/or additional staffing cannot be projected at present, but should be considered.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C03A	Carve out pharmacy from Salud!	3.08	DNP	4-8	Pharmacy
C03B	Carve out pharmacy from per member per month (PMPM) rate, but pay managed care organizations (MCOs) to manage the benefit and coordinate care	1.85	DNP	U	Pharmacy
C03C	Direct the Human Services Department (HSD) to conduct a cost-benefit analysis on the carveout of pharmacy from Salud!	3.77	DP	8-1	Pharmacy

OPTION C4

Provide greater flexibility to MCOs in management of the pharmacy benefit; allow MCOs to manage the benefit similar to the commercial market.

CATEGORY

Program Change

STRATEGY

Pharmacy Cost Containment

PROS

1. MCOs are already managing much of the Medicaid population; they have systems in place and the experience to manage the benefit more aggressively.
2. Preserves “physician centered” drug utilization review.
3. Preserves the risk aspect of managed care; the MCOs retain the incentive to manage the benefit.
4. Allows customization of the pharmacy benefit and market application to a public program.

CONS

1. The program remains fragmented between FFS and Salud!
2. Most program changes that mirror the commercial population would require a waiver.
3. Pharmacies would be reimbursed less, disrupting their fragile profit margin.
4. Medicaid beneficiaries are more vulnerable and shouldn’t be treated the same as those with the ability to purchase insurance.

PROGRAM IMPACT

1. Very little disruption to the current HSD management process.
2. Requires renegotiation of MCO contracts.
3. Beneficiaries could experience more limited access to prescription drugs.

FISCAL IMPACT

1. Potential for reduced PMPM, however short-term savings are limited.
2. Currently, pharmacy represents between 9.1% and 10.5% of the PMPM; the approach should result in reduction of that to more closely mirror the commercial population.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C04	Provide greater flexibility to MCOs in management of the pharmacy benefit; allow MCOs to manage the benefit similar to the commercial market.	2.29	S		Pharmacy

OPTION C5

Establish a prescription drug purchasing cooperative to combine the buying power of Medicaid, IBAC (state employees, retirees and teachers), DOH, VA, Corrections and other potential purchasers; consolidate contract administration and negotiation under one state agency.

CATEGORY

Program Change

STRATEGY

Pharmacy Cost Containment

PROS

1. Aggregates the purchasing power of several entities.
2. Uses the larger pool of covered lives to leverage more favorable financial arrangements.
3. When combined with a uniform preferred drug list, creates the ability to move market share.
4. Administrative overhead cost savings could be achieved by consolidating pharmacy benefit functions across entities.
5. More than 20 states have explored or are implementing interstate or intra-agency bulk purchasing arrangements.
6. Processes and the preferred drug list would be uniform, even if access to discounts and rebates vary (e.g. Medicaid, 340B).

CONS

1. Possibly no direct savings to the Medicaid program due to the existence of the rebate program.
2. Bulk purchasing alone has not resulted in great savings.
3. Pharmacy benefit managers for IBAC, DOH and VA could be reluctant to participate if it means changing their current management practices and adopting a uniform preferred drug list.
4. CMS could rule that the combination negates the "Best Price" provisions for Medicaid.
5. The state could be sued by the industry.

PROGRAM IMPACT

1. Many New Mexicans (beyond Medicaid) could benefit from lower prescription drug prices.
2. Medicaid beneficiaries will not benefit directly, though indirectly the Medicaid program could benefit from overall savings to the state.

FISCAL IMPACT

1. A new, similar Texas law projects savings of \$13.3 million in the first year and discounts of up to 60% off AWP.
2. The Winkleman Report (commissioned by the Northeast Legislative Association on Prescription Drug Prices) projects 40% savings for both Medicaid and commercial populations for the 8 states involved.
3. Massachusetts projects savings representing 0.7% - 1.2% of its total costs in the first year (\$6 to \$9.6 million) for a similar model.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C05A	Establish a prescription drug purchasing cooperative to combine the buying power of Medicaid, IBAC, DOH, Veterans Administration (VA), Corrections Department and other potential purchasers; consolidate contract administration and negotiation under one state agency.	2.88	DP	U	Pharmacy
C05B	Establish drug purchasing cooperative or refer to the Attorney General's Office.	3.24	S		Pharmacy

OPTION C6

Expand use of community health advisors ("promotores" model):

- A) from existing resources and MCO cost savings for Salud!;
- B) as part of a PCCM program for FFS populations; or
- C) through the personal care option, long-term care services.

CATEGORY

Program Changes

STRATEGY

Managing Health Care Better

PROS

1. Reduction of emergency room visits, hospital visits, length of time in a hospital and the number of complications for certain illnesses.
2. Provides culturally and linguistically appropriate services.
3. Help in obtaining non-medical services that reduce barriers to medical care for some people.
4. Promotes improved timely use of medical services and better compliance with medical care providers' treatment instructions.
5. Language competencies assures compliance with the policy guidance under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et seq.

CONS

1. Wages need to exceed minimum wages and provide benefits in order to compete with other service jobs in urban areas and rural communities.
2. May eventually require training, certification or licensure that will add to health care costs.

PROGRAM IMPACT

1. Shift cost savings of MCOs to hire advisors or contract with PCP (for advisors) in managing care of high-risk and low-income populations.
2. Promotores provide family support, health education, follow-up and advocacy across array of populations.
3. Increased availability of cost-effective, community- and home-based services in rural areas.

FISCAL IMPACT

Promotores may help decrease the rate of preventable hospitalizations for ambulatory care sensitive conditions (ACSC) (asthma, congestive heart failure, hypertension, diabetes) and preventable ER visits.

Reduced hospitalization costs

- o For every 1% savings in hospitalization costs, the savings would be approximately \$1.2 million or \$300 thousand SGF.

Reinvest SALUD profit margins

Average profit margin of SALUD 2001 PMPM = 14.87 (low margin = 4.71; high margin = 29.39)

Enrollees = 226,523

14.87 PMPM x 226,523 enrollees = \$3,368,397

- o Reinvest 1% back into community health models = \$33,684
\$33,684/\$10.94 per hour = 3,090 hours of promotores
- o Reinvest 5% back into community health models = \$168,420
168,420/\$10.94 per hour = 15,451 hours of promotores

In 1998, the average wage range for CHA/promotores was \$7.90 to \$10.90 per hour
\$1,000,000 would yield 91,743 hours of community health caregiver time

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C06	REPLACED WITH C06B (Related to primary care case management)	4.68			Managing health care better
C06B	In collaboration with DOH, HSD and the MCOs, implement a pilot program with FFS and Salud! expanding the use of promotores/community health representatives utilizing findings from existing programs in the northwest, border areas and northern New Mexico.	3.58	DP	U	Managing health care better

OPTION C7

Strengthen disease management (DM) programs targeted to selected diseases and high-risk populations, e.g., asthma, diabetes, cardiovascular, depression and maternal health:

- A) require MCOs to strengthen DM programs and coordinate more closely with PCP through incentives for participation and service to underserved areas;
- B) design, implement and conduct cost-effective analysis of DM program with FFS population sub-sample;
- C) ensure case management is a core medical service provided within the DM programs for FFS & SALUD.

CATEGORY	STRATEGY
Program Changes	Managing Health Care Better

PROS

1. Effective DM programs decrease high costs (high/inappropriate hospitalizations and prescription drug use).
2. DM firms conduct assessment of target populations and diseases and offer two choices: PMPM fee or a FFS per disease allowing NM to bill for only those enrolled in DM (Matria H. Care).
3. Improvements in key self-management areas: exercise, cognitive symptom management, communication w/ physicians, general health, health distress, fatigue, disability and social/role activities of limitation.

CONS

1. Validating cost savings of a disease management program from the perspective of a payer has been problematic; net savings needs to be 20% greater than the cost of a disease management program (Krause, 2000).
2. Asthma and diabetes are among the hardest DM programs within which to demonstrate return on investment.

PROGRAM IMPACT

Strengthen integrated health care delivery and increased access for Medicaid populations:

1. Increase **diabetes** management among high-risk populations.
 - o Prevalence in NM adults was 6.5% in 1999, but twice as high in Hispanics (8.0%) and Native Americans (9.9%) as in white non-Hispanics (4.6%).
2. Decrease hospitalizations and ER use for children with **asthma**.
 - a. Medicaid discharges for Ambulatory Care Sensitive Conditions for children below 18 was 26.3% compared to 23.8% children with private insurance and 25.5% for uninsured children (NM HIDD 2000).
 - b. Nationally in 1998, asthma hospitalizations for adults were 13/10,000 but 25/10,000 for children below 18 and highest at 47/10,000 for children below 5.
 - c. Similarly, asthma ER visits in 1998 were 124/10,000 for children below 18 and 59/10,000 for adults over 18.

FISCAL IMPACT

1. Harvard Community Health Plan study of an **asthma**: ER admissions reduced 79% (72/yr to 15/yr); Hospital admissions reduced 86% (35 to 5 per year); \$87,000 in cost savings (after factoring in \$11,115 of cost for part of an outreach nurse's time).
2. **Pediatric asthma** DM in Florida reports annual savings among frequent users of ER services after intervention was estimated = \$4845.29 per patient.
3. A Virginia study on **asthma** reported a 41% reduction in ER visits over previous year, a 25% increase in some reliever drugs and direct Medicaid savings of \$3-\$4 for every incremental dollar on DM support to physicians.
4. Diabetes study by The Lewin Group of seven managed care plans using **Diabetes** Treatment Centers: gross economic adjusted savings of \$50 per diabetic member per month (12.3%), with gross unadjusted savings of \$44 (10.9%) per diabetic member per month. Hospital admissions per 1,000 diabetic member years decreased by 18% and bed days fell by 21%.
5. American Healthways diabetes management program produced independently verified outcomes showing first-year costs savings of \$0.27 PMPM. Preventive care resulted \$1.48 savings in PMPM in year three to \$2.20 savings in PMPM in year five.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C07A	Require MCOs the strengthen DM programs and coordinate more closely with PCPs through incentives for participation and service to underserved areas.	4.22	DP	U	Managing health care better
C07B	Replaced with C07D (related to disease management)	4.14			Managing health care better
C07C	Ensure case management is a core medical service provided within the DM programs for FFS/Salud!	4.32	DP	U	Managing health care better
C07D	Utilize a DM firm to design a pilot program for FFS by using key health status indicators and accountability for clinical benefits and cost savings.	4.33	DP	U	Managing health care better

OPTION C8

Direct HSD to conduct a comprehensive feasibility study and cost-benefit analysis on the replacement of the current managed care model with a statewide primary care case management (PCCM) model with options:

- A. HSD contracting directly with primary care providers (PCPs) and for medical/utilization review (MUR);
- B. HSD contracting with an intermediary for PCPs and MUR;
- C. HSD using MCOs' networks or as administrative service organizations; or
- D. other scenarios that use PCCM approach.

CATEGORY

Program Change

STRATEGY

Managing Health Care Better

PROS

- 1. Studies have indicated that managed care models are no longer able to contain costs.
- 2. Administrative expenses and profits totaling 10% to 15% are not affordable at a time of double-digit medical inflation.
- 3. The state must seek alternatives for the administration of a Medicaid program that will continue to grow based on economic and demographic projections.
- 4. The Primary Care Network model initiated in New Mexico prior to managed care had early success and was generally received well by primary care physicians.
- 5. PCCM uses many of the same managed care principles but, depending on the model, may allow a direct contractual relationship between HSD and the PCP.

CONS

- 1. Managed care is able to control costs as illustrated by the fact that it currently operates with 44% of the Medicaid budget while covering 67% of the enrollees.
- 2. A change of this proportion will have significant start-up costs and its success will not be known for several years.
- 3. Providers are recognizing some managed care efficiencies and may be opposed to a new approach to managing health care, particularly because of their administrative costs for training and reorganization.
- 4. Managed care organizations have the incentive and ability to control inappropriate care and referrals that an HSD-contract PCP may not have.
- 5. HSD would need to hire a sizable staff with direct health care management and administration knowledge while the MCOs already have the existing infrastructure and experience.
- 6. A change in a system is not necessarily a reduction in costs.

PROGRAM IMPACT

A comprehensive feasibility study will provide the legislative and executive branches with the information necessary to determine how best to manage and administer the Medicaid program for the next five to 10 years.

FISCAL IMPACT

Fiscal impact is unknown.

HSD may be able to obtain a grant for such a study as was done with SCI.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C08	Direct HSD to conduct a comprehensive feasibility study and cost-benefit analysis on the replacement of the current managed care model with a statewide primary care case management (PCCM) model with options.	3.74	DP	U	Managing health care better

OPTION C9

Apply for grant from Agency on Health Care Research and Quality (Center for Primary Care Research) to implement a pilot/demonstration project for PCCM model for FFS population or sub-population to ensure medical and utilization review.

CATEGORY

Program Changes

STRATEGY

Managing health care better

PROS

1. Ability to use 1993 evaluation of the NM Primary Care Network (PCN) as a pre-managed-care baseline.
2. Enhance capacity and promote best practices based on research with minimal financial risks.
3. PCCM enhances quality of health care by emphasizing primary care and case management, promoting continuity of care, increasing access to preventive care and facilitating early diagnosis and treatment.
4. Decreases preventable hospitalizations and ER use; promotes early intervention with increased use of primary care providers, prenatal care and EPSDT services.
5. Increases beneficiary access (Rosenbaum et al., 2002).

CONS

1. Reliance on grants is not a substitute for systems change.
2. Availability and accessibility of PCPs must meet demand.
3. PCCM contracts can be unclear about the scope of provider's obligations regarding coverage, especially in EPSDT services (Rosenbaum et al., 2002).
4. Still need incentive or mechanism for PCPs to manage and control utilization.

PROGRAM IMPACT

1. Expected similar costs savings as the PCN in key areas such as hospitalizations and ER use.
2. More effective, cost-efficient health care can be provided if patients have ongoing access to a centralized source of preventative care and early diagnosis and treatment.

FISCAL IMPACT

1. An evaluation of the NM PCN (1993) demonstrated \$53 million in savings with the largest proportion of savings in hospitalizations (\$31.5 million), physician services (\$7.0 million), prescribed drugs (\$4.1 million) and outpatient hospital (\$3.9 million).
2. Between \$342.9 thousand and \$737 thousand may be available for PCCM pilot/demonstration project, based on FY 99, AHRQ average grant awards with emphasis on minority health and primary care research totaling \$16.8 million.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C09	Apply for grant from Agency on Health Care Research and Quality (Center for Primary Care Research) to implement a pilot/demonstration project for PCCM model for FFS population or sub-population to ensure medical and utilization review.	4.22	DP	U	Managing health care better

OPTION C10

Carve out and manage non-emergency transportation from Salud! and manage FFS through:

- A) Brokerage model
 - _ State hires one or more public or private agencies to manage transportation by region
 - _ State establishes eligibility criteria and minimum service standards
 - _ Broker provides and/or contracts for transportation services based on state requirements
 - _ Broker is responsible for all aspects of program management (eligibility verification, trip scheduling, service monitoring, billing and quality assurance).
- B) State-administered model
 - _ Provider reimbursements are paid directly by the state
- C) Conduct a cost-effectiveness analysis of brokerage model vs. state-managed model using MAD/HSD transportation utilization data from FFS and SALUD and incorporate 2003 findings from the Sandoval county transportation coordination study to develop state criteria and service standards.

CATEGORY	STRATEGY
Program Changes	Selective Contracting

PROS

1. Under CMS, NM is required to provided non-emergency Medicaid trips.
2. Strengthen access to health services in rural areas if brokers are part of local support system and not managed from the MCO level.
3. Brokerage model is recognized as the most effective approach to managing Medicaid transportation (assigns each trip to the most cost-effective carrier that meets client/family needs, e.g., Medicaid bus passes can be used instead of more costly taxis).
4. Carving out transportation would require that the state set and approve reimbursement rates and create a program in which policies for transportation are consistent and cost-effective.

CONS

1. Transportation brokers are not qualified to make decisions about access to health care for consumers.
2. Before implementation, the state needs to determine whether a carveout through a brokerage model will produce cost savings over current transportation costs under Salud!
3. MCOs may not be willing to share “proprietary” utilization and cost data.

PROGRAM IMPACT

1. Increased coordination between Medicaid and transportation programs.
2. Statewide service standards and reporting requirements to ensure consistent service quality.

FISCAL IMPACT

1. MAD/HSD transportation utilization data from FFS and Salud! are needed to project savings.
2. Growth rate in non-emergency transportation costs from FY 2002 to 2003 estimated at 15.86%.
3. Non-emergency transportation costs under FFS from July 01-August 02 = 7,731,919
 - o 10% cost savings from FFS: \$773,191
 - o 20% cost savings from FFS: \$1,546,383
 - o 25% cost savings from FFS: \$1,932,979

Findings of cost savings for other states using Medicaid bus passes include:

Connecticut:	\$4 million
Dade County, FL	\$19 million
Volusia County, FL	\$3 million
Philadelphia, PA	\$2.7 million

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C10A	Carve out and manage non-emergency transportation from Salud! and manage FFS through a brokerage model.	3.04	DNP	3-7	Managing health care better
C10B	Carve out and manage non-emergency transportation from Salud! and manage FFS through a state-administered model.	2.78	DNP	U	Managing health care better
C10C	Conduct a cost-effectiveness analysis of non-emergency transportation comparing brokerage model vs. state-managed model.	3.68	DP	U	Managing health care better
C10D	Conduct a pilot in a rural and an urban area for non-emergency transportation carveout in FFS only.		DP	U	Managing health care better

OPTION C11

Consolidate information system for managed care and FFS to provide all claims processing, reimbursement, data repository and real-time, online reporting capability while maintaining integrity and security for respective users.

CATEGORY

Program Change

STRATEGY

Selective Contracting/Managing Health Care Better

PROS

1. Timely and accurate data is critical for information needed to manage health care delivery, access and costs.
2. State can realize economies of scale from use of one information system hardware and software architecture as opposed to four information systems currently in use.
3. Can be competitively bid for best service and best price.
4. May provide MCOs with opportunities for other lines of business.
5. Eligible for 90% FMAP if Medicaid Management Information System (MMIS) compliant.
6. Allows HIPAA administrative simplification initiatives to be handled through one system.
7. System can have necessary security and firewall protection to ensure MCO confidentiality of proprietary information.
8. Medicare has reduced its administrative expense ratio from 3% to 1.8% through systems consolidation and regionalization.

CONS

1. MCOs may be reluctant to share common information system.
2. MCO security and confidentiality may be jeopardized without appropriate protections.
3. Implementation costs, even at 90% FMAP, will be substantial, particularly considering HIPAA and other mandatory security measures.
4. System failure without contingency system could be disastrous.
5. MCO hands-on control may be diminished.

PROGRAM IMPACT

HSD/MAD could have desktop reporting capability for real-time analysis of Medicaid services, utilization, services, reimbursement and costs.

FISCAL IMPACT

CMS allows for 90% FMAP for implementation of MMIS.

MCO reports to the Insurance Division do not consistently break down information system costs.

The state paid approximately \$15.8 million for the use of Omnicaid, an MMIS-compliant system currently used by Consultec, the New Mexico FFS fiscal agent, at 90% federal match.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C11	Consolidate information system for managed care and FFS to provide all claims processing, reimbursement, data repository and real-time, online reporting capability while maintaining integrity and security for respective users.	3.13	DNP	5-7	Managing health care better

OPTION C12

HSD to develop and submit 1115 Global Funding Waiver (GFW) *and* include preliminary cost-effectiveness estimations of GFW by January 2003.

CATEGORY

Program Changes
Care

STRATEGY

Reconfiguring Long-Term

PROS

1. Home- and community-based services (HCBS) are less expensive than institutional care.
2. Consumers prefer HCBS to institutional care.
3. Promotes state's compliance with *Olmstead* decision.
4. The GFW can be developed to include individuals with traumatic brain injury (TBI) to address their need for long-term support services.

CONS

1. If not adequately funded, consumer choice may be limited due to waiting lists.
2. Demand may exceed supply resulting in waiting lists.
3. This options shifts costs to the community at lower rates in order to serve more consumers and decrease current waiting lists.

PROGRAM IMPACT

HSD to determine in future how GFW will affect an increase or decrease in LTC services costs and benefits.

FISCAL IMPACT

1. According to HSD, approximately \$21.2 million will be available in FY 04 for the GFW due to recidivism and turnover from nursing facilities.
2. CMS requires that the GFW costs should be \$20,586, which is 80% of NF costs (\$25,733) per year per consumer.
 - C \$21.2 million serves 824 consumers in nursing facilities @ \$25,733 per year
 - C \$21.2 million serves 1,030 consumers thru GFW @ \$20,586 per year
 - C 206 more consumers could be served per year in the community in FY 04

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C12	HSD to develop and submit 1115 Global Funding Waiver (GFW) and include preliminary cost-effectiveness estimations of GFW by January 2003.	4.23	DP	U	Long-term care

OPTION C13

Conduct a cost-benefit analysis of the Personal Care Option (PCO) sampling a *sub-population* of consumer-directed (146) vs. consumer-delegated (6,139) care and evaluating:

- A. costs and benefits to each choice (consumer-directed vs. consumer-delegated);
- B. how the two options under the PCO model are being implemented;
- C. type of fiscal and quality monitoring each choice provides;
- D. quantity of services per deemed level of care (high NF & low NF);
- E. consumer satisfaction; and
- F. level of agency involvement for each option.

CATEGORY	STRATEGY
Program Changes	Reconfiguring Long-Term Care

PROS

- 1. Investigates whether services are being offered with appropriate level of need.
- 2. Establishes what elements of the consumer-directed vs. consumer-delegated is the most cost-effective.
- 3. Isolates program costs and problems.
- 4. Determines the effective components of each choice to re-design the PCO to be cost-effective and promote consumer choice.
- 5. Prevents arbitrary cut or expansion to the PCO while ensuring those who need services receive them.
- 6. Currently, there is no evaluation research literature on the cost-effectiveness of Medicaid personal care services programs (DHHS, June 2002).

CONS

- 1. No immediate savings; money would have to be invested in a small study to determine cost-benefits and save money long-term.
- 2. PCO is already one of fastest-growing services in Medicaid; a lower-cost model may do little to contain costs.

PROGRAM IMPACT

- 1. Increased costs of the PCO could be controlled by strengthening the design and implementation without eliminating the PCO altogether.
- 2. Consumer-directed allows consumer to direct all the care.
- 3. Consumer-delegated option has agency perform all employer-related tasks and administrative functions.

FISCAL IMPACT

A **study could cost** between **\$50,000 and \$125,000** depending on the level of in-kind institutional support and the sample size.

PCO Growth over last three years (HSD/MAD)

	FY2002		FY2001		FY2000	
Consumer-Delegated	774	\$4,926,031	3,029	\$50,877,191	6,139	\$123,167,047
Consumer-Directed	61	\$44,559	110	\$772,257	146	\$1,660,441
All (Unduplicated)	820	\$4,970,590	3,078	\$51,649,448	6,253	\$124,827,489

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C13	Conduct a cost-benefit analysis of the personal care option (PCO) sampling a sub-population of consumer-directed vs. consumer-delegated care with evaluation of various factors.	3.25	DP	U	Long-term care

OPTION C14

Continue the Personal Care Option (PCO) with increased consumer *awareness* of consumer-directed services as a choice in addition to consumer-delegated (agency-directed services).

CATEGORY

Program Changes

STRATEGY

Reconfiguring Long-Term Care

PROS

1. PCO provides choice.
2. Consumers can hire or fire their own caregivers. They can direct their care and be more responsible for its quality.
3. Allows consumers to hire their own family members and persons who may be more culturally and linguistically competent.

CONS

1. PCO only covers personal care attendant & homemaker services.
2. The supply-side of homecare workers and assistants may not match the demand, especially in rural areas.
3. According to a 1999 report by the DHHS, states have not been able to determine cost-effectiveness of the PCO.
4. No statutory requirement that PCO must demonstrate cost-effectiveness or budget neutrality vis-à-vis spending on nursing home care.
5. Without fiscal monitoring and planning, PCO could result in "runaway" spending since it is available to all who meet the criteria.
6. PCO via the consumer-directed model may be at greater risk for fraud without the oversight of a fiscal agent.

PROGRAM IMPACT

1. Short- and long-term benefits to consumers.
2. Lack of fiscal monitoring may result in increased runaway costs regardless of model.

FISCAL IMPACT

PCO Service Costs FY 2002 (HSD/MAD)

	Unduplicated service recipients	% of Service Recipients	Aggregate Service Cost	FY Service Cost per recipient per year	Costs per hour
Consumer Delegated	6,139	98%	\$123,167,047	\$20,063	\$16.00
Consumer Directed	146	2%	\$1,660,441	\$11,373	\$10.20
	6,253	100%	\$124,827,489	\$19,963	\$13.10 (avg)

Projected Cost Savings if recipients chose lower-priced model:

- 50% - \$26.5 million
- 25% - \$12.9 million
- 10% - \$4.8 million

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C14	Continue the PCO with increased consumer awareness of consumer-directed services as a choice in addition to consumer-delegated (agency-directed) services.	4.46	DP	U	Long-term care

OPTION C16

- A) Contain the growth of nursing home beds by creating a formal evaluation process to determine the need for expansion with nursing home capacity.
- B) Establish a 5- and 10-year maximum bed expansion rate to achieve long-term cost containment measures.

CATEGORY

Program Changes

STRATEGY

Reconfiguring Long-Term Care

PROS

- 1. Creating an evaluation process asking for a justification for size is less intensive and expensive than a formal certificate of need program.
- 2. Ensures that supply is directly parallel to demand and needs of consumers.
- 3. Shift to home and community-based services (HCBS) by de-emphasizing institutional care.
- 4. Method to control rate of growth of institutional beds.

CONS

- 1. Controlling rate of growth of institutional capacity does not necessarily result in cost savings for long-term care unless NM achieves cost-effectiveness for HCBS.
- 2. Cost savings are achieved long-term and are not immediate.
- 3. The increase in the aging population, 65+ and especially 85+, creates an ongoing demand for nursing facility (NF) beds (of 1.8 million New Mexicans, 15% or 280,000 are 60+ years and in 2020 the 60+ age group is projected to be 525,381, a growth rate of 47%).

PROGRAM IMPACT

De-emphasizes institutional care.

FISCAL IMPACT

Medicaid patients occupy 70.3% of the available NF beds in NM.

Cost per recipient for FY 02 is \$25,624
 Total recipients = 6,405
 Total Aggregate Service Costs = \$164 M
 NF Projected FY 03 Costs = \$178 M
 NF Projected FY 04 Costs = \$186 M

Growth rate for nursing homes and ICF/MR enrollees from 1992 to 2002 was 33% and was higher than growth rates of HCBS enrollees (per HSD/MAD/ISD).

Would need to determine long-term potential cost savings if controlled bed growth and NF utilization while shifting costs to HCBS waiver.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C16A	Contain the growth of nursing home beds by creating a formal evaluation process to determine the need for nursing home capacity expansion and establish a five- and 10-year maximum bed expansion rate to achieve long-term cost containment.	2.46			Long-term care
C16B	Incorporated into C16A				Long-term care

OPTION C17

Expand Program of All-Inclusive Care for the Elderly (PACE) in urban areas of the state beyond current 187 consumers in Albuquerque (e.g. Las Cruces, Roswell or Santa Fe).

CATEGORY

Program Changes

STRATEGY

Reconfiguring Long-Term Care

PROS

1. PACE promotes a full array of Medicaid health and social services and includes systems coordination, e.g., assisted living, home health, day care/day treatment, physician, nutrition, housing, transportation and pharmacy.
2. PMPM of \$2,500 or \$30,000 yearly includes housing, transportation and pharmacy.
3. PACE contracted agencies hold full risks for consumers.
4. Pilot implemented in Albuquerque has demonstrated effectiveness and provides an alternative to nursing facility (NF) institutional care.
5. PACE programs are funded by both Medicare and Medicaid and participants must be eligible for both.

CONS

1. Data from a San Francisco feasibility study show that rural models are not as effective due to transportation issues.
2. The typical PACE program serves fewer than 300 individuals (DHHS, October 2000).
3. In FY 04, CMS is changing the “cost-effectiveness” requirement which will require NM to compare costs to D&E waiver costs at \$16,000 per person per year in addition to NF costs, which average to \$36,000 per person per year. PACE program will have to be maintained at even lower costs in the community than before, which could decrease the current array of services provided.

PROGRAM IMPACT

1. Quality of life through integrated array of services benefits to elderly population and their families.
2. Costs of institutional care replaced by community care.

FISCAL IMPACT

NF average cost per consumer is \$3,000 per consumer per month (if medical care included).

NF averages \$30,000 to \$42,000 per year average per consumer.

PACE costs \$2,500 PMPM or \$30,000 per year per consumer

Difference of \$500 x 100 consumers = \$50,000

\$50,000 x 12 months = \$600,000

Projected savings if 100 consumers shifted from NF to PACE in urban area: \$600,000

Projected SGF savings: \$150,000 for every 100 consumers

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C17	Expand Program of All-Inclusive Care for the Elderly (PACE) in urban areas of the state beyond current 187 consumers in Albuquerque (e.g., Las Cruces, Roswell or Santa Fe).	4.09	DP	7-3	Long-term care

OPTION C18

Consolidate long-term care (LTC) services provided by DOH, CYFD, HSD and SAoA)

- A) under one agency for adult services only; or
- B) for all services from birth to death.

A or B includes developing the LTC Link to be a centralized statewide resource database of health and social service providers, government agencies related to LTC and public benefits, and other related entities serving seniors and disabled children and adults.

CATEGORY

STRATEGY

Program Changes

Reconfiguring Long-Term Care

PROS

- 1. Improved delivery and availability of services.
- 2. Decreased duplication of effort and fragmentation of services, as well as increased access for individuals in need of such services.

CONS

- 1. Program responsibility issues would have to be resolved to determine which state agency would have sole administration of LTC services.
- 2. Requires more up-front administrative and staff costs in consolidating agencies. HSD would have to amend the state plan and have CMS approval to effect the transfers.
- 3. Federal law precludes the single state agency (HSD) from delegating the exercise of administrative functions, including the issuance of policies, rules and regulations on program matters. The new state agency could not substitute its judgment for that of HSD concerning policies, rules and regulations issued by HSD. (Joint Powers Agreements (JPAs) could be executed to effect the transfers, with caveats concerning HSD's single-state agency status.)

PROGRAM IMPACT

- 1. Outcomes and benefits are achieved long-term.
- 2. The Adult Protective Services (APS) currently shares an emergency call service with the Child Protective Services component of CYFD. A disruption in this emergency reporting process may have serious repercussions on the adult clients.
- 3. JPAs may be necessary for appropriate oversight.

FISCAL IMPACT

- 1. Reorganization funding as determined from the Fiscal Impact Report of HB 915 (2001), "Creating An Adult Services Department", was estimated to be \$250,000, which could potentially be matched in whole or in part, for expenditures over a three-year period.
- 2. Currently, there are 22 states in the nation where the aging office administers adult protective services and one or more home- and community-based waivers BUT no state has consolidated all LTC services for children, youth, adults and older adults. No states have definitive cost-benefits analysis studies of consolidation.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C18A	Consolidate long-term care (LTC) services provided by DOH, CYFD, HSD and the State Agency on Aging (SAoA) under one agency for adult services only (including LTC Link development).	3.50			Long-term care
C18B	Consolidate LTC services provided by DOH, CYFD, HSD and SAoA under one agency for all services from birth to death (including LTC Link development).	3.44	DP	U	Long-term care

OPTION C19

Amend the tax code in a way to allow individuals tax credits for purchasing and maintaining long-term care insurance.

CATEGORY

Other

STRATEGY

Tax Credits

PROS

- 1. Tax credits can be targeted to lower-income individuals.
- 2. Protection of consumer choice with a “pay as you go” financing system.

CONS

- 1. Mixed opinions regarding the cost savings due to tax credits since current methods are computer simulated.
- 2. Cost savings are not immediate but rather long-term gains.

PROGRAM IMPACT

Long-term care insurance may allow low-income families to plan and invest for their future while slowing the growth of Medicaid.

FISCAL IMPACT

According to a study by ABT Associates, the assistance tax credits for lower-income individuals has a greater effect on Medicaid costs than tax deductions.

Under *tax deductions*, Medicaid saves only \$0.08 and \$0.79 in 2025 and 2050, respectively, for every dollar lost due to the deduction. Under *tax credits*, Medicaid saves \$1.16 and \$2.67 in 2025 and 2050 for every dollar lost due to the credit. Medicaid spending on health care, as a % of GDP, grows only by 67% under tax credits as compared to 93% under current law, and 89% under tax deductions.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C19	Amend the Tax Code in a way to allow individuals tax credits for purchasing and maintaining long-term care insurance.	4.17	DP	U	Long-term care

OPTION C20

Develop a pilot Medicaid behavioral health waiver under an 1115 research and demonstration waiver for 100 recipients with severe and persistent mental illness (SPMI) and a co-occurring addiction disorder in Dona Ana County.

CATEGORY

Program Change

STRATEGY

Reconfiguring Long-Term Care

PROS

1. Allows the state to expand community-based services to a very vulnerable population in an under-served area of the state, without extending an entitlement to recipients.
2. Uses DOH Behavioral Health Services Division dollars to obtain federal match.
3. Allows thorough evaluation of a model of treatment and data collection to support potential application statewide after five years; achieves cost neutrality through savings to other parts of the Medicaid program.
4. Targets Medicaid-eligible people who are dually diagnosed with SPMI and an addiction disorder, and who are at risk of repeated hospitalizations and arrests.
5. Uses assertive community treatment (ACT) and integrated treatment services for substance abuse.
6. Allows the state to demonstrate savings to Medicaid with a controlled study.
7. Builds the service delivery infrastructure in the area of the pilot.
8. Addresses a recommendation of the substance abuse task force.

CONS

1. Serves only 100 people in one part of the state, when the identified need for such services is much greater (GAP analysis).
2. Is limited to people with co-occurring disorders.
3. CMS has recently announced it does not intend to approve any more behavioral health waivers.

PROGRAM IMPACT

1. Requires submission of a waiver.
2. Serves a vulnerable and greatly under-served population.
3. Promotes and supports interagency cooperation.

FISCAL IMPACT

\$250,000 of state general fund dollars from BHSD will develop a \$1 million service delivery system.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C20	Develop a pilot Medicaid behavioral health waiver under an 1115 research and demonstration waiver for 100 recipients with severe and persistent mental illness (SPMI) and a co-occurring addiction disorder in Dona Ana County.	3.17	DNP	6-6	Long-term care

OPTION C21

Strengthen fraud and abuse detection, reporting and recovery.

CATEGORY

Program Change

STRATEGY

Managing Health Care Better

PROS

1. The substantial growth of Medicaid coupled with the limited oversight of some service programs requires better control of spending and review of appropriateness of service.
2. The coordination among the Attorney General's Medicaid Fraud Unit, HSD and the MCOs has improved, but it must be significantly better to deter and detect fraud and abuse.
3. There are still outstanding concerns about the number and appropriateness of referrals to the AG from HSD and the MCOs that must be addressed and resolved.
4. Recent corporate and accounting scandals have demonstrated that fraud and abuse are more prevalent than regulatory bodies recognized.

CONS

1. Overzealous oversight of Medicaid services may have the effect of limiting service delivery and access to otherwise appropriate health care.
2. Additional reporting and coordination requirements may not produce a positive cost-benefit.
3. There are already numerous federal statutes and regulations aimed at deterring fraud and abuse.

PROGRAM IMPACT

Ensuring that only appropriate care for Medicaid beneficiaries is provided and reimbursed can help to conserve scarce funding in the health care industry, where inflation is expected to exceed 10% per year for the foreseeable future.

FISCAL IMPACT

In a state Medicaid program quickly approaching \$2 billion, for every 1% of expenditures attributable to fraud and abuse, recovery nets \$20 million, of which \$5 million is SGF.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
C21	Strengthen fraud and abuse detection, reporting and recovery.	3.96	DP	9-3	Managing health care better

OPTION L1

Impose a monthly premium on select Medicaid beneficiaries.

CATEGORY

Program Limitations

STRATEGY

Cost-Sharing

PROS

1. Could make the consumer of services more cost-conscious and aware of the Medicaid benefits.
2. The administrative burden on providers is reduced if premiums are collected by HSD.
3. Could promote a more seamless continuum of care between Medicaid coverage and other insurance options for families.
4. Could generate revenue for the Medicaid program.

CONS

1. Increases out-of-pocket health care costs for low-income people.
2. Research shows premiums serve as a barrier to initial enrollment in Medicaid as well as the decision to remain in the program, thereby reducing access to health care for some.
3. HSD would assume a new administrative burden in collecting monthly premiums, tracking payments and monitoring to ensure that mandatory caps (5% of yearly income) are not exceeded.
4. Imposing premiums on beneficiaries shifts some of the cost of Medicaid from the federal government to those who can least afford it.

PROGRAM IMPACT

1. More closely aligns Medicaid with other insurance models, such as SCI and the state employees program.
2. Reductions in Medicaid enrollees could increase the number of uninsured people in New Mexico.
3. Medicaid beneficiaries would have a new monthly requirement to remain eligible for Medicaid.
4. Would require submission of a waiver and CMS's approval is uncertain.
5. Medicaid regulations prohibit assessing both a premium *and* a co-pay; the waiver application would have to address that, or the premium would have to be restricted to only those who do not already pay a co-payment.

FISCAL IMPACT

It is difficult to price this option, because Medicaid monthly enrollment reports do not generally segregate populations according to income level. The following projections are based on Kaiser Family Foundation reports of non-elderly Medicaid enrollees by poverty level (1999-2000):

100% -199% FPL:	63,642 x \$20 x 12 months = approximately \$15.3 million
At or above 200% FPL:	36,707 x \$20 x 12 months = approximately \$8.8 million
Total (combined) possible premiums:	\$24.1 million

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
L01	Impose a monthly premium on selected Medicaid beneficiaries.	2.32	DP	10-2	Cost sharing

OPTION L2

Impose co-payment on emergency room (ER) services unless patient is admitted as a result of ER evaluation.

CATEGORY

Program Limitations

STRATEGY

Cost-Sharing

PROS

1. Could decrease utilization of ER for primary care services.
2. Could foster ownership and personal responsibility for health care among beneficiaries.
3. Could generate revenue for the Medicaid program.
4. Local experience (UNM Care) supports the effectiveness of this model.
5. Could be applied only to *inappropriate* ER use.
6. Could be combined with “next-day” care approach, without affecting outcomes of care.

CONS

1. Poor women and children already have a difficult time obtaining appropriate and timely care; this could make it more difficult.
2. Some genuine emergencies might not be appropriately treated if beneficiaries were unwilling or unable to pay.
3. This option does not address the problem of insufficient primary care providers and inadequate hours of service.
4. Hospitals would have to provide care regardless of the patient's ability to pay, potentially leaving providers with the burden of collection or bad debt.
5. Savings to the state could be from beneficiaries going without care rather than from cost-sharing.
6. Co-payments shift to beneficiaries costs that are otherwise borne largely by the federal government; dollars collected from co-payments are not eligible for federal match.

PROGRAM IMPACT

1. Would require a waiver since current Medicaid regulations prohibit cost-sharing for ER services.
2. Would require amendment to MCO contracts.
3. Administrative costs to collect the co-payments could reduce or offset the projected savings.
4. Beneficiaries could delay care, which could make the illness or injury more difficult and costly to treat.

FISCAL IMPACT

Neither MCO or FFS cost data is routinely broken out by ER information with admission/non-admission percentages, so an accurate projection cannot be made at this time.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
L02	Impose a co-payment on emergency room (ER) services unless the patient is admitted as a result of ER evaluation.	2.45	DP	8-4	Cost sharing

OPTION L3

Impose tiered co-payments on higher-cost prescription drugs to provide incentives to use generic drugs.

CATEGORY

Program Limitations

STRATEGY

Cost-Sharing

PROS

1. Could increase the use of generic prescriptions and decrease the use of higher cost, brand name drugs.
2. Preserves prescription drug choice for beneficiaries and reduces use of less essential drugs.
3. Could foster personal responsibility and ownership for health care.
4. Could generate significant savings if the percentage of generic drugs increases substantially.

CONS

1. Studies show that while tiered co-pays reduce use of less essential drugs, they also reduce use of drugs essential for disease management and prevention.
2. Such co-payments affect those with chronic illnesses the most.
3. In TennCare, a study showed that 22% of beneficiaries were unable to meet the co-pay requirement at the time of purchase and of those, two thirds went without the prescribed drug.
4. Recent study (RAND) showed tiered co-payments did *not* lead to substantial increase in generic drugs.
5. NM Medicaid reports it already has a ratio of approximately 85% use of generic to brand drugs.

PROGRAM IMPACT

1. Would require a waiver to charge higher co-payments or cover a wide range of Medicaid recipients.
2. Would require the renegotiation of MCO contracts.
3. Administrative costs to collect the co-payments could reduce the projected savings.
4. Beneficiaries could delay care, which could make the illness or injury more difficult and costly to treat.

FISCAL IMPACT

Neither HSD nor the MCOs were able to provide the number of generic prescriptions filled. Information provided was not presented in the same form and did not reflect the same time period.

MCO prescription drug expenditures (Jun '01): \$5 million; generic use: 58.5% or \$2.9 million
Prescriptions filled (in one year) for MCOs: approximately 160,000/month

FFS prescription drug expenditures (Sep '02): \$6.3 million; generic use: \$1 million or about 15%
Prescriptions filled (in one year) for FFS: approximately 143,000/month

Salud!:

\$10 generic drug co-pay estimate:	\$936,000 (160,000 x 58.5% x \$10)
\$20 brand name co-pay estimate:	\$1,328,000 (160,000 x 41.5% x \$20)

FFS:

\$10 generic drug co-pay estimate:	\$836,550 (143,000 x 58.5% x \$10)
\$20 brand name co-pay estimate:	\$1,186,900 (143,000 x 41.5% x \$20)

(Accurate projection difficult without average generic drug utilization so based on MCO breakdown)

Effect on generic/brand use over time cannot be projected accurately.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
L03	Impose tiered co-payments on higher-cost prescription drugs to provide incentives for greater use of generic drugs when there is a generic or lower-cost equivalent available.	2.82	DP	8-3	Cost sharing
L03B	Impose co-payments for drugs not on the preferred drug list.	4.36	DP	U	Cost sharing

OPTION L4

Impose a \$5.00 co-pay on office visits and prescription drugs for Medicaid beneficiaries at or above 133% FPL.

CATEGORY

Program Limitations

STRATEGY

Cost-Sharing

PROS

1. Could control the use of health care services in Medicaid.
2. Could foster ownership and personal responsibility for health care among beneficiaries.
3. Could generate revenue for Medicaid.

CONS

1. Research shows that cost-sharing causes reductions in the use of essential services and drugs (RAND, 1997; TennCare, 1996; and Ku & Rothbaum, 2002).
2. Higher co-payments lead to an increase in preventable medical problems and in emergency room use.
3. Co-payments have the most adverse impact on the elderly and disabled and those with chronic poor health.
4. Low-income children are disproportionately affected.
5. Low-income people are less able to afford co-payments than in past years due to increased housing and child care costs.
6. Co-payments shift cost responsibilities to providers and local governments.
7. Co-payments shift to beneficiaries costs that are otherwise borne largely by the federal government; dollars collected from co-payments are not eligible for federal match.
8. Could prove administratively burdensome to providers and the state to administer.

PROGRAM IMPACT

1. Would probably require amendment to MCO contracts.
2. Would require submission of a waiver.
3. Administrative costs to collect the co-payments could reduce the projected savings.
4. Beneficiaries could delay care, which could make the illness or injury more difficult and costly to treat.

FISCAL IMPACT

This projection was developed by Mercer, in response to a request by the HSD in April of this year.

If a waiver were approved by CMS, the following savings could be achieved:

FFS:	\$2.8 million
Salud!:	\$24.6 million

These savings cannot be used to obtain federal match.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
L04	Impose a tiered copay on office visits and prescription drugs for Medicaid beneficiaries at or above 133% of the federal poverty level (FPL) with the provider held harmless.	2.52	DNP	6-6	Cost sharing

OPTION L5

Reduce Medicaid payments across the board by a fixed percentage:

- a. to Medicaid Salud! MCOs; or
- b. to Medicaid FFS providers.

CATEGORY

Program Limitations

STRATEGY

Rate Adjustments

PROS

1. Immediate impact on state budget/Medicaid funding.
2. Distributed equally to all providers or MCOs.
3. Numerous states plan to implement Medicaid reimbursement rate cuts.
4. MCOs and FFS providers should also share in belt-tightening initiatives and seek greater efficiencies within their own operations.
5. Minimal administrative cost to implement.
6. MCOs received a 6% increase in PMPM for FY 03 while other provider rates were frozen or cut.

CONS

1. Any cuts of Medicaid reimbursement would be "loathed" by MCOs and FFS providers.
2. More providers would decline to participate in Medicaid.
3. Medicaid reimbursement is already very low.
4. MCOs may have difficulty maintaining or expanding provider networks.
5. Ancillary services offered by MCOs would be impacted.
6. MCOs may find it more difficult to offset high-cost cases.

PROGRAM IMPACT

MCO payments and FFS provider payments account for approximately 44% and 56% of Medicaid program operational expenditures, respectively.

FISCAL IMPACT

Based on approximately 250,000 Salud! members and an average PMPM of \$286:

- A. 0.5% reduction to \$284.57 PMPM would result in SGF savings of \$1.0725 million
- B. 1.0% reduction to \$283.14 PMPM would result in SGF savings of \$2.145 million

Based on approximately \$745 million reimbursement for FFS providers:

- A. 0.5% reduction would result in GF savings of \$0.93125 million
- B. 1.0% reduction would result in GF savings of \$1.8625 million

Combined reductions could save the SGF between \$2 and \$4 million.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
L05A	Reduce Medicaid Salud! MCO PMPM payments by 0.5% - 1.0%.	2.26	S		Rate adjustment
L05B	Reduce Medicaid FFS provider payments by 0.5% - 1.0%.	1.61			Rate adjustment

OPTION L6.1

Reduce or Eliminate "High-Cost" Optional Services

- A) Institutional Care
- B) Personal Care Services
- C) Prescription Drug

CATEGORY

Program Limits

STRATEGY

Benefits Reduction

- 1. Immediate impact in reducing Medicaid SGF.
- 2. Addresses concerns that state Medicaid program should focus on expenditures for federally mandated benefits.

CONS

- 1. Negative impact on Medicaid populations include socio-economic hardships, compromised health care and diminished health status.
- 2. Lack of services imposes greater financial burdens on the safety-net institutions, social service providers, counties and other health care providers to provide uncompensated care.
- 3. Reduction of \$1 in SGF for Medicaid will mean loss of approximately \$3 in federal funds.

PROGRAM IMPACT

- 1. Medicaid providers will lose reimbursement for these services.
- 2. Medicaid beneficiaries will lose some or all access to these services.

FISCAL IMPACT

SGF Savings in Millions*

Optional Service	10% Cut	20% Cut	30% Cut	40% Cut	50% Cut	75% Cut	Eliminate Optional Services
Institutional**	\$2.8	\$5.6	\$8.4	\$11.2	\$14.0	\$21.6	\$28.0
Prescribed Drugs	\$2.4	\$4.9	\$7.3	\$9.76	\$12.2	\$18.3	\$24.4
Personal Care Services***	\$2.5	\$5.12	\$7.6	\$10.24	\$12.8	\$19.2	\$25.6
Total Savings	\$7.70	\$15.62	\$23.30	\$31.2	\$39.00	\$59.10	\$78.00

*Includes FFS & managed care savings based on 2003 projections in HSD letter to Senator Altamirano & Representative Coll, January 24, 2002.

**All non-SSI adults would be ineligible for this service. SSI eligibles currently on the D&E waiver would be eligible for this service and the savings reflect their inclusion in institutional care.

***This service is provided on a FFS basis only.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
L06.1A	Eliminate optional institutional care services.	1.08			Program cuts
L06.1B	Eliminate optional PCO services.	1.13			Program cuts
L06.1C	Eliminate optional prescription drug services.	1.04			Program cuts
L06.1D	Reduce by 10% optional institutional care services.	1.91			Program cuts
L06.1E	Reduce by 10% optional PCO services.	1.82			Program cuts
L06.1F	Reduce by 10% optional prescription drug services.	1.91			Program cuts

OPTION L6.2

Reduce or Eliminate “Moderate-Cost” Optional Services:

- A) Other Practitioners
- B) D & E Waiver
- C) ICF/MR
- D) Medical Supplies

CATEGORY	STRATEGY
Program Limits	Benefits

PROS

1. Immediate impact in reducing Medicaid SGF shortfall.
2. Addresses concern that state Medicaid program should focus on expenditures for federally mandated benefits.

CONS

1. Negative impact on Medicaid populations include socio-economic hardships, compromised health care and diminished health status.
2. Lack of services imposes greater financial burdens on the safety-net institutions, social service providers and counties to provide “uncompensated” care.
3. Reduction of \$1 in SGF for Medicaid will mean loss of approximately \$3 in federal funds.

PROGRAM IMPACT

1. Medicaid providers will lose reimbursement for these services.
2. Medicaid beneficiaries will lose some or all access to these services.

FISCAL IMPACT

SGF Savings in Millions*

Optional Service	10% cut	20% cut	30% cut	40% cut	50% cut	75% cut	Eliminate Optional Services
A) Other Practitioners (includes optometrists, therapists, psychologists, social workers, podiatrists, etc. (adults only)).	\$.51	\$1.02	\$1.53	\$2.04	\$2.6	\$3.83	\$5.1
B) D&E Waiver (other HCBW have their general fund budget at DOH).	\$.79	\$1.58	\$2.37	\$3.16	\$3.95	\$5.9	\$7.9
C) ICF-MR (approx. 90% of individuals in ICF-MR are adults).	\$.48	\$.96	\$1.44	\$1.92	\$2.4	\$3.6	\$4.8
D) Medical Supplies (includes Durable Medical Equipment as well as regular medical supplies (adults only)).	\$.55	\$1.1	\$1.65	\$2.2	\$2.75	\$4.13	\$5.5
Total Savings	\$2.33	\$4.66	\$6.99	\$9.32	\$11.70	\$17.46	\$23.30

*Includes FFS & Managed Care Savings based on 2003 projections, HSD letter to Senator Altamirano & Rep. Coll, 01/24/02

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
L06.2A	Eliminate optional other practitioner services.	1.16			Program cuts
L06.2B	Eliminate optional disabled and elderly (D&E) waiver services.	1.13			Program cuts
L06.2C	Eliminate optional intermediate care facility for the mentally retarded (ICF/MR) services.	1.13			Program cuts
L06.2D	Eliminate optional medical supply services.	1.67			Program cuts
L06.2E	Reduce optional other practitioner services.	2.22	S		Program cuts
L06.2F	Reduce optional D&E waiver services.	2.05	S		Program cuts
L06.2G	Reduce optional ICF/MR waiver services.	1.70			Program cuts
L06.2H	Reduce optional medical supply services.	1.83			Program cuts
L06.2I	Primary care provider (PCP) gatekeeper for services by other practitioners.	3.55	DNP	2-5	Program cuts
L06.2Ia	PCP gatekeeper for services by other practitioners being in collaboration with and communication to the PCP with the exception of self-referral services.		DP		Program cuts

OPTION L6.3

Reduce or eliminate "lower-cost" optional services:

- A) Case management
- B) Dental
- C) Pre-PACE
- D) Breast and cervical cancer

CATEGORY	STRATEGY
Program Limits	Benefits Reduction

PROS

1. Immediate impact in reducing Medicaid SGF shortfall.
2. Addresses concern that Medicaid program should focus on expenditures for federally mandated benefits.
3. Other states have reduced or cut optional services at this lower level but, according to the Medicaid Spending Growth 2002 Survey, these options are "penny-wise" and "pound-foolish".

CONS

1. Negative impact on Medicaid populations include socio-economic hardships, compromised health care and diminished health status.
2. Lack of services imposes greater financial burdens on the safety-net institutions, social service providers and counties to provide uncompensated care.
3. Reduction of \$1 in general fund for Medicaid will mean loss of approximately \$3 in federal matching funds.

PROGRAM IMPACT

1. Medicaid providers will lose reimbursement for these services.
2. Medicaid beneficiaries will lose some or all access to these services.

FISCAL IMPACT

SGF Savings in Millions*

Optional Service	25% Cut	50% Cut	75% Cut	Eliminate Optional
Case Management	\$.6	\$1.2	\$1.8	\$2.4
Dental	\$.63	\$1.25	\$1.88	\$2.5
**Pre-PACE	\$.35	\$.7	\$1.05	\$1.4
**Breast & Cervical Cancer	\$.33	\$.65	\$.98	\$1.3
Total Savings	\$1.91	\$3.80	\$5.71	\$7.60

*Includes FFS & managed care savings based on 2003 projections, HSD letter to Senator Altamirano and Representative Coll, January 24, 2002.

**This service is provided on FFS basis only.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
L06.3A	Eliminate optional case management services.	1.33			Program cuts
L06.3B	Eliminate optional dental services for adults.	1.54			Program cuts
L06.3C	Eliminate optional pre-PACE services.	1.63			Program cuts
L06.3D	Eliminate breast/cervical cancer services.... OPTION OMITTED	1.13			Program cuts
L06.3E	Eliminate optional eyeglass services.	1.54			Program cuts
L06.3F	Reduce optional case management services by 10%.	1.65			Program cuts
L06.3G	Reduce optional dental services for adults by 10%.	1.96			Program cuts
L06.3H	Reduce optional pre-PACE services by 10%.	1.50			Program cuts
L06.3J	Reduce optional eyeglass services to commercial plan level (e.g., one exam every two years with cap on eyeglass refills).	3.35	DP	7-5	Program cuts

OPTION C1

Cut or reduce recipient eligibility for optional populations:

- A) Limit presumptive eligibility for children
- B) Children between 133% - 185% FPL
- C) SCHIP (children between 185%-235% FPL)
- D) Working disabled

CATEGORY	STRATEGY
Program Limits Reductions	Eligibility

PROS

1. Immediate impact in reducing Medicaid SGF shortfall.
2. Addresses concern that Medicaid program should focus on expenditures for federally mandated eligibility categories.

CONS

1. The number of uninsured children will grow:
 - o In 2000, 20.2% of NM children 0-18 were uninsured as compared to 11.6% US.
 - o Of the 34.5% with public insurance, Medicaid covered 32.2% in NM as compared to 20.4% US.
2. Negative impact on Medicaid populations include socio-economic hardships, compromised health care and diminished health status.
3. Lack of services imposes greater financial burdens on the safety-net institutions, social service providers, counties and health care providers to provide uncompensated care.

PROGRAM IMPACT

June 2002 children enrollment: SCHIP 185%-235% FPL = 10,561; Children 133%-185% FPL=79,871

May not be able to eliminate SCHIP coverage if SCI waiver is implemented

FISCAL IMPACT

SGF Savings in Millions

Optional Eligibility	Eliminate Optional Populations	# Persons Cut
A) *Presumptive eligibility for Children This represents costs for services for up to two months while regular Medicaid Eligibility is being determined	\$1.0	6,400
B) Children between 133% - 185% FPL	\$90.0	79,871
C) SCHIP (children between 185% - 235% FPL)	\$4.3	10,561
D) Working disabled	\$1.4	662
Total Savings	\$95.30	97,494

*PE is provided on FFS basis only: managed care savings are not available as a result of elimination of optional services by the state.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
L07.1	Eliminate presumptive eligibility for children.	1.13			Program cuts
L07.1B	Eliminate coverage for children between 133-185% FPL.	1.09			Program cuts
L07.1C	Eliminate State Children's Health Insurance Program (SCHIP) coverage for children between 185-235% FPL.	1.09			Program cuts
L07.1D	Eliminate coverage for working disabled.	1.13			Program cuts

OPTION L7.2

Reduce recipient eligibility for optional populations:

- A) Reduce children’s eligibility to 200% of poverty
- B) Reduce children’s eligibility to 167.5% of poverty
- C) Reduce children’s eligibility to 150% of poverty

CATEGORY	STRATEGY
-----------------	-----------------

Program Limits Reductions	Eligibility
------------------------------	-------------

PROS

1. Immediate impact in reducing Medicaid SGF shortfall.
2. Reductions not as drastic as wholesale cuts across optional populations.

CONS

1. Growth in number of uninsured children beyond current level:
 - o In 2000, 20.2% of NM children 0-18 were uninsured as compared to 11.6% US.
 - o Of the 34.5% with public insurance, Medicaid covered 32.2% in NM as compared to 20.4% US.
2. Negative impact on Medicaid populations include socio-economic hardships, compromised health care and diminished health status.
3. Lack of services imposes greater financial burdens on the safety-net institutions, social service providers, counties and health care providers to provide uncompensated care.

PROGRAM IMPACT

June 2002 children enrollment: SCHIP 185%-235% FPL = 10,561; Children 133%-185% FPL = 79,871

May not be able to eliminate or reduce SCHIP coverage if SCI waiver is implemented

FISCAL IMPACT

Optional Eligibility	Eliminate Optional Eligibility	# Persons Cut
A) Reduce children's eligibilty to 200% of poverty	\$3.0	5,530
B) Reduce children's eligibility to 167.5% of poverty	\$13.3	26,889
C) Reduce children's eligibility to 150% of poverty	\$26.7	40,334
Total Savings	\$43.0	72,753

MAD Medicaid budget reduction options (in millions), letter from HSD Secretary Robin Otten to Representative Luciano “Lucky” Varela, December 21, 2001.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
L07.2A	Reduce children's eligibility to 200% FPL	1.44			Program cuts
L07.2B	Reduce children's eligibility to 167.5% FPL	1.09			Program cuts
L07.2C	Reduce children's eligibility to 150% FPL	1.09			Program cuts

OPTION L7.3

Reduce eligibility of institutionalized aged, blind and disabled from current 225% FPL to:

- A) 200% of SSI; or
- B) SSI level (73%).

CATEGORY	STRATEGY
Program Limits Reductions	Eligibility

PROS

- 1. Immediate impact in reducing Medicaid SGF shortfall.
- 2. Reductions not as drastic as wholesale cuts across optional populations.

CONS

- 1. Impact on vulnerable populations protected under the 1999 *Olmstead* ruling, under the Americans with Disabilities Act.
- 2. Negative impact on Medicaid populations include socio-economic hardships, compromised health care and diminished health status.
- 3. Lack of services imposes greater financial burdens on the safety-net institutions, social service providers, counties and health care providers to provide uncompensated care.

PROGRAM IMPACT

- 1. Medicaid providers will lose reimbursement for services provided to these populations.
- 2. Persons will lose some or all access to needed services.

FISCAL IMPACT

Optional Eligibility	Eliminate Optional Populations	# Persons Cut
A) 200% of SSI	\$14.0	3,000
B) SSI level (73%)	\$28.0	6,000
Total Savings	\$42.0	9,000

MAD Medicaid Budget Reduction Options (dollars in millions), letter from Sec. Otten to Honorable Luciano Varela, 12/21/01.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
L07.3A	Reduce eligibility of institutionalized aged, blind and disabled from current 225% FPL to 200% SSI.	1.25			Program cuts
L07.3B	Reduce eligibility of institutionalized aged, blind and disabled from current 225% FPL to SSI level.	1.00			Program cuts
L07.4	Explore waivers for innovative reduced benefit packages.	4.29	DP	U	Program cuts

N01	WITHDRAWN				
N02	An outside firm to conduct an analysis of how pharmaceuticals are being used and what trends exist, and to look for cost savings.		DP	U	Pharmacy
N03	Direct HSD to reverse its policy that took away incentives for pharmacies to use generic prescription drugs.	3.55	DP	U	Pharmacy
N04	Apply for waivers for populations served by other agencies' programs or services that are currently state general fund (SGF) only to enable Medicaid match.	4.36	DP	U	Maximization and matching
N05	Change lookback period (assets) from 3 to 5 years if permissible by federal law.	4.30	DP	U	Program cuts
N06	Require counties to assess an additional 1/16th gross receipts tax (GRT) for the county indigent claims fund.	1.91			New funding

OPTION F1

Match SGF dollars allocated for health care related programs or services in other state agencies that are reimbursable under Medicaid:

- A. Rural Primary Health Care Act funding (see option F6);
- B. School health and behavioral health;
- C. Children's medical services;
- D. Recruitment and retention efforts;
- E. DOH lab
- F. Behavioral health and substance abuse (see option C20);
- G. HIV/AIDS expansion;
- H. Tobacco settlement fund cessation programs; and
- I. Other state agencies.

CATEGORY

STRATEGY

Funding

Matching and maximization

PROS

1. Potential to negotiate an alternative reimbursement methodology for primary health care clinics.
2. Pilot program exists for school health and behavioral health that can be evaluated for expansion.
3. Potential to certify some administrative costs for case management services provided by DOH to Medicaid kids.
4. Potential to certify funds spent by DOH on recruitment and retention in rural areas if the population served is Medicaid eligible or efforts ensure access to care for Medicaid population.
5. Potential for DOH to bill for services provided for Medicaid patients.
6. Potential for behavioral health services waiver (see option C20).
7. Potential to expand existing HIV/AIDS waiver to include DOH-provided prevention services.
8. Potential for providers to bill for cessation services to Medicaid.
9. Various other agencies' SGF dollars have matching potential.

CONS

1. Most SGF-only health care programs have already been matched or maximized.
2. There may be significant implementation and transition costs.
3. New constituencies may be created that may demand increased funding in the future.
4. May have adverse impact on non-Medicaid, uninsured, poor population.
5. Conflicts may exist with statutory obligations for public health and primary and preventive efforts.

PROGRAM IMPACT

Various SGF-only health care programs may lose their effectiveness and independence by being rolled into the Medicaid program and accompanying federal requirements. Persons not on Medicaid who depend on these programs may lose access to some or all of the services. Still, additional federal funding may help strengthen the programs and provide greater reach to affected persons.

FISCAL IMPACT

SGF-only program	FY03 Budget	10% of SGF x 75% federal match potential
Rural primary health care	\$10.7 million	\$800 thousand
School/behavioral health	\$0.21 million	\$15 thousand
Children's medical service	\$1.8 million	\$135 thousand
Behavioral health & SA	\$34.1 million	\$2.6 million
HIV/AIDS	\$6.8 million	\$510 thousand
Potentially matched	\$53.6 million	\$4.0 million

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F01	Match SGF dollars allocated for health-care-related programs or services in other state agencies that are reimbursable under Medicaid.	4.74	DP	U	Maximization and matching

OPTION F2

Maximize the 100% federal match available for services rendered to Native Americans in IHS or tribally operated facilities by:

1. encouraging IHS facilities to limit outside referrals;
2. encouraging MCOs to contract with IHS facilities for primary care providers; and
3. continuing to pressure CMS to have 100% match follow patient if referred outside IHS (work with other states and NM congressional delegation).

CATEGORY

Funding

STRATEGY

Matching and
Maximization

PROS

1. Services provided to Medicaid-enrolled Native Americans "within the four walls" of IHS or tribally operated facilities require no state general fund share.
2. Native Americans already use IHS or tribally-operated facilities more often.
3. Any 100% federal match provides SGF savings or availability for other services.

CONS

1. CMS interpretation of 100% match conditions limited to "four walls" of facility despite longstanding efforts of other states with substantial Native American populations.
2. Unlikely that federal government will agree to have 100% match follow Native American beneficiaries outside IHS or tribally operated facilities; congress could amend law and remove ambiguity.
3. IHS is severely underfunded and unable to limit its referrals to other providers.
4. IHS facilities often lack resources and personnel to adequately provide primary care provider arrangements.

PROGRAM IMPACT

1. Could adversely impact Native Americans by limiting their access to specialty providers outside IHS or tribally operated facilities.
2. Implementation of the New Mexico Tribal Health Care Alliance Medicaid MCO could considerably change the reimbursement mechanisms for Native American health care.

FISCAL IMPACT

Approximately \$50 million is currently paid for care to Native Americans in IHS or tribally operated facilities without any general fund expenditure.

If between \$10 million and \$50 million is paid for Native Americans referred to other providers, initiatives to provide care within the "four walls" could produce a cost savings of between \$2.5 to \$12.5 million (based on a 25% SGF share).

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F02	Maximize the 100% federal match available for services rendered to Native Americans in Indian Health Service (IHS) or tribally operated facilities (limited referrals, IHS facilities as primary care providers (PCPs), working with the Centers for Medicare and Medicaid Services (CMS), NM congressional delegation, and other states).	4.41	DP	U	Maximization and matching

OPTION F4

- A. Earmark a percentage of the distribution of the severance tax permanent fund for Medicaid; include a sunset provision.
- B. Earmark a percentage of gaming revenues for Medicaid.

CATEGORY

Funding
Source

STRATEGY

New Funding

PROS

- 1. Dedicates predictable dollars to Medicaid in tight budget situations.
- 2. The shortfall of Medicaid funding constitutes a "crisis".
- 3. A sunset provision could extend the earmarking beyond one year, yet still limit it.
- 4. The earmarking does not reduce the corpus of the severance tax permanent fund.
- 5. The Indian gaming revenues and the portions of the severance tax funds that are distributed to the general fund are not now earmarked for any specific purpose.

CONS

- 1. The formula for distribution of severance tax funds is set in the constitution, as well as in statute. The amount to be distributed cannot be increased without a constitutional amendment.
- 2. The money distributed from the severance tax fund and from gaming revenues already flows to the general fund and is already available for use for Medicaid funding.
- 3. A specific amount of money from gaming revenues cannot be earmarked without altering the compacts, which requires negotiations with the tribes, approval by the federal Department of the Interior and legislative approval.
- 4. Any percentage earmarked from gaming revenues would vary from year to year and is therefore unpredictable.
- 5. Earmarking is only for one year regardless of a sunset provision. Legislative appropriation power cannot be bound in excess of one year.
- 6. Earmarking reduces the amount in the general fund available for other purposes and restricts the ability of the legislature to appropriate efficiently.
- 7. This does not really represent a new source of funding.
- 8. This funding source is short-term and unstable over time.
- 9. This is a cost-avoidance measure; it allows us to avoid reform of Medicaid.

PROGRAM IMPACT

- 1. The Medicaid program shortfalls could be entirely met in this way.
- 2. Other programs of state government would be impaired.

FISCAL IMPACT

Unknown without specific percentages and revenue projections.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F04A	Earmark a percentage of the distribution of the severance tax permanent fund for Medicaid; include a sunset provision.	2.46	S		Earmarking
F04B	Earmark a percentage of gaming revenues for Medicaid.	2.63	DP	8-3	Earmarking

OPTION F5

Increase percentage of tobacco settlement funds dedicated to Medicaid support.

CATEGORY

Funding

STRATEGY

New Funding

Source

PROS

1. Section 6-4-10 NMSA 1978 indicates that “any health or health care program or service for prevention or treatment of illness” is a legitimate use of the funds.
2. When matched, it greatly extends the use to which these funds are put.
3. Money could be used within Medicaid to fund a pilot disease management program or primary care case management program that supports smoking cessation efforts or addresses tobacco-related illnesses.
4. Due to the average age of Medicaid recipients, this population commonly needs prenatal care, asthma treatment and treatment of prematurity; all these conditions are related to prevention and support smoking cessation efforts.
5. Tobacco settlement funds granted to the DOH for smoking cessation programs in part fund services that are covered by Medicaid and are used for Medicaid clients; providers should be billing for these services, but no tracking mechanism currently exists to identify the extent to which this is occurring. Granting a portion of the DOH money directly to Medicaid ensures that Medicaid providers and Medicaid clients benefit from the funding *and* that the federal match is obtained.
6. The amount being requested represents approximately 10% of the 14% of Medicaid funds currently being expended to treat tobacco-related illnesses.

CONS

1. There is a great demand from numerous entities for other important and under-funded areas.
2. The Tobacco Settlement Revenue Oversight Committee may prefer to earmark funds for specific purposes rather than individual client needs.
3. Over time, the fund will decline and any ongoing dependence on these funds for Medicaid expenditures will be problematic.
4. Medicaid reform efforts should be focused on cutting or controlling costs, not simply on identifying and using other sources of revenue.

PROGRAM IMPACT

1. The tobacco settlement fund is positively impacted, as the money is effectively tripled, thereby expanding the number of people helped.
2. The Medicaid program is positively impacted, as it decreases the need to limit eligibility or cut services to this needy population.

FISCAL IMPACT

AMOUNT REQUESTED: \$20-\$22 million

When matched, \$20-\$22 million generates \$60-\$66 million in federal funds, or \$80-\$88 million combined. This step alone would substantially reduce the anticipated Medicaid shortfalls for FY04.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F05	Increase percentage of tobacco settlement funds dedicated to Medicaid support.	4.88	DP	U	Earmarking

OPTION F6

- A. Establish an alternative payment methodology for FQHCs that will allow true reimbursement of 100% of costs.
- B. Reimburse primary care clinics for Medicaid outreach and enrollment activities.

CATEGORY

Funding

STRATEGY

Intergovernmental
Transfer

PROS

1. Could be a win/win situation for the state, clinics and clients.
2. Covers shortfall in PPS reimbursement to cover pharmaceuticals and fully adjust for inflation (A).
3. Reimburses clinics for activities already being performed and saves Medicaid from having to place state employees at those sites to perform enrollment and outreach activities.
4. Maintains critical infrastructure of safety net providers.
5. Allows RPHCA funds to be used for purposes other than making up the clinics' shortfalls.
6. Holds harmless the approximately 34% of indigent people served by the primary care clinics.

CONS

1. Clinics have a strong need to be held harmless; fear loss of funding and instability.
2. Care must be taken not to disrupt critical funding bases for certain populations or clinics.
3. HSD believes clinics are already reimbursed at 100% of costs.
4. Clinics are already performing outreach and enrollment activities without being reimbursed; they have a strong motivation to engage in these activities anyway.

PROGRAM IMPACT

1. FQHCs would continue to serve Medicaid recipients and indigent populations at their sites.
2. Clients eligible for Medicaid would continue to be enrolled onsite.
3. FQHC reimbursement is increased, while overall savings to the Medicaid program are achieved.
4. DOH would be able to transfer a portion of RPHCA funding to HSD to be matched for Medicaid.

FISCAL IMPACT

A combined general fund savings of \$2 million is projected.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F06A	Establish an alternative payment methodology for federally qualified health centers (FQHCs) that will allow true reimbursement of 100% of costs.	4.29	DP	U	Intergov'tal transfers
F06B	Reimburse primary care clinics for Medicaid outreach and enrollment activities.	4.04	DP	U	Intergov'tal transfers

OPTION F7

Double the amount collected for the county-supported Medicaid fund by requiring counties to authorize the imposition of an additional 1/16th gross receipts tax or by using existing dollars collected for the county indigent hospital claims fund.

CATEGORY

Funding
Transfer

STRATEGY

Intergovernmental

PROS

1. Can be accomplished with an amendment to existing law.
2. Doubles the amount collected for this established purpose, which can then be matched.
3. Would help hospitals and other providers in counties.

CONS

1. Counties will strongly resist and they will be reluctant to impose new taxes.
2. Reduction to the counties' current funds limits their ability to pay existing claims.
3. Taxes are assessed locally but used for statewide needs.
4. Counties will be limited in their ability to serve indigents.

PROGRAM IMPACT

1. Medicaid benefits from additional funds.
2. The counties suffer in that their funds to serve indigents are reduced.
3. A new tax may need to be imposed.

FISCAL IMPACT

Generates an estimated \$20.4 million; when matched, generates \$61.2 million in federal funds, for a total of \$91.6 million combined.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F07	Double the amount collected for the county-supported Medicaid fund by requiring counties to authorize the imposition of an additional 1/16th GRT or by using existing dollars collected for the county indigent hospital claims fund.	1.69			Intergov'tal transfers

OPTION F8

Use county medical indigent funds to obtain Medicaid match; direct HSD to work with the counties to apply for a waiver to permit redistribution of funds back to counties.

CATEGORY

Funding
Transfer

STRATEGY

Intergovernmental

PROS

1. Would quadruple currently unmatched county dollars (expended).
2. May allow the counties to serve more indigent patients.
3. Would help hospitals and other providers in counties.
4. Would permit expansion of services or eligibility categories.
5. May be able to identify ways in which counties are currently using county indigent hospital claims fund dollars and construct a waiver to cover those services and individuals.

CONS

1. No such waivers have been approved; typically, waivers are not allowed for purposes that appear to be for the purpose of obtaining a federal match.
2. Federal cost neutrality is required and would be hard to demonstrate.
3. CMS indicates the waiver must have "comparable population" to Medicaid; the indigent population is not comparable to Medicaid.
4. The waiver must be statewide; not all counties have indigent funds.
5. Counties will lose flexibility and autonomy in managing their indigent programs.
6. Counties are concerned with how quickly they would get back their (matched) money; lack of timeliness would jeopardize already fragile programs.

PROGRAM IMPACT

1. The base of Medicaid-eligible populations is increased.
2. If successful, the counties would have four times the money they now have to serve their indigent populations.

FISCAL IMPACT

Generates an estimated \$20.4 million; when matched, generates \$61.2 million in federal funds, for a total of \$91.6 million, combined.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F08	Use county medical indigent funds to obtain Medicaid match; direct HSD to work with the counties to apply for a waiver to permit redistribution of funds back to counties.	3.31	DP	8-4	Intergov'tal transfers

OPTION F9

Require application of premium tax on Medicaid MCO PMPM payments.

CATEGORY

Funding

STRATEGY

New Funding

Source

PROS

1. The premium tax is reimbursable under Medicaid, and available for federal match (to be matchable, must be a tax that is not imposed solely for the purpose of obtaining a match).
2. The exemption (from premium tax) for state employees insurance premiums was never intended to extend to the MCOs for Medicaid.
3. The PMPM would be increased (to cover the additional tax); however, the federal government would cover approximately three fourths of the increase.
4. The premium tax would be collected by the taxation and revenue department for the general fund, where it would be available to be appropriated for Medicaid purposes.

CONS

1. Care should be taken to ensure that “downstream” provider contracts are not affected by the imposition of this tax.
2. The PMPM would be renegotiated to include the cost of the tax.
3. If additional money is *not* appropriated from the general fund to Medicaid, then Medicaid would suffer a loss for the increased PMPM amount.

PROGRAM IMPACT

1. No effect on service provision or eligibility.
2. Some administrative (but expectedly minimal) impact for the MCOs to account for and pay the premium tax.

FISCAL IMPACT

1. A total of \$18 million would be added to the general fund, calculated as follows:
 - \$800 million SALUD! premiums × 3% (current premium tax) = \$24 million
 - \$24 million comes into the Medicaid program but the state Medicaid share only \$6 million
 - \$6 million = state share (approximately 25%)
 - \$18 million = federal match (approximately 75%)

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F09	Require application of premium tax on Medicaid MCO PMPM payments.	4.73	DP	U	New funding

OPTION F10

Repeal 50% gross receipts tax exemption on for-profit hospitals or impose gross receipts tax on nonprofit hospitals; increase reimbursement rate to hospitals to cover cost of tax.

CATEGORY

Funding

STRATEGY

New Funding Source

PROS

1. The gross receipts tax is reimbursable under Medicaid and available for a federal match.
2. The hospitals' costs would increase by the amount of the tax although reimbursement rates to hospitals could be increased by an amount equal to the tax.
3. The federal government would pay approximately 3/4 of the increased reimbursement rate.
4. The GRT would go into the general fund, where it would be available for Medicaid program appropriation.

CONS

1. Could jeopardize hospitals' stability, especially rural and border hospitals.
2. Additional reimbursement would be limited to Medicaid expenditures and would adversely impact other lines of business revenue and expenditures.
3. If the additional money collected is *not* appropriated to Medicaid, then Medicaid would suffer a loss for the additional reimbursement paid to hospitals.
4. Other not-for-profit entities might fear imposition of gross receipts taxes and hence oppose the measure.

PROGRAM IMPACT

1. Effect on services or eligibility may depend on fiscal impact on hospitals.
2. Some administrative impact for the hospitals to account for and pay this tax.

FISCAL IMPACT

1. Could generate between \$13 million and \$120 million, depending on whether one or both proposals are adopted, and based on inflationary factors.
2. Conservatively, presuming the entire amount collected is appropriated to Medicaid, \$13 million would generate \$39 million in federal funds, or a total of \$52 million.
3. Approximately \$3.25 million may have to be subtracted from the above \$13 million, to account for the increase in reimbursement to hospitals.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F10	Repeal 50% GRT exemption on for-profit hospitals or impose GRT on nonprofit hospitals; increase reimbursement rate to hospitals to cover cost of tax.	1.74			New funding

OPTION F11

Increase premium tax on health insurance to 4%.

CATEGORY

Funding

STRATEGY

New Funding Source

PROS

1. Health insurance companies are exempt from GRT obligations; the current premium tax is less than half of the GRT.
2. An additional 1% would not be overly burdensome.
3. Over time, the GRT has gone up while the premium tax has stayed at the same level (GRT was 3.75% when the premium tax was enacted).

CONS

1. Could result in a disincentive to purchase health insurance if costs passed along to consumers.
2. There is an established correlation between increased health insurance costs and increased numbers of uninsured.
3. It could have the effect of increasing the number of people on Medicaid.
4. It is considered a regressive tax.

PROGRAM IMPACT

1. Would benefit the Medicaid program if the additional general fund dollars were appropriated to Medicaid.
2. The benefit may be offset if the number of Medicaid enrollees increased.

FISCAL IMPACT

1. An additional \$12 - \$13.5 million would be collected.
2. If appropriated to Medicaid, this would generate \$36 - \$40.5 million in federal funds, for a total of \$48 - \$54 million combined.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F11	Increase premium tax on health insurance to 4%.	1.82			New funding

OPTION F12

Impose an excise tax on alcohol sales; earmark funds for a combination of Medicaid funding and the development of a statewide trauma system.

CATEGORY

Funding

STRATEGY

New Funding
Source

PROS

1. The estimated cost to the state for alcohol-related illnesses and accidents is \$70 million, of which approximately \$23.5 million is for uninsured alcohol-related trauma and illnesses.
2. The state loses more (\$70 million) than it collects (\$35 million).
3. Both the Medicaid program and the network of hospitals in the state are negatively impacted by the lack of a statewide trauma system.
4. A higher tax on alcohol may result in a decrease in the purchase of such products, particularly for the young.
5. A collaborative effort more than doubles the benefit of the potential dollars collected.
6. It is reasonable for the state to collect an amount equal to that required for the state to treat alcohol-related illnesses and injuries.

CONS

1. New taxes (even "sin" taxes) would harm the alcohol industry and retailers.
2. This may be an unstable source of revenue if the use of alcohol declines.
3. The proposal involves earmarking, the provisions of which cannot be extended beyond one year.
4. The increased costs, due to the excise tax, would be passed along to consumers, so in reality it would be the consumers of alcohol products, *not* the industry, who would bear the burden.
5. The state already collects an estimated \$35 million in excise fees, the use of which is primarily targeted at DWI prevention and treatment.
6. This is not Medicaid reform and does not seek to reduce or control costs.

PROGRAM IMPACT

1. States with statewide trauma systems have reported significant reductions in preventable deaths due to traumatic injury.
2. The Medicaid program benefits not only by the infusion of matchable funds, but also by the development of a trauma system. The trauma system reduces various burdens now borne by New Mexico's hospitals, such as overcrowding and difficulty of staffing emergency rooms.

FISCAL IMPACT

1. Imposition of an additional 10% excise tax would generate an estimated \$42.8 million; the amount needed to fund a statewide trauma system is estimated at \$24.4 million, leaving a potential for \$18.4 million for Medicaid.
2. When matched, \$24.4 million generates \$55.2 million in federal funds, for a total of \$79.6 million, combined.
3. This is new revenue.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F12	Impose an excise tax on alcohol sales; earmark funds for a combination of Medicaid funding and the development of a statewide trauma system.	4.59	DP	7-4	New funding

OPTION F13

Increase cigarette tax by \$0.60 per pack earmarked (in whole or in part, with or without sunset clause) for the Medicaid program.

CATEGORY

Funding

STRATEGY

New Funding Source

PROS

1. Would generate substantial revenues.
2. Would serve as deterrent to smoking, especially among low-income and young people.
3. Is consistent with the “benefits received” principle of taxation.
4. Smoking-related illnesses impose a significant cost on the Medicaid program.

CONS

1. Could be a declining source of revenue if many people quit smoking.
2. Could negatively impact businesses that sell cigarettes.
3. Could drive purchasers to tribes or the Internet.
4. It is a regressive tax.
5. Will be vigorously opposed.

PROGRAM IMPACT

1. Would benefit Medicaid if the funds were appropriated to Medicaid.
2. Medicaid could realize additional savings over time as fewer people smoke and health benefits are realized.

FISCAL IMPACT

1. \$50 million in new revenues is estimated.
2. If appropriated to Medicaid, this would generate \$150 million in federal funds for a total of \$200 million combined.

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY
F13	Increase cigarette tax by \$0.60 per pack earmarked (in whole or in part, with or without sunset clause) for the Medicaid program.	4.54	DP	7-4	New funding

APPENDIX 16

MEDICAID REFORM COMMITTEE
Options Considered November 13-15, 2002

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY	NOTES		
C01A	Require a uniform, preferred drug list for FFS and Salud!	3.62	DP	U	Pharmacy			
C01B	Require a uniform, preferred drug list for Medicaid, IBAC, DOH, and other potential purchasers	3.83	DP	U	Pharmacy			
C02	Maximize the use of the federal 340B discount drug program	4.33	DP	U	Pharmacy			
C03A	Carve out phmcy from Salud!	3.08	DNP	4-8	Pharmacy			
C03B	Carveout pharmacy from PMPM rate, but pay MCOs to manage the benefit and coordinate care	1.85	DNP	U	Pharmacy			
C03C	Direct HSD to conduct a cost/benefit analysis on the carveout of pharmacy from Salud!	3.77	DP	8-1	Pharmacy			
C04	Provide greater flexibility to MCOs in management of the pharmacy benefit; allow MCOs to manage the benefit similar to the commercial market.	2.29	S		Pharmacy			
C05A	Establish a prescription drug purchasing cooperative to combine the buying power of Medicaid, IBAC, DOH, VA, Corrections and other potential purchasers; consolidate contract administration and negotiation under one state agency.	2.88	DP	U	Pharmacy			
C05B	Establish drug purchasing cooperative or refer to AG.	3.24	S		Pharmacy			
C06	REPLACED WITH C06B (Related to primary care case management)	4.68			Managing health care better			

MEDICAID REFORM COMMITTEE
Options Considered November 13-15, 2002

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY	NOTES		
C06B	In collaboration with DOH, HSD, and the MCOs implement a pilot program with FFS and Salud! expanding the use of promotores/community health representatives utilizing findings from existing programs in the Northwest, border areas, and Northern New Mexico.	3.58	DP	U	Managing health care better			
C07A	Require MCOs to strengthen DM programs and coordinate more closely with PCPs through incentives for participation and service to underserved areas.	4.22	DP	U	Managing health care better			
C07B	Replaced with C07D (Related to disease management)	4.14			Managing health care better			
C07C	Ensure case-management is a core medical service provided within the DM programs for FFS/Salud!	4.32	DP	U	Managing health care better			
C07D	Utilize a disease management firm to design a pilot program for FFS by using key health status indicators and accountability for clinical benefits and cost savings.	4.33	DP	U	Managing health care better			
C08	Direct HSD to conduct a comprehensive feasibility study and cost-benefit analysis on the replacement of the current managed care model with a statewide primary care case management (PCCM) model with options.	3.74	DP	U	Managing health care better			

MEDICAID REFORM COMMITTEE
Options Considered November 13-15, 2002

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY	NOTES		
C09	Apply for grant from Agency on Health Care Research and Quality (Center for Primary Care Research) to implement a pilot/demonstration project for PCCM model for FFS population or sub-population to ensure medical and utilization review.	4.22	DP	U	Managing health care better			
C10A	Carveout and manage non-emergency transportation from Salud! and manage FFS through a brokerage model.	3.04	DNP	3-7	Managing health care better			
C10B	Carveout and manage non-emergency transportation from Salud! and manage FFS through a state administered model.	2.78	DNP	U	Managing health care better			
C10C	Conduct a cost-effectiveness analysis of non-emergency transportation comparing brokerage model vs. state managed model.	3.68	DP	U	Managing health care better			
C10D	Conduct a pilot in a rural and urban area for non-emergency transportation carve-out in FFS only.		DP	U	Managing health care better			
C11	Consolidate information system for managed care and FFS to provide all claims processing, reimbursement, data repository, and real-time, online reporting capability while maintaining integrity and security for respective users.	3.13	DNP	5-7	Managing health care better			
C12	HSD to develop and submit 1115 Global Funding Waiver (GFW) and include preliminary cost effectiveness estimations of GFW by January 2003.	4.23	DP	U	Long-term care			

MEDICAID REFORM COMMITTEE
Options Considered November 13-15, 2002

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY	NOTES		
C13	Conduct a cost-benefit analysis of the personal care option (PCO) sampling a sub-population of consumer-directed vs. consumer-delegated care with evaluation of various factors.	3.25	DP	U	Long-term care			
C14	Continue the personal care option (PCO) with increased consumer awareness of consumer-directed services as a choice in addition to consumer-delegated (agency-directed) services.	4.46	DP	U	Long-term care			
C16A	Contain the growth of nursing home beds by creating a formal evaluation process to determine the need for nursing home capacity expansion and establish a five- and ten-year maximum bed expansion rate to achieve long term cost containment.	2.46			Long-term care			
C16B	Incorporated into C16A				Long-term care			
C17	Expand Program of All-Inclusive Care for the Elderly (PACE) in urban areas of the state beyond current 187 consumers in Albuquerque (e.g., Las Cruces, Roswell or Santa Fe).	4.09	DP	7-3	Long-term care			
C18A	Consolidate long-term care (LTC) services provided by DOH, CYFD, HSD, and AoA under one agency for adult services only (including LTC Link development).	3.50			Long-term care			
C18B	Consolidate long-term care (LTC) services provided by DOH, CYFD, HSD, and AoA under one agency for all services from birth to death (including LTC Link development).	3.44	DP	U	Long-term care			
C19	Amend the tax code in a way to allow individuals tax credits for purchasing and maintaining long-term care insurance.	4.17	DP	U	Long-term care			

MEDICAID REFORM COMMITTEE
Options Considered November 13-15, 2002

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY	NOTES		
C20	Develop a pilot Medicaid behavioral health waiver under an 1115 research and demonstration waiver for 100 recipients with severe and persistent mental illness (SPMI) and a co-occurring addiction disorder in Dona Ana County.	3.17	DNP	6-6	Long-term care			
C21	Strengthen fraud and abuse detection, reporting, and recovery.	3.96	DP	9-3	Managing health care better			
F01	Match SGF dollars allocated for health care related programs or services in other state agencies that are reimbursable under Medicaid.	4.74	DP	U	Maximization and matching			
F02	Maximize the 100% federal match available for services rendered to Native Americans in IHS or tribally-operated facilities (limited referrals, IHS facilities as PCPs, working with CMS, NM congressional delegation, and other states).	4.41	DP	U	Maximization and matching			
F03	NONE							
F04A	Earmark a percentage of the distribution of the severance tax permanent fund for Medicaid; include a sunset provision.	2.46	S		Earmarking			
F04B	Earmark a percentage of gaming revenues for Medicaid.	2.62	DP	8-3	Earmarking			
F05	Increase percentage of tobacco settlement funds dedicated to Medicaid support.	4.88	DP	U	Earmarking			
F06A	Establish an alternative payment methodology for FQHCs that will allow true reimbursement of 100% of costs.	4.29	DP	U	Intergov'tal transfers			

MEDICAID REFORM COMMITTEE
Options Considered November 13-15, 2002

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY	NOTES		
F06B	Reimburse primary care clinics for Medicaid outreach and enrollment activities.	4.04	DP	U	Intergov'tal transfers			
F07	Double the amount collected for the county-supported Medicaid fund by requiring counties to authorize the imposition of an additional 1/16th GRT or by using existing dollars collected for the county indigent hospital claims fund.	1.69			Intergov'tal transfers			
F08	Use county medical indigent funds to obtain Medicaid match; direct HSD to work with the counties to apply for a waiver to permit redistribution of funds back to counties.	3.31	DP	8-4	Intergov'tal transfers			
F09	Require application of premium tax on Medicaid MCO PMPM payments.	4.73	DP	U	New funding			
F10	Repeal 50% GRT exemption on for-profit hospitals or impose GRT on non-profit hospitals; increase reimbursement rate to hospitals to cover cost of tax.	1.74			New funding			
F11	Increase premium tax on health insurance to 4%	1.82			New funding			
F12	Impose an excise tax on alcohol sales; earmark funds for a combination of Medicaid funding and the development of a statewide trauma system.	4.59	DP	7-4	New funding			
F13	Increase cigarette tax by \$0.60 per pack earmarked (in whole or in part, with or without sunset clause) for the Medicaid program.	4.54	DP	7-4	New funding			
L01	Impose a monthly premium on selected Medicaid beneficiaries.	2.32	DP	10-2	Cost sharing			
L02	Impose co-payment on ER services unless patient is admitted as a result of ER evaluation.	2.45	DP	8-4	Cost sharing			

MEDICAID REFORM COMMITTEE
Options Considered November 13-15, 2002

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY	NOTES		
L03	Impose tiered co-payments on higher cost prescription drugs to provide incentives for greater use of generic drugs when there is a generic or lower-cost equivalent available.	2.82	DP	8-3	Cost sharing			
L03B	Impose co-payments for drugs not on the preferred drug list.	4.36	DP	U	Cost sharing			
L04	Impose a tiered copay on office visits and prescription drugs for Medicaid beneficiaries at or above 133% FPL with the provider held harmless.	2.52	DNP	6-6	Cost sharing			
L05A	Reduce Medicaid Salud! MCO PMPM payments by 0.5% - 1.0%.	2.26	S		Rate adjustment			
L05B	Reduce Medicaid FFS provider payments by 0.5% - 1.0%	1.61			Rate adjustment			
L06.1A	Eliminate optional institutional care services.	1.08			Program cuts			
L06.1B	Eliminate optional PCO services.	1.12			Program cuts			
L06.1C	Eliminate optional prescription drug services.	1.04			Program cuts			
L06.1D	Reduce by 10% optional institutional care services.	1.91			Program cuts			
L06.1E	Reduce by 10% optional PCO services.	1.82			Program cuts			
L06.1F	Reduce by 10% optional prescription drug services.	1.91			Program cuts			
L06.2A	Eliminate optional other practitioner services.	1.16			Program cuts			
L06.2B	Eliminate optional D&E waiver services.	1.12			Program cuts			
L06.2C	Eliminate optional ICF/MR services.	1.12			Program cuts			
L06.2D	Eliminate optional medical supply services.	1.67			Program cuts			
L06.2E	Reduce optional other practitioner services.	2.22	S		Program cuts			
L06.2F	Reduce optional D&E waiver services.	2.05	S		Program cuts			

MEDICAID REFORM COMMITTEE
Options Considered November 13-15, 2002

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY	NOTES		
L06.2G	Reduce optional ICF/MR waiver services.	1.70			Program cuts			
L06.2H	Reduce optional medical supply services.	1.83			Program cuts			
L06.2I	PCP gatekeeper for services by other practitioners.	3.54	DNP	2-5	Program cuts			
L06.2I a	PCP gatekeeper for services by other practitioners being in collaboration with and communication to the PCP with the exception of self-referral services.		DP		Program cuts			
L06.3A	Eliminate optional case management services.	1.33			Program cuts			
L06.3B	Eliminate optional dental services for adults.	1.54			Program cuts			
L06.3C	Eliminate optional pre-PACE services.	1.62			Program cuts			
L06.3D	Eliminate breast/cervical cancer services ... OPTION OMITTED	1.12			Program cuts			
L06.3E	Eliminate optional eyeglass services.	1.54			Program cuts			
L06.3F	Reduce optional case management services by 10%.	1.65			Program cuts			
L06.3G	Reduce optional dental services for adults by 10%.	1.96			Program cuts			
L06.3H	Reduce optional pre-PACE services by 10%.	1.50			Program cuts			
L06.3J	Reduce optional eyeglass services to commercial plan level (e.g., one exam every two years with cap on eyeglass refills).	3.35	DP	7-5	Program cuts			
L07.1	Eliminate presumptive eligibility for children.	1.12			Program cuts			
L07.1B	Eliminate coverage for children between 133-185% FPL.	1.09			Program cuts			
L07.1C	Eliminate SCHIP coverage for children between 185-235% FPL.	1.09			Program cuts			
L07.1D	Eliminate coverage for working disabled.	1.13			Program cuts			
L07.2A	Reduce children's eligibility to 200% FPL	1.44			Program cuts			
L07.2B	Reduce children's eligibility to 167.5% FPL	1.09			Program cuts			

MEDICAID REFORM COMMITTEE
Options Considered November 13-15, 2002

OPTION:	DESCRIPTION	MEAN	PASS	VOTE	SUB-CATEGORY	NOTES		
L07.2C	Reduce children's eligibility to 150% FPL	1.09			Program cuts			
L07.3A	Reduce eligibility of institutionalized aged, blind, and disabled from current 225% FPL to 200% SSI.	1.25			Program cuts			
L07.3B	Reduce eligibility of institutionalized aged, blind, and disabled from current 225% FPL to SSI level.	1.00			Program cuts			
L07.4	Explore waivers for innovative reduced benefit packages.	4.29	DP	U	Program cuts			
N01	WITHDRAWN							
N02	An outside firm to conduct an analysis of how pharmaceuticals are being used, what trends exist, and look for cost savings.		DP	U	Pharmacy			
N03	Direct HSD to reverse its policy that took away incentives for pharmacists to use generic prescription drugs.	3.54	DP	U	Pharmacy			
N04	Apply for waivers for populations served by other agencies' programs or services that are currently SGF only to enable Medicaid match.	4.36	DP	U	Maximization and matching			
N05	Change lookback period (assets) from 3 to 5 years if permissible by federal law.	4.30	DP	U	Program cuts			
N06	Require counties to assess an additional 1/16th GRT for the county indigent claims fund.	1.91			New funding			

APPENDIX 17

MEDICAID REFORM COMMITTEE
Recommendations from November 13-15, 2002

	PROGRAMMATIC CHANGE	STUDY/ANALYSIS/PILOT/WAIVER	TAX	EARMARKING	RANK * VOTE * \$
1	Require a uniform, preferred drug list for FFS and Salud! C01A				3.63, U, \$0.8 to \$2.4 SGF svgs
2	Require a uniform, preferred drug list for Medicaid, IBAC, DOH and other potential purchasers. (This would incorporate #1 above.) C01B				3.83, U, \$0.8 to \$2.4 SGF svgs
3	Maximize the use of the federal 340B discount drug program. C02				4.33, U, \$0.5 to \$1.5 SGF svgs
4		Direct HSD to conduct a cost-benefit analysis on the carveout of pharmacy from Salud! C03C			3.77, 8-1, study
5	Establish a prescription drug purchasing cooperative to combine the buying power of Medicaid, IBAC, DOH, VA, Corrections and other potential purchasers; consolidate contract administration and negotiation under one state agency. C05A				2.88, U, \$0.375 to \$1.125 SGF svgs

MEDICAID REFORM COMMITTEE
Recommendations from November 13-15, 2002

	PROGRAMMATIC CHANGE	STUDY/ANALYSIS/PILOT/WAIVER	TAX	EARMARKING	RANK * VOTE * \$
6	In collaboration with DOH, HSD, and the MCOs, implement a pilot program with FFS and Salud! expanding the use of promotores/ community health representatives utilizing findings from existing programs in the Northwest, border areas and Northern NM. C06B				3.58, U, \$0.131 to \$0.525 SGF svgs
7	Require MCOs to strengthen DM programs and coordinate more closely with PCPs through incentives for participation and service to underserved areas. C07A (Overlap with C07C and C07D)				4.22, U, \$0.013 to \$0.038 SGF svgs
8	Ensure case management is a core medical service provided within the DM programs for FFS and Salud! C07C				4.32, U, \$0.013 to \$0.038 SGF svgs

MEDICAID REFORM COMMITTEE
Recommendations from November 13-15, 2002

	PROGRAMMATIC CHANGE	STUDY/ANALYSIS/PILOT/WAIVER	TAX	EARMARKING	RANK * VOTE * \$
9	Utilize a disease management firm to design a pilot program for FFS by using key health status indicators and accountability for clinical benefits and cost savings. C07D (Overlap with C07A)				4.33, U, \$0.013 to \$0.038 SGF svgs
10		Direct HSD to conduct a comprehensive feasibility study and cost-benefit analysis on the replacement of the current managed care model with a statewide primary care case management (PCCM) model with options. C08 (May overlap with C09)			3.74, U, study
11		Apply for grant from the Agcy on Health Care Research & Quality (Ctr for Primary Care Research) to implement a pilot/demonstration project for PCCM model for FFS population or sub-population to ensure medical/utilization review. C09 (May overlap with C08)			4.22, U, study

MEDICAID REFORM COMMITTEE
Recommendations from November 13-15, 2002

	PROGRAMMATIC CHANGE	STUDY/ANALYSIS/PILOT/WAIVER	TAX	EARMARKING	RANK * VOTE * \$
1 2		Conduct a cost-effectiveness analysis of non-emergency transportation comparing brokerage model vs. state-managed model. C10C (May overlap with C10D)			3.68, U, study
1 3		Conduct a pilot in a rural and urban area for non-emergency transportation carveout in FFS only. C10D (May overlap with C10C)			Not ranked, U, study
1 4		HSD to develop and submit 1115 Global Funding Waiver (GFW) and include preliminary cost effectiveness estimations of GFW by January 2003. C12			4.23, U, in process
1 5		Conduct a cost-benefit analysis of the personal care option (PCO) sampling a sub-population of consumer-directed vs. consumer-delegated care with evaluation of various factors. C13 (May overlap with C14)			3.25, U, study

MEDICAID REFORM COMMITTEE
Recommendations from November 13-15, 2002

	PROGRAMMATIC CHANGE	STUDY/ANALYSIS/PILOT/WAIVER	TAX	EARMARKING	RANK * VOTE * \$
1 6	Continue the PCO with increased consumer awareness of consumer-directed services as a choice in addition to consumer-delegated (agency-directed) services. C14 (May overlap with C13)				4.46, U, \$0.6 TO \$1.2 SGF svgs
1 7	Expand Program of All-Inclusive Care for the Elderly (PACE) in urban areas of the state beyond current 187 consumers in Albuquerque (e.g., Las Cruces, Roswell or Santa Fe). C17				4.09, 7-3, \$0.015 to \$0.150 SGF svgs
1 8	Consolidate long-term care (LTC) services provided by DOH, CYFD, HSD and SAoA under one agency for all services from birth to death (including assessment, information and referral development). C18B				3.44, U, initial cost estimated at \$0.250 SGF

MEDICAID REFORM COMMITTEE
Recommendations from November 13-15, 2002

	PROGRAMMATIC CHANGE	STUDY/ANALYSIS/PILOT/WAIVER	TAX	EARMARKING	RANK * VOTE * \$
19			Amend the tax code to allow individuals tax credits for purchasing and maintaining long-term care insurance. C19		4.17, U, short-term costs or long-term savings unknown
20	Strengthen fraud and abuse detection, reporting and recovery. C21				3.96, 9-3, \$2.5 to \$5.0 SGF svgs
21	Match SGF dollars allocated for health-care-related programs or services in other state agencies that are reimbursable under Medicaid. F01 (May overlap with N04)				4.74, U, \$0.22 to \$0.44 SGF svgs
22	Maximize the 100% federal match available for services rendered to Native Americans in IHS or tribally operated facilities (limited referrals, IHS facilities as PCPs, working with CMS, NM congressional delegation and other states). F02				4.41, U, \$0.5 to \$2.5 SGF svgs

MEDICAID REFORM COMMITTEE
Recommendations from November 13-15, 2002

	PROGRAMMATIC CHANGE	STUDY/ANALYSIS/PILOT/WAIVER	TAX	EARMARKING	RANK * VOTE * \$
2 3				Earmark a percentage of gaming revenues for Medicaid. F04B	2.63, 8-3, additional new funds unknown
2 4				Increase percentage of tobacco settlement funds dedicated to Medicaid support. F05	4.88, U, \$0.8 to \$22 additional funds
2 5	Establish an alternative payment methodology for FQHCs that will allow true reimbursement of 100% of costs. F06A				4.29, U, \$0.5 to \$0.8 SGF svgs
2 6	Reimburse primary care clinics for Medicaid outreach and enrollment activities. F06B				4.04, U, \$0.25 to \$1.0
2 7				Use county medical indigent funds to obtain Medicaid match; direct HSD to work with counties to apply for a waiver to permit redistribution of funds back to counties. F08	3.31, 8-4, \$0 to \$10 additional funds
2 8			Require application of premium tax on Medicaid MCO PMPM payments. F09		4.73, U, \$18.38 to \$21.06 additional funds

MEDICAID REFORM COMMITTEE
Recommendations from November 13-15, 2002

	PROGRAMMATIC CHANGE	STUDY/ANALYSIS/PILOT/WAIVER	TAX	EARMARKING	RANK * VOTE * \$
29			Impose an excise tax on alcohol sales; earmark funds for a combination of Medicaid funding and the development of a statewide trauma system. F12		4.59, 7-4, \$27.6 to \$55.2 additional funds
30			Increase cigarette tax by \$0.60 per pack earmarked (in whole or in part, with or without sunset clause) for the Medicaid program. F13		4.54, 7-4, \$25 to \$50 additional funds
31	Impose a monthly premium on selected Medicaid beneficiaries. L01 (Federal law prohibits application of both premiums and copays on the same eligibility category.)				2.32, 10-2, \$2.4 to \$6.0 SGF svgs
32	Impose co-payment on ER services unless patient is admitted as a result of ER evaluation. L02 (Federal law prohibits application of both premiums and copays on the same eligibility category.)				2.45, 8-4, \$0.02 to \$0.04 SGF svgs

MEDICAID REFORM COMMITTEE
Recommendations from November 13-15, 2002

	PROGRAMMATIC CHANGE	STUDY/ANALYSIS/PILOT/WAIVER	TAX	EARMARKING	RANK * VOTE * \$
3 3	Impose tiered co-payments on higher-cost prescription drugs to provide incentives for greater use of generic drugs when there is a generic or lower-cost equivalent available. L03 (Federal law prohibits application of both premiums and copays on the same eligibility category.)				2.82, 8-3, \$0.837 to \$1.3 SGF svgs
3 4	Impose co-payments for drugs not on the preferred drug list. L03B (Federal law prohibits application of both premiums and copays on the same eligibility category.)				4.36, U, \$0.837 to \$1.3 SGF svgs
3 5	PCP gatekeeper for services by other practitioners being in collaboration with and communication to the PCP with the exception of self-referral services. L06.21a				Not ranked, ___, \$ unknown

MEDICAID REFORM COMMITTEE
Recommendations from November 13-15, 2002

	PROGRAMMATIC CHANGE	STUDY/ANALYSIS/PILOT/WAIVER	TAX	EARMARKING	RANK * VOTE * \$
3 6	Reduce optional eyeglass services to commercial plan level (e.g., one exam every two years with cap on eyeglass refills). L06.3J				3.35, 7-5, \$0.025 to \$0.050 SGF svgs
3 7		Explore waivers for innovative reduced benefit packages. L07.4			4.29, U, study
3 8		An outside firm to conduct an analysis of how pharmaceuticals are being used, what trends exist, and possible cost savings. N02 (May overlap with C01A, C01B, C02, C03C, C05A and N03)			Not ranked, U, study
3 9	Direct HSD to reverse its policy that took away incentives for pharmacists to use generic prescription drugs. N03				3.55, U, \$ unknown
4 0		Apply for waivers for populations served by other agencies' programs or services that are currently SGF-only to enable Medicaid match. N04 (May overlap with F01)			4.36, U, study

	PROGRAMMATIC CHANGE	STUDY/ANALYSIS/PILOT/WAIVER	TAX	EARMARKING	RANK * VOTE * \$
4 1	Change lookback period (assets) from 3 to 5 years if permissible by federal law. N05 (Permissible only for trusts)				4.30, U, \$ unknown

CMS - Centers for Medicare and Medicaid Services
 CYFD - Children, Youth and Families Department
 DOH - Department of Health
 FFS - fee-for-services
 FQHC - federally qualified health center
 HSD - Human Services Department
 IBAC - Interagency Benefits Advisory Committee
 MCO - managed care organization
 PCCM - primary care case management
 PCP - primary care provider
 PMPM - per member per month
 SAoA - State Agency on Aging
 SGF - State general fund
 VA- Veterans Health Administration

APPENDIX 18



NEW MEXICO HUMAN SERVICES DEPARTMENT

Office of the Secretary • P.O. Box 2348 • Santa Fe, New Mexico 87504-2348
Phone: (505) 827-7750

Gary E. Johnson
Governor

Robin Dozier Otten
Secretary-Designate

December 21, 2001

The Honorable Luciano "Lucky" Varela, Chair
Legislative Finance Committee
Capitol, Room 416
Santa Fe, NM 87504

Dear Chairman Varela:

As I committed during our hearing before the Legislative Finance Committee on December 11, 2001, enclosed is a list of specific reductions in Medicaid Optional Services, which I have presented to Governor Johnson that might be taken to meet the budget restrictions of the coming fiscal year. Representative Coll asked, also during the December 11 hearing, that a column be added to the list previously submitted to this committee to indicate the potential impact of each option. Attached is the compilation of this information. I would appreciate it if committee staff could ensure that each committee member receives a copy of this response and the list.

The Medical Assistance Division (MAD) of the Human Services Department has been considering programmatic changes to develop a Medicaid budget that reflects the reduced availability of State revenue. Our analysis suggested it would be prudent to target a reduction of \$50,000,000 in State General Funds from the original FY 2003 Medicaid budget submission.

In the interim, we have received additional and more accurate information about the potential savings for each option, including potential *Salud!* savings. (The original list that totaled \$125 million addressed only the fee-for-service benefits.) Also, we have calculated the cost and savings for alternative depths of reduction for some of the options that are not yes/no choices. The attached revised options list has been sorted into four categories:

1. reductions in provider reimbursement
2. reductions in recipient eligibility
3. reductions in benefits or programs
4. other considerations.

Each of the possible options presented, with the exception of other considerations, includes information about State General Fund dollars saved, associated federal Medicaid dollars, number of clients affected, and number of providers affected. Reducing certain Medicaid services may result in increased use of other Medicaid services. The potential shifting of costs across

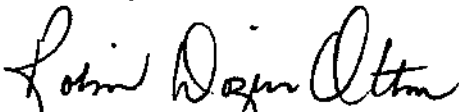
Recognized for Leadership and Excellence

Chairman Varela
December 21, 2001
Page 2

categories of service is addressed by netting the fiscal impact the service reduction has on the Medicaid budget.

I hope this refined list responds appropriately to the committee members' questions and comments at the December 11 hearing. The Executive is not, at this time, recommending any specific combination of these options. We have presented the options in this format because it allows each interested person or group to create the option they view as least onerous. As always, we are prepared to review and discuss with all parties any of the options individually or the entire list as presented. Please let me know if I can provide any additional information.

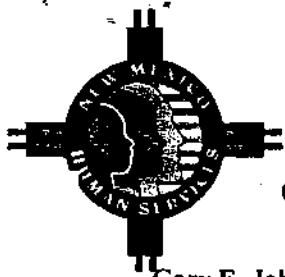
Sincerely,



Robin Dozier Owen
Secretary-Designate

RDO:LST:

cc: David McCumber, Chief of Staff
David Abbey, Director, Legislative Finance Committee
Mark Weber, HSD Analyst, Legislative Finance Committee
Alex Valdez, Secretary, Department of Health
Michelle Lujan Grisham, Director, State Agency on Aging
Duffy Rodriguez, Department of Finance & Administration
Adolfo Alarid, Department of Finance & Administration
Susan Rehr, Acting General Counsel, Human Services Department
Rob Maruca, Director, HSD Medical Assistance Division



NEW MEXICO HUMAN SERVICES DEPARTMENT

Office of the Secretary • P.O. Box 2348 • Santa Fe, New Mexico 87504-2348
Phone: (505) 827-7750

Gary E. Johnson
Governor

Robin Dozier Otten
Secretary-Designate

January 24, 2002

The Honorable Ben D. Altamirano, Chair
Senate Finance Committee
Capitol, Room 322
Santa Fe, NM 87503

The Honorable Max Coll, Chair
House Appropriations and Finance Committee
Capitol, Room 307
Santa Fe, NM 87503

Dear Chairman Altamirano and Chairman Coll:

According to your request at the joint committee hearing of the Senate Finance and House Appropriations and Finance Committees on January 17, I am sending a copy of the Human Services Department's (HSD's) revised spreadsheet, which indicates the impact of elimination of optional services on the Medicaid budget. This document has been reformatted and modified to match the spreadsheet that was previously distributed to list the Medicaid budget reduction options. I would like to extend my apology to both committees for any confusion over the differences in these two charts.

The spreadsheet enclosed here lists all of the optional Medicaid services and eligibility categories, as well as the corresponding cost savings to the state general fund if the option were to be eliminated. All dollar amounts are shown in millions.

I hope this chart provides a helpful reference point to you. I would request that committee staff ensure distribution of this list to each committee member as well. If you would like further information, or if you have any questions about the data listed on this spreadsheet, please do not hesitate to let me know.

Sincerely,


Robin Dozier Otten
Secretary-Designate

cc: David Abbey, Director, Legislative Finance Committee
Mark Weber, HSD Analyst, Legislative Finance Committee

Recognized for Leadership and Excellence

**Impact of Elimination of Optional Services on Medicaid Budget
(State General Funds only)
Fee-for-Service and SALUD! Managed Care**

Optional Service or Eligibility Category <u>[Total SGF Savings]</u>	Fee-For-Service in Millions		Managed Care in Millions	
	State Gen Funds only FY03 Request	State General Fund Savings	State Gen Funds only FY03 Request	State General Fund Savings
Prescribed Drugs <i>This is for all drug expenditures including over-the-counter (adults only).</i> <u>[Total SGF \$ 24.4 M]</u>	\$ 21.3	\$ 13.0	\$ 21.8	\$ 11.4
Personal Care Services <i>All recipients of this service are adults (some offset NH care).</i> <u>[Total SGF \$ 25.6 M]</u>	25.6	25.6	*	*
Other Practitioners <i>Includes optometrists, therapists, psychologists, social workers, podiatrists, etc. (adults only).</i> <u>[Total SGF \$ 5.1 M]</u>	8.1	4.6	1.7	0.5
D&E Waiver <i>Other Home and Community-Based Waivers have their general fund budget at DOH (Olmstead implications).</i> <u>[Total SGF \$ 7.9 M]</u>	7.9	7.9	*	*
ICF-MR <i>Approximately 90% of individuals in ICF-MR are adults.</i> <u>[Total SGF \$ 4.8 M]</u>	5.3	4.8	*	*
Medical Supplies <i>Includes Durable Medical Equipment (DME) as well as regular medical supplies (adults only).</i> <u>[Total SGF \$ 5.5 M]</u>	5.3	3.0	10.3	2.5

APPENDIX 19

APPENDIX 20

GLOSSARY of MEDICAID TERMS and ACRONYMS

(Revised 11/02)

ACS State Healthcare (formerly Consultec) - the fiscal intermediary for Medicaid services, this organization processes and pays Medicaid claims and manages information for the state agency under contract.

AFDC - see Temporary Assistance for Needy Families

Assets - see Resources

BCBS - Blue Cross Blue Shield of New Mexico; the entity used by MAD to make prior authorization determinations, and to conduct service audits and medical record reviews.

Beneficiary - an individual who is eligible for, and enrolled in, the Medicaid program in the state in which he or she resides.

BHS - behavioral health services

Capitation Payment - a payment made by the state Medicaid agency under a risk contract, generally to an MCO. The payment is usually made on a monthly basis at a fixed amount on behalf of each Medicaid beneficiary enrolled in the MCO.

Categorical Eligibility - describes Medicaid's policy of restricting eligibility to members of certain groups, or categories, such as children, the aged or individuals with disabilities. Individuals who fall into approved eligibility categories must also satisfy certain financial requirements, to include income limitations and (usually) resource tests.

Categorically Needy - describes groups of people who qualify for the basic mandatory package of Medicaid benefits. States are required to cover some "categorically needy" groups such as pregnant women and children up to 133% of the federal poverty line. Other "categorically needy" groups are optional. See also Medically Needy; Spend Down.

CCIC - coordinated community in-home care; The general name for four programs operated under separate waivers to provide services at home to people who qualify for nursing home care. The four waivers are the D&E waiver, serving the disabled and elderly, the DD waiver, serving the developmentally disabled, the MFC waiver, service medically fragile children, and the HIV/AIDS waiver, serving people afflicted with the AIDS virus. See also Home- and Community-Based Services Waiver.

CMS - Center for Medicare and Medicaid Services; the federal agency within the DHHS responsible for the administration of Medicare, Medicaid and SCHIP (formerly called the Health Care Financing Administration or HCFA).

Copayment - a cost-sharing arrangement in which the Medicaid beneficiary pays, to the provider, a specified amount for a specific service.

Credentialing - the process of determining whether physicians and other health care providers meet the qualifications for hospital privileges and to serve as providers in managed care settings. Credentials and performance are periodically reviewed and privileges may be denied, modified or revoked.

CYFD - Children, Young and Families Department

DD - developmentally disabled; developmental disability

D&E - disabled and elderly

Deemed Income - a federal term used to identify the dollars "deemed" to belong to a household member; this standard is not currently in use in New Mexico.

DHHS - federal Department of Health and Human Services

Disproportionate Share Hospital (DSH) Payments - additional Medicaid payments made by a state's Medicaid program to hospitals that the state has designated as serving a "disproportionate share" of low-income or uninsured people.

DME - durable medical equipment

DOH - Department of Health

DRG - Diagnosis Related Group; a term used to describe the amount of reimbursement a hospital is entitled to receive for an inpatient stay under Medicare and Medicaid based on the admitting diagnosis of the patient.

DSH - see Disproportionate Share Hospital Payments

Dual Eligibles - Individuals who are eligible for both Medicare and for full Medicaid coverage, as well as coverage for Medicare premiums, co-payments and deductibles. Some Medicare beneficiaries are eligible for Medicaid to pay for their Medicare premiums, co-payments and deductibles, but are NOT eligible for other Medicaid benefits.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services - a mandated service for all Medicaid-eligible children under the age of 21. States must provide follow-up treatment that is assessed as necessary whether or not the service needed is part of the benefit package of the state's Medicaid program.

Entitlement - refers to a legal obligation of the federal government to a person, business or unit of government based on eligibility criteria, benefits and payment structures prescribed by law. Medicaid is both an individual entitlement program, as well as an entitlement to the states that participate in it.

EPSDT - see Early and Periodic Screening, Diagnostic and Treatment Services

Federal Financial Participation (FFP) - the technical term for federal Medicaid matching funds paid to states for covered Medicaid services or administrative expenses. FFP rates are based on per capita income and/or type of administrative cost.

Federal Medical Assistance Percentage (FMAP) - the statutory term for the federal Medicaid matching rate - i.e., the portion the federal government bears. FMAP for covered services varies from state, ranging from 50% to 83%, based on per capita income. FMAP for administrative costs varies based on the type of administrative cost incurred.

Federal Poverty Level (FPL) - the federal government's working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility. It is adjusted annually.

Federally Qualified Health Center (FQHC) - health care clinics that are funded under Section 330 of the Public Assistance Act that provide primary care and other health services in under-served areas. Services provided by FQHCs (and other "look-alike" clinics) must be included in the basic Medicaid service benefit package.

Fee-For-Service (FFS) - A traditional method of paying for services under which providers are paid for each service rendered. See also Capitation Payment.

FFP - see Federal Financial Participation

FFS - see Fee-For-Service

Financial Eligibility - describes Medicaid's policy of requiring an individual to meet certain financial requirements in addition to categorical requirements. Financial requirements generally include income limits as well as the amount of resources a person may have to qualify for Medicaid.

FMAP - see Federal Medical Assistance Percentage

FQHC - see Federally Qualified Health Center

GME - graduate medical education; a term used to describe the costs incurred at a teaching hospital, like UNMH, that finances the support of the education of physicians. These costs include residents' salaries while on hospital rotation.

GRT - gross receipts tax

HCBS - see Home- and Community-Based Services Waiver

Health Insurance Portability and Accountability Act (HIPAA) - a federal law passed in 1996 that requires the standardization of electronic patient, financial and health data to achieve administration simplification; includes mandatory privacy and confidentiality standards.

HIPAA - see Health Insurance Portability and Accountability Act

Home- and Community-Based Services (HCBS) Waiver - allows a state Medicaid agency to individuals in lieu of nursing home care. In New Mexico, the program is sometimes referred to as CCIC (coordinated community in-home care), and includes waivers for the disabled and elderly (D & E waiver), developmentally disabled (DD waiver), medically fragile children (MFC waiver) and HIV/AIDS patients (HIV waiver).

HSD - see Human Services Department

Human Services Department (HSD) - the state agency that administers the Medicaid program

ICF/MR - see Intermediate Care Facility for the Mentally Retarded

IME - indirect medical education; a term used to describe the costs incurred by teaching hospitals that are not covered through the reimbursement to those hospitals under DRGs (diagnosis related groups); indirect medical costs are determined by a formula.

Income Support Division (ISD) - a division of HSD that is responsible for determining eligibility for Medicaid and other services.

Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a public or private facility that provides inpatient services to individuals with mental retardation or related conditions. State Medicaid programs may cover these services at their option.

IPRO - see Island Peer Review Organization

ISD - see Income Support Division

Island Peer Review Organization (IPRO) - the organization used by MAD to conduct audits of quality standards and provider satisfaction and effectiveness.

LTC - long-term care

MAD - see Medical Assistance Division

Managed Care Entity - the federal, statutory term for a managed care plan that participates in Medicaid.

Mandatory - those services and eligibility categories that are required for a state that chooses to participate in Medicaid. These services and groups are identified as "mandatory" to distinguish them from "optional" groups and services that a state may choose to cover.

Matching Rate - see FMAP

MCO - managed care organization

Means Testing - The policy of basing eligibility for services upon an individual's lack of means, as measured by income and/or resources. Medicaid and SCHIP are means tested. Medicare is not.

Medical Assistance Division (MAD) - the division within HSD that administers the Medicaid program.

Medically Needy - a term used to describe an optional Medicaid eligibility group who become eligible for Medicaid by virtue of incurring high medical expenses. This group becomes eligible as they "spend down" their income and resources to pay for medical costs. New Mexico does not have a "medically needy" category of eligibility. See also **Categorically Needy; Spend Down**.

Medicare - a federal program of health care coverage for people over 65 years of age, and for disabled individuals who qualify. Medicare is divided into two parts: Part A, which covers inpatient care, hospice and home health care; and Part B, which covers outpatient services. Part A is automatically available to those who qualify, while Part B is purchased with a monthly premium. Nursing home care and outpatient prescription drugs are not covered benefits under Medicare, except in very limited situations.

Medicare Buy-In - the informal term referring to the payment of Medicare deductibles, Part B premiums and co-payments on behalf of eligible, low-income Medicare beneficiaries. The term is also used to describe the ability of a state to extend Medicaid benefits to some working, disabled populations who otherwise exceed the income and resource qualifications.

Mental Health Statistical Health Improvement Project (MSHIP) - a system for tracking the efficacy of the delivery of mental health services; mandated by the Balanced Budget Act.

MFC - medically fragile children

MMIS - Medicaid Management Information System

MOSAA - Medical On-Site Application Assistance; a process by which hospitals and other health care providers may enroll eligible people in the Medicaid program at the time they receive services.

MSHIP - see Mental Health Statistical Health Improvement Project

Optional - the term used to describe Medicaid-eligible groups or services that a state chooses to cover and for which the state may receive federal matching funds. The term is used to distinguish these groups and services from those that are "mandatory", or required for states participating in Medicaid.

PACE - see Program of All-Inclusive Care for the Elderly.

PCCM - see Primary Care Case Management

PCP - primary care provider

PE - see Presumptive Eligibility

PMPM - per member per month rate paid by the state to an MCO

PPS - prospective payment system

Pre-PACE - A pilot project that provides medically necessary, long-term care services on a partially capitated basis. The project is designed to use intensive case management services, combined with a range of home- and community-based services, to reduce the need for nursing home care for eligible individuals. States must demonstrate success in implementing Pre-PACE programs under Medicaid in order to become eligible to be PACE programs, and be fully funded by Medicare.

Presumptive Eligibility (PE) - a process by which eligible pregnant women and children may be temporarily enrolled in the Medicaid program at the service delivery site, with the full application process to follow.

Primary Care Case Manager (PCCM) - physicians, physician groups or entities having arrangements with physicians and that contract with state Medicaid agencies to coordinate and monitor the use of primary care services by enrolled beneficiaries.

Program of All-Inclusive Care for the Elderly (PACE) - PACE programs are federally funded demonstration programs based on the On-Lok model of care for elders, which is designed to keep people independent in their own homes. See also Pre-PACE.

Promotoras/es - community health representative, also known as community health advisors or workers, who provide outreach, education, case management and a variety of other health-related services to individuals and families in their communities and act as a link between community members and health and social services.

RBRVS - see Resource-Based Relative Value System

Resource-Based Relative Value System (RBRVS) - a term used to describe the Medicare reimbursement methodology for physicians and other practitioners.

Resources - items of economic value that are not income; sometimes referred to as "assets". Resources include such things as savings accounts, personal property (like automobiles) and real estate. Some eligibility groups must meet resource tests to qualify for Medicaid.

RFP - request for proposals

RPHCA - Rural Primary Health Care Act

SAoA - State Agency on Aging

SALUD - the program for Medicaid managed care in New Mexico.

SCHIP - see State Children's Health Insurance Program

SCI - see State Coverage Initiative

SCPH - see Sole Community Provider Hospital

Section 209(b) State - amendments to the Supplemental Security Income section of the Social Security Act that permit states to use their own eligibility criteria (vs. SSI criteria) to determine Medicaid eligibility for the elderly and disabled.

Section 1115 Waiver - a section of the Social Security Act that permits the waiving of many requirements of the Medicaid program to enable states to demonstrate different approaches to "promoting the objectives of" the Medicaid program while continuing to receive federal matching funds. The HCBS waivers in New Mexico are 1115 waivers.

Section 1915(b) Waiver - a section of the Social Security Act that permits the waiving of "freedom of choice" and "statewideness" requirements of the Medicaid program to allow states to operate Medicaid under a managed care model. The SALUD program in New Mexico is administered under a 1915(b) waiver.

Section 1931 Parent Coverage - a section of the Social Security Act that permits states to "de-link" eligibility for Medicaid from eligibility for cash assistance for parents with dependent children. This section gives states the option of extending Medicaid coverage to parents with family incomes and resources higher than those that are allowed in the state's TANF program.

Section 1932 State Plan Option - a section of the Social Security Act that allows states to require Medicaid beneficiaries to enroll in managed care plans by submitting an SPA to CMS. Unlike Section 1115 and 1915(b) waivers, Section 1932 need not be periodically renewed by CMS.

SGF - state general fund

Sole Community Provider Hospital (SCPH) - a term used to describe hospitals that serve a disproportionate share of poor or indigent people and that are entitled to an additional amount of reimbursement under Medicaid. See also Disproportionate Share Hospital Payments.

SPA - see State Plan Amendment

Spend Down - a process by which an individual is able to meet the income and resource eligibility requirements for Medicaid by "spending down". In this process, the medical expenses incurred during a specific period are deducted from an individual's income, thereby making it possible for that person to qualify for Medicaid.

SSI - see Supplemental Security Income

Standard - as used in the context of Medicaid eligibility determinations, the dollar amount of income or resources that an individual is allowed to have and still qualify for Medicaid.

State Children's Health Insurance Program (SCHIP) - a federal-state matching program of health insurance coverage for uninsured, low-income children. Unlike Medicaid, SCHIP is a block grant to the states, and eligible children have no individual entitlement to benefits. Children who are eligible for Medicaid are not eligible for SCHIP. States have the option of administering their SCHIP program through, or separate from, their Medicaid program, or as a combination.

State Coverage Initiative (SCI) - an initiative developed under a Robert Wood Johnson Foundation grant to expand coverage to the uninsured population of New Mexico through a public/private venture. A Medicaid waiver was submitted to allow use of SCHIP dollars to fund the state subsidy portion of the program.

State Medicaid Plan - the written plan by which a state describes its approach to administering the Medicaid program. No federal matching funds are available to a state unless the plan has been submitted and approved by the secretary of DHHS. The state Medicaid plan must meet over 60 federal statutory requirements.

State Plan Amendment (SPA) - the process by which a state submits a request to alter its Medicaid eligibility criteria, covered services or provider reimbursement rates, or responds to new federal requirements. State plan amendments must be submitted to the secretary of DHHS for approval.

Statewideness - the requirement that Medicaid be operated throughout the state and may not exclude individuals residing in, or providers operating in, any particular county or municipality. This requirement may be waived in 1115 waivers.

Supplemental Security Income (SSI) - a program of cash assistance for low-income elderly and disabled individuals authorized through an amendment to the Social Security Act.

TANF - see Temporary Assistance for Needy Families

Temporary Assistance for Needy Families (TANF) - a block grant program that makes federal matching funds available to states for cash assistance and other assistance to low-income families with children. TANF was established in 1996 and replaced its predecessor, Aid to Families with Dependent Children (AFDC).

Title XIX - the federal statute that authorizes the Medicaid program.

Transfer of Assets - the practice of disposing of countable resources such as savings, stocks and other personal or real property for less than fair market value in order to qualify for Medicaid. Transfers such as this are usually done in connection with actual or anticipated need for long-term nursing home care. This practice is limited by federal law.

UNMH - University of New Mexico Hospital

UPL - see Upper Payment Limit

Upper Payment Limit (UPL) - a term used to describe an aggregate test used to ensure that Medicaid does not pay hospitals for services at a rate that exceeds the rate that would be paid by Medicare; in essence, Medicare payments become the upper payment limit.

Waivers - various statutory authorities under which a state is permitted to waive certain requirements of the federal Medicaid law and still receive federal matching funds.