Medicaid Advisory Committee - MAC Meeting
Monday, August 3, 2020
MINUTES

Time: Start-1:04 pm End-3:16 pm Location: GoToMeeting

Chair: Larry A. Martinez, Presbyterian Medical Services

Recorder: Alysia Beltran, Medical Assistance Division

Committee Members

Sylvia Barela, Santa Fe Recovery Center
Jeff Bustamante, BeWellNM
Ruby Ann Esquibel, LFC
Kurt Rager, Lutheran Advocacy Ministry NM
Gary Housepian, Disability Rights NM
Kathy Kunkel, NM DOH
Kristina Leeper, NMMIP
Meggin Lorrino, NM Association for Home & Hospice Care
Rick Madden, Family Physician
Rodney McNease, UNMH
Travis Renville, NDC
Nancy Rodriguez, NM Alliance of School-Based Health Care
Laurence Shandler, Pediatrician
Dale Tinker, NM Pharmacists Association
Vicente Vargas, NM Health Care Association
Brian Blalock, NM CYFD
Jeff Dye, NM Hospital Association
Eileen Goode, NM Primary Care Association
Katrina Hotrum-Lopez, NM ALTSD
Sharon Huerta, BCBSNM
Liz Lacouture, PHS
Ellen Leitzer, Senior Citizens Law Office
Carol Luna-Anderson, The Life Link
Sireesha Manne, NM Center on Law & Poverty
Carolyn Montoya, UNM College of Nursing
Sharon Finarelli, NM Alliance of Health Councils
Buffie Ann Saavedra, AARP
Latha Shankar, WSCC
Russ Toal, OSI
Anthony Yepa, Indian Pueblos Council

Absent Members:

Brian Blalock, NM CYFD
Travis Renville, NDC
Anthony Yepa, Indian Pueblos Council
Kathy Kunkel, NM DOH
Buffie Ann Saavedra, AARP
Ellen Leitzer, Senior Citizens Law Office

Staff & Visitors Attending:

Nicole Comeaux, State Medicaid Director
Elisa Moran-Walker, HSD/MAD Deputy Director
Valerie Tapia, MAD
Angelica Bruhnke, Versatile Med Analytics
Carolyn Griego, WSCC
Colin Baillio, OSI
Dauna Howerton, BHSD
Erica Archuleta, MAD
Jenny Felmley, LFC
Karen Wiley, NMDVR
Mike Nelson, Tri Core
Nat Dean, Disability Advocacy
Quinn Lopez, WSCC
Samantha Storsberg, HSD
Tamara Espinoza,
Wade Carlson, CYFD
Megan Pfeffer, HSD/MAD Deputy Director
Lorelei Kellogg, HSD/MAD Deputy Director
Carmen Juarez, MAD
Annabelle Martinez, MAD
Cathy Salazar, Parents Reaching Out
Cynthia Romero, HSD
Devi Gajapathi, MAD
Erin Colgan, AmeriHealth Caritas
Jim Jackson, DRNM
Kim Carter, MAD
Loretta Cordova, HSD
Neal Bowen, BHSD
Roy Jeffus,
Susie Kimble, BHPC
Tara McKinley,
Wanicha Burapa, MAD
Linda Gonzales, HSD/MAD Deputy Director
Abuko Estrada, HSD/MAD
Alicia Bernal, MAD
Carlos Ulibarri, MAD
Christopher Cameron, WSCC
Dan Lanari
Ellen Pinnes,
Jennifer Vigil, MAD
Juanita Reese, HSD
Marilyn Bennett, New Vistas
Marla Shoats,
Pei Huang, MAD
Scott Allocco, Sellers Dorsey
Tallie Tolen, MAD
Theresa Belanger, MAD
Rick Hernandez,

Alan Shugart,
Coleen Fong,
Jean Ritter, Zealand Pharma
Kathy Slater-Huff, HSD
Kristen Tjaden, Viiv Health Care
Mary Eden, PHS
Susan Mathers, HSD
Barbara Webber, Health Action NM
Cristobal Munoz,
Jeanne McLaws,
Kelly Klundt, NM Legislative
Leon Lopez, Santa Fe Recovery
Patsy Nelson,
Tiffany Wynn, BHSD
Charles, NM Legislative
Ellen Interlandi,
Jennifer Swanberg, HSD
Kendra Garcia, New Vistas
Lisa Howley, HSD
Patty Kehoe,
Waymond Morris,

DISCUSSION ITEM	OUTCOME	FOLLOW-UP ACTION	RESPONSIBLE PERSON/ DEPARTMENT	EXPECTED OR REQUIRED COMPLETION DATE
1. Meeting Protocols	**Director Nicole Comeaux presented an overview of meeting protocols** Everyone should be getting used to the different platforms by now. We are utilizing GoTo Meeting. There is a reminder in the chat to please update your name and email address under attendees. There are instructions listed on how to do so. Some friendly reminders during today'smeeting: please mute microphones when not speaking, Committee Members can ask questions throughout the presentation, the chat function will be open for the Public Comments throughout the presentation, along with an open period at the end for others to speak and give their public comment. Presenters include Nicole Comeaux, Larry Martinez, and Elisa Walker-Moran.Finally this meeting is being recorded and will be available for the public at a later date.	None	Nicole Comeaux, Director, Medical Assistance Division, Human Services Department	Completed
2. Introductions	**Larry Martinez convened the meeting and led the introductions** Chairperson Martinez acknowledged the retirements of two Committee Members and thanked them for their service: retiring. Ruth Hoffman with Lutheran Advocacy Ministry of NM and Terry Rodriquez with NM Alliance of Health Councils. Chairperson Martinez welcomed two new members of the committee: Sharon Finarelli with NM Alliance of Health Councils and Kurt Rager with Lutheran Advocacy Ministry NM. Chairperson Martinez conducted a roll call for all Committee Members.	None	Larry Martinez, MAC Chairperson	Completed
3. Approval of Agenda	The agenda for the meeting was approved by all Committee Members in attendance, with no recommended changes.	None	Larry Martinez, MAC Chairperson	Completed
4. Approval of Minutes	The minutes from the April 27, 2020 meeting were approved by the committee.	Finalized minutes will be posted on the HSD website.	HSD/MAD Director's office	Completed

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5. MAD Director Update	**Director Nicole Comeaux presented the Medical Assistance Division (MAD) Director Update** **Congratulations:** Congratulations to Kari Armijo on being promoted to Deputy Secretary and congratulations to Lorelei Kellogg as she is the new Deputy Director of Programs at MAD. Medicaid provided updates on the Public Health Emergency response and an overview of the Medicaid budget projections. An overview of potential cost reduction measures as well as state and Medicaid budgets were provided. **Human Services Department COVID-19 Response Efforts:** Medical Assistance Division (MAD) has received approval on 18 waivers. MAD is now in the process of making some adjustments to the waivers as the public health emergency has evolved. MAD has also received approval on five State Plan Amendments (SPA), which were emergency SPAs to change rates. The Income Support Division (ISD) has received 11 approved waivers and four Program Flexibilities were Granted. **MAD COVID-19 Response -** **Reducing Administrative Burden and Financial Support for Providers:** High-level overview of the efforts that MAD has made that are included in the waivers referenced to reduce administrative burden and to provide financial support to providers. This information is posted on the website for anyone that may have questions regarding these efforts. **MAD COVID-19 Response - Protecting and Extending Access to Coverage and Care for New Mexicans:** High-level list of efforts that have been underway to protect and extend access to coverage and care for New Mexicans. There has been great effort underway to create this coordinated coverage umbrella for New Mexicans between the various entities. **Other Top MAD Priorities:** In the mist of the pandemic, there is still the normal work of Medicaid. These are other key top priorities that have taken place with the pandemic response. Some of these are particularly important to committee members and public representatives in attendance. Listed is the work and priorities that are still occurring. Please see slides 13 and 14 for a complete list of MAD priorities listed by bureau.	None	Nicole Comeaux, Director, Medical Assistance Division, Human Services Department	Completed

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	Federal Coronavirus Relief **Federal Legislation Summary:** This is an overview of the Federal Relief packages that have been granted by congress to date to respond to the Public Health Emergency. There are two key pieces of legislation that have impacted Medicaid most significantly, which are the Families First Coronavirus Response (FFCR) Act and Coronavirus Aid, Relief, and Economic Security (CARES) Act. FFCR is a critical piece of legislation for Medicaid because impacting that legislation, Congress took significant steps to safeguard Medicaid Benefits by temporarily increasing the federal Medicaid matching rate (FMAP) by 6.2 percentage points with requirements. They have provided free testing for the Coronavirus with no cost sharing and allowed states to extend Medicaid coverage for testing to the uninsured. They also have strengthened food assistance, enhanced unemployment aid, and established paid leave. The CARES Act put in place significant relief for providers in the form of the Provider Relief Fund. **Medicaid Increased Match - Maintenance of Effort Requirement:** States must attest to the compliance with the statutory requirements below to receive the 6.2 percent increase and if they violate these terms, they will be required to return all additional federal funds. The requirements are: No new eligibility and enrollment requirements that are more restrictive than were in place prior to the Public Health Emergency (PHE), no cost-sharing for testing, no increases in premiums, and no disenrollment during PHE declaration. Prior to the emergency, New Mexico averaged seven thousand disenrollment's per month, which is 0.84 percent of membership. **Federal Provider Relief Fund (PRF):** Health and Human Services (HHS) has dispersed or announced disbursement of approximately $106 billion of the total $175 billion appropriated to the PRF. This leaves approximately $69 billion for reimbursement to dentists and the uninsured, as well as subsequent funding tranches. HHS had stated it would issue another $10 billion to hotspots but with cases dramatically increasing across the country, the agency may need to tweak the previous formula or increase the amount of the tranche. **FFRCA Impact on State Budgets:** Federal Medicaid Matching Rate (FMAP) increases during public health crises, natural disasters, or economic downturns are intended to help states address higher Medicaid costs resulting from higher enrollment as people lost their jobs or see their hours or wages reduced and become eligible for Medicaid. It also allows for greater financial support to the health care safety net that disproportionately serves			

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	Medicaid beneficiaries (and the uninsured) and is likely to face growing, severe stress in coming weeks and months. With the growth, the 6.2 percent is not going to be enough to cover the growth in the population. MAD has been working with other states, the National Governor's Association, the Congressional Delegation, and National Association of Medicaid Directors (NAMD) in support of a joint request that the next federal release package, includes another 5.8 percent, taking the total FMAP to 12 percent. We believe with this level of support we will be able to cover our anticipated shortfall as well as provide very needed support to the Safety Net that disproportionately serves Medicaid Beneficiaries. **6.2% FMAP Extension Timeline:** January 31, 2020, Secretary Azar first declared COVID-19 a nationwide public health emergency utilizing his authority under Sec.319 of the Public Health Service Act. Under Sec. 319, the Secretary may extend the PHE declaration for subsequent 90-day periods for as long as the PHE continues to exist. April 26, 2020, Secretary Azar issued a renewal of the determination of which was scheduled to expired on July 25, 2020. July 25, 2020, the newest declaration will be effective from through October 23, 2020, unless Secretary Azar determines that the PHE has ceased to exist prior to that date. **Duration of FMAP Increases:** Expansion of the Federal Medicaid Matching Rate (FMAP) steps down again on January 1, 2019 to 93 percent and on January 1, 2020 to 90 percent. For the Children's Health Insurance Program (CHIP) Reauthorization, 100 percent expired in September 30, 2019, phase-out increased to states' E-FMAP by 11.5 percent through September 30, 2020, and the E-FMAP reverts back on October 1, 2020. As a result of the FFCRA, FFY 20 receives a 6.2 percent FMAP increase for the months of January to December 2020. FFY21 is projected to receive a 6.2 percent FMAP increase for the months of October to December 2020. This will last until the end of the quarter in which the public health emergency ends. COVID-19 testing and related services for uninsured are 100 percent Federal Financial Participation (FFP). **Medicaid FMAP and 6.2% Increase Impact:** Pre-PHE Federal and State FFP: for a State FFY blended FFP is 78.75 percent Federal Match, 21.25 percent State Match, which is Federal to State ratio of $3.71. Policy Adjusted Federal and State FFP: The Federal Match with a 6.2 percent is a State FY blended FFP of 80.60 percent with a State Match with 6.2 percent is at 19.40 percent with a Federal to State ratio of $4.15, which overall leads to a 19 percent chance from 6.2 percent.			

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	Dollar Impact on General Fund from 6.2% FMAP Increase: In SFY20 quarters three and four, the FY20 6.2 percent impact by program was a total of 137 thousand. In SFY21 quarters one and two, the FY 21 6.2 percent FMAP impact by program total was 148 thousand. **Groups that Believe that 6.2% FMAP is Insufficient to Fund Medicaid Cost Growth in the Pandemic:** These are some highlights that were previously mentioned. These organizations and many others are with us no-where near enough to cover the growth and the increase of Medicaid members. The 6.2 percent is less than what states need to fill budget shortfall that will result in even 1 percentage rise in unemployment. From February to May, the unemployment rate in New Mexico rose from 4.8 percent to 9.2 percent. There is a critical need for further, large FMAP increases to sustain state Medicaid programs during economic crisis. **Emergency Provider Support** **Medicaid Provider Rate Increases Related to COVID-19:** Some of these payments are still in process with the Center for Medicare and Medicaid Services (CMS) and some are requiring retroactive work. These expenditures were budgeted in FY20 and will be applied retroactively. We will be working with the Managed Care Organizations to make sure the payments are put out. They will be expiring by the end of the quarter. There is an exception for the hospital increase and potentially one other payment. CMS has worked with states on a great amount of flexibility. They have also put in place some significant challenges in trying to work within their states budgets and also make quick changes to payments as a result of the volatility. These payments that are listed will be retroactive from the quarter that it began in April and ended in June with the exception of the hospital payment and possibly one other payment. This list can be found on slide 27. **Medicaid Provider Rate Increases Related to COVID:** In March, when major portions of hospital functions were closed, it was quickly identified that hospitals would face severe revenue shortfalls. In addition, other providers cited cost of care increases for Personal Protected Equipment (PPE), electronic communications systems (e.g., for televisits and telecommuting staff). The Federal Government provided financial relief for some, but not all providers. HSD calculated that the temporary aggregate provider revenue shortfall would be negative $65 million and submitted CMS waivers to increase provider payment. In the past, we have increased capitation rates to MCOs to cover the increased provider rates. In this case we did not.			

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6. Medicaid Budget Projections	**Deputy Director, Elisa Walker-Moran presented on the Medicaid Budget Projections:** **Guiding Medicaid Principles:** Our guiding principles outline that as one of the largest payers in the state, and growing daily, we have a responsibility to ensure that healthcare providers are paid fairly so they are able to serve us all; we do that with the goal of maximally leveraging federal funds always with strict adherence to the law that governs this program. **Medicaid Budget Projection:** The Medicaid budget projection is produced quarterly by economists in the Budget Planning and Reporting Bureau at the Medical Assistance Division of the New Mexico Human Services Department. The team has taken steps to shift the January projection to December (this will limit our data for that projection) but will address the issue of the projection coming out after we have had to meet with the legislature in January. **Risks to the Budget:** There are some risks to the Medicaid budget which include the following: General Fund Revenue Declines from Oil and Gas, Prolonged health and Economic Crisis, Continued Enrollment Changes, Duration and amount of increased federal match, Financial Wellbeing of Providers, and Future Managed Care Rates. **Fiscal Year (FY)19, FY20 & FY21 Budget Overview:** **Medicaid Budget Update: Expenditures:** This budget projection includes significant revisions related to COVID-19, enrollment changes, the current economic outlook and stimulus policy. In FY19, $7.8M change in expenditures due to change in presentation of Clinic Services (CS), and additional HMS recoveries. In FY20, $25M change in expenditures primarily due to small reductions in the Fee-For-Service (FFS) lines, Managed Care Organization (MCO) enrollment changes, removing New Mexico Medicaid Insurance Pool (NMMIP) potential budget increase and shifting $1 Pharmacy curbside dispensing fee cost that cannot be retro-active so it has been moved to FY21. In FY21, $170M change in expenditures due to enrollment changes, and $66M in 1 quarter extension of the rate increase for acute care hospitals. **Revenues:** The General Fund Need for FY19 is now $918.6 million. This is a decrease of $5.1 million from the March 2020 Projection. To date HSD has reverted $10.3 million. This reversion amount was not previously included. The FY19 surplus is $4.9 million. An increase of $5.1 million after accounting for the reversion amount's inclusion. There is a $1.0 million change that affected FY20 that is primarily due to Medicare Part D which is 100% GF from the reduced claw back rate	None	Elisa Walker-Moran, Deputy Director, Medical Assistance Division, Human Services Department	Completed

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	from the 6.2% Federal Medical Assistance Percentages (FMAP) and the UNM IGT reduction. Most of the surplus is due to receiving the 6.2 percent FMAP from January to June 30th. That amount was built into the March projections, and there was a surplus previously. If we had not received that 6.2 percent FMAP, we would be experiencing a shortfall. In FY21, our GF need is just over $1B growing and our shortfall is just under $72M. That shortfall comes from including the 6.2 percent FMAP. In addition, there is $148M for GF for Quarters (QTR) 1 and 2 of FY21. **Utilization Analysis:** Nicole did talk about the utilization analysis and this is a pretty detailed analysis. We have provided information slides, but we will not cover them in detail. **Issues with Reporting Accurate Utilization Data:** We do recognize there are delays in our claim's submissions and processing, due to the emergency programing for COVID related cases. **Analysis of Providers Since Last Projection:** We did some preliminary analysis and as you can see, we do have mixed results. There is an increase in utilization in some providers and decrease in utilization for other providers. This is basically the difference in the claims, and we didn't do dollars in this slide. You may go through it in detail later. **Early Experience with MCO Cost Changes: Net Savings?** HSD had done some internal analysis of the utilization decreases then Mercer took that data and did some estimates of what the changes are and the impact to the MCO's. There is about $67M in cost reductions to the MCO's per month. There is about $77M in cost reductions. Because of the proposing initiatives, that we have asked the MCO's to undertake, including the rate increases, that is offset by $67M in expenditures. Therefore, the net impact on the decrease on the utilization on the MCO's is about $9.7M for a GF impact of about $1.4M. **New Mexico COVID-19 Prevalence by Poverty Rate:** This COVID-19 prevalence slide shows the number of COVID-19 cases per 100,000 by poverty rate. As you can see, the lower the Federal Poverty Level (FPL) the higher the cases. **Options for Adjusting 2020 MCO Capitation Rates:** As discussed at the Legislative Finance Committee (LFC) hearing, there are three ways Centers for Medicare and Medicaid Services (CMS) is recommending states can recoup money from MCOs. 1) Increase or decrease MCO capitation rates by 1.5 percent, but to maintain actuarially sound rates. We cannot take the MCOs below the			

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	bottom of the rate range. If we take them to the bottom of the rate range, there is about $7.8M in GF savings. 2) Directed payments where we tell the MCOs to spend dollars in a specific way. Currently CMS has now said that if states put these payments in place, which subject the MCOs to more risk at this time. We must also put in place a two-sided risk corridor. Meaning, right now we only share in the MCOs profits. When they make more than a three percent profit, we start to get money back, BUT if they lose money we don't share in that risk. CMS states if we employ this strategy to recoup cost reductions, we must share in the losses. Some states are employing this TO GET MONEY back, but as Secretary Scrase outlined at the LFC, we do not have highly profitable MCOs in NM. In fact, two of the three are operating at significant losses prior to the pandemic so we are likely to incur additional GF need by implementing this strategy. 3) Review rate setting assumptions retrospectively when we have more data through the normal process. This takes up to 18 months after the end of the Calendar Year (CY). We could address a significant amount of the shortfall with the MCO cost reductions. We certainly intend to include these options on the list for cost containment of course and will continue to explore all options. **3 Years of Underwriting Gain ("Profit Margin") for Centennial Care:** Lowering the limit to increase the gains shared with the state would only result in additional savings to HSD if the MCOs earned an underwriting gain above the lower limit. Alternatively, HSD may also increase the rate of sharing above the limit which is currently at 50-50. We have three percent profit margin, so anything above that we share 50-50. Consideration should be given to allowing the MCOs an opportunity to operate successfully in the marketplace. **Enrollment Projection:** **Medicaid Enrollment in Context:** As you all know we are providing health care coverage for a significant number of clients in NM. There are more than 40 percent of New Mexicans enrolled in Medicaid. That number seems to be increasing over time. There is a significant number if children also enrolled in Medicaid. Medicaid also covers 72 percent of births in NM. **Medicaid Enrollment Changes:** COVID-19, Maintenance of Effort (MOE) requirements, the current economic outlook, and stimulus policies are influential factors in the current FY20 and FY21 enrollment and budget projections. We have seen significant growth in the Medicaid program. The Medicaid/CHIP enrollment is estimated at 869 thousand individuals in June 2020 and is projected to reach 884 thousand by June 2021. Growth in			

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	Medicaid/CHIP enrollment over this time-period reflects the effects of the Health Emergency and increased take-up from losses in employer-based health insurance. **Evolution of Enrollment Projection:** This is a graphical representation of what we had projected back in December, which we are calling the pre-COVID period. Pre-COVID we had about 837 thousand members. In July we had about 877 thousand members. What is built into the projection is the slight declined line that is the Maintenance of Effort (MOE) ends in December, is built into the base projection. This includes the 6.2 percent expiring at the end of December; therefore, the MOE requirements expire so we can start dropping clients. This just shows you the evolution of the projection. **Impact of COVID-19 Recession on MCO Enrollment Costs & State General Fund (Compared to 12/2019):** This includes the costs associated, it tells you what the additional member months are from different projections and the costs associated with them. The first half of FY21, how many additional member months due to COVID, and the second half of FY21, the base projection of about $150M. If we received an additional 6.2 percent, we would be held to the MOE requirements and have additional growth. **COVID-19 Economic Recession & Health Insurance Status:** Nicole had previously discussed this; we are at about 9.2 percent of unemployment and how much we have grown in our program from pre-COVID to post-COVID in our enrollment. **Enrollment Predictors:** This shows the unemployment rate as compared to employment. We do monitor this information to predict where our enrollment is going to fall in the next few months. **Supplemental Food and Nutrition (SNAP) Benefit Uptake v. Medicaid Uptake:** This is a comparison of SNAP enrollment and Medicaid enrollment. **New Mexico Medicaid Enrollment:** This enrollment slide includes our entire enrollment, including managed care and fee-for-service. Prior to June, enrollment was plateauing until COVID hit, then enrollment increased. This is the base enrollment projection and not the alternative scenarios and includes the MOE expiring at the end of December. **Enrollment Changes by Program:**			

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	This chart is where we are in terms of the average program. For all the fee-for service and managed care programs, our average enrollment from June to March, was 836 thousand individuals. From April to June the average was about 859 thousand individuals. From July to September, we are expecting to grow to 881 thousand individuals, then from October to December about 890 thousand individuals. Comparing the second quarter to the first quarter, the all programs growth was about 2.8 percent which equals to 23 thousand members. The largest growth was in the Physical Health (PH) and the expansion populations. From the first quarter to the fourth quarter, we expect that growth to be about 6.5 percent, which most of this growth is in the PH, followed by the expansion population with 54 thousand members. **NM Medicaid Enrollment Projection FY20 and FY21:** These are the monthly changes for the projection that was already discussed. **New Mexico Managed Care Enrollment FY20:** This is the managed care enrollment to include PH, Long Term Services and Supports (LTSS), and Medicaid Expansion, in FY20. Most of our additional member months are in the PH population. We have seen a significant growth in our PH. Some of this growth is due to mothers with children. **New Mexico Managed Care Enrollment FY21:** This is the same chart, except for FY21 and this is where we expect our month growth in membership. **FY2019 Projection** **Medicaid Budget Projection FY19 Expenditures:** Indian Health Service (IHS) Hospital decreased slightly for FY19, with a negative 1.36 percent change from FY18. Clinic Services is an accounting change. We previously only included the federal funds that went along with clinic and now we are including the total expenditures. Others is primarily due to HMS recoveries we receive after the year is closed. There are very small changes in the Home and Community Based Service (HCBS) Waivers. **Medicaid Budget Projection FY19 Revenues:** One of the big changes for FY19 is the UNM IGT. The expenditures for UNM claims did increase and they are transferring additional money to us. Those additional dollars have been included in FY19. The MSBS CPE has increased to reflect the entire amount that they have transferred to us. The GF need is $918.4M, which is a decrease of $5.1M from the March 2020 projection. We have already reverted $10.3M so we have a remaining surplus of $4.9M.			

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	FY2020 Projection **Medicaid budget Projection FY20 Expenditures:** We wanted to put this to show you the primary drivers of some of the surplus in FY20. Medicare Part D did decrease because of the 6.2 percent money back in FY20. Which reduced the projection by $5.5M. The Hospital and Provider Rate Increases removed the placeholder for the potential budget increase in NMMIP. The dispensing fee was moved into FY21. The total of $6.7B projection is a change of $25M total expenditures. **Medicaid Budget Projection FY20 Expenditures:** Disproportionate Share Hospital (DSH)/Graduate Medical Education (GME)/ Indirect Medical Education (IME) decreased by $1.3 million. The GME expansion and GME pilot program were enacted and funded for FY20. However, the budgets have been shifted to FY21 due to change in implementation. The UC Pool/ Targeted Access Payment (TAP) has an estimate increased by $7.3 million due to the advanced payment made to hospitals in the first 2 quarters of CY20 to assist them during the COVID-19 crisis. This does not change the annual amount of payments to the hospitals. Hospital Access Payments (HAP) are reflected in the managed care lines. The estimate is revised down by $1.7 million from the previous projection due to lower utilization from March-June 2020 during the PHE. IHS Hospital is revised down by $11.8 million as a result of lower utilization from March-June 2020 during the PHE. Most of the decrease comes from IHS Outpatient Hospital. The estimate is revised down by $4.1 million. The majority includes a $2.0 million decrease in dental services due to lower utilization during the PHE, and $1.3 million in PACE because of lower than expected new clients added. The $0.2 million for a temporary PACE rate increase is also included in this line. The FY21 projection is revised up by $2.9 million compared with our last projection. $1.3 million increase is due to the higher utilization in DD Mi Via services, and at the same time, a $0.1 million increase in administrative expenses paid to Conduent for processing more Mi Via claims. It also includes the $1.4 million impact of a second round of temporary rate increases until June 2020 for DD case management, Mi Via consultant, and Medical Fragile Waiver (MFW) procedures. Overall, the managed care did increase by $44.8M, which puts us over $5.1B. Most of this change was from higher member months. What was previously SNCP is now HAP, which is now a managed care program and is built into the managed care capitation rates. **Medicaid Budget Projection FY20 Revenues:**			

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	The UNM IGT in FY20, there was a slight lower adjustment. Currently, we are working with UNM Hospital to come to an agreement on the IGT transfer. The drug rebate had a slight increase due to additional revenues that we received. The general fund need for FY20 is $958M. This is an increase of $1M from the March projection. Which we are projecting a shortfall of almost $62M. Most of the surplus is from the 6.2 percent FMAP that we received. **FY2021 Projection:** **Medicaid Budget Projection FY2021 Expenditures:** The DSH/GME/IME line now includes the GME expansion and reflects new resident positions, higher per resident amount (PRA), especially for primary care and psychiatric residents as prescribed in the GME strategic plan. The projection is revised up by $1.7M; it includes a $4.3M decline of the hospital targeted access payment due to the advanced payment paid in the first half of CY20, and a $6M increase due to the change in the Hospital Quality Improvement Incentive Pool (HQII). HQII will be moved from FFS to MCO starting on 1/1/2021. Physician services is revised down as the PHE and the Lower utilization continue in the first quarter. The projection for DD waiver is revised down. As a result of the special session, there were cuts in Medicaid and DOH, and in order to incorporate the appropriation, they reduced the number of new client's allocation. There was also a drop elated to the budget cut on Acuity Assessment for removing clients from Waiting List. For the Managed Care we are projecting about $5.7B, which is an increase of $171M. The temporary DRG hospital rate increase from FY20 is included in the first quarter of FY21. For Medicare part D, the claw back rate from the 6.2 percent, we see the saving in the part D in the projection which is 100 percent GF. The utilization review and contracts projection was revised down by $4.9M. This is due to the movement of the Mercer contract back to the administrative budget. The Hospital and Provider Rate Increases now includes the pharmacy curb side for one quarter. The DOH Designated Trauma Hospitals this reduction is now included in the capitation rates, which is reflected in the managed care lines. COVID-19 related expenditures include the potential costs of the continuation of the PHE throughout the fiscal year. The estimate of $39.5M is calculated based on the MOE for enrollment not ending and enrollment growing until June 2021 due to economic conditions. The cost of covering premiums for NMHIX members in Medicaid was removed from the projections. **Medicaid Budget Projection FY2021 Revenues:** This includes DOH and HSD's appropriation from the special session. The original FY appropriation is just over $1B. That appropriation was reduced by three percent which is about $33M. During the special session, the GF Swap, the LFC and Department of Finance			

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	Administration (DFA) assumed we would get an additional quarter of the 6.2 percent. So, they reduced our appropriation by that amount as well. With a revised appropriation of about $969M, we are still projecting a shortfall of about $71.7M. This now includes two quarters of 6.2 percent increased FMAP. **Director, Nicole Comeaux presented on Cost Reduction Options** **What Variables Drive Medicaid Expenses:** HSD is usually able to influence enrollment, benefit plans, provider rates, and utilization, and MCO contracts within actuarial limits. HSD can influence, under FFCR, provider rates and utilization, and MCO contracts within actuarial limits. **Options for Expense Reductions - Benefits:** There are five options for expense reductions related to benefits: co-pays, premiums for the Adult Group, reduce or eliminate adult dental services, reduce or eliminate adult vision benefits, and reduce or eliminate coverage for adult hearing aids. Options cannot be combined and are not additive and cannot be employed in combination. Employing any of the options would violate the Maintenance of effort requirement and would result in loss of the 6.2 percent match, which is up to $204M in General Funds for three quarters (January through September 2020). **Options for Expense Reductions - Other Program Options, Potential Benefit Impact:** There are three other options for expense reductions with a potential benefit impact: reduce or eliminate the Centennial Rewards program (incentives for preventive services and medication adherence), postpone statewide expansion for the Home Visiting Program, and postpone the Behavior Management Skills Pilot. These options cannot be combined and are not additive and cannot be employed in combinations. Currently, HSD is awaiting a CMS response on if these changes would violate Maintenance of Effort requirements from the Families First Act. **Options for Expense Reductions - Managed Care Organizations:** There are four expense reduction options for MCOs: Move MCOs down to the bottom of the rate range (12 month), reduce MCO care coordination staffing levels, require MCOs to pay $340B prices for drugs, and recoup unused capitation amount (calculated based on assumptions – not actuals). These options cannot be employed in combination. **Options for Expense Reductions - Provider Rates:**			

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	A reduction in hospital inpatient rates, hospital outpatient rates, across-the board reduction to physician and other professional services rates, a reduction to hospital FFS, and reduction to all other providers FFS by one percent. Provider rate will update the cost-to-charge-ratio (CCR) for hospital outliner claims with a GF savings of $11M. All Medicare type codes to 90 percent of Medicare (Medicaid only codes excluded) have a GF savings of $2.4M. All Medicaid only codes equivalent to 90 percent of Medicare (1.24 percent rate decrease) has a GF savings of $2.3M. All Medicare type codes to 85 percent of Medicare (Medicaid codes only excluded) have a GF savings of $12.5M. All Medicaid only codes equivalent to 85 percent of Medicare (6.27 percent rate decrease) has a GF savings of $12M. These options cannot be combined and are not additive and cannot be employed in combination. A sum of 1 percent on provider rate reductions have a $7.4M GF impact. **Options for Expense Reductions - Other Program Options, Potential Rate Impact:** GME Expansion has a GF savings of $0.17M. Medicare Premium Savings from 6.2 percent has GF saving in FY20 for two quarters of $4.6M and in FY21 for one quarter of $2.6M. Hospital Access Program (formerly SNCP) Reduction from $69M to $34Mhas a GF saving of $7M.			
7. Public Comment	During the public comment portion of the presentation, Committee Members presented questions, which were addressed by the Human Services Department, Medical Assistance Division. There were no public comments received.	None		Completed
8. Adjournment	The meeting adjourned at 3:16 pm.	See HSD website for upcoming meeting date(s)	Larry Martinez, MAC Chairperson	Completed

Respectfully submitted: Alysia Beltran — Recorder

September 17, 2020 — Date