Medicaid Advisory Committee - MAC Meeting
Monday, November 2, 2020
MINUTES

Time: Start-1:06 pm End-3:23 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:

Brian Blalock, NM CYFD
Buffie Ann Saavedra, AARP
Anthony Yepa, Indian Pueblos Council
Kathy Kunkel, NM DOH
Sylvia Barela, Santa Fe Recovery Center
Rodney McNease, UNMH

Staff & Visitors Attending:

Nicole Comeaux, State Medicaid Director
Elisa Moran-Walker, HSD/MAD Deputy Director
Valerie Tapia, MAD
Angelica Bruhnke, Versatile Med Analytics
Alan Shugart,
Andrew Tramel, FEI Systems
Bryce Pittenger, HSD
Christopher Cameron, WSCC
Dan Lanari
Devi Gajapathi, MAD
Donna Lopez, MAD
Ellen Pinnes,
Jake Nissle, AmeriHealth Caritas
Jennifer Vigil, MAD
Joe Germain, Bio Gen
Megan Pfeffer, HSD/MAD Deputy Director
Lorelei Kellogg, HSD/MAD Deputy Director
Carmen Juarez, MAD
Annabelle Martinez, MAD
Alex Castillo Smith, HSD
Shelly Begay, HSD
Carlos Ulibarri, MAD
Colin Baillio, OSI
Daniel Burke, DOH
Deluvina Martinez, HSD
Doug Wood,
Erica Archuleta, MAD
Jane Wishner,
Jenny Felmley, HSD
Julie Lovato, MAD
Linda Gonzales, HSD/MAD Deputy Director
Abuko Estrada, MAD
Adrienne Smith,
Aja Sanzone,
Alicia Bernal, MAD
Bill Jordan, NM Voices
Charles Canada, MAD
Cynthia Romero, HSD
Dauna Howerton, BHSD
Derek Lin,
Elizabeth Reed,
Erin Colgan, AmeriHealth Caritas
Jeff Dye,
Jim Jackson, DRNM
Julie Weinberg,

Karen Wiley, NMDVR
Kathy Slater-Huff, MAD
Marilyn Bennett, New Vistas
Loretta Cordova, HSD
Nat Dean, Disability Advocacy
Nicolas Cordova, NM Poverty Law
Quinn Lopez, WSCC
Sahar Hassanin,
Tallie Tolen, MAD
Theresa Belanger, MAD
Wanicha Burapa, MAD
Karen Squarrell Shablin, FE I Systems
Katrina,
Maria Kniskern, MAD
Martha Payne, MAD
Neal Bowen, BHSD
Pamela Blackwell, NM Hospital Assoc.
Roy Jeffus,
Shane Shariff, MAD
Tammy Soveranez, HSD
Tiffany Wynn, HSD
Wendy Basgall,
Kathy Leyba, MAD
Kendra Garcia, New Vistas
Mike Nelson, Tri Core
Michael McGrory, X Ray NM
David Nater,
Pei Huang, MAD
Scott Allocco, Sellers Dorsey
Susie Kimble, BHPC
Luisiana Tegan,
Wade Carlson, CYFD

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 introduced a new committee member, Troy Clark from NM Hospital Association. MAD Business Operations Manager, Valerie Tapia 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 August 3, 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** For the Director's Update today, I want to talk you through some general updates to COVID-19 relief efforts and changes to federal guidance based on COVID-19. There will also be other updates on MAD activities, which are still underway. **Current 6.2% Federal Medical Assistance Percentages (FMAP) Extension Timeline:** The Families First Coronavirus Response (FFCR) Act provided us with an additional 6.2 percent FMAP. We are subject to a Maintenance of Effort (MOE) requirement, in order to continue to receive the additional match, and this match is tied to the Public Health Emergency Declaration. The declarations come in 90-day increments, unless the Secretary for Health and Human Services at the federal level, determines prior to that 90-day period, the declaration needs to be terminated. On October 2, 2020, the declaration was renewed for an additional 90-days through January 21, 2021. This means we receive an additional quarter of the enhanced 6.2 percent FMAP. This will be elaborated more in the budget section so we can understand what this means in dollars. **Recent COVID-19 Response Efforts:** There has been extensive waiver and State Plan Amendment (SPA) activities since the beginning of the Public Health Emergency (PHE). Since we last met, we have had two additional approved 1135 Waivers, four more approved Appendix K Waivers, and one pending although, it may have been approved. There have been five approved Disaster SPAs and one regular SPA. We have two disaster SPAs and six regular SPAs pending. All of this is also posted on the website, which gives details what each waiver and SPA is for. **Medicaid Waiver Activities:** A non-COVID activity that we wanted to give an update on is the Developmental Disabilities (DD) waiver amendment was approved effective October 1, 2020. The Mi Via Waiver is currently operating under a 90-day extension until December 29, 2020. The Medically Fragile Waiver amendment was approved effective July 1, 2020. The Supports Waiver has had six applicants that have an approved level of care; one has an approved Coverage of Eligibility (COE) and is working on a service plan and budget. Department of Health (DOH) does intend to send 500 additional offers in October and November. Finally, we have completed random moment time studies with sister agencies to contract procurement and awarded contract to Fairbanks, LLC. This is really critical to us on the state level because this allows us to continue to engage with all of our sister agencies and allows them to claim	None	Nicole Comeaux, Director, Medical Assistance Division, Human Services Department	Completed

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	and draw down Medicaid match for things they are doing where they are primarily serving Medicaid members. **Medicaid Provider Rate Increases:** We continue to hear from Providers across all service sectors that utilization is still down and that costs either, remain higher than they previously were or are continuing to go up. At the out-set when we knew we had the initial quarter of enhanced FMAP, we made efforts to put in place these provider rate increases. We are almost at the tail end of implementing these, and there is one new increase that we have been asked to consider by the Governor and the Secretary. Just to give you an update, in order to address what we knew would be a decrease in hospital revenues, followed by a potential increase with surges, we put into place a 50 percent increase to Intensive Care Unit (ICU) visits to facilities, which are Diagnosis Related Group (DRG) providers. That increase has been paid and there will be another adjustment after this past quarter run out. That increase was from the quarter from March through June, and one additional quarter through October. The majority of these except the hospital increase were from the quarter from March through June of 2020. There is a 12.4 percent increase to all other inpatient stays for DRG Providers. There is a 12.4 percent increase to all other inpatient stays for non-DRG Providers. This is paid of the Fee-For-Service (FFS) side and the Letter of Direction (LOD) was just released, so if Managed Care Organizations (MCO) haven't already began making those payments, they will be making them any day now. There is a 30 percent increase to Nursing Facilities (NF) for COIVD positive patients. FFS has began paying this and is almost complete. On the Managed Care side, our actuary is digging through some data that the MCO's submitted, and we hope to have this finalized and payments adjusted within the next two weeks. There is a five percent increase to Assisted Living Facilities, which has been paid for on the FFS and Managed Care side. There is a five percent increase to PACE providers and has been paid out on the FFS side. We have put into place a $1 add on payment to pharmacies for curbside and drive thru pickup. We are awaiting Centers for Medicare and Medicaid Services (CMS) approval on this SPA that has been submitted but as of right now there is no approval. There is a rate increase to Evaluation and Management (E&M) and non-E&M codes with a minimum of 6.81 percent and not to exceed 98 percent of Medicare. The goal here is to increase all codes to 98 percent of Medicare. When we applied this to the codes, that increase on average was about 6.81 percent. So we then took that percentage and said where ever we don't have a Medicare reference, we will raise all other codes by that same percentage. We are waiting for the SPA approval from CMS on this one as well. In tied up in this approval is an 11.5 percent increase to non-emergency medical transportation vendors. Part of that increase is going to come from the code increase and the remainder will be a			

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	separate non-risk adjustment payment. The last increase is not related to COVID, but is related to the legislature and some activity in the past session, and has become critical in light of our hospital setting that are reaching capacity around the state, there is an increase to Air Ambulance rates to bring them up to 75 percent of Medicare, which will be effective November 15, 2020. **Other Activities:** HSD published an online scorecard. The scorecard link is provided in the slides. We have outlined a set of goals associated with our mission. Our mission is to transform lives, working with our partners, we design and deliver innovative, high quality and health and human services that improve the security and promote independence for New Mexicans in the communities. There are four different goals with different data sets along with interesting graphs that we are tracking on an ongoing basis. Additionally, CMS just published their Medicaid scorecard for all Medicaid's across the country. This is an incredible tool for us to decide and engaging on strategic planning and continuing to move the program forward. There was an update on the Hepatitis C guidance that was issued in 2020. So therefore, we are revising the following forms and templates; the Uniform Checklist/Prior Authorization (PA) form has been revised and should be simplified to allow for lab results from longer dates in the past and should also accommodate members and providers during COVID emergencies, additionally we are updating the Quarterly MCO Hep C Treatment Reporting Template, which is also being simplified so that the MCO's will be able to report liver cirrhosis assessment using the information from the new PA form and will be modified to capture the number of unique members receiving treatments in each quarter and broken down by various types of members. Finally, a very brief update on Campaign Efforts, MAD has been working on the states Flu Shot Campaign with our state partners as well as Childhood Immunization Campaign, "Call, Don't Cancel". We want to thank all the providers who have made extensive efforts to make parents feel safe. **New CMS COVID-19 Guidance** **Additional Policy and Regulatory Revisions in Response to the COVID-19 PHE:** On October 28, 2020, CMS issued its fourth COVID-19 interim final rule (IFC). It was jointly issued by CMS, the Department of Labor, and the Internal Revenue Service (IRS) and addresses a range of COVIS related topics. **Overview of the IFC:** There are four broad categories, so the rule address COVID vaccines and how states should implement coverage policies for vaccines and			

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	their administration for Medicare, Medicaid, and CHIP beneficiaries and speak to private coverage in some degree. The next area they cover is how Medicare payment policies will be structured for authorization COVID-19 treatments. The coverage that Medicare puts in place will have a great way on how HSD decides to cover those treatments as well. The third category is Price Transparency which requires providers to publicly display the cash price for COVID-19 diagnostic tests. Lastly, the fourth is additional provisions; Coverage of COVID-19 preventive services, and one that is critical to us is changes to the rules around states receiving increases in the FMAP and what the MOE requirement is being interpreted to mean by CMS at this time. **Interim Final 42 C.F.R. 433.400: The New "Blended Interpretation of Section 6008(B)(3):** There is certainly a lot in the interim final rule, and we are going to only elaborate on the Medicaid and Medicare portions that impact us. The FFCRA put in place this MOE requirement for us to receive the 6.2 percent FMAP. According to the MOE, we have to maintain eligibility standards, methodologies or procedures, we also have to cover COVID testing and treatment without cost-sharing including vaccines, specialized equipment, and therapies. Since the off set of CMSs interpretation, states across the county have expressed concerns with the way the CMS has rolled out that guidance. They have prohibited states from changing the benefit packages that individuals were enrolled in as of March 18, 2020, even if their circumstances changed. This does not mean that only those circumstances that would make someone ineligible, but also have prohibited us from moving members across categories of eligibility. Currently, we do not have any plans on how we change how we structure the benefit packages. We do want to look at the option to shift members between eligibility categories if that will mean that they still have coverage available to them during this PHE. The other issues that this has raised is that this creates a large backlog of redeterminations for states after the PHE ends. States as well as NM have asserted that the only option open to states is to cut provider rates which would weaken already fragile provider networks. States are now allowed to move an enrollee's between benefit packages if that package meets certain criteria. There are three new levels that they outline in this rule. The other change is that we can make "programmatic changes", such as changing the medical necessity criteria or utilization control procedures in determining coverage for benefits. This can also eliminate optional benefits, which was not allowed in their previous interpretation. Increase in cost-sharing responsibilities are now also permitted, if they are not related to coverage of testing and treatment for COVID-19. It is not our intent to change the benefit structure or enrollment practices currently.			

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	IFC: Medicare Coverage of COVID-19 Vaccines: This slide references Medicare's coverage of COVID-19 vaccines at a really high level from the rule. CMS has never covered vaccines authorized vaccines under the Emergency Use Authorization (EUA), but it is stated in the rule that they believe that this is appropriate to extend coverage to COVID-19 vaccines for obvious reason. In particularly the high-risk nature of the Medicare population. CMS intends to reimburse COVID-19 vaccines at 95 percent of the average wholesale price. CMS is going to establish a unique administration code for each COVID-19 vaccine as soon as it receives approval. If coverage of a COVID-19 vaccine results in significant costs during the 2020 and 2021 contract years, coverage of the vaccines will be provided through Medicare FFS until the capitation payments take a significant cost in developing appropriate rates for those. **IFC: COVID-19 Vaccine Coverage for Medicaid, CHIP, and BHP Beneficiaries During PHE:** To continue to receive the 6.2 percent FMAP, NM is required to cover the vaccine. For the duration of the PHE we will be able to cover all of the individuals in the program. However, Medicaid is not required to cover COVID testing and treatment for limited benefit categories. Health Recourses and Services Administration (HRSA) COVID-19 portal, will cover the cost of the vaccine and vaccine reimbursement costs for these individuals. The rule indicated that there is an option for states to submit a SPA, also an 1115 depending on which limited benefit category we wanted to cover, in order to make sure to cover those costs through Medicaid. After the PHE ends, we will continue to cover the vaccine for all Medicaid enrolled children under the age of 21 who qualify for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), Medicaid enrolled or uninsured, or Indian children who are given the vaccine by an Federally Qualified Health Center (FQHC) or under the Vaccines for Children (VFC) program, if Centers for Disease Control and Prevention (CDC) determines that it will be included. Population covered under the Alternative Benefit Plans, including Medicaid adult expansion population would also be covered. However, the remainder of our population, we would be submitting a SPA for, in order to make sure that we can cover those vaccine administration costs after the PHE ends. **IFC: Price Transparence for COVID-19 Diagnostic Tests:** CMS is requiring providers of diagnostic test to make cash prices for such test public on the internet. Links to the IFC Fact Sheet and the rule are on the slide presentation.			
6. Medicaid Budget Projections	**Deputy Director, Elisa Walker-Moran presented on the Medicaid Budget Projections**	None	Elisa Walker-Moran, Deputy Director, Medical	Completed

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	FY20, FY21 and FY22 Budget Overview: **General Fund Impact from 6.2% FMAP Increase:** The budget provides updates on a quarterly projection from the economist from MAD. **General Fund (GF) Impact from 6.2% FMAP Increase:** The 6.2 percent FMAP increase was talked about extensively. For Fiscal Year (FY) 20, we did receive just over $138M, which reduced our GF need. As of now, that 6.2 percent is in effect during the PHE which started in January 2020 until March 2021. We receive the 6.2 percent for the full quarter for in which the PHE is in effect. For FY 20, we benefited by $138M, and because we have three quarters of the 6.2 percent, our projection is that our GF need will decrease by $217M, in FY21, once the expenditures come through. **Medicaid Budget Update: Expenditures:** This is an overview of the expenditures, and there is a PDF attachment that is very detailed, line item projections by program, that was included on the invite and will be available on our website. The current quarterly budget projection is updated with data though September 2020. In the current projection, we expect to have $6.6B in expenditures for FY20. This is a slight decrease of $33M from the last projection. For FY21, we are just over $7.3B or a $23M increase from the previous projection. For FY22 we expect about $7.2B in expenditures or a decrease of $72M from the previous projection. Some of the things driving this projection are enrollment changes, we are growing faster than we previously thought. **Medicaid Budget Update: Revenues:** This is the overview for the revenues, we do get transfers from other agencies, other revenue sources, as well as federal revenue. Our GF state revenue surplus is about $66M in FY20, after the GF need of $953M. We have already reverted some of that money to the state which, leaves us with a smaller surplus of $14M. For FY21, there is a projection shortfall of $21M, which is a change of about $50M. For FY22, after a GF need of over $1.1B, we project to have a shortfall of almost $162M. **Enrollment Projection:** **Medicaid Enrollment in Context:** As mentioned previously, by September, we already had 891,000 individuals enrolled. By October, we are projecting that we will reach 896,000, which is approximately 43 percent of the state's population, which is about 2.1 million. By March of 2021, we expect to get to 917,000 individuals. The MOE expires April 1, 2021, so at that time we can start letting individuals naturally drop off or a 90-day roll off-of		Assistance Division, Human Services Department	

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	those individuals. When we start rolling those individuals off, by June 2021, we expect to decrease to 875,000 individuals. During this time, we have approximately 60,000 individuals enrolled, due to the MOE eligibility requirements and the economic conditions. We don't assume that all these individuals are not eligible. Some of them will remain eligible after the MOE expires. By the time we get to March 2021, we think we will have almost 84,000 individuals enrolled due to the MOE requirements. This is what is built into the budget projection. **Medicaid Enrollment Changes:** What is built into our enrollment projections is COVID-19, MOE requirements, the current economic outlook, and the stimulus polices. Also, the PHE does impact the schools and individuals' decisions about schooling. There is an increased take-up from losses in employer-based health insurance. Those mentioned factors are causing an increase in our employment. **New Mexico Medicaid Enrollment:** This is our overall enrollment projection. It includes the expansion population of adults, traditional adult population, and our Medicaid children. The projection is current month is through September, and we continue to grow over that time. Then as of April 1, 2021, when the MOE expires, then some of those individuals will drop off. **NM Medicaid Enrollment Projection FY20:** The month over month change, in April, is really when the enrollment started growing, as the PHE began. In April, we had an 11,000 increase in one month. It started going down a little bit, but we still had month over month changes. In May there were over 9,000 individuals and in June, there were just over 7,000 individuals. We do continue to see that growth month over month and this information is built into the projection. **NM Medicaid Enrollment Projection FY21:** By March 2021, we do expect a 2.7 percent increase from October 2020. The month over month increase continues to slow down, then in April 2021, there are 14,000 individuals that drop off, in May 2021, there are 13,900 decline of individuals and in June 2021, there are 13,800 individuals that will drop off over 90-days as the MOE expires. **NM Medicaid Enrollment Projection FY22:** We did submit the FY22 budget request and there is no change from prior because this was not publicly released and only built for the budget request. As you can see, we do anticipate the economy slowly starts to recover, we will lose individuals. We won't see a significant change because we do expect many of these individuals to remain eligible for an extended period.			

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	NM Medicaid Managed Care Enrollment FY20: This is the Managed Care enrollment, and you can see we did have a bigger change in the managed care at the beginning of the PHE. What we have seen is a shift from some of the individuals that were partial benefit and now are on full benefit and have moved to managed care, and new individuals that were not previously on Medicaid. Those make up some of the month over month change in the 12,000 individuals. One of the populations that the PHE has not impacted is Long-Term Services and Supports (LTSS). The Physical Health (PH) and the Medicaid Expansion population are the ones that have seen the most change during this PHE. **NM Medicaid Managed Care Enrollment FY21:** The PH population here you can see there are some changes from the previous projections. The expansion population is still growing, but not as quickly as we anticipate, and the PH population (children and parent caretakers) is growing a little faster than we previously anticipate. We have made some adjustments to our enrollment projections now that we have more data. The April, May and June month over month numbers are again, a portion of the 84,000 individuals that we expect to drop off as the MOE requirements expire. **NM Medicaid Managed Care Enrollment FY22:** In the Managed Care population, there is a steady growth with a little bit of a decline as the economy improves again. **NM Medicaid Native American Enrollment:** We have included this slide to show you what has happened to the Native American enrollment during this time frame. Enrollment has grown during this PHE. The full benefit population is growing month over month, the partial FFS is growing, but not as quickly as the full benefit. The managed care population is also growing at a much faster rate. The Native American population is about 15 percent of our total enrollment. **Evolution of Enrollment Projection:** This is a snapshot of our enrollment. The projection we had in December, before the COVID-19 pandemic, was growing at a steady rate. In December, we had projected through FY21, and for comparison, there is a trend line of what December would have looked like if we would have included FY22. There was a projection to reach 846,000 individuals by March of 2021. We are now projecting significant growth to 917,000 individuals, and currently we are at 891,000 individuals. Our current projection assumes the current law MOE that expires April 1, 2021, so we have that decline, and it is steady throughout FY22. The alternative scenario, which is the shaded dashed line in the graph,			

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	assumes what would happen if the MOE were extended another quarter and we received the 6.2 percent for that additional quarter. In that case, the enrollment would continue to grow and of course those individuals would not continue to drop-off. Every quarter that the 6.2 percent is extended, we do receive somewhere between $60M and $80M in GF. **Evolution of Enrollment Projection:** This graph is the projection over time. The solid dark line is the December 2019 projection, the dashed line is March 2020 projection, the outlined line is the June 2020 projection and then finally the current dotted line is the September 2020 projection. We must make sure everyone is aware that what we include in the projection is our current plan. CMS has indicated that they intend to issue guidance that will outline how state will be required potentially to disenroll the individual that maintained due to the MOE. **FY2020 Projection:** **Medicaid Budget Projection FY20 Expenditures:** Inpatient hospital is revised down by $2M. The estimate of the temporary rate increase is revised down by $1.3M with the exclusion of outlier claims; lower utilization accounts for another $0.7M. The Indirect Medical Examination (IME) is revised down by $14M. The payment for the 4th quarter is $5.4M less than previously estimated based on preliminary discharge data; the reconciliation estimate is revised down by $5.3M from ten to six percent of the four quarterly IME payments based on the most recent historical reconciliation results; and IME payment for the additional IME expansion hospitals is revised down by six percent. Physician Services is revised down by $1M due to a narrower Upper Payment Limit (UPL) gap between what Medicaid paid and the average commercial rate after the rate change. For a total FFS change of almost $20M down. The Home and Community Based (HCB) Waivers is revised down by $5.2M. This revision included a $1.3M decrease due to a delay in the rate increase from March to July 2020, a $1.3M decrease due to a lower estimated impact from the rate increase for support living, a $0.6M decrease from shifting the unused environmental modification (EMOD) budget to FY21, and $1.9M decrease due to lower utilization in the DD traditional waiver. There are not many changes in the managed care lines. Overall a $2.3M change, most of it is due to a slight change in Per Member Per Month (PMPM). Which is the average cost of PMPM for PH, LTSS and the BH line. The Health Information Technology (HIT) is revised down by $5.7M due to lower expenditures than previously projected and this budget has been moved to FY21. This program is 100 percent federally funded therefore has no impact on the general fund need. **Medicaid Budget Projection FY20 Revenues:**			

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	DOH has also reverted money for FY20, so they revised $7M, which DOH has a surplus of $9M. The UNM IGT has an inter-governmental transfer, for the Graduate Medical Education (GME)/ Indirect Medical Education (IME) and other expenses. Because of the fourth quarter decline, that transfer has also declined accordingly as well. The estimate also includes the impact of 6.2 percent FMAP increase through March 2021. The Health Care and Disability Health Care Facility Funds were revised down so we have the final collection from FY20. These totals are no longer projections and reflect the actual collections. We have a GF need of just over $953M, which is a decrease of the $5.1M from the previous projection. This leaves us with a surplus of $14M, after we already reverted $52.5M. **FY2021 Projection:** **Medicaid Budget Projection FY21 Expenditures:** For the DSH/GME/IME, we now have one quarter of actual expenditures and we are also seeing reductions in expenditures in that line in the first quarter. We have adjusted the end of year reconciliation percentage and we have increased the GME to have 36 Full-Time Equivalent (FTEs). For PH we adjusted the UPL gap down in FY21. IHS Hospital is revised down by $2.4M from the previous projection due to lower utilization during the first quarter based on actuals. Clinic Services is revised down by $1.7M from the previous projection due to lower utilization in large part from continued school closures and the substitution of web-based learning vs in school learning during the first quarter of FY21. The BH FFS had the opposite effect and increased $1.2M from the previous projection due to higher utilization in both inpatient and outpatient psychiatric services. In total FFS did decline about $13.2M in FY21. The HCBW revised up by $7.8M from the previous projection. The extension of the rate increase for selected procedures through September 2020, a shift in the FY20 EMOD budget to be accounted for in FY21, with lower utilization in FY21, which resulted in a net reduction of $0.1M. In managed care there is an increase in the projection of about $38M. In the enrollment slides, you can see that much of the increase had to do with PH line and the Medicaid expansion. Most of the changes, the $32.9M in PH was due to increase in member months. The PMPMs didn't change much within the populations. LTSS decreased a little bit because of the PMPMs individuals that were in a less expensive cohort. The BH lines are impacted by the individuals that are in PH and LTSS get a BH payment. The Medicaid Expansion BH is also impacted by the enrollment. Medicare Part B is revised up by about $2M. We do have the most recent Part B rate that was released by CMS. Part D was revised down by $5.3M and is 100 percent GF. The rate is impacted by the 6.2 percent FMAP. With this FMAP we did benefit with a lower rate, which decreased our costs. The SB246 Health Care Quality Surcharge (HCQS) is revised down by $2M. HSD can use some of the HCQS money for administrative			

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	purposes. There are some administrative costs that support this program, which has been moved over to the admin budget in order to support those efforts. There was not much change in the COVID-19 related expenditures. We will be moving some of those expenditures as they are built into the actual rates, then we will move them to the appropriate lines. The total projection increased by $23M. **Medicaid Budget Projection FY21 Revenues:** The UNM IGT is revised down by $7.7M. This was a benefit from the 6.2 percent FMAP. DOH has a projected a surplus which is also from the 6.2 percent FMAP. Our GF need is $973M with a shortfall of $21.5M. This does include the 6.2 percent FMAP through March 2021. **FY2022 Projection:** **Medicaid Budget Projection FY2022 Expenditures:** The FY22 projection is a trend from historical actuals. There are four quarters of FY20, one quarter of actuals for FY21, so we are projecting based on the historical. The DSH/GME/IME is revised down and part of that is from the current experience. For the HAP/TAP/HQII line we did change this projection by $12M, which does not affect the bottom line. IHS revision is down due to the trend and we will continue to monitor that. BH has increased accordingly due to the higher utilization in inpatient and outpatient psychiatric services. The Waiver is increased due to the DOH's plan to increase the cap for the MF Traditional waivers. On the managed care lines, overall, the managed care has been reduced by $74M. For PH, we did increase from the previous projection due to the enrollment changes we are seeing. We expect some of that growth to continue in FY22. The Medicaid expansion population, we did reduce that growth that we are seeing. Much of that change is from the lower enrollment and the MOE. Part B rates that were released by CMS, have a higher cost. The HIT was revised based on the most recent budget projection for that effort. **Medicaid Budget Projection FY2022 Revenues:** One of the changes for DOH is that, their appropriation request is about $121M. There is a need because the appropriation they requested is not enough to support the amount of expenditures that they expect. They do expect to use the prior year fund balance to support the expenditures in FY22. As of now, we do not have an appropriation, and we use the FY21 appropriation. From the special session, the FY21 appropriation was cut by three percent. The FY21 adjusted operating budget was just over $1B. For FY22 we had another three percent reduction of $30M, so our remaining FY22 appropriation projection was $996M. We are projecting that our GF need is over $1.1B, which is a shortfall of $161M.			

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7. 1115 Demonstration Waiver	**Deputy Director Lorelei Kellogg Presented on the 1115 Demonstration Waiver Amendment 2** **Expansion of Severe Mental Illness (SMI)/Serious Emotional Disorder (SED) Residential Treatment:** The first part of the 1115 Waiver we are expanding is for the purpose of SMI/SED in our facilities. SMI/SED are currently allowed for inpatient treatment for individuals as long as the have a comorbidity of a substance use disorder. Additionally, these stays are restricted to 15 days. If there is an individual between the ages of 16-64, that does not have a co-existing IMD diagnosis, they are restricted from receiving these services. The Waiver amendment is intruded to increase service availability by allowing admission without SUD comorbidity as well as extending the 15 days. The extended stay is expected to provide enough recovery support to decrease the admission risk, but also to allow individuals to re-integrate into the community. This is not intended to lead to long term institutionalization for the majority of members but to ensure that the level of care required for re-integration into the community is allowed for and not restricted to a two week stay when a longer stay is necessary to keep both the member and the care-takers safe. Currently Medicaid is having to negotiate case specific service agreements for individuals who meet these criteria, and so the Waiver amendment is intended to eliminate those specific case service agreements and allow us to reach a larger group of our population. **Bryce Pittenger from Behavioral Health presented on High Fidelity Wraparound:** High Fidelity Wraparound is for the children and families in our system with the heaviest burden that are involved with multiple systems. Children, Youth, and Family Department (CYFD) with the help of national experts, created high fidelity wraparound, which is intensive care coordination, which an approach not a service. So, if people get their underlined needs met, they move towards health. The idea is to utilize the child and adolescent needs and strengths (CANS), which are child and adolescent needs assessment, which is a validated metric tool that CYFD has been utilizing internally. Part of this contract is to provide High Fidelity Wraparound services to all children eligible in child welfare and protective services. However, we are looking at all children in the state of NM to eventually being able to receive High Fidelity Wraparound if they are eligible. Currently there are eight providers in ten counties that are serving and utilizing funding, sometimes it is gross receipt tax in the Albuquerque area, federal funding, and a lot of system of care. The higher the fidelity to the wraparound, the more return we get. There are 3 fidelity tools that we utilize and work with	None	Lorelei Kellogg, Deputy Director, Medical Assistance Division, Human Services Department Bryce Pittenger, CEO of Behavioral Health Collaborative, Human Services Department	Completed

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	University of Seattle, University of Washington and New Mexico State University, to make sure we are providing wraparound to the high fidelity that we can. Of those children/youth who have completed wraparound, 76 percent have been discharged to a family setting, as opposed to 46 percent of those who did not complete it. 70 percent of those children/youth who completed the Wraparound stated their quality of life had improved greatly as opposed to four percent of those who did not complete it. Out of those who completed the wraparound, 16 percent of the children were adopted, as opposed to zero percent in the control group. So, the idea is that the state is looking at the 1115 Waiver to expand high fidelity wraparound to the corners of the state, to the children and the families that can benefit. One of the pieces of the high fidelity wraparound is to keeping kids out of home placements and out of out-of-state placements. **Alex Castillo-Smith from Office of the Secretary presented on Primary Care Graduate Medical Education (GME) expansion:** HSD released a five-year strategic plan related to GME this January. Through interview with stakeholders, we determined that with support from the state and support from Legislators, there is an environment right for primary care GME expansion. We anticipate that programs will grow 63 percent in the next five years, and the number of primary care residents in training will grow by 105 percent. The more residents that we can train in NM the more likely they will stay in NM and practice NM post-residency. The map shown on this slide shows where we anticipate programs to expand by specialty. Some statistics related to the investment in primary care physician expansion are to the right of the map. Related to the Waiver specifically, we will be requesting some support from CMS for GME development program funding that we provide to programs.		Alex Castillo-Smith, Office of the Secretary, HSD	
8. Public Comment	**The public had the following public comments:** There were no public comments.	None		Completed
9. Adjournment	The meeting adjourned at 3:23 pm.	See HSD website for upcoming meeting date(s)	Larry Martinez, MAC Chairperson	Completed

Respectfully submitted: Alysia Beltran

Recorder

November 12, 2020

Date