Medicaid Advisory Committee - MAC Meeting
Monday, January 19, 2021
MINUTES

Time: Start-1:00 pm End-3:10 pm Location: GoTo Meeting

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
Troy Clark, 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:

Kathy Kunkel, NM DOH
Kristina Leeper, NMMIP
Brian Blalock, NM CYFD
Carolyn Montoya, UNM College of Nursing
Anthony Yepa, Indian Pueblos Council
Rodney McNease, UNMH
Travis Renville, NDC
Ellen Leitzer, Senior Citizens Law Office
Buffie Ann Saavedra, AARP

Staff & Visitors Attending:

Nicole Comeaux, State Medicaid Director
Elisa Moran-Walker, HSD/MAD Deputy Director
Angelica Bruhnke, Versatile Med Analytics
Alex Castillo Smith, HSD/ OOS
Ben Kellman,
Brenna Gaytan, BCBS
Carmen Sanchez, HSD/ MAD
Cathy Salazar, Parents Reaching Out
Consuelo Mondragon, HSD/ BHSD
David Roddy,
Donna Lopez, HSD/ MAD
Erica Archuleta, HSD/ MAD
Jane Wishner
Jennifer Vigil, MAD
Megan Pfeffer, HSD/MAD Deputy Director
Lorelei Kellogg, HSD/MAD Deputy Director
Annabelle Martinez, MAD
Amy Miller Bowman, AmeriHealth
Bill Jordan, NM Voices
Bryce Pittenger, NMHSD
Carolyn Griego,
Chi Kohloff,
Cynthia Romero, HSD
Derek Lin,
Elizabeth Reed,
Everet Apodaca, HSD/ MAD
Janis Gonzales, DOH
Jason Espinoza, NFIB
Linda Gonzales, HSD/MAD Deputy Director
Abuko Estrada, HSD/ MAD
Alan Shugart,
Shelly Begay, HSD/ OOS
Brenda Trujillo, HSD/ BHSD
Carlos Ulibarri, MAD
Carrisa Tashiro,
Colin Baillio, OSI
Dan Lanari
Devi Gajapathi, HSD/ MAD
Ellen Pinnes,
Jake Nissle, AmeriHealth Caritas
Jason Cornwell, DOH
Jeanelle Romero, HSD/ MAD

Jeanette Gurule, HSD/ MAD
John Padilla, HSD/ MAD
Karen Wiley, NMDVR
Ken Searby, New Vistas
Marilyn Bennett, New Vistas
Luisiana Tegan, AmeriHealth
Mika Tari, HSD/ BHSD
Neal Bowen, HSD/ BHSD
Paoze Her, HSD/ MAD
Quinn Lopez, WSCC
Renay Martinez, HSD/ MAD
Scott Allocco, Sellers Dorsey
Susan Loubet,
Theresa Belanger, MAD
Wade Carlson, CYFD
Jennifer Swanberg, HSD
Julie Lovato, HSD/ MAD
Karey Barrie, Finity
Kendra Garcia, New Vistas
Mike Nelson, Tri Core
Melodee Koehler, HSD/ MAD
Mitchel Newberry,
Nicolas Cordova, NM Poverty Law
Patty Kehoe,
Rachel Biggs,
Roberta Marquez, HSD/ MAD
Sahar Hassanin, OSI
Tallie Tolen, HSD/ MAD
Tiffany Wynn, HSD/ BHSD
Wanicha Burapa, MAD
Jenny Felmley, HSD/ BHSD
Karen Armitage, Salud
Kathy Slater-Huff, HSD/ MAD
Kim Carter, HSD/ MAD
Loretta Cordova, HSD/ MAD
Michael McGrory, X Ray NM
Monae Ortega, HSD/ MAD
Orlando Vasquez, HSD/ MAD
Pei Huang, HSD/ MAD
Rajan Bishwakarma,
Roy Jeffus,
Shane Shariff, MAD
Tammy Soveranez, HSD
Tracie Collins,
Vivian Ulibarri, HSD/ MAD

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 protocol** Everyone should be getting used to the different platforms at this point. Some friendly reminders during today's meeting: please mute microphones when not speaking, please update your name and email address under attendees, 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, please remember to indicate when to transition slides, and 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 took a moment of silence to remember Dr. Larry Lubar, who was a Dentist and Kenneth Carriza, who represented Pharmacy, served as members on the Committee. MAD Director, Nicole Comeaux conducted roll call for all committee members.	None	Larry Martinez, MAC Chairperson	Completed
3. Approval of Agenda	The agenda for this 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 November 2, 2020 meeting were approved by the committee.	Finalized minutes will be	HSD/MAD Director's office	Completed

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		posted on the HSD website.		
5. MAD Director Update	**Director Nicole Comeaux presented the Medical Assistance Division (MAD) Director Update** There are three large sections to get through. The plan is to spend the first hour getting through the introductory remarks and the Director's Update. We will then take a five-minute break, and then we will move onto the 1115 Waiver Amendment and Public Hearing and Public Comment for the 1115 Waiver Amendment. We will then take another five-minute break and conclude with the review of the Medicaid Budget. The current dashboards are not available due to late submission of data in the last quarter. **COVID-19 Policy Update:** **Medicaid 6.2% Increased Match:** **Maintenance of Effort Requirement (MOE):** This is a reminder for those who may not be tracking as closely, who may not have participated in more recent Legislative hearings or MAC meetings. The result of the Coronavirus First Response Act, which is one of the first pieces of the Federal Legislative passed, in response to the Public Health Emergency (PHE). Medicaid agencies received a 6.2 percent increased match rate. Normally the match rate on average is about 72 percent. So, for every dollar invested in state general funds, usually gets back about $3.72. As a result of this increase, during the PHE, for every dollar that is put in place from the state, gets back about $4.78. Currently there are a lot of investments from the Federal Government to ensure that Medicaid agencies can sustain health care coverage for many individuals who are coming onto the Medicaid roll across the country as a result of the continued economic recession and a need for health care at the same time. There is a need for healthcare and the need for funding to support it, and at the same time there are separate budgets available during PHEs to support the programs. This was an act by Congress to ensure that we can support that increased enrollment. While we receive these dollars, we also have an MOE that states all individuals who enrolled in the program as of March 18, 2020, must stay enrolled. Prior to the PHE, NM averages about 7,000 individuals that roll off every month, which is about one percent of our membership. We usually only gain, outside of the PHE, about .1 percent of enrollment every single month. Since the PHE began, we have had almost no individuals rolling off the program because of the MOE. Instead of the .1 percent gain month over month (MOM), we have gained on average 1.5 percent in our enrollment. **6.2% FMAP Extension Timeline:**	None	Nicole Comeaux, Director, Medical Assistance Division, Human Services Department	Completed

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	The declaration for the PHE has been extended. The 6.2 percent increased Federal Medical Assistance Percentage (FMAP), is tied to the PHE declaration that the current Secretary, and the next Secretary of Health and Human Services will be responsible for continuing the declaration. The declarations come in 90-day increments unless they are terminated earlier by the Secretary. Which means, given the most recent declaration, that the emergency would be renewed on January 21, 2021. We know now that we will still receive that enhanced funding through April 21, 2021. For the MOE, we will have until that month, until the end of April, to maintain those individuals who are currently on the program. At that point, individuals will start to return to the normal eligibility criteria, as it is outlined in federal rule at this time, which in time we would start to see these individuals roll off the program. **COVID-19 Response Efforts:** We wanted to highlight these waivers for you, and we have two overarching 1135 Waivers. The 1135 Waivers are those that are only permissible under a PHE. The 1135 Waivers have a bunch of waivers inside of them. There are five approved Appendix K Waivers. The Appendix K waivers are also associated with the PHE, that are for the 1915c population and some other parts of the program. The link to the detail around each of those are in this presentation. In addition to the waivers, we have also submitted a significant number of State Plan Amendments (SPA). There is now a Disaster SPA that is permitted for submission by Centers for Medicare and Medicaid Services (CMS) at this time, as well as the regular SPA process. We just recently submitted some additional SPAs. A couple of new updates on some of the response effort around the waivers, we have been working over the past year to ensure where we have had funds available. We are trying to push them back out to providers and/or work with the Managed Care Organizations (MCOs) to do so. We know that many providers across the board have either experienced decreased revenue, or an increase in their costs during this PHE. We have tried to push funding out where we could, which is the reason we had to submit such a significant number of SPAs and preprints throughout this process. The MCOs have been fantastic in responding to all of these efforts. It has been quite a bit of work for all of us on the state side, but certainly just as much work for them in making system changes, adjusting payments, which also trickles to the providers. **Vaccine Plan Implementation:** This is around the implementation of the reimbursement for vaccine administration. New Mexico has a fantastic plan in place, and we are so grateful to all the other state partners for their work here. We want to ensure there was adequate reimbursement for the administration. Also, that all the individuals covered under Medicaid currently would have reimbursement for vaccine administration. In the Federal			

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	guidance that came out, CMS indicated they would cover the cost of the actual vaccine. However, states and payers would be responsible for covering the actual administration cost. Medicare put out an initial set of rates for both single and double dose administration, so we will be mirroring the Medicare reimbursement at this time. There has been some concern of the appropriateness of this reimbursement, and there have been some questions that it may change. We will keep you all posted as we see the new administration come in, and we intend to stay in line with Medicare rates. If it increases, we will increase as well. At the current rate, the estimated financial impact for the administration of the vaccine, align with the 60 percent compliance rate is $10M for Federal Fiscal Year 21 (FFY21) and $15M for FFY22. Lastly on the vaccine plan, we are also submitting an 1115. Currently Medicaid programs don't normally cover the administration of the vaccination for the limited benefits population and we want to ensure we have that coverage in place. **IT Update: Electronic Visit Verification (EVV) Go-Live 1/1/2021** In addition to the work that the state has been doing on COVID-19 response efforts, there are also ten different IT projects currently in the works. The Medicaid Management Information System (MMIS) replacement effort is a very significant IT build and is pretty demanding of the Medicaid resources. We also have several other projects like interoperability rules that the feds have put out as well as working with our partners at the Health Insurance Exchange to ensure we have an integrated system and go-live later this year. This IT project just went live on 1/1/2021 and it impacted a significant number of individuals. **Timeline/ Issues the State has Faced:** The EVV system is a federal mandate that was required to be implemented by all states by 1/1/2021, or states would face monetary penalties. Essentially this is for individuals providing services in the home, both through the MCOs and Fee-For-Service (FFS) side, through the Developmental Disabilities (DD) and Mi Via Waivers. The intention behind the implementation of EVV from the federal perspective was to ensure we are doing a better job at trying to eliminate fraud, waste, and abuse. This project essentially allows for individuals to clock-in and clock-out through a phone, an IVR process, in the first phase, or in the second phase they will be able to use an app to log in and out. One thing that has created challenges is in the last year we had to terminate the system integrator for the overall MMIS project. This MMIS runs all the back-end process in Medicaid. The system integrator is the hub, and there are different modules that feed into that system integrator. It is the system integrators job to make sure they can all talk to each other. We have experienced a number of challenges with that vendor and we have terminated and that has a ripple effect on all the other contracts from the different spokes. One of those challenges was			

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	the contract that was to support the EVV effort. As a result, the contracts were not able to be completed for this until early October, with each of the sub-contractors that we needed, to build this effort out. This means we had about three months to do an IT development for this go-live date, for a project that should have been a six to nine-month build and as a result, there have been some bumps in the road. We have met the requirements for CMS, so we will not be subject to any decreases in the FMAP, which is the consequence for not being compliant. However, for the population that we are working with in this implementation you can imagine that this has created some challenges to those who are not used to using different IT systems, or having to log in and out or clock in and out in this manner. Certainly, our priority has been to ensure continued services for waiver participants and continued support and payment of providers. We have ensured that clients continue to get paid and that we continue to try to put out as much clear communication as possible to make clients comfortable with this implementation. **Phase 1 and Phase 2 Components:** Phase 1 of this project went live on January 1st, means that we are currently requiring clients to log in and out through the telephone Interactive Voice Recognition (IVR) system. They can use either a landline from the client's home that they are serving or can also use a registered cell phone to clock in and out. They can continue to make sure their payments and hours are submitted through the existing system, so payments remain accurate. In Phase 2, which goes live on April 1st, will have full EVV functionality. So, clients can call in from the registered landline or call in from their phone or use the Authenticare app on their mobile phone. These all run GPS on the back end so we can ensure clients are delivering services where they are supposed to be. **EVV Implementations:** On the Managed Care side, the Agency Based Community Benefit (ABCB) was implemented in 2016, so only the Self-Directed Community Benefit (SDCB) population is impacted with the new implementation. On the FFS side, Agency Based, the DD Waiver, and the Supports Agency Based Waiver, were part of this roll out. On the Self-Directed, Mi Via Self-Directed Waiver and Supports Participant Directed Waiver, were also impacted by this implementation. Our partners at Department of Health (DOH) have been working with us in the next step throughout this effort. **Where to Find More Information:** There are a significant number of presentations and Frequently Asked Questions (FAQs) about this implementation if there is additional information that one might need. The Consolidated Customer Service Center (CCC) can also take questions about this implementation. Clients			

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	shall call the CCSC line and press star (*), to be transferred to the vendor so they can answer more specific questions. **2021 Legislative Session** **2021 Legislative Session Dates:** Legislation must be pre-filed by January 15, 2021. Opening day is January 19, 2021 starting at noon. February 18, 2021 is the deadline for introductions, and session ends on March 20, 2021 at noon. **Governor's Legislative Priorities:** The Governor's Legislative priorities are listed now on the main webpage. A few of those are: Pandemic relief for small business, expanding opportunities for more NM business owners and keeping local dollars local. Establishing an essential new revenue source for the state and employment source for tens of thousands of New Mexicans. Ensuring every New Mexican can create a fulfilling career with the required education and skills without burdensome debt. Protecting NM consumers by reforming lending practices and investing in generational improvements in education and well-being for NM children. Reduce the cost of health insurance and medical expenses for working families. Boost poor school districts and communities and address needs of differently abled NM students. Protecting health care providers. Acknowledging and reducing institutional racism with government and creating a Clean Fuel Standard. To elaborate more on the reducing the cost of health insurance and medical expenses for working families: There is a piece of legislation that will be going through that Human Services Department (HSD) is not leading but is certainly supporting in coordination with Office of the Superintendent and Tax and Revenue. That is the affordability funds legislation. This legislation is critical in working to reduce the costs of participating in the Health Insurance Exchange. Also allowing for the continued efforts that we began here at HSD to try to look at other opportunities to cover the remaining uninsured population in the state. We will be working together with the other agencies and the sponsors, as well as the Governor's Office to support that legislation. In addition, HSD has a Child Support Bill, that is outside of Medicaid, but within HSD. This is a main bill that we are pushing through session this year. Another bill we are supporting are the primary care counsel legislation that looks to ensure we address shortages of providers in the state and also looks to ensure that we have a group of individuals working on a continual basis to ensure we are providing adequate reimbursement.			

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6. 115 Demonstration Waiver Amendment #2	**Director, Nicole Comeaux presented on the 1115 Demonstration Amendment #2** **Formal Public Hearing:** The 1115 Waiver allows us to operate Centennial Care 2.0. We amended that waiver previously to make some changes when the new administration began. At this time, we are working on the second waiver amendment, this is a formal public hearing to accept comments for the 1115 Demonstrations Amendment #2, also known as the Medicaid Program's Centennial Care 2.0. Upon the approval of the 1115 Waiver, changes associated will be effective July 1, 2021. HSD is conducting two public hearings via GoTo Meeting due to the COVID-19 pandemic on January 19, 2021 from 1:00 p.m. – 4:00 p. m and January 28, 2021 from 9:30 a.m. – 10:30 a.m. **Formal Public Hearing Comments:** Comments are currently being accepted via email, mail or by phone. More information about the waiver amendment and public comment process may be found on the Department's website. **Formal Public Hearing Process:** The Public Hearing process is a formal process that the state utilizes to obtain public feedback. This presentation is a summary of the proposed changes to the waiver that were released on December 31, 2020 and are available on the HSD website. As part of the formal hearing process, we will accept and record all the comments but will not engage in a discussion about the comments. Our response to the comments will be documented in a section of the final 1115 waiver amendment application that is submitted to CMS in March 2021. **Proposed Timeline of the 1115 Demonstration Waiver Amendment #2 Process:** The following is the proposed timeline for the 1115 Demonstration Waiver Amendment. In December, we released the draft of the application. Right now, we are going through the Public and Tribal Comment Periods and Public Hearings. The draft application will be finalized in February. In March, we will submit the application to CMS. These programs will then become effective July 1, 2021. **1115 Demonstration Amendment #2 Proposed Changes** At a high level what we are seeking in this amendment is the federal authority to amend the program to make the following four changes: the first is to request a waiver of the Institution for Mental Disease (IMD) exclusion; the second is to implement High Fidelity Wraparound (HFW) services expansion; third is to expand Primary Care Graduate Medical Education (GME); and fourth is to request that we be allowed to reimburse for coverage for vaccine administration for the limited benefit population for the COVID-19 Vaccine.	None	Nicole Comeaux, Director, Medical Assistance Division, Human Services Department	Completed

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	Proposed Change #1 – IMD Waiver: The first amendment requests a waiver for the IMD exclusion for all Medicaid beneficiaries, ages 21-64 regardless of the delivery system. The objective of the waiver is to maintain and enhance beneficiary access, for Behavioral Health (BH) services in appropriate settings and to ensure individuals receive care in a facility most appropriate to their needs. Specifically, the waiver for the IMD exclusion would allow psychiatric facilities, for example hospitals or other institutions of more than 16 beds that are primarily engaged in providing diagnosis treatment or care to persons with mental diseases, including medical attention, and nursing care and related services, to also be able to provide reimbursable services to Medicaid recipients for stays of more than 15 days. Federal law currently prohibits Medicaid funding for services to members between the ages of 21-64 to receive those services in an IMD. The legislative intent was for states to be responsible for the institutional care of people with mental illness. An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. In 2016 there was a new managed care regulation restricting federal funding for IMD stays any longer than 15 days for this population. In addition, they eliminated the option for us to use the "in lieu of" option which was previously permitted in how we worked with the MCOs to provide care in appropriate settings for these individuals. The new managed care rule stated that states could no longer engage with their MCOs in that way to cover needed services for these individuals. The impact of that rule change was that if a member's stay in an IMD is longer the 15 days, the state is required to recoup the entire capitation payment for the month, and not just the amount associated with the IMD stay. The member is still enrolled with the plan and the plan is still responsible for the care, but it is uncompensated. This can result in members being discharged too early and needing emergency care later. Another challenge includes developing an adequate network of non IMD alternatives and the higher costs of care alternatives. Additionally, it creates a lot of burden on the families and the caretakers. To maintain managed care member's access to care in IMDs, we are requesting CMS to allow federal funding for stays longer than 15 days, also requesting federal funding for FFS members so they have equal access to care. **Proposed Change #2 – High Fidelity Wraparound:** Proposed change #2 is adding high fidelity wraparound (HFW) to the 1115 Medicaid Waiver. HFW is an intensive team-based Care Coordination model that is structured and applied to populations with intense needs. Important points about the Wraparound process is that it is team-based, it ensures there is one coordinated plan of care and one accountable care coordinator, which is the wraparound facilitator. This		Bryce Pittenger, Director, CEO Behavioral Health	

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	is not a service, but is a structured approach to service planning and care coordination based on a set of core values. The goal is to improve care for children and families in NM and to decrease costs of care. HFW is not for everyone. If regular care coordination, screening assessment and service provision is working, then we don't need HFW. So, with children with serious emotional disturbance, its those children and families that have a heavy burden as evidence by. **Prevalence/ Utilization Triangle:** This illustrates the point of intensive services for about five percent of the Medicaid recipient population with children with serious emotional disturbances. Most of those funds go to residential treatment centers and more of a restricted setting of care. **Proposed Change #2 – High Fidelity Wraparound:** The top ten percent of highest expenditures are an average of about 46 thousand dollars a year. So, to continue to reduce costs is providing the best possible care coordination for children and child welfare, juvenile justice, and multiple systems. The traditional case management and care coordination approaches have proven insufficient for children and youth with significant behavioral health needs. HFW also address Social Determinants of Health. We are about 50th in the nation in terms of some indicators of child well-being so HFW incorporates all domains of a child and families lives to increase productiveness and decrease risk. With regards to HFW, fidelity is key. We have been working with Mercer in a process to understand what the per member per month (PMPM) rate will be. We have been taking into consideration those administrative costs of training, coaching, credentialing, and continuing administrative costs to provide a quadrant of facilitators and coaches in NM. The Eligibility Criteria is Serious/ Severe Emotional Disturbance (SED), functional impairment in two or more domains, involved in multiple systems and at risk for in an out of home placement. NM currently has 10 teams with 61 facilitators. To serve Phase 1, we are looking at adding an additional 100 facilitators across the state. The current status and the next steps submitted to CMS with the 1115 Waiver Amendment, working currently with Mercer to determine the rate, including training, coaching, fidelity, Child and Adolescent Needs and Strength Assessment (CANS) to determine the functional impairment and Family Peer Support. We are utilizing the NMSU Center of Innovation (COI) to support the administrative roll out. As part of the structure, there will be an Interagency Council. **Proposed Change #3 – Primary Care Graduate Medical Education (GME):** We are proposing to CMS is to establish a GME expansion funding mechanism that will help in the development of the new or expanded		Collaborative, Human Services Department	

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	programs in the fields of primary care such as General Psychiatry, Family Medicine, General Pediatrics and General Internal Medicine. We have been working with Community-Based GME primary care program Directors and staff to think about, "What does a Primary Care Physician expansion look like?", and "How can we expand it in NM?". We have put together a five year strategic plan that we first released in January 2020, and we have updated that plan, which is available online, and we anticipate with all the consultations with our partners, that between 2019 and 2025, the number of Primary Care GME programs will grow from eight to thirteen. Within a year we have created two additional programs. We awarded a little over 1M to three programs in Fiscal Year (FY)20. Our current application cycle for FY21 is open now, and programs have until the end of February to apply. We anticipate we will have up to six programs expressing interest. We have a General Fund (GF) for the program, and the funding mechanism that we are proposing in the 1115 Waiver is, are we able to leverage federal CMS funding with our existing GF to grow the total amount of money we have available to fund these programs. **Proposed Change #4 – COVID-19 Vaccine Coverage** We are proposing to add coverage to the COVID-19 vaccine and its administration for all populations covered under the waiver. We are planning on covering specifically the Family Planning Category of Eligibility (COE), Emergency Medical Services of Aliens (EMSA), Uninsured Individuals who have enrolled through the COVID-19 testing group that was put into place following the Families First Corona Virus Response Act (FFCRA) and also those individuals that are covered by Medicaid under the Pregnancy related services category. Otherwise, we would not be able to cover reimbursement for these individuals.		Alex Castillo-Smith, Office of the Secretary, Human Services Department	
7. Formal Public Comment	**The public had the following public comments:** **Laurence Shandler:** The Primary Care GME, to remind members and the public that physicians tend to stay in the communities they do their residency, rather than where they went to Medical school. Having residency programs that are outside of Albuquerque and extend into rural areas will be a benefit for NM. **Troy Clark:** Thanks to MAD Director Comeaux and the MAD team. Thinks we have a great need to enhance access and increase our numbers of providers throughout our state.	None		Completed
8. Medicaid Budget Projections	**Deputy Director, Elisa Walker-Moran presented on the Medicaid Budget Projections** We completed a Medicaid Budget Projection with data through November 2020 to provide the Department of Finance Administration (DFA) and Legislative Finance Committee (LFC) with an updated budget prior to the legislative session. This budget includes the 6.2	None	Elisa Walker-Moran, Deputy Director, Medical Assistance Division, Human Services Department	Completed

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	percent FMAP that was extended through June 30, 2021 as the PHE was recently extended another 90 days. **FY20, FY21 & FY22 Budget Overview** **General Fund Impact from 6.2% FMAP Increase:** The question is, how much did our GF need decline as a result of the additional 6.2 percent FMAP from the federal government? In FY20 the Medicaid GF need declined by about $123.3M and in FY21 the GF need is projected to decline by $262.6M. This is an offset that the Feds are contributing an additional match, which means our GF need goes down. **Medicaid Budget Update: Expenditures:** The projected expenditures in FY20 is about $6.6B which is a decrease of about $11.3M from the previous September 2020 data projection primarily due to a change in the health insurance premium fee. The projected expenditures in FY21 is about $7.3B, which is a decrease of about $20.7M from the previous projection. The projected expenditures in FY22 is about $7.4B and an increase of about $114.6M from the previous projection. Part of this increase in enrollment is due to the Maintenance of Effort (MOE) extension. **Medicaid Budget Update: Revenues:** The projected general fund need in FY20 is about $947.7M with a projected surplus of $19.4M, an increase of about $5.4M from the previous September 2020 data projection. The projected general fund need in FY21 is about $906.3M with a projected surplus of $45.8M because of the extension of the 6.2 percent FMAP for another quarter. We were previously projecting a shortfall. The projected general fund need in FY22 is almost $1.17B with a projected shortfall of $169.7M. **Enrollment Projection** **Medicaid Enrollment in Context:** Entering Calendar Year (CY)21, the Medicaid enrollment for January 2021 is projected to reach 908 thousand people, approximately 43 percent of the State's population (2.1 million). There were 900 thousand total beneficiaries in November 2020, and 931 thousand anticipated by June 2021. We anticipate by September 2021, there will be 883 thousand after MOE ends. Currently 82 percent are enrolled in managed care, 43 percent (up from 40 percent pre-COVID) of all New Mexicans are enrolled in Medicaid. 43 percent of beneficiaries are children and 58 percent (up from 5 percent pre-COVID) of New Mexico			

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	children are enrolled in Medicaid. 72 percent of all births in New Mexico are covered by Medicaid. **Medicaid Enrollment Changes:** These are some of the assumptions that are built into the enrollment; MOE requirements, the current economic outlook, and the stimulus policies are all factors in the current FY20, FY21 and FY22 enrollment and budget projections. Some other key things are, the PHE, Schooling decisions, which have had an impact on enrollment, as well as incentives for job search activities. **NM Medicaid Enrollment Projection FY20:** In March and April 2020, you can see the month over month change. We consider pre-COVID for Medicaid to be February 2020, because that is when we started to see a slight increase in enrollment, starting in March and April. There was a significant change in our enrollment. **NM Medicaid Enrollment Projection FY21:** For FY21, the month over month enrollment change has started coming down, but it is still a significant positive number. For this projection, we did build in the month over month as continuous through June 2021 as we do have the MOE requirement. **NM Medicaid Enrollment Projection FY22:** The month over month change, starting in July, August, and September starts to decline, as individuals leave the program due to income eligibility. We do assume that about 50 percent of those enrollees, will remain eligible for Medicaid. **NM Medicaid Managed Care Enrollment FY20:** Since most of our population is enrolled with Managed Care, it pretty much follows the same trend as the total enrollment that was previously discussed. **Enrollment – Pre and Post COVID:** When we considered the budget projection in December 2019, this was before we knew there would be a PHE. This is considered our base line. At that time, we did not have FY22 built in so we added a trend line where the enrollment would have been if we would have continued the enrollment at that time with the most recent projection, which was November 2020 data. In March we were at 846 thousand individuals, in June we were at 931 thousand individuals and from there we would slowly decline. **FY2020 Projection:** **Medicaid Budget Projection FY20 Expenditures:**			

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	In FY20 the biggest changes in FFS were in Outpatient Hospital with an estimated decrease by $1.3M due to lower utilization. For the DD, MF and Mi Via Waiver, the estimate increased by $1.1M due to higher actual administrative costs which come from a three percent rate increase effective January 1, 2020 and an increase in cases that were processed. Medicaid Expansion, the FY20 estimate is revised up by $5.6M. This is due to a change in the distribution of Indian Health Services (IHS) reconciliation funds from what was previously projected based off actuals received. These are 100 percent Federally matched and do not impact the general fund. The Health Insurance Provider Fee, for CY20, payment year was paid in December 2020. The payment was $14.9M less than the previous estimate. **Medicaid Budget Projection FY20 Revenues:** The general fund need for FY20 is $947.7M. This is a decrease of $5.4M from the previous projection. The state revenue surplus for FY20 is $19.4M, an increase of $5.4M. This still includes the reversion amount of $52.5M. Most of this surplus was because we did receive the 6.2 percent FMAP for two quarters in FY20. **FY2021 Projection** **Medicaid Budget Projection FY21 Expenditures:** The estimate for the Uncompensated Care Pool (UC Pool)/Targeted Access Payment (TAP) is revised down by $9M. The TAP budget in FFS was shifted to the MCO lump sum payment starting from January 1, 2021. The estimate for Outpatient Hospital is adjusted down by $2.5M due to lower utilization as the PHE continues. The estimate for DD & MF Traditional, and Mi Via Waivers is adjusted down by $2.6M. This includes a $2.6M drop due to higher attrition in the past five months, a $1.2M drop due to lower actuals of the temporary rate increase impact, and a $1.2M increase due to higher administrative cost for utilization review. The estimate for the Supports Waiver is adjusted down by $22.8M due to individuals declining the allocation to the supports waiver. The number of clients we projected to use the services in FY21 was adjusted down from 2,000 to 250 individuals due to the low acceptance of the support waiver. The FY21 estimate for the Physical Health program is revised up by $33.9M from the previous projection. This reflects an increase of $16.6M in member-months, a PMPM increase of $12.2M driven by the rebasing of CY19 costs accounting for the various fee increases and trended to the CY21 rates, and lump sum changes of $5.1M. The TAP budget in FFS was shifted to the MCO lump sum payments starting from January 1, 2021. The FY21 estimate for the Long Terms Services and Support program is revised up by $13.9M from the previous projection. This reflects $13.2M from CY21 PMPM changes, especially adjustments for minimum wage regulations impacting PCS, and -$0.6M from member-months, and $1.3M			

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	in lump sum changes, The TAP budget in FFS was shifted to the MCO lump sum payments starting from January 1, 2021. The FY21 estimate for the Behavioral Health program, serving Physical Health and LTSS clients, is revised down by $10.3 million. This reflects an increase of $3.2 million from member months and a decrease of $14.0 million from CY21 PMPM changes. The PMPM change reflects lower annual trends and prospective adjustment compared to the July-December 2020 rates. Lump sum changes are $0.5 million. The Targeted Access Payment budget in FFS was shifted to the MCO lump sum payments starting from 1/1/2021. The FY21 estimate for the Medicaid Expansion Physical Health program is revised up by $14.7M. The decrease reflects $15.8M from member months, -$6.0M from PMPM changes, and $4.9M from lump sum changes. The TAP budget in FFS was shifted to the MCO lump sum payments starting from January 1, 2021. The FY21 estimate for the Medicaid Expansion Behavioral Health program serving Medicaid Expansion clients is revised up by $7.3 million, reflecting an increase of $2.1 million in member month changes and an increase of $5.0 million in PMPM changes. Compared to the BH rate for the Legacy population, the Medicaid Expansion increase reflects a higher annual trend and a higher prospective adjustment. The lump-sum changes are $0.2 million. The Targeted Access Payment budget in FFS was shifted to the MCO lump sum payments starting from 1/1/2021. The estimate for Medicare Part D is adjusted down by $2.6 million due to the lower clawback rate which is due to the extension of 6.2% FMAP increase to June 2021. **Medicaid Budget Projection FY21 Revenues:** The UNM-IGT is adjusted down by $2.8M due to the extension of the 6.2 percent FMAP increase to June 2021. The general fund need of FY21 is $906.3M. This represents a decrease of $67.3M. The projected surplus is $45.8M. This is an increase of $67.3M from the previous projection. This now includes the inclusion of the 6.2 percent enhanced FMAP through June 2021. **FY2022 Projection:** **Medicaid Budget Projection FY2022 Expenditures:** The FY22 projection for the Physical Health program is revised up by $23M from the previous projection. This reflects a decrease of $0.7M from member month changes, an increase of $23.7M from PMPM changes. The FY22 projection for the Long Terms Services and Support program is revised up by $29.2M from the previous projection. This reflects an increase of $2.2M from member month changes, and $27M from PMPM changes. The FY22 projection for the Behavioral Health program is revised down by $27.3M, reflecting -$1.3M from member month changes and -$26M from PMPM changes. The FY22 projection for the Medicaid Expansion Physical Health program is			

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	revised up by $68.9M. This reflects $80.3M from higher member month, and -$11.4M from PMPM changes. The FY22 estimate for the Behavioral Health program serving Medicaid Expansion clients is revised up by $19.8M, reflecting an increase of $10.4M in member month changes and an increase of $9.4M from PMPM changes. **Medicaid Budget Projection FY2022 Revenues:** The GF need in FY22 is $1.16B. This is an increase of $7.8M from the previous projection. The projected shortfall in FY22 is $169.7M. This is a decrease of $7.8M from the previous projection. **Risk Factors in the Budget:** This is just a reminder of what was just discussed. We have built in the Prolonged Health and Economic Crisis in this projection. There is significant uncertainty in Employment and Unemployment, whether an individual works part time or full time has an impact on our enrollment. Duration and amount of increased federal match, we are surprised to have the 6.2 percent extended to another quarter and that is built in now, and the future cost of the Managed Care Rates. Some potential future risks that have not been built into this projection yet are, financial wellbeing of providers, GF Revenue uncertainties, FY22 GF appropriation, vaccine distribution plan and costs, and the Indian Managed Care Entity.			
	Cost Containment: Closing out FY2020 with some additional surplus, closing out FY21 now that we have the next quarter of funding of about a $45M surplus, and projecting a FY22 $170M shortfall, which is of course pending additional federal revenue. Cost containment conversations throughout the interim, during LFC presentations from HSD, we don't intend to act on any of these options at this time, we are certainly hopefully about the new administration at the federal level and the changes at the Congressional level as well, that they will likely result in additional funds. It would be irresponsible of an agency not to think about cost containment efforts, facing that significant of a shortfall in the future. We have continued to update that list and make sure we are thinking though every policy option and we must put forward any cost containment measures we need to. With our priority being limiting the impact to the beneficiaries and providers. **Potential Cost Containment:** You can see at a high level this is a significant shortfall and this is GF revenue. So, with high of a match rate that we have, it ends up becoming a big programmatic impact as well. This is a list of changes that we would have to be making programmatically to balance our budget.		Nicole Comeaux, Director, Medical Assistance Division, Human Services Department	
9. Public Comment	**The public had the following public comments:**	None		Completed

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	There were no public comments.			
10. Adjournment	The meeting adjourned at 3:10 pm.	See HSD web-site for upcom-ing meeting date(s)	Larry Martinez, MAC Chairper-son	Completed

Respectfully submitted: Alysia Beltran — March 26, 2021

Recorder — Date