

New Mexico Medicaid Projections by County for 2014

INTRODUCTION

The Patient Protection and Affordable Care Act, known as the Affordable Care Act (ACA), was passed into law March 23, 2010 and amended by the Health Care and Education Reconciliation Act March 30, 2010. On June 28, 2012, the United States Supreme Court ruled upholding major provisions of the ACA.

PROJECTIONS BRIEF

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This is one in a [series](#) of briefs that make county-level projections for various states.

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The ACA aims, in part, to extend health insurance to millions of U.S. citizens. This extension will occur by insuring individuals, expanding Medicaid and providing subsidies to help people with low incomes buy coverage through newly established Health Benefit Exchanges, functioning in states as insurance marketplaces starting January 1, 2014. In many cases, the federal government will either set up the exchanges or partner with states in doing so.

Until recently, whether the exchanges would be established and the expansion would occur remained in question. Twenty-six states challenged the constitutionality of the ACA in court. A group representing businesses similarly filed a lawsuit. The U.S. Supreme Court heard arguments about these cases in March 2012.

On June 28, 2012, the Supreme Court handed down opinions. In a 5-4 decision, the Court found the ACA constitutional. However, the ruling did afford states flexibility with the Medicaid expansion contained in the ACA. This latter part of the ruling means that, in some states, many people who would have otherwise been covered under Medicaid will not be (see details below).

After the Court ruling, the State of New Mexico announced formation of a task force to develop a proposal for creating a state-based health legislation to establish an exchange. Then, in 2012, authorizing legislation did not pass.

Now, to operate a state-based exchange, New Mexico must submit an exchange [blueprint](#), consisting of an application and a declaration letter signed by the Governor, to the Centers for Medicare and Medicaid Services Center for Consumer Information and Insurance Oversight (CCIIO) by November 16, 2012. New Mexico has until January 1, 2013 to demonstrate to the satisfaction of the U.S. Department of Health and Human Services that it will have an exchange fully or conditionally operational (likely to be fully operational) by January 2014. Otherwise, the federal government will assume responsibility for running a health insurance exchange in the state.

The administration of New Mexico's governor is also working on a Medicaid renovation, trying to determine how to slow the growth of the program without cutting enrollment or changing eligibility. The state wants to have the revamped Medicaid program implemented by January 1, 2014.

The U.S. Supreme Court's decision on the constitutionality of the Medicaid expansion is complicated. However, basically, it said: A) Congress acted constitutionally in offering states funds to expand Medicaid coverage; B) so states

can expand coverage in exchange for those new funds; C) if states accept the expansion funds, they must abide by the new rules and expand coverage; D) but states can elect not to participate in the expansion without losing all of their Medicaid funding. Instead, states will have the option of continuing their current, unexpanded plans, unaffected by the ACA.

A significant expansion population under the ACA is persons who do not have health insurance and will become eligible for Medicaid. The ACA expands Medicaid to persons with incomes at or below 138 percent of the Federal Poverty Level (FPL) starting January 1, 2014. The FPL is the income level at which the federal government considers someone to be living in poverty. The FPL for one person in 2012 is a gross annual income of \$11,170. The 138 percent of FPL represents a \$15,415 gross annual income for an individual or \$26,344 for a family of three.

Some confusion surrounds the income-eligibility threshold for the new Medicaid population. According to initial language in the ACA, childless adults whose gross yearly income is less than or equal to 133 percent of the FPL are eligible for Medicaid coverage.

However, a complicated set of provisions later contained in the ACA raises the Medicaid eligibility threshold to 138 percent of the FPL. So, states using ACA monies to fund Medicaid expansions will need to include childless adults up to 138 percent of the FPL. To defray costs to the states, [enhanced federal funding](#) will be available to finance the "newly eligible."

New Mexico citizens and likely the government will benefit from the Medicaid expansion. The state has a high uninsured rate. The Medicaid expansion will extend coverage to single adults and a sizeable number of the state's adults are likely to be new Medicaid beneficiaries. New Mexico currently receives about 69 percent federal funding for Medicaid. Starting in 2014, this will increase to 100 percent for the Medicaid expansion population until 2016, reducing incrementally to 90 percent in 2020 and beyond.

Planning for and predicting the effects of health reform, as specified in the ACA, requires knowing which persons have health insurance and which do not. While it is important to understand what is occurring with insurance at the state level, looking only at the state level gives an incomplete understanding of what is

occurring within the state at the county level.

Projections of persons who will be newly insured in 2014 can promote successful ACA preparation and implementation as well as access to care.

This brief is a revised version of one that gives the estimated numbers and percentages of adults who will be newly eligible for Medicaid in 2014 for New Mexico and each of its 33 counties. It then makes projections of the numbers and percentages of those eligible who will become new Medicaid beneficiaries in 2014.

MAKING PROJECTIONS AND PLANNING

Access to healthcare services in the U.S. typically depends on whether people have insurance coverage. In 2014, several important ACA provisions intended to expand coverage take effect. That's when the Health Benefit Exchanges are to be operational and when the Medicaid expansion occurs in some states.

The healthcare system will change dramatically but we can't foresee exactly how. Although it is impossible to

know precisely how many individuals will gain coverage because of the ACA, it is possible to make close approximations.

METHODS

To do so, Health Policy and Research Solutions (HPR) invested a great deal of time building and testing complex statistical models to develop a conceptual framework and a set of proprietary data modeling tools to make county-level projections of persons newly insured in 2014 under the ACA. In application, we fine-tune these tools to capture the subtle mixes of demographic and socio-economic factors of each state and its counties.

We examined the "gray" literature, then academic works using multiple search engines including JSTOR, Medline and PubMed. These searches disclosed that HPR was the first nationwide to develop this county-level structure and proprietary technology and to publish projections based on them.

The HPR framework and methodology makes county-level projections by age and ACA populations including overall persons newly insured, new Medicaid beneficiaries and individuals using subsidies to

purchase policies through state exchanges.

As indicated, the current brief revises one that provides Medicaid projections for New Mexico. It also outlines benefits the projections offer New Mexico and other states.

METHODS, DATA AND FINDINGS

Map 1 gives the percentages and Table 1 gives the numbers and percentages of New Mexican adults newly eligible for Medicaid in 2014.

See page seven of this brief for an explanation about the methodology used to make the projections. For additional information about methods, data and findings, please [contact us](#).

IMPLICATIONS

The projections HPR makes benefit state residents, governments, organizations, businesses and other stakeholders.

Medicaid

These projections can inform decision-making processes of New Mexico and other states about whether to expand their Medicaid programs. The forecasts enumerate human costs and benefits. They quantify

both how many people living where would be insured with this expansion and how many who would otherwise have been insured will not be without it.

These predictive analytics will help states expanding Medicaid plan according to expected enrollment and provider network adequacy. They will help states manage the enrollment surge, develop state plans and create programs. They can similarly aid restructuring activities like that underway in New Mexico.

By matching the projections with their financial and enrollment data and ACA provisions (i.e., enhanced federal match), states can determine how the expansion could impact their budgets.

The projections benefit many stakeholders that depend on Medicaid or are expecting increased Medicaid revenues in 2014. Among these are mental health and home care providers, long-term care facilities, Community Health Centers (CHCs) and professionals serving special populations such as children and adults living with disabilities or with HIV. In states that expand Medicaid, residents in need will have healthcare security as their providers have a dependable source of reimbursement to serve them.

Providers, especially health systems and hospitals, are facing unknowns. Added revenue from the Medicaid expansion was intended to offset the billions of dollars cut from Medicare payments and the planned loss of DSH payments. Hospitals in some states are uncertain about the fate of Medicaid and won't know until next year whether they will lose Disproportionate Share Hospital payments if their states opt out of the expansion.

Advocacy

Professionals, associations and advocacy groups (e.g., hospital and long-term care associations, HIV Councils, the Cancer Society, the Heart Association and AARP) are lobbying state governments to expand their Medicaid programs.

These individuals are advocating to have positions upheld that benefit their causes, professions or persons served. The projections are independent and do not have agendas. Therefore, *if* these data support advocacy positions, they firmly undergird those positions and strengthen advocacy voices. Advocates can lobby governments much more effectively armed with hard unbiased data than unarmed.

Providers make valuable contributions to communities. For example, they help keep people healthy and stimulate the economy. Expected changes such as in reimbursement that threaten their stability also threaten their ability to continue making these contributions.

The projections reveal geographically how many individuals will be with and without coverage to access services. Coupled with fiscal data, they also reveal future provider operating revenues with the Medicaid expansion and losses without it by service areas for state and county advocacy. This advocacy may include other issues such as reimbursement rates and services considered essential health benefits covered under insurance plans.

In addition, the projections data allow providers to plan, contingent upon whether states do or do not expand their Medicaid programs.

More about Providers

Professionals providing most kinds of care can use the projections to inform their planning and practices. Some include those providing primary, specialty, home, mental health, long-term care and substance abuse treatment as well as hospitals and systems.

To strategize for success in the new health reform landscape, providers will probably want to develop baselines. Then, initially and each year, analyze how reform will reshape insurance status, demand, reimbursement streams, utilization revenues and operating margins. They will likely want to re-compute where patient volume will come from in the future.

The projections serve as the analysis of how reform will reshape insurance status and demand. They also re-compute from where future patient volume will come.

Providers will also want to determine the size and demographic characteristics (e.g., age and income) of the populations to be served and the amount of revenue to expect by population and geographic area.

The projections give patient size and demographics to expect in current catchment areas and others from which providers draw. The projected volumes matched with expected reimbursement rates classified by ACA provisions and payment sources (e.g., Medicaid, commercial) disclose amounts of revenue to expect in these service areas.

Expecting increasing numbers of patients to serve and

payment reforms, providers will likely want to focus on revenue while driving efficiencies. To expand their capacity to assure access and to be competitive, providers may want to expand their market share geographically among the growing volume of patients.

The projections unearth the amount of potential volume for this practice expansion and its direction from pinpointed geographic growth areas. Since these predictive analytics also give population demographics, potential new revenues can be determined for growth areas with the method used for calculating future revenues in current service areas.

Predicting volume is one of the biggest challenges healthcare managers face with budget planning since it is the primary driver of revenues and expenses and affects all outlays except fixed expenditures for facilities. Volume from the projections should reduce this particular challenge.

In the reform landscape, ACA provisions (e.g., payment modifications and penalties for unnecessary hospitalizations and acquired infections) mean providers will have to pay much more attention to prevention, wellness, quality and patient safety. With more persons

insured, providers who have allocated portions of their budgets to uncompensated care could instead funnel the funds into resources such as staffing, prevention, decision-making software and electronic health records.

The projected volumes linked with fiscal data let providers decide upon the percentages of allocations by location to redirect at baseline, which can be adjusted in subsequent care. Providers will likewise know overall where to direct resources and in what amounts.

Access and Systems

Regardless of how the large number of people newly insured affects provider revenue, it may well present quite a challenge for the healthcare system when it is faced with delivering care to all in need. Even though more individuals will be insured, coverage doesn't equate to access to healthcare services. So, providers will also want to focus on expanding their service capacity.

In addition to quantifying future need, some other ways the projections will promote access to care, expansion and systems development and maintenance appear below:

- informing network structure and adequacy and planning to meet geographic need for services mapped with provider types, locations, capacities, expansion plans and insurance acceptance practices
- aiding initiatives to expand service capacity and identify and fill gaps in access (e.g., targeted outreach for Medicaid/CHIP [Children's Health Insurance Program]) enrollment
- guiding activities aimed at reducing health disparities such as outreach according to need (e.g., mental health)
- dovetailing with medical workforce development efforts (matching geographic need and demand with provider supply and education);
- documenting need for expanded scopes of practice for essential healthcare professionals
- tracking ACA implementation, effects and need/demand met and unmet over time, ideally matched with overall population projections.

Prevention and Quality

The projections benefit the health community and the public in other ways such as:

- enhancing prevention (e.g., prevention networks) and quality improvement efforts including integrated care
- offering direction for eHealth network planning/implementation and meaningful use

Other Areas

- The projections document future population needs used for multiple purposes in myriad fields such as nonprofit grant writing.
- Insurance companies can survey their future marketplace as depicted by the projections and see where to direct their marketing and outreach. The same holds true for consultants and medical equipment and pharmaceutical companies.

States will enjoy economic impact from growth in the healthcare industry. Economic development experts can use the projections to inform their activities according to areas of expected financial stimulus and needed stimulus. Local businesses will likewise have a

blueprint for the future in the forecasts.

State Exchanges

The projections have practical implications for the state exchange in New Mexico and those in other states. They can enhance New Mexico's demonstration of readiness needed for HHS approval (e.g., outreach plan development).

Moreover, state exchanges will require sound evidence to successfully operate and comply with [ACA requirements](#), some of which follow:

- Conducting outreach and education to educate consumers about the exchange and insurance affordability programs to encourage participation
- Reaching out to and enrolling vulnerable and underserved populations (populations that may be exempt from enrollment in a benchmark plan and likely to qualify for Medicaid)
- Assuring adequacy of qualified health plan (QHP) networks that include sufficient numbers and geographic distributions of providers for low-income and medically underserved individuals in the QHP's service area.

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About the Projections

Aggregated state projections of persons who will be newly insured in 2014 under the Affordable Care Act (ACA) do not capture the nuances and variability of smaller geographic areas needed for states, organizations, providers and businesses to effectively implement ACA provisions and strategize for success in the new reform landscape.

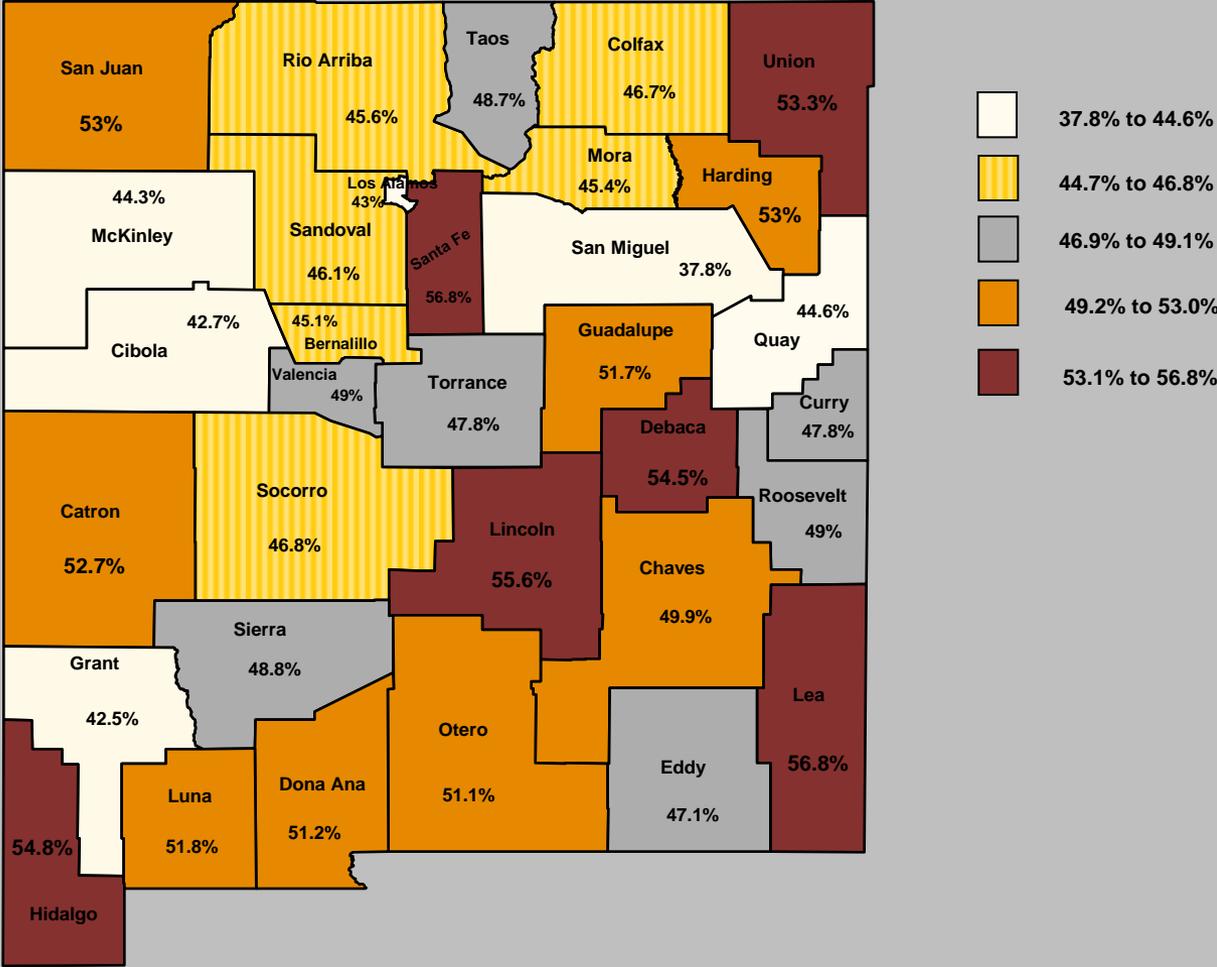
Therefore, investing a great amount of time, HPR created a conceptual framework and built and tested statistical models to develop a set of proprietary data modeling tools to help entities better prepare for implementation of the ACA and to plan. These tools allow us to make projections at more granular levels - for all state counties, groupings of counties, single counties and metropolitan areas.

Each state, its counties and other geographic areas have unique, subtle mixes of demographic and socio-economic factors that change how we fine-tune and use the tools in application. You cannot extrapolate subsets and make accurate projections for single states

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Map 1. Percentages of New Mexicans Adults Eligible for Medicaid Expansion in 2014



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Table 1. New Mexicans Adults Newly Eligible for Medicaid in 2014

County	Number Newly Eligible	Percent Newly Eligible	County	Number Newly Eligible	Percent Newly Eligible
Santa Fe	9,244	56.8%	Taos	2,786	48.7%
Lea	4,481	56.8%	Torrance	1,508	47.8%
Lincoln	1,683	55.6%	Curry	3,407	47.8%
Hidalgo	500	54.8%	Eddy	2,948	47.1%
De Baca	164	54.5%	Socorro	1,831	46.8%
Union	302	53.3%	Colfax	778	46.7%
San Juan	9,968	53.0%	Sandoval	5,965	46.1%
Harding	61	53.0%	Rio Arriba	2,945	45.6%
Catron	337	52.7%	Mora	492	45.4%
Luna	2,949	51.8%	Bernalillo	37,114	45.1%
Guadalupe	516	51.7%	Quay	727	44.6%
Dona Ana	20,060	51.2%	McKinley	7,436	44.3%
Otero	5,555	51.1%	Los Alamos	154	43.0%
Chaves	5,361	49.9%	Cibola	2,280	42.7%
Roosevelt	2,001	49.1%	Grant	1,899	42.5%
Valencia	5,516	49.0%	San Miguel	2,131	37.8%
Sierra	1,094	48.8%			
State	144,193	48.3%			