Health Notes

Program Evaluation Unit
Legislative Finance Committee
Date: January 13, 2017

Centennial Care Medicaid Managed Care Payment Rates

AT A GLANCE

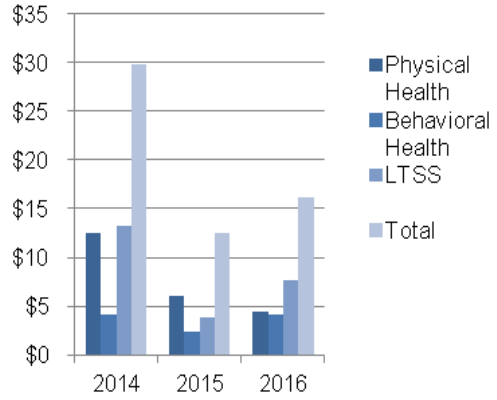
New Mexico's Medicaid program has been primarily a managed care model since the late 1990s. The majority of the state's Medicaid population, approximately 77 percent or 684 thousand people, receive health care services through the Centennial Care managed care program. The other 23 percent of the state's Medicaid recipients are exempt by state and federal regulations from managed care and are covered by the fee for service (FFS) program. Expenditures for the state's Medicaid managed care program were nearly $4.3 billion in FY16 and are projected to reach $4.7 billion by the end of FY17.

For the managed care portion of the program, the Human Services Department (HSD) contracts with MCOs to provide Medicaid services on a prospective at-risk capitated payment basis: the department pays the MCO a flat per member per month (PMPM) payment, and the MCO provides necessary covered services, ideally containing healthcare costs without compromising quality of care or outcomes through improved management and coordination of healthcare services.

This Health Note will focus on Centennial Care Medicaid managed care rates. The brief will review how the rates were developed at the beginning of Centennial Care in 2014 and how the department has adjusted them over the last three years to handle program growth and change. Current challenges include recent changes to federal regulations that may limit appropriators' options through removing the use of rate ranges. In the meantime, there are opportunities for cost containment through future rate development: HSD's decision to pay MCOs at the mid-point within the allowable rate ranges, rather than the lower boundary of those ranges, resulted in unrealized potential savings for the state general fund of approximately $58 million over the last three years: $29.8 million in 2014, $12.5 million in 2015, and $16.1 million in 2016.

Given the precarious financial situation the state is currently facing, HSD should carefully consider the option of dropping MCO payments to the bottom of the actuarially sound rate range to capture any possible savings for FY17 and beyond.

Chart 1: Potential General Fund Savings from Lower MCO Payments



Source: HSD

Health Notes are briefs intended to improve understanding of healthcare finance, policy, and performance in New Mexico.

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Medicaid Managed Care

New Mexico began using a managed care model for portions of its Medicaid program in the late 1990s. Centennial Care, implemented in January 2014, restructured and streamlined the state's Medicaid program by combining several distinct Medicaid programs, including behavioral health, into a single program. The formerly separate programs had been divided along demographic and health care need characteristics, like the Salud program for low income children and their families, or the Coordination of Long Term Services (CoLTS) program for recipients needing long-term care. Under Centennial Care, these different populations are now all part of the same program and access their benefits through whichever of the four contracted MCOs they choose to enroll in: Blue Cross Blue Shield, Molina Health Care, Presbyterian Health Plan, or United Healthcare.

Under Centennial Care, Medicaid recipients are provided the full array of benefits they are eligible for by whichever of the four contracted MCOs they choose to enroll in: Blue Cross Blue Shield, Molina Health Care, Presbyterian Health Plan, or United Healthcare.

At the same time, the state expanded Medicaid eligibility under the Affordable Care Act, providing coverage to an entirely new population – adults between the ages of 19 and 64, with annual incomes at or below 138 percent of the federal poverty level.

In a managed care system, the state endeavors to negotiate MCO contracts and set payment rates that ensure recipients receive quality health care for an affordable – and predictable – cost. From an economic perspective, the department's goal is to establish payment rates that are high enough to ensure quality of care and sufficient providers, while at the same time coming as close as possible to actual MCO expenditures to avoid overpayment, a balancing act that takes place on many levels of the program simultaneously.

Once HSD sets the per member per month rate for each MCO, the department is relatively immune from how much health care costs, and increasing expenditures are driven primarily by changes in enrollment.

The Human Services Department (HSD) contracts with the Centennial Care MCOs to provide Medicaid services. HSD determines who is eligible for which category of Medicaid services and establishes the benefit packages and contractual guidelines for service delivery, provider access, quality of care standards, and other program requirements. The basic contracts, program components, and rules are the same for all four MCOs, but HSD sets payment rates separately with each of them, based on factors discussed in more detail in the following sections. Once the per member per month (PMPM) rate is set with each MCO, the department is relatively immune from how much healthcare individual recipients use or how much that care costs, and increasing expenditures are driven primarily by changes in enrollment.

On the other side of the equation, the MCOs must provide services of sufficient quality to meet the requirements of their contracts with the state and to compete with the other MCOs for Medicaid recipient enrollees, while at the same time keeping costs down so they can make a profit. MCOs manage this process by ensuring individuals are eligible for the services they request, verifying those services are medically necessary, and negotiating the prices they pay to the individual providers in their networks. In the fee for service (FFS) portion of Medicaid, HSD makes payments directly to individual health care providers according to a fee schedule established by the department. The Centennial Care MCOs use the department's FFS rate schedule as a starting point but they are not required to follow it exactly

and may pay providers more or less, depending on their own organizational priorities. Payment agreements between providers and MCOs are generally highly confidential; HSD has a glimpse into this arena when MCOs report their expenditures in financial reports, but does not have precise or complete information.

Capitated PMPM rate development

The concept of flat capitated payments may sound simple but in reality it is quite complex. The Centers for Medicare and Medicaid Services (CMS) requires that MCO rates be actuarially sound; Mercer, the actuarial firm HSD contracts with, defines actuarially sound rates as those which, when combined with other revenue sources available to the MCO such as investment income, cover all "reasonable, appropriate, and attainable costs," including health benefits, administrative expenses, and government fees and taxes.

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Mercer does not determine the exact PMPMs the state will pay to the MCOs – HSD sets those rates with each MCO. For 2014, the first year of Centennial Care, the rate setting process began with rates proposed by MCOs as part of the competitive bidding process; final rates for that year were then negotiated by HSD. In subsequent years, the process has begun when Mercer establishes the ***rate ranges***, with lower and upper bounds, for each type of client; for example, there are different rate ranges for children, adults, the elderly and the disabled. HSD considers an array of specific information about the recipients enrolled with each MCO and then determines, within the range, the actual PMPM it will pay.

Historically, and for this current review, HSD has made a strong argument that revealing the rates it pays to each MCO – or even averages of actual payments – would make future negotiations more difficult for the department, potentially pushing costs up. The department also notes that MCO rates are highly dependent on key characteristics of each MCO's membership, which are not readily available for public scrutiny.

LFC staff agreed not to include actual MCO rates in this brief, but has included average annual PMPMs paid by HSD for the five large programs. Publishing an annual average PMPM here is not likely to be any more harmful to HSD's negotiating position than the department's routine inclusion of average quarterly PMPMs in its Medicaid projections. Further, LFC retains the position that there is a public interest in some degree of transparency regarding MCO payment rates for budgetary and oversight purposes as well as for quality and performance evaluation. For example, LFC staff has not been able to find any correlation between each MCO's payment rates and the health outcomes it reports through the Healthcare Effectiveness Data and Information Set (HEDIS) and other measures, something HSD presumably takes into consideration when setting rates.

Unique rate ranges are developed for each cohort. Medicaid recipients are grouped into to 33 different cohorts based on age, gender, health status, and category of eligibility, as well as whether they are dually eligible for Medicare and Medicaid. In addition, when HSD reintegrated behavioral health services back into

the program it maintained a system of tracking utilization and costs for these services by creating a behavioral health program with its own eight distinct cohorts, for a total of 41 cohorts. To ensure the MCOs receive payments that are matched to actual anticipated costs, the department develops PMPM rates for each of the 41 cohorts. The cohorts are organized together into four programs: physical health, behavioral health, long term services and supports (LTSS), and the expansion population or 'other adult group' (OAG). Appendix A lists all Centennial Care cohorts and MCO payment rate ranges for 2014 – 2016.

Current year rate ranges are based on past years' data combined with assumptions about the future. Mercer and HSD use both encounter data and MCO financial reports in the process of developing prospective rates. Encounter data includes detailed information about the types, amount, and costs of health care used by Medicaid recipients, and may also reveal important information about potential savings from managed care efficiencies like appropriate use of generic drugs, potentially preventable hospital admissions, or avoidable non-emergent use of emergency rooms. MCO financial reports are an additional source of information about medical costs, as well as about non-medical costs such as administration, investment income, and prescription drug rebates received directly by the MCOs.

Mercer begins the process of establishing the rate ranges for each coming year by selecting a base time period for which it has sufficient data and during which the program was as similar as possible to the projected time period. For example, 2014 rate ranges were set using CY2011 Medicaid data for the physical health, behavioral health, and LTSS cohorts, and using FY2012 State Coverage Insurance (SCI) data for the OAG cohort. Mercer then makes a series of adjustments to the base data to account for financial updates, programmatic changes, and enrollment projections, and then develops projected medical and non-medical costs for the coming year, including specific estimates for components of care such as pharmacy, care coordination, administration and MCO profit. This process of data adjustment and projected costs is applied to each category of eligibility within each cohort – referred to as a ***rate cell*** – taking into account the particular cost and utilization patterns of each group.

A risk corridor is a mechanism that cushions both HSD and the MCOs from extreme gains or losses: if MCO actual costs are higher than projected, HSD pays a portion of the higher costs; if MCO actual costs are lower than projected, HSD is able to recover the majority of its overpayment.

There are other factors that influence rates that are not controlled by HSD. These include assessments that are levied against the MCOs for the New Mexico Medical Insurance Pool (NMMIP) and the New Mexico Health Insurance Exchange (NMHIX). The NMMIP assessment allocated to Medicaid has increased from $44.2 million in 2014 to $46.6 million in 2016. The NMHIX assessment, first levied in 2015, contributed to an increased cost to the Medicaid program and the rate ranges. The amount of the assessment allocated to Medicaid was $3.7 million in 2015 and $13.0 million in 2016.

Prospective rates are based on assumptions about the future; despite careful consideration, some of these assumptions do not materialize. For example, the rate development process for CY15 contained assumptions about utilization and spending for hepatitis C drugs that did not occur. Many fewer recipients received

treatment at a substantially lower cost than Mercer had included in the rates for that year, leading to an overpayment to the MCOs of about $100 million for FY15 and about $114 million in FY16.

HSD reports it was able to recoup most of the CY15 overpayment from the MCOs through the risk corridors it has in place for the OAG population, and for hepatitis C in particular. Many of the people who obtained coverage under Medicaid expansion had no previous health insurance and presumably limited prior access to health care, and there was a great deal of uncertainty about how much or what types of health care they would use. Because the OAG population represented such a high degree of financial risk for both HSD and the MCOs, HSD put a risk corridor into place for this cohort. And as new and very expensive hepatitis C drugs became available in 2014, the department also created a risk corridor for hepatitis C expenditures. HSD ended the OAG program risk corridor in CY17 because enough credible historical data about that cohort now exists to enable the development of more accurate rates. However, the risk corridor for hepatitis C will continue as both utilization and the cost of treatment remains highly fluid.

Over 125,000 recipients, or 16.8 percent of the Medicaid managed care population, did not access services in any way during 2015. Centennial Care MCOs received PMPMs for these individuals regardless of their lack of utilization, one of the trade-offs characteristic of a risk-based managed care system.

One assumption whose implications are not clearly spelled out in the actuarial letters reviewed for this brief is the anticipated number of Medicaid enrollees who will not use any of the program's healthcare services at all. According to MCO reports, over 125,000 recipients, 16.8 percent of the Medicaid managed care population, did not access services in any way during 2015. The MCOs received PMPMs for these individuals regardless of their lack of utilization. As noted, managed care is a risk-based system: some members will use far more services than are covered by the PMPM, and some will use far less—or none at all. The actuarial letters delve in great detail into anticipated costs of high utilizers, and certainly HSD takes utilization patterns into account when determining final MCO rates, but this part of the rate setting process is not transparent.

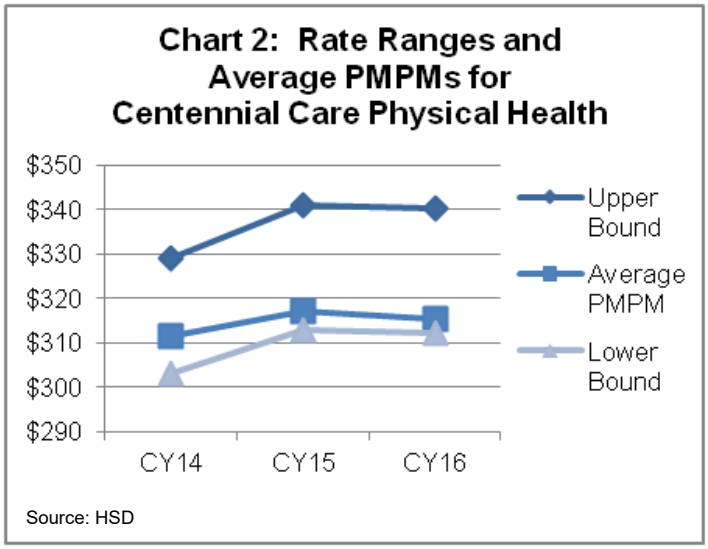
Rates, and rate ranges, can and do change during the course of a calendar year. The initial rate ranges are submitted to CMS for approval prior to the beginning of each year. But during the course of the year there may be changes made to the program that require adjustment of the rates. For example, there may be changes to provider or hospital reimbursement levels.

HSD provided the LFC with an averaged range of rates for each year, which blends the numerous mid-year changes for comparative purposes. The following sections of this brief discuss the rate histories for the major components of the Centennial Care program—physical health, behavioral health, OAG and LTSS — for calendar years 2014 through 2016, distilled from the twenty-nine actuarial rate letters drafted by Mercer.

Centennial Care rate ranges: physical health

As Centennial Care began, HSD and Mercer already had a good bit of data to work with for the base physical health population. There were nonetheless impor-

tant prospective changes to the new program that needed to be taken into account, such as HSD's decision to shift recipients of the breast and cervical cancer waiver from fee for service into managed care. This is a relatively small but very costly population and added to the overall cost projections for the year. Further, care coordination, one of the hallmark elements of Centennial Care, was anticipated to bring only incremental new costs since Mercer assumed any existing MCO would already be doing at least some care coordination.



Another concern as this first set of Centennial Care rates was being developed was the 'woodwork effect,' or the premise that New Mexicans who were already eligible for Medicaid but had not enrolled would be encouraged to do so by the highly-publicized roll-out of the ACA and expanded Medicaid. Anticipating how much and what kinds of health care this group would use added uncertainty to the rate development process.

The average 2014 rate range for the physical health program was between $303 and $329 PMPM; the average PMPM paid by HSD for this cohort was $312, about 1.4 percent below the midpoint of the range (Chart 2). (Note: throughout this brief, all PMPM rates have been rounded to the nearest dollar.)

For the 2015 rates, Mercer made a similar set of adjustments as for 2014, with one major change: costs for hepatitis C. In early 2014, new, more effective – and much more costly – specialty drugs for the hepatitis C virus (HCV) became available nationwide. No special allowance for the high cost of these drugs was made when the MCO rates for 2014 were developed, and HSD reports that the MCOs did not have substantial treatment expenses for hepatitis C that year. In 2015, however, HSD directed Mercer to include substantial anticipated costs for HCV treatment during rate range calculations and established a hepatitis C risk corridor in case the assumptions did not materialize. Other factors of note that figured into the 2015 rates were increased reimbursements for safety net care pool hospitals and the continuing woodwork effect on enrollment.

In July 2016, HSD implemented a number of cost containment changes, primarily reduced provider and hospital reimbursements. As a result, the averaged 2016 rate range for the physical health program was marginally lower than the average range for 2015, indicating progress in HSD's cost containment efforts.

Cumulatively, projected enrollment growth and these anticipated increased expenditures led to a rate range approximately 3.5 percent higher than the range for 2014. This upward shift allowed HSD to set MCO payments that were higher in absolute value, while at the same time lower relative to the midpoint of the range. The average 2015 rate range for the physical health program was between $313 and $341 PMPM; the average PMPM paid by HSD was $317, about 3 percent below the midpoint of the range and about 1.8 percent higher than the 2014 average PMPM (Chart 2).

For 2016, Mercer had a full year of new Centennial Care data available, and shifted to using 2014 as the base time period. With this data, the actuary was able

to use more current starting points for prospective adjustments, which again largely focused on hepatitis C costs. Based on anticipated increased expenditures as well as continued enrollment growth, the initial rate range for 2016 was approximately 1.5 percent higher than the range for 2015.

That picture changed by the middle of the year, however. In response to the worsening revenue situation for the state, HSD implemented a number of cost containment changes in July 2016, including reduced reimbursements for primary care physicians, dentists and hospitals, as well as reductions to administrative costs for care coordination.

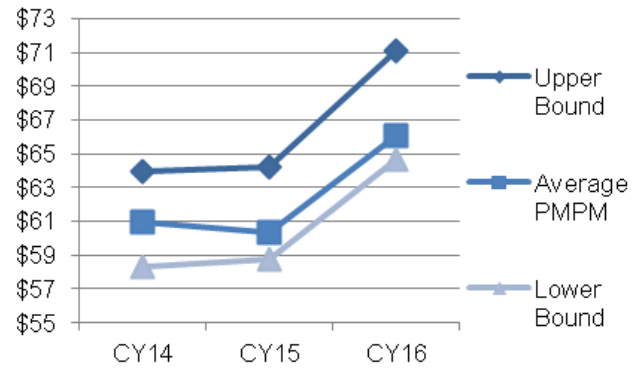
After adjusting rates to account for these changes, the average 2016 rate range for the physical health program was between $312 and $340 PMPM – marginally lower than the average range for 2015, indicating progress in HSD's cost containment efforts. HSD paid an average $315 PMPM for the year, about 3.3 percent below the midpoint of the range and about half a percent lower than the 2015 average PMPM (Chart 2).

Centennial Care rate ranges: behavioral health

A key change of the new Centennial Care program was to reintegrate – or 'carve in' – behavioral health services with the rest of health care. Medicaid recipients in all categories of eligibility have access to behavioral health services through their MCO, although, as noted above, HSD has maintained a system of tracking utilization and costs for these services by creating a behavioral health cohort, with its own seven categories and PMPMs. Further, HSD anticipated the new expansion population would use behavioral health services so differently than the traditional population that it created a separate cohort and PMPM for that group (discussed in OAG section, below).

As with the physical health cohort, HSD had solid data with which to begin the Centennial Care behavioral health rate development process. Beginning with the 2013 base time period, Mercer made adjustments for factors such as expected savings from some behavioral health prescription medications that were losing patent protection, as well as anticipated increased expenditures related to medication assisted treatment (MAT) for opioid addiction. Mercer also accounted for the apparent ability of an unknown number of core service agencies (CSAs) to negotiate higher reimbursement rates with the MCOs, which needed the CSAs in their networks to meet contractual requirements for access. Other programmatic factors influencing 2014 rates included the addition of recovery, family support, and respite services, and the same woodwork effect on enrollment as discussed above.

Chart 3: Rate Ranges and Average PMPMs for Centennial Care Behavioral Health



Source: HSD

The average 2014 rate range for the behavioral health program was between $58 and $64 PMPM. The average PMPM paid by HSD that first year was $61, about a quarter of a percent below the midpoint of the range (Chart 3).

For the 2015 rates, Mercer again adjusted for medications losing patent protection. In this case, switching from brand-name drugs Abilify and Cymbalta, which together made up over 48 percent of the program's total pharmacy spend, to new generic versions of the drugs were projected to lead to savings of over 25 percent of the pharmacy portion of the rates.

The actuary also adjusted rate ranges based on projected continued increased utilization of medication assisted treatment services, continuing higher MCO reimbursements to some CSAs, as well as the impact of HSD's decision to raise reimbursement levels for a number of behavioral health services. Behavioral health rate ranges were adjusted again in August of 2015 when HSD added treatment for autism spectrum disorder to the benefit package, as mandated by CMS.

The average 2015 rate range for the behavioral health program was between $59 and $64 PMPM. The average PMPM HSD paid in 2015 was $60, about two percent below the midpoint of the range and about one percent lower than the average 2014 PMPM (Chart 3).

Prior to the development of the 2016 rates, HSD found that much of the cost of behavioral health prescription medication had routinely been included with the physical health pharmacy expenditures. The actuarial letter for 2016 rates includes many of the same projected costs and savings as the 2014 and 2015 letters, with only this pharmacy adjustment as new information, so pulling these costs into the behavioral health pharmacy services line presumably was the key driver for the approximately 10 percent increase in rate ranges from 2015 to 2016. (The shift had a less noticeable impact on the larger and more complex 2016 physical health rates.)

The most far-reaching change to the state's Medicaid program was the 2014 expansion to cover adult New Mexicans with household incomes under 138 percent of the federal poverty limit.

Cost containment changes made by HSD to reimbursement rates in mid-2016 focused on physical health, and led to only minimal changes for behavioral health. After adjusting rates to account for these minor changes, the average 2016 rate range for the behavioral health program was between $65 and $71 PMPM. HSD paid an average $66 PMPM in 2016, about two and a half percent below the midpoint of the range but over eight percent higher than the average PMPM for 2015 (Chart 3).

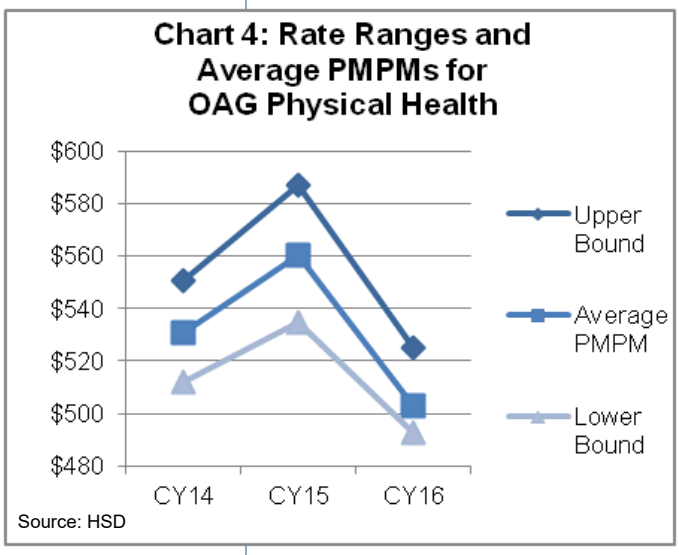
Centennial Care rate ranges: other adult group (OAG) physical and behavioral health

The most far-reaching change to the state's Medicaid program was the 2014 expansion to cover adults between the ages of 19 and 64, with annual incomes at or below 138 percent of the federal poverty limit. From a payment rates perspective, the challenge was to build rate ranges for a large and diverse group of people, for

many of whom the department had no previous health care utilization data.

To develop the rate ranges, Mercer began with historical SCI data, and divided the new OAG population into 12 age and sex based cohorts, as well as a single additional cohort for behavioral health services. Then Mercer conducted a series of adjustments for relatively known factors such as the differences between the new Medicaid benefit package and the old SCI package.

The actuary also had to make adjustments for more uncertain factors such as probable enrollment numbers, the potential that the new population would have an unknown degree of pent-up demand for services, adverse selection driven by less-healthy people enrolling more quickly than healthy people, and a factor Mercer referred to as 'reverse managed care,' or the idea that recipients with no history of accessing healthcare in a managed care system would be less likely to use that system efficiently. Given the uncertainties with this cohort, Mercer and HSD also implemented an OAG-specific risk corridor.

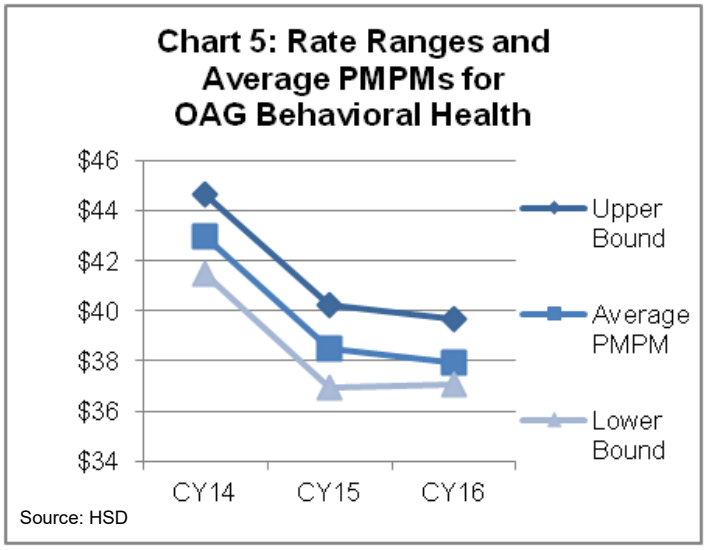


All of these dynamics led Mercer to develop an average 2014 rate range for the OAG physical health program that was significantly higher than the range for the existing physical health program. The average 2014 OAG physical health rate range was between $512 and $551 PMPM. HSD paid an average PMPM of $531 for this cohort for 2014, over $200 higher than the rate for the base physical health cohort and less than one tenth of one percent below the midpoint of the range (Chart 4).

Conversely, based on the same set of assumptions Mercer developed a rate range for OAG behavioral health that was somewhat lower than the base behavioral health. The average 2014 OAG behavioral health rate range was between $41 and $45 PMPM. The average PMPM paid by HSD was $43, about $17 lower than the base behavioral health cohort and less than two tenths of one percent below the midpoint of the range (Chart 5).

In 2015, the rate ranges included adjustments to reflect new emerging hepatitis C drugs and HSD's coverage guidance issued to the MCOs. According to Mercer's certification letter for 2015, aggregate acute care projections for the OAG physical health population would have dropped by about 5 percent, based on downward recalculations of both the adverse selection and pent-up demand factors, neither of which turned out to be as large as 2014 assumptions suggested.

However, the savings from those assumptions were replaced by a new concern that the OAG population was at the greatest risk of needing hepatitis C treatment, based on characteristics such as age, gender, and previous lack of access to health care. Hepatitis C costs were the key driver for the approximately 5.6 percent increase in OAG physical health rate ranges from 2014 to 2015.



The average 2015 OAG physical health rate range was between $535 and $587, per member per month. HSD paid an average $560 PMPM, less than two tenths of one percent below the midpoint of the range and slightly over 5 percent higher than the average PMPM in 2014 (Chart 4).

Rates for the behavioral health portion of the OAG program dropped in 2015, as might be expected with lower pent-up demand and adverse selection than projected, and without the counter-balancing hepatitis C expenditures. The average 2015 OAG behavioral health rate range was between $37 and $40 PMPM. The average PMPM paid by HSD was $39, less than a quarter of one percent below the midpoint of the range and 11.7 percent lower than the average PMPM for 2014 (Chart 5).

For 2016, both OAG physical and behavioral health rate ranges dipped slightly initially, and the physical health rates dropped further mid-year, due to the same cost containment changes discussed above. The average 2016 OAG physical health rate range was between $492 and $525 PMPM. HSD paid an average PMPM of $503, slightly more than one percent below the midpoint of the range and 11.4 percent lower than the average 2015 PMPM (Chart 4).

The average 2016 OAG behavioral health rate range was between $37 and $40 PMPM. The average PMPM paid by HSD was $38, also slightly more than one percent below the midpoint of the range and 1.5 percent lower than the average 2015 PMPM (Chart 5).

HSD made strong corrections to rates for the OAG group once evidence showed the high costs anticipated for this group were not materializing. Despite that fact, however, the gap between the average physical health PMPM for the OAG and base populations remains large, nearly $200 per month. Although not yet released by the department, the 2017 rates will presumably continue to close the gap.

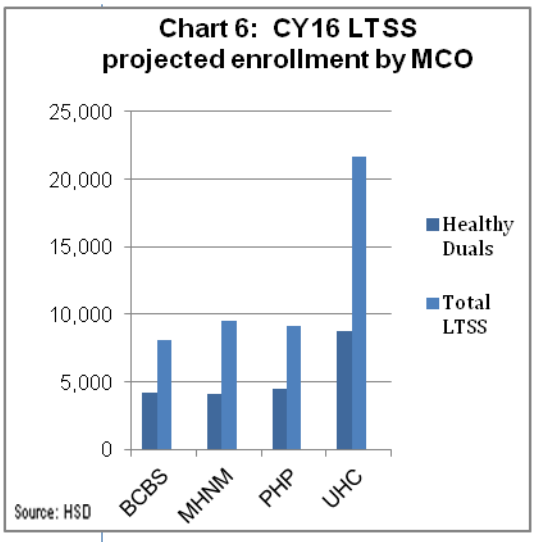
On a per person basis, long term services are the most expensive portion of the Medicaid program, with average annual per person costs exceeding $20 thousand.

Centennial Care rate ranges: long term services and supports

Unlike the other Centennial Care cohorts, there is no single range of rates developed for the Long Term Services and Supports (LTSS) program. The LTSS program, formerly known as CoLTS, consists of enrollees who are dually eligible for Medicare and Medicaid, seniors who are not eligible for Medicare, and Mi Via and other self-directed home and community-based service recipients. On a per person basis, long term services are the most expensive portion of the Medicaid program, with average annual per person costs exceeding $20 thousand.

Because the costs of caring for this diverse population can vary so greatly, and because they are so unevenly spread across the four MCOs, Mercer develops four separate MCO-specific rate ranges, within which HSD sets actual rates. Chart 6

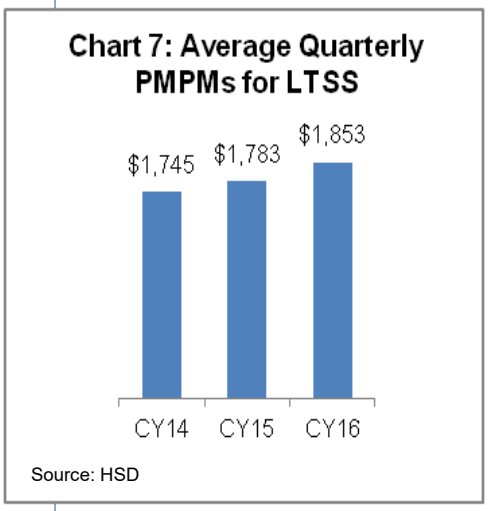
shows some of that variation, with projected total LTSS enrollment by MCO for CY16, as well as the portion of enrollment that are in the 'healthy dual' cohort, the program's least costly group whose members are eligible for both Medicare and Medicaid and who do not need a nursing facility level of care.



There is so much variation in the rate ranges and actual rates among the MCOs for the LTSS cohorts that HSD did not provide any average rate range for the entire program. Having separate rate ranges for each MCO makes it impossible to compare LTSS rates with the same approach as used for other programs. For this part of this brief, all of the information HSD provided to the LFC was MCO-specific, and HSD requested that the LFC not publish MCO-specific data. The department indicated it would consider an acceptable method for comparison, but ultimately did not provide any alternative. This brief therefore uses the average quarterly PMPM HSD publishes in its Medicaid projections as a reasonable stand-in.

The 2014 and 2015 LTSS rates began with the 2011 base time period, similar to the other programs. In general, factors that went into the development of the 2014 LTSS rates included the same sorts of adjustments as discussed previously for the other programs, including (but not limited to) enrollment, managed care efficiencies, pharmacy utilization, and care coordination. Unique to this cohort were adjustments for the fact that under Centennial Care, for the first time, all Medicaid recipients would have access to community benefits when appropriate without having to wait for assignment through a waiver. In another first, HSD included self-directed waiver services in the rates, as well as the associated administrative costs for the financial management agency and consultant agencies. Prior to 2014, only acute care costs for this population were included in the capitated rates.

2014 LTSS rates were adjusted upwards mid-year. The largest single driver was HSD's increased reimbursement rates for safety net care pool hospitals (mentioned in the other programs as well); other key drivers were HSD's fee increases for personal care services and for nursing facilities. HSD reported the average quarterly LTSS PMPM for 2014 was $1,745 (Chart 7).



The 2015 MCO rate ranges increased by an aggregate one percent; the rise was driven by generally increasing health care utilization and costs as opposed to any significant program or administrative changes, although there was a four percent mid-year fee schedule increase for nursing homes. HSD reported the average quarterly PMPM for 2015 was $1,783, approximately 2.2 percent higher than the 2014 average quarterly PMPM (Chart 7).

For 2016, HSD and Mercer used 2014 for the base period; presumably, using recent Centennial Care data would require fewer adjustments. For the first set of 2016 rates, the primary prospective adjustment was for HSD's increased reimbursement rates for nursing facility fees. Later in July two sets of new rates

were developed that took into account the same cost containment changes discussed for the physical health programs, including but not limited to reduced reimbursements for primary care physicians, dentists, hospitals, and community benefits, as well as reductions to administrative costs for care coordination. Despite those cost containment efforts, HSD reported the average quarterly PMPM for 2016 was $1,853, nearly 4 percent higher than the 2015 average quarterly PMPM (Chart 7).

Challenges going forward: federal rule changes

The Centennial Care program already meets many of the requirements of the new CMS rule and HSD should be able to build on the existing program structure and MCO contracts to come into full compliance.

All elements of New Mexico's managed care program require federal review and approval. The Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicaid program nationally, recently issued a new set of final regulations that include the first major overhaul of Medicaid managed care in over a decade, and may have a number of implications for managed care rates in New Mexico.

According to a summary of the new rule prepared by the Kaiser Commission on Medicaid and the Uninsured, CMS's stated goals are to align key Medicaid and CHIP managed care requirements with other health coverage programs, such as the ACA marketplaces, where appropriate; enhance beneficiary experience, quality of care and protections; strengthen actuarial soundness of payment provisions and program integrity; and support delivery system reforms. The general effective date of the rule is July, 2016, but individual sections become effective at different times over the next three years.

It should be noted that the final rule is very similar to the rule as first proposed in early 2015, which itself included aspects for improvement that had been discussed by CMS for several years prior. Forward-thinking states have therefore had years to consider how to bring their programs into compliance.

New Mexico clearly falls into this category. The Centennial Care program already meets many of the requirements of the new rule, in part or in whole, and HSD should be able to build on the existing program structure and MCO contracts to come into full compliance. For example, Centennial Care MCOs are already contractually required to identify and assess members with long term needs and develop comprehensive plans for their care, just as they are already limited to a medical loss ratio (MLR) of 85/15 percent. Centennial Care contracts already include delivery system and payment reform elements, performance measures and performance improvement projects.

On the other hand, the new rule strengthens standards for the development of actuarially sound capitation rates. Of particular interest are requirements that the rate for each cohort must be independently valid and cannot attempt to take advantage of different federal matching rates for different populations; rates for one cohort also cannot be used to subsidize the rates for another cohort.

Last, and possibly most important, the new rule prohibits the use of rate ranges entirely beginning July 1, 2018. HSD and its actuary will soon have to certify not rate ranges but the final rate paid to each MCO. According to the Kaiser Foundation summary, states will retain some flexibility and will have authority to increase or decrease payments to an MCO by up to 1.5 percent without having to submit a new certification to CMS. This change will limit the cost containment options available to legislative appropriators by, for example, ruling out the option of finding cost savings by maneuvering within the rate range.

Opportunities for further cost containment

According to the averaged data provided by HSD for this brief the Centennial Care MCOs are currently receiving rates at or below the midpoint of the actuarial range. But averaged rates mean that for every part of the program, some MCOs are negotiating rates that are above the midpoint of the range in question, and/or for some of the individual cohorts within the programs.

HSD could have saved more than $58 million in general fund dollars if it had paid all four MCOs the lowest actuarially sound rate for the physical health, behavioral health and LTSS cohorts for the past three years of Centennial Care.

Given the extreme financial situation the state is currently facing, HSD should carefully consider the option of reducing MCO payments to the bottom of the actuarially sound rate range. The fundamental premise of actuarial soundness is that the range takes all "reasonable, appropriate, and attainable costs" into consideration; therefore, any rate HSD pays within that range should be sufficient to pay claims.

Based on data provided by the department, if HSD had paid all four MCOs the lowest rate in the rate ranges for the physical health, behavioral health, and LTSS cohorts, the state could have saved approximately $29.8 million in general fund dollars in CY14, $12.5 million in CY15, and another $16.1 million in CY16 (Table 1).

Table 1: Potential General Fund Savings from Lower MCO Payments
in millions

	Physical Health	Behavioral Health	LTSS	Total
CY14	$12.5	$4.1	$13.2	$29.8
CY15	$6.1	$2.4	$3.9	$12.5
CY16	$4.4	$4.1	$7.6	$16.1

Source: HSD

The trend from CY14 to CY16 has moved in the right direction, but it appears clear that by not paying at the lowest rate HSD has foregone substantial unrealized general fund cost savings. The $16.1 million for CY16 represents a significant portion of the Medicaid program's projected FY17 shortfall of $25 million. Similar savings for FY17 and FY18 would be of substantial assistance to the program.

For the OAG cohorts, any CY16 savings would have reverted to the federal government, since the federal match for that population was 100 percent from CY14 through CY16. But the OAG cohort could be a source of substantial savings in the future as the federal portion dropped to 97 percent in FY17 and will drop to 94 percent in FY18.

Appendix A:
Centennial Care Cohorts and Averaged MCO Payment Rate Ranges
CY2014 - CY2016

Physical Health

Cohort	Cohort Description	Averaged CY14 Rate Range		Averaged CY15 Rate Range		Averaged CY16 Rate Range	
		Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound	Upper Bound
001	TANF / AFDC, CYFD 0 - 2 Months M&F	$ 3,957.66	$ 4,301.18	$ 3,970.72	$ 4,326.43	$ 4,903.16	$ 5,429.39
002	TANF / AFDC 2 Months - 20 Years M&F	$ 164.35	$ 178.84	$ 165.23	$ 181.36	$ 171.03	$ 186.48
003	TANF / AFDC 21 - 49 F	$ 440.88	$ 478.24	$ 474.51	$ 514.34	$ 410.99	$ 445.79
004	TANF / AFDC 21 - 49 M	$ 315.25	$ 342.32	$ 393.81	$ 425.24	$ 339.73	$ 367.45
005	TANF / AFDC 50+ M&F	$ 779.26	$ 844.48	$ 759.87	$ 821.83	$ 733.15	$ 795.62
006	SSI & Waiver 0 - 1 Year M&F	$ 6,048.59	$ 6,599.45	$ 6,048.05	$ 6,615.08	$ 3,472.67	$ 3,815.47
007	SSI & Waiver 1 - 20 Years M&F	$ 938.42	$ 1,014.33	$ 959.75	$ 1,039.21	$ 838.05	$ 910.46
008	SSI & Waiver 21 - 39 F	$ 781.75	$ 846.82	$ 802.34	$ 871.80	$ 786.09	$ 851.59
009	SSI & Waiver 21 - 39 M	$ 773.31	$ 836.92	$ 835.96	$ 906.21	$ 703.98	$ 765.60
010	SSI & Waiver 40+, Aged 65+ M&F	$ 1,197.66	$ 1,296.31	$ 1,258.57	$ 1,365.21	$ 1,286.83	$ 1,398.66
011	PW, MA, 15 - 49 F	$ 957.26	$ 1,036.13	$ 958.57	$ 1,041.44	$ 1,077.80	$ 1,177.32
012	CYFD 2 Months - 21 Years M&F	$ 279.32	$ 303.19	$ 284.81	$ 311.11	$ 262.18	$ 285.50
TOTAL - Weighted on Statewide Enrollment		**$ 303.08**	**$ 329.01**	**$ 312.78**	**$ 340.91**	**$ 312.15**	**$ 340.28**

Behavioral Health

Cohort	Cohort Description	Averaged CY14 Rate Range		Averaged CY15 Rate Range		Averaged CY16 Rate Range	
		Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound	Upper Bound
201	TANF/AFDC – All Ages M&F	$ 38.06	$ 41.66	$ 39.18	$ 42.69	$ 42.11	$ 46.23
202	CYFD – All Ages M&F	$ 559.73	$ 621.27	$ 610.27	$ 668.66	$ 631.86	$ 695.22
203	SSI, B&D, Waiver – Ages 0 to 14 Years Old M&F	$ 357.54	$ 390.85	$ 382.38	$ 418.74	$ 429.33	$ 475.08
204	SSI, B&D, Waiver – Ages 15 to 20 Years Old M&F	$ 403.90	$ 441.72	$ 356.89	$ 390.85	$ 387.94	$ 430.68
205	SSI, B&D, Waiver – Ages 21+ M&F	$ 148.23	$ 162.21	$ 126.40	$ 138.68	$ 158.34	$ 174.64
206	LTSS Non Dual – 21+ M&F	$ 149.79	$ 164.34	$ 142.59	$ 156.84	$ 186.05	$ 206.82
207	LTSS Dual – 21+ M&F	$ 29.97	$ 32.95	$ 31.56	$ 34.18	$ 31.60	$ 34.35
TOTAL - Weighted on Statewide Enrollment		**$ 58.33**	**$ 63.95**	**$ 58.79**	**$ 64.21**	**$ 64.62**	**$ 71.10**

Other Adult Group

Cohort	Cohort Description	Averaged CY14 Rate Range		Averaged CY15 Rate Range		Averaged CY16 Rate Range	
		Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound	Upper Bound
110	ABP, ages 19-20 Male	$ 344.68	$ 370.37	$ 371.42	$ 406.93	$ 264.80	$ 282.01
111	ABP, ages 19-20 Female	$ 416.92	$ 448.92	$ 430.61	$ 472.57	$ 293.49	$ 312.86
112	ABP, ages 21-29 Male	$ 344.68	$ 370.37	$ 371.42	$ 406.93	$ 264.80	$ 282.02
114	ABP, ages 21-29 Female	$ 416.92	$ 448.92	$ 430.61	$ 472.57	$ 293.49	$ 312.85
115	ABP, ages 30-39 Male	$ 391.88	$ 421.76	$ 424.04	$ 464.87	$ 441.28	$ 470.26
116	ABP, ages 30-39 Female	$ 477.62	$ 514.10	$ 487.99	$ 536.02	$ 372.49	$ 397.08
117	ABP, ages 40-49 Male	$ 604.82	$ 650.03	$ 643.54	$ 704.83	$ 673.57	$ 717.12
118	ABP, ages 40-49 Female	$ 601.55	$ 647.42	$ 627.11	$ 689.63	$ 562.79	$ 599.88
119	ABP, ages 50-59 Male	$ 704.64	$ 757.46	$ 727.42	$ 798.74	$ 787.18	$ 839.60
120	ABP, ages 50-59 Female	$ 704.64	$ 757.46	$ 727.42	$ 798.74	$ 787.21	$ 839.63
121	ABP, ages 60-64 Male	$ 704.64	$ 757.46	$ 727.42	$ 798.74	$ 787.17	$ 839.59
122	ABP, ages 60-64 Female	$ 704.64	$ 757.46	$ 727.42	$ 798.74	$ 787.17	$ 839.59
TOTAL - Weighted on Statewide Enrollment		**$ 511.99**	**$ 550.67**	**$ 535.00**	**$ 587.13**	**$ 492.45**	**$ 524.93**
208	OAG Behavioral Health	$ 41.45	$ 44.67	$ 36.96	$ 40.23	$ 37.07	$ 39.69

Source: HSD

Appendix A:
Centennial Care Cohorts and Averaged MCO Payment Rate Ranges
CY2014 - CY2016

Long Term Services and Supports				
Cohort	**Cohort Description**	**No averaged payment data provided**		
300	Phase I, III, IV—NF LOC—Dual			
301	Mi Via / Self Directed - Dual			
302	Phase I, III, IV - NF LOC - NonDual			
303	Mi Via / Self Directed - NonDual			
304	Healthy Dual			
310	Phase II - NF LOC - Dual			
312	Phase II - NF LOC - NonDual			
320	Phase V - NF LOC - Dual			
322	Phase V - NF LOC - NonDual			

Source: HSD