



State of New Mexico
Medical Assistance Program Manual
Supplement



DATE: April 29, 2016

NUMBER: 16-01

TO: PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: *NHL* NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION

SUBJECT: NOTICE OF PROPOSED REDUCTIONS TO THE MEDICAID FEE SCHEDULE AND OTHER MEDICAID PAYMENT REDUCTIONS

Due to a serious shortfall in state revenue, largely related to reduced oil and gas taxes, many state program budgets were either reduced or not sufficiently increased to cover current program costs during the 2016 session of the New Mexico Legislature. The New Mexico Human Services Department (HSD) must comply with the State Legislature's mandate in 2016 House Bill 2, which states that "the department shall reduce reimbursement rates paid to Medicaid providers..." As such, there will be reductions to many Medicaid provider payment rates beginning on July 1, 2016. The proposed reductions will result in targeted savings, while still ensuring that Medicaid provider reimbursement is reasonable.

HSD convened a subcommittee of the Medicaid Advisory Committee (MAC) that was charged with the task of providing a set of recommendations for reductions to provider payments that can be implemented by July 1, 2016, in accordance with House Bill 2. HSD responded to multiple requests for data by the Provider Payments Cost-Containment Subcommittee to assist with the analysis of options for Medicaid provider payment reductions. The subcommittee voted on a final set of recommendations on April 5, 2016, that were formally submitted to HSD on April 8, 2016.

While it was not a requirement that HSD work through a subcommittee of the MAC to arrive at its proposal for provider rate reductions, the subcommittee was extremely helpful in this effort. However, the subcommittee's recommended reductions would result in less than the targeted amount of \$30 million in general fund savings (or \$140 million total) that are needed from provider rate reductions.

Extensive analysis has been conducted in the development of HSD's proposed Medicaid provider rate reductions, including input from various stakeholders through the MAC subcommittee and public comments received via HSD's website and dedicated email address. Throughout the process, HSD has remained committed to the goal of controlling the growth in Medicaid program costs, while also preserving the core principles of Centennial Care.

After careful consideration of the MAC subcommittee's recommendations and in recognition of the targeted savings goal of \$30 million in general funds, HSD developed its full proposal for provider payment reductions, which are outlined on Page 7 of this notice.

A negative impact on Medicaid recipient access to providers as a result of these reductions is not expected. HSD will study the impact of these reductions on Medicaid recipient access and provider participation in the Medicaid program.

Some of the proposed provider payment reductions require revisions to the New Mexico Medicaid State Plan that HSD must file with the federal Centers for Medicare and Medicaid Services (CMS). Proposed revisions to the Medicaid State Plan pages, when applicable, are available to view as described in this letter.

Current Procedural Terminology (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright © 2015 American Medical Association. All rights reserved.

Current Dental Terminology (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright © 2015 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

A. Practitioner and Dental Reimbursement; Reductions to Community Benefit Providers and Agencies

Effective July 1, 2016, HSD proposes to reduce Medicaid payments to physicians and other practitioners who are paid according to the Medicaid fee schedule for medical services, evaluation and management services, surgical procedures, laboratory and pathology procedures, radiology procedures, and mental health counseling. The reduction is proposed as follows:

- A 2% reduction for all codes/services currently paid below 90% of the Medicare fee schedule, with the exception of preventive and obstetrical services;
- A 4% reduction for all codes/services currently paid between 90%-100% of the Medicare fee schedule, with the exception of preventive and obstetrical services; and
- A 6% reduction for all codes/services currently paid at greater than 100% of the Medicare fee schedule. If any code/service remains with reimbursement above 94% of the Medicare fee schedule, then the rate would be reduced to 94% of the Medicare rate.

This reduction would include laboratory codes paid on the Medicare Clinical Diagnostic Laboratory fee schedule; as well as "facility-based" services that are typically performed in a physician's office setting, to include the service settings of inpatient hospital, emergency department and nursing facilities.

The proposed reduction was not applied to:

- Codes in the CPT© anesthesia code section that are paid using a rate per anesthesia unit;
- Codes in the CPT© maternity care and delivery section;
- Preventive medicine codes to pay for screenings under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program or for vaccine administrations under the Vaccines for Children program;
- Telehealth transmission fees;

- Ambulatory surgical centers that are paid for facility costs rather than the service performed; and
- Codes for which there is not a current associated Medicare rate.

Besides the CPT© codes, the HCPC Level II codes for some professional and laboratory services were reduced as indicated in the chart of proposed fee schedule changes.

Providers affected by these payment reductions include any Medicaid practitioner whose services are billed using codes in the CPT© code range 10023 through 99607, with the exception of the excluded codes described above.

Behavioral health providers are affected by these proposed reductions for codes that are in the CPT© code ranges for psychiatric diagnoses, evaluations, and therapies, but **not** for the specialized behavioral health services described below:

- Assertive Community Treatment
- Behavior Management Skills Development
- Comprehensive Community Support Services
- Crisis Intervention other than as a PSR service
- Day Treatment
- Intensive Outpatient Program
- Opioid Treatment Program (formerly known as MAT) methadone services
- Multi-Systemic Therapy
- Psychosocial Rehabilitation (PSR) Program Services
- Partial Hospitalization and Free-Standing Psychiatric Hospitals
- Autism Intervention Services

HSD proposes one additional change to a behavioral health code for H2010 - Comprehensive Medication Services, which is proposed to be reduced from \$54.31 to \$30.00.

In addition to the Medicaid practitioner payment reductions described above, HSD proposes to reduce payment levels for dental services paid according to the Medicaid fee schedule by 3%. HSD also proposes to reduce Medicaid payments to Community Benefit providers and agencies by 1%. Community Benefit services are reimbursed by the Centennial Care managed care organizations (MCOs) at rates determined by the MCOs.

Payment rates for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and IHS and tribal health facilities are not being reduced for services that are paid at encounter or OMB rates.

Estimated Total Financial Impact

The anticipated reduction in fee schedule payments to Medicaid practitioners is estimated to be approximately \$6-\$7.5 million in state general funds (or approximately \$29-\$33 million total).

The anticipated reduction in payments to dentists is approximately \$600,000-\$1 million in state general funds (or approximately \$3-\$4.5 million total).

The reduction in payments to Community Benefit providers and agencies is approximately \$850,000-\$1.2 million in state general funds (or approximately \$3-\$4 million total).

The proposed fee schedule changes chart can be found at the following website:
<http://www.hsd.state.nm.us/providers/fee-for-service.aspx>.

Impact on Recipient Access

A negative impact on recipient access to providers as a result of these reductions to the Medicaid fee schedule is not expected. Most Medicaid recipients are enrolled in the Centennial Care managed care program. The managed care organizations (MCOs) are contractually required to meet recipient access standards.

Of the estimated total reduction in payments to providers, over 80% of the reduced amount would come from lowering payments on codes/services that were being paid at rates greater than 94% of the Medicare fee schedule. This action allowed the Department to make smaller reductions on other codes/services.

B. Increased Reimbursement for Certain Preventive Services

HSD proposes to increase Medicaid payments for preventive medicine codes used to pay for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens by 5%. This will increase the amount paid for Well-Child screens from \$150.55 to \$158.08.

Estimated Total Financial Impact

The increase in payments to providers is estimated to be between \$200,000-\$330,000 in state general funds (or approximately \$1-\$1.5 million total).

Impact on Recipient Access

Because this is an increase in payment to providers, a negative impact on recipient access to providers as a result of this change is not expected.

C. Discontinuing the Primary Care Provider (PCP) Enhanced Payment Program

HSD proposes to discontinue the Primary Care Provider (PCP) Enhanced Payment Program. The PCP Enhanced Payment Program was defined in sections 1902(a)(13), 1902(jj), 1905(dd) and 1932(f) of the Social Security Act, as amended by the Patient Protection and Affordable Care Act (ACA), and was originally put into effect for the years 2013 and 2014. Enhanced federal funding was available to states to pay for the increased payments through 2014. HSD chose to extend the PCP Enhanced Payment Program throughout 2015 and into 2016, but proposes to end the program, which is no longer supported by enhanced federal funding, beginning July 1, 2016.

Approvals of provider attestations under the PCP Enhanced Payment Program will end on May 31, 2016. No qualifying claim will be paid at the enhanced rate unless processed and paid prior to October 1, 2016. HSD will cease making enhanced payments through both the Medicaid fee-for-service (FFS) and Centennial Care programs.

Estimated Total Financial Impact

The anticipated reduction in payments to providers by ending the PCP Enhanced Payment Program is estimated at approximately \$5-\$6 million in state general funds (or approximately \$24-\$26 million total).

Impact on Recipient Access

A negative impact on provider access as a result of ending the PCP Enhanced Payment Program is not expected. Payments made under the program are not broad-based, so the financial impact on most providers is relatively small. There are currently 1,982 individual providers of various specialties who have met the qualifications and conditions for the enhanced payment. This is fewer than 30 percent of all PCPs enrolled in the Medicaid program.

D. Hospital Reimbursement

New Mexico hospitals have benefited significantly from the Adult Expansion of Medicaid. For this reason, HSD proposes to reduce hospital outpatient payments effective July 1, 2016, for hospitals whose reimbursement is based on Outpatient Prospective Payment System (OPPS) rates as follows:

- A 3% reduction to hospital outpatient services at acute care, critical access and outpatient rehabilitation hospitals; and
- A 5% reduction to hospital outpatient services at the University of New Mexico Hospital.

HSD also proposes to reduce hospital inpatient payments effective July 1, 2016, for hospitals whose reimbursement is based on the Diagnosis Related Group (DRG) methodology as follows:

- A 5% reduction to the inpatient DRG base rate and pass through amount at acute care and critical access hospitals; and
- An 8% reduction to the inpatient DRG base rate and pass through amount at the University of New Mexico Hospital.

In addition, HSD proposes to reduce Safety Net Care Pool (SNCP) hospital enhanced rates to the level of matching funds available from counties and the \$10 million general fund appropriation in HSD's base budget.

Estimated Total Financial Impact

The anticipated reduction in payments to hospitals for outpatient services is approximately \$3-\$4 million in state general funds (or approximately \$12.5-\$17 million total).

The anticipated reduction in payments to hospitals for inpatient services is approximately \$8-\$10 million in state general funds (or approximately \$38-\$45 million total).

The reduction in payments to hospitals under the SNCP reduction is approximately \$3-\$4 million in state general funds (or approximately \$28-\$33 million total). Note that state

general fund savings are lower due to the contribution of state matching funds by the University of New Mexico Hospital.

Impact on Recipient Access

A negative impact on recipient access to providers as a result of these reductions is not expected. Most Medicaid recipients are enrolled in the Centennial Care managed care program. The managed care organizations (MCOs) are contractually required to meet recipient access standards.

E. Opportunity to View Documents and Make Comments

Medicaid providers, Medicaid recipients, and other interested parties are invited to make comments on this proposal.

Draft State Plan Amendments (SPAs), if necessary to effect these changes, may be found on the Department's website at:

<http://www.hsd.state.nm.us/public-notices-proposed-rule-and-waiver-changes-and-opportunities-to-comment.aspx>.

SPA 16-004 Terminate Primary Care Providers Enhanced Payments
SPA 16-005 Outpatient Hospital Reimbursement
SPA 16-006 Inpatient Hospital Reimbursement
SPA 16-007 Practitioner and Dental Reimbursement

When applicable, proposed fee schedules may be found on the Department's website at:

<http://www.hsd.state.nm.us/providers/fee-for-service.aspx>. Scroll to the bottom of the page, click on "agree"; then click on "submit". On the page that appears, scroll to the section "Proposed Fee Schedules or Rates."

A written copy of these proposed documents may be requested by contacting the HSD Medical Assistance Division (HSD/MAD) in Santa Fe at (505) 827-6252.

Recorded comments may be left by calling (505) 827-1337. Electronic comments may be submitted to madrules@state.nm.us. **All comments must be received no later than 5:00 p.m. MDT, June 1, 2016.** Written or e-mailed comments are preferred because they become part of the record associated with these changes.

Interested persons may address written comments to:

Human Services Department
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Copies of all comments will be made available by HSD/MAD upon request by providing copies directly to a requestor or by making them available on the HSD/MAD website or at a location within the county of the requestor.

HSD Proposed Rate Reductions

	Recommendation	Providers Affected	Admin Impact	Total Cost Savings	GF Savings
1	2% reduction for all services currently paid below 90% of Medicare (all codes except preventive and obstetrical)	All providers paid by fee schedule	SPA	\$3-\$4 million	\$650,000-\$900,000
2	4% reduction for all services currently paid at 90-100% of Medicare (all codes except preventive and obstetrical)	All providers paid by fee schedule	SPA	\$2-\$3 million	\$400,000-\$650,000
3	6% reduction for all services currently paid at greater than 100% of Medicare. If any code remains above 94% of the Medicare rate, reduction of the rate to 94% of Medicare (all codes except preventive and obstetrical).	All providers paid by fee schedule	SPA	\$24-\$26 million	\$5-\$6 million
4	Discontinue optional enhanced PCP rate increase established by the ACA	Qualifying physicians (1,982 providers)	SPA	\$24-\$26 million	\$5-\$6 million
5	Raise reimbursement for certain preventive services codes by 5%	All providers paid by fee schedule	SPA	(\$1-\$1.5 million)	(\$200,000-\$330,000)
6	5% reduction to hospital inpatient services; 8% reduction to inpatient services at UNM Hospital	All hospitals – inpatient services	SPA and regulation change	\$38-\$45 million	\$8-\$10 million
7	3% reduction to hospital outpatient services; 5% reduction to hospital outpatient services at UNM Hospital	All hospitals – outpatient services	SPA and regulation change	\$12.5-\$17 million	\$3-\$4 million
8	Reduce SNCP enhanced rates to the matching funds available by counties and a \$10 million GF appropriation	SNCP hospitals	SPA	\$28-\$33 million	\$3-\$4 million**
9	1% reduction – community benefits providers and agencies	All community benefits providers and agencies	SPA	\$3-\$4 million	\$850,000-\$1.2 million
10	3% reduction – dental providers	All dental providers	SPA	\$3-\$4.5 million	\$600,000-\$1 million
TOTAL:				\$136.5-\$161 million	\$26-\$33.5 million

NOTE: Rates paid in accordance with OMB Circular A-87 will not be reduced.

*** State general fund savings are lower due to UNM contribution of state matching funds.*