Con Alma Foundation
Regional Convening on Health Care Reform in New Mexico
Gallup – June 6, 2013

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I.
Expanding Health Coverage for Low-Income Adults: The Medicaid Opportunity under the Affordable Care Act (ACA)

Medicaid background

- Joint federal-state program
  - Federal legal framework; each state designs its own program within that framework
  - Shared cost; New Mexico's current federal match ~70% (state pays ~30%)
- Eligibility: Low income not sufficient; must be in a recognized eligibility "category" (e.g., child, parent, disability) – i.e., must be "poor and something else"
  - Income eligibility levels vary widely for different groups – e.g., kids to 235% of the federal poverty level (FPL); parents to 30% FPL

ACA expansion

- People up to age 64 with incomes up to 138% FPL (~$15,850 for 1 person, ~$32,500 for family of 4)
  - No longer have to be "poor and something else"
  - Includes childless adults
- Groups with higher income eligibility stay eligible
- Doesn't include undocumented
- Part of a comprehensive plan to provide access to health coverage across the income spectrum:
  - <138% FPL – Medicaid
  - 138-400% FPL – Subsidized insurance through the Exchange
  - >400% FPL – Unsubsidized insurance in or outside Exchange
- Effective January 1, 2014; enrollment begins October 1, 2013
- Newly eligible will get "alternative benefit plan" rather than full Medicaid benefits

Paying for expansion – Increased federal match for newly eligible:

- 100% 2014-16 (state pays nothing)
- Phases down to 90% 2017-20
  - 2017 – 95% (state pays 5% of cost)
  - 2018 – 94% (state share 6%)
  - 2019 – 93% (state share 7%)
  - 2020 and later – 90% (state share 10%)

Where do things stand with expansion?

- Supreme Court decision (June 2012) upheld ACA provision for expansion but essentially made it optional, so up to each state to decide
- New Mexico WILL expand!
  - 170,000 New Mexicans are expected to gain coverage

Uninsured in New Mexico

- NM consistently has one of the highest uninsured rates in the U.S.
  - Approximately 1/3 of adults aged 19-64 are uninsured
  - Adults 19-64 make up 77.3% of uninsured New Mexicans
  - Among adults 19-64 <139% FPL, 46% are uninsured
    (Sources: Kaiser Family Foundation State Health Facts 2010-11; NM Human Services Dept. 2008)
- Effects of uninsurance:
  - Delayed/inadequate care
  - Poorer health; earlier death
  - Debt and financial insecurity
  - Cost-shifting
  - Exacerbates health disparities

Effects of expanding Medicaid in New Mexico

1) **Improved health and well-being**
   - Improved access to care
   - Improved health status; reduced disability/mortality
   - Increased productivity
   - Reduced medical debt/improved financial security
   - Reduce health disparities
   - Increased control of communicable disease

2) **Reduced uncompensated care and a stronger health care system**
   - Reduces burden on hospitals and other providers
   - Reduces burden on county indigent funds
   - Reduces cost-shifting to costs of insurance and health services
   - Funds health care infrastructure

3) **Benefits to the state's economy**
   - $4-$5.4 billion net additional federal dollars flowing into economy 2014-20
   - Resulting economic activity and jobs
     - $4.6-$8.5 billion increased economic activity
     - 6,000-8,500 jobs created – directly in health care services and administration and indirectly through the multiplier impact as money cycles through the economy

     (Source: UNM Bureau of Business & Economic Research, 10/31/2012)

4) **State treasury revenues and savings**
   - Revenues (from existing taxes)

        - Insurance premium tax (virtually all Medicaid recipients are enrolled in managed care organizations)
        - Gross receipts tax
        - Income tax
    - Savings:
        - End State Coverage Insurance (SCI) program – cover people with better benefits at lower cost to state
        - Move from high-risk pool to Medicaid
        - Medical and criminal justice savings due to increased access to mental health and substance abuse coverage

Medicaid expansion is a money-maker for New Mexico.

- Revenues to the state treasury will exceed expenditures 2014-19
- After 2019?
    - Legislative Finance Committee analysis: may be small net cost beginning 2020
    - UNM Bureau of Business & Economic Research finds net gain continuing 2020 and beyond

II.
Medicaid "Redesign": Centennial Care

Proposed restructuring of virtually the entire Medicaid program

- Combine almost all parts of Medicaid into a single program to reduce administrative burden on HSD
- Must be approved by federal Medicaid agency (CMS)
    - Application submitted August 2012; awaiting federal decision
- To begin January 1, 2014
- Human Services Department's stated goals:
    - "Bend the cost curve" – i.e., save money
    - Improve health care through focus on quality and outcomes

HSD's "guiding principles" for Centennial Care

- Care coordination
- Personal responsibility
- Pay for performance
- Administrative simplification

Key elements of the new program

- *Reduce number of managed care organizations*
    - Currently seven (4 in Salud, 2 in Coordinated Long-Term Services (CoLTS), 1 for behavioral health)
    - Four in Centennial Care (Blue Cross, Molina, Presbyterian, United)

- *Each MCO to provide all services to all populations*
  - Including physical health, behavioral health, long-term services and supports
  - Exception: Developmental Disabilities waiver services
  - Concerns:
    - Will all MCOs have the experience and ability to administer all services?
    - Many people will have to change MCOs and health care providers, causing disruption and raising issues relating to continuity of care/services

- *All Medicaid participants will be screened to determine service needs. People with higher needs are supposed to get greater care coordination and case management*.
  - Goal is to assure needs are identified and people get the care they need, reducing the need for more expensive services.
  - Not clear how/whether this will work or improve on current system.

- *Co-pays will be charged in certain circumstances*:
  - Non-emergency use of ER
  - Brand-name prescription drugs when generic available
    - Exception for psychotropic medications
    - Process for exception for other meds when needed

- *Incentives for healthy behaviors*
  - Rewards for positive actions such as participating in weight loss or smoking cessation programs, taking child for all well-baby checks
  - Awarded through credits to pay for non-Medicaid-covered items such as over-the-counter medications).

- *"Pay for performance" for providers*
  - Intent is to emphasize quality and outcomes instead of quantity of services provided
    - Promote use of best practices through peer-to-peer comparative data
    - Pilot projects for new payment approaches
  - Concerns: Pay for performance is in its infancy. Not clear how to achieve.

- *Increased access to community-based long-term services for seniors and people with disabilities*
  - This is one of the major improvements proposed in Centennial Care.
  - Access to services without a waiver "slot"
  - People who don't otherwise qualify for Medicaid (e.g., >138% FPL) will still need a waiver slot, so waitlists will continue.
  - May be individual cap on dollar amount of services, denying services to persons with more severe disabilities/higher levels of need.

- *12-month continuous eligibility for adults*
  - Reduces "churning" in and out of Medicaid eligibility.
  - Promotes continuity of care.

- *Elimination of retroactive eligibility (payment for health care expenses incurred in three months before enrollment in Medicaid)*
  - Would leave people with large medical bills
  - Large part of burden would fall on providers, whose bills wouldn't be paid
  - No decision yet re whether CMS will approve this change

- *Reduced income eligibility for family planning and breast/cervical cancer coverage*
  - These programs currently cover people up to 185% FPL for family planning and 250% FPL for breast and cervical cancer. The state proposes to reduce the eligibility level to 138% FPL for both programs. Individuals with income above that level would no longer be eligible for Medicaid and would have to get coverage through the Health Insurance Exchange instead.

Native Americans in Centennial Care

- Currently, opt-in for Salud and mandatory enrollment in CoLTS
- HSD wanted mandatory enrollment for all Native American enrollees; tribes opposed
- CMS disapproved; current system to continue (opt-in except for individuals eligible for CoLTS)

The devil is in the details.

- Many of the details of Centennial Care implementation are still unknown.
- Process of developing the program has not been transparent.
- Implementation workgroups are internal to HSD (state staff only); limited opportunities for stakeholder input.

People who become eligible for Medicaid through the expansion will be enrolled in Centennial Care.

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For more information:

Medicaid expansion—

- "The Medicaid Opportunity in New Mexico", NM Center on Law and Poverty (10/2012), http://nmpovertylaw.org/WP-nmclp/wordpress/WP-nmclp/wordpress/wp-content/uploads/2012/11/Brief-CLP-Medicaid-Opportunity-in-NM-Issue-Brief-FINAL-2012-10-26.pdf
- "Economic and Fiscal Impacts of the Proposed Medicaid Expansion in New Mexico", University of New Mexico Bureau of Business and Economic Research (10/31/2012), http://bber.unm.edu/pubs/Medicaid_Expansion_10-12.pdf

Centennial Care—

- Human Services Department's waiver application to CMS (8/17/2012): http://www.hsd.state.nm.us/pdf/Medicaid%20Modernization/Waiver%20Submission%20to%20CMS%20-%2008.17.2012.pdf
- Summary by Disability Rights New Mexico: http://www.drnm.org/uploads/PDFs/DRNM%20Summary%20Centennial%20Care%20Revised%20092012.pdf