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Progress Report:
Centennial Care Waiver and Medicaid Managed Care Costs

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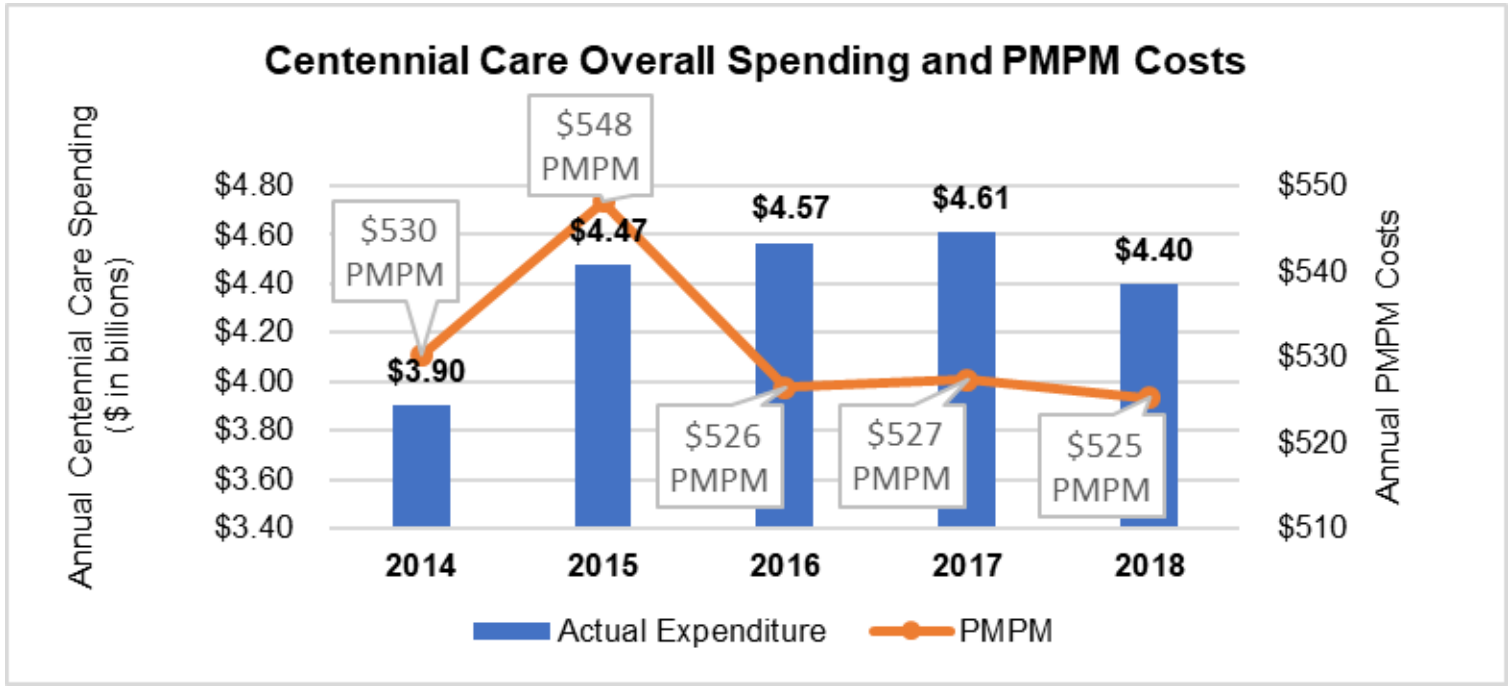
September 30, 2020

Background: Centennial Care Waiver Program

- First iteration of Centennial Care operated between 2014 – 2018
- Managed Care Organizations (MCOs) – established healthcare networks, coordinate members' healthcare needs, paid fixed monthly rate per enrollee (capitation payment)
- In 2018, program provided healthcare services to 660 thousand New Mexicans
    - Accounted for 80 percent of New Mexico Medicaid beneficiaries
- LFC 2015 Program Evaluation key findings:
    1. Growing costs of Medicaid with lower projected savings
    2. Poor utilization data, difficulty assessing amount of care provided
    3. Need for additional budget oversight by the Legislature

Enrollment & Provider Rates Drove Program Costs

- Enrollment growth between 2014 – 2017
- Provider rate cuts and rate freezes in FY17
- True cost savings of Centennial Care remain unknown



Per Member Per Month (PMPM) – the average per-member, per-month amount in capitation payments HSD pays to MCOs.

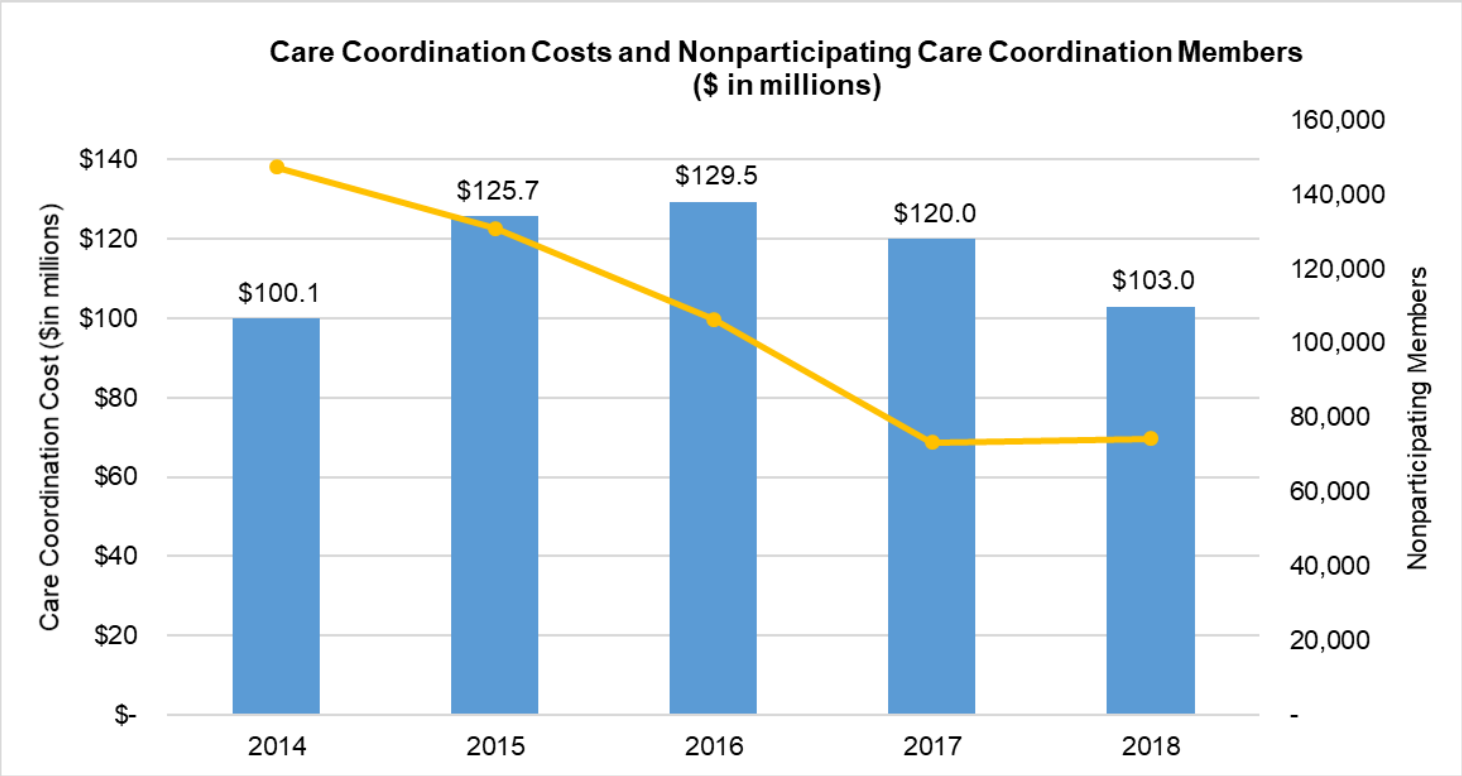
$93 Million (General Fund) Potential Savings Existed if MCOs Paid at Lower Bound

- Negotiated rates between HSD and MCOs typically fell between middle and lower bound of actuarially sound range, but savings potential remained
- MCO specific adjusted rates

Potential GF Savings from Lower MCO Payments (in millions)

	Physical Health	Behavioral Health	LTSS	Physical Health - Medicaid Expansion	Behavioral Health - Medicaid Expansion	Total
2014	$12.5	$4.1	$13.2			$29.8
2015	$6.1	$2.4	$3.9			$12.4
2016	$4.4	$4.1	$7.6			$16.1
2017	$4.2	$4.8	$5.6	$1.0	$0.3	$14.6
2018	$4.6	$6.4	$8.6	$1.4	$0.3	$19.6
Total	**$31.8**	**$21.8**	**$38.9**	**$2.4**	**$0.6**	**$92.5**

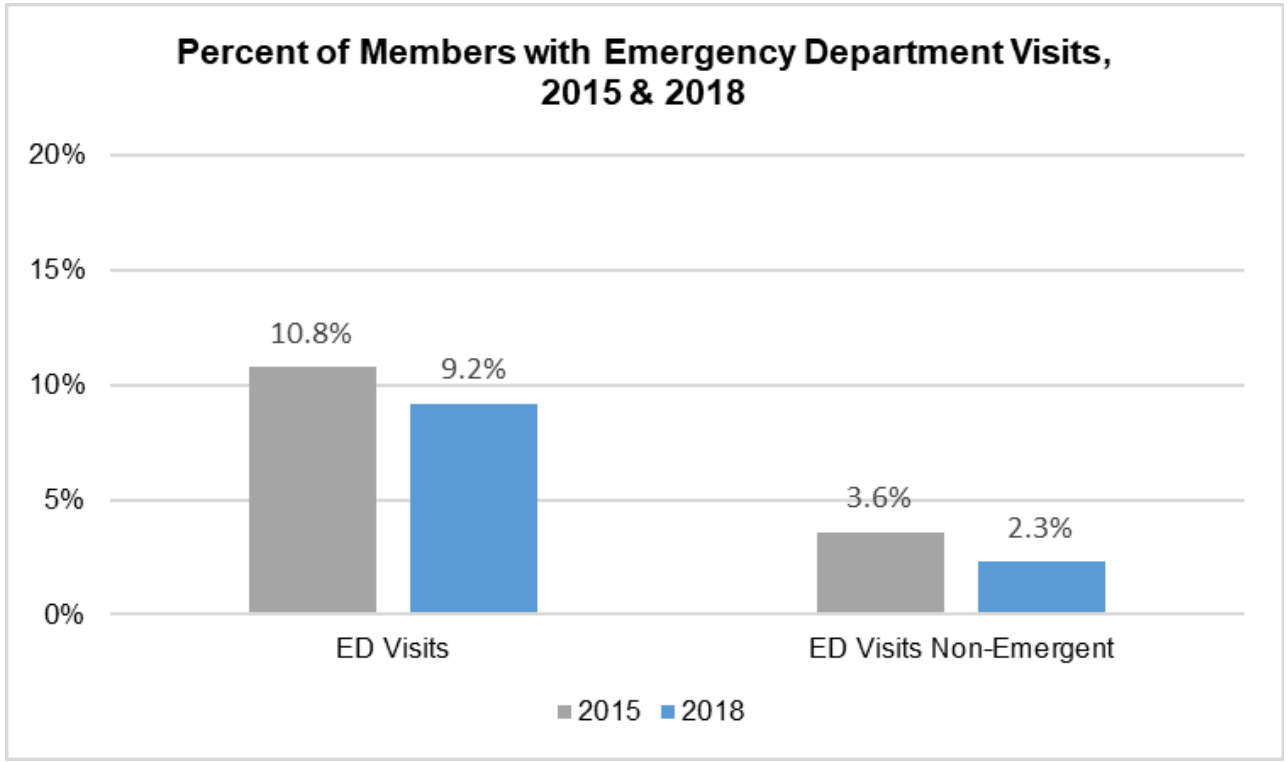
Key Cost Saving Elements Not Fully Realized



- Care coordination costs totaled $575 million
  - Nonparticipating members (unreachable and declined care coordination) remains significant, representing potential cost savings

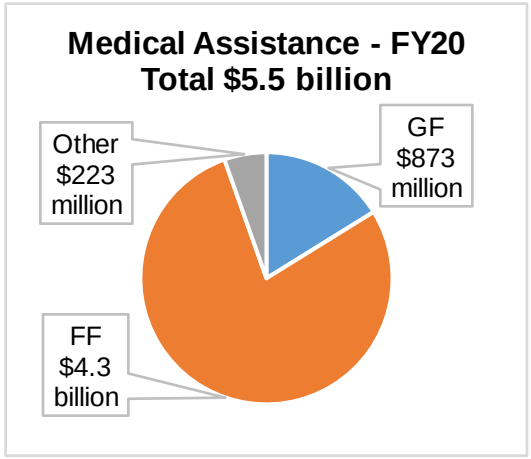
Healthcare Utilization Data Reporting Improved from 2014, Highlighting Improvement Opportunities

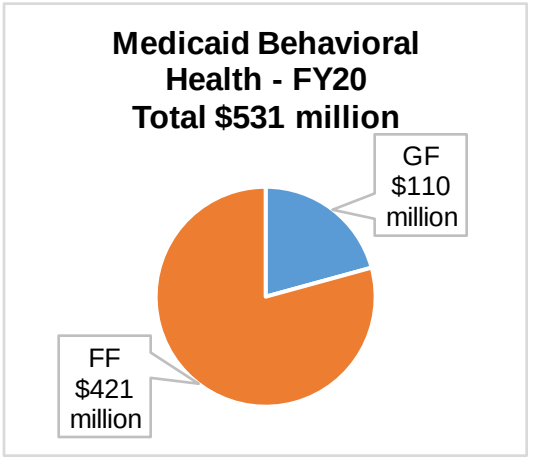
- Centennial Care members receiving a preventive care visit decreased from 86 percent to 76 percent between 2013 – 2017
- Percentage of members utilizing the ED decreased, but can be further reduced



Centennial Care Lacked Strong Legislative Oversight

- Medicaid is budgeted and appropriated under two line items: physical health ($5.5 billion) and behavioral health ($531 million), FY20





- Other states use sub-category appropriations for increased transparency
- New Mexico relies on AGA performance measures

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LFC Program Evaluation Unit

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Progress Report

Program Evaluation Unit
Legislative Finance Committee
September 30, 2020

Centennial Care Waiver and Medicaid Managed Care Costs

Summary

The Centennial Care managed care program, which operated under its first iteration between 2014 and 2018, provided healthcare services to 31 percent of all New Mexicans at the end of 2018. Centennial Care aimed to modernize the Medicaid program by improving the efficiency and effectiveness of health delivery, advancing person-centered models of care, and slowing the rate of Medicaid program costs. Currently, New Mexico's Medicaid managed care program continues to operate under Centennial Care 2.0.

Three key findings were identified during this progress report of the first iteration of Centennial Care, program enrollment and provider rates drove Centennial Care program costs, key cost saving elements of the program were not fully realized, and the program lacked strong legislative oversight.

While program costs grew from $3.9 billion to $4.4 billion over these five years, and enrollment grew from 595 thousand members to 690 thousand members, overall per-member, per-month (PMPM) costs remained stable, largely attributed to provider rate cuts and rate freezes implemented by the Human Services Department (HSD) in FY17 at the direction of the Legislature.

From an overall cost-savings perspective, Centennial Care greatly exceeded its initial cost-saving estimates, as required and defined by the Centers for Medicare and Medicaid Services (CMS), over the five-year

The Evaluation: *The 2015 evaluation Centennial Care Waiver and Medicaid Managed Care Costs* identified three central themes in the early stages of Centennial Care: 1) the growing costs of Medicaid with lower than originally projected savings; 2) the inability to determine trends in the amount of care enrollees are receiving; and 3) the need for additional budgetary detail and control by the Legislature. The evaluation also revealed the Human Services Department scaled back its requirements of managed care organizations, leading to the delay of cost containment initiatives and placing potential cost savings at risk.

Progress Reports foster accountability by assessing the implementation status of previous program evaluation reports, recommendations and need for further changes.

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demonstration period. However, true cost savings to New Mexico remain unknown because CMS' methodology likely inflates estimated cost-savings. This finding highlights the need to establish and monitor program cost-saving benchmarks moving forward.

A key past finding was for HSD to better negotiate payment rates with MCOs; setting rates closer to the lower bound of the actuarially sound rate range. While MCO rates were generally found to be between the best estimate and the lower bound, HSD could have saved about $93 million in general fund dollars between 2014 and 2018 had managed care organizations been paid the lowest actuarially sound rate across all programs.

Another key area for deriving additional cost-savings within Centennial Care is care coordination. The number of Centennial Care members not participating in care coordination (either declining to participate or unable to be reached) was around 12 percent at the end of 2018. As care coordination aims to facilitate individualized healthcare and prevent costly acute healthcare services use, the nonparticipating care coordination members, totaling over 70 thousand, represent potential cost savings.

Healthcare utilization data and reporting, which improved in quality and quantity since 2015, highlights further improvement areas and cost-saving opportunities. Between 2013 (pre-Centennial Care) and 2017, the number of members who received a preventive care visit decreased from 86 percent to 76 percent. As preventive care visits have been directly linked to lowering future healthcare spending, increased preventive care visits among members likely would have generated cost savings.

Lastly, the 2015 evaluation noted the lack of legislative oversight over Medicaid spending and recommended potential changes to the appropriations process, possibly by following the lead of other states and making appropriations at the program level. Currently, the program receives $6 billion split into two line items, limiting budget transparency and oversight.

HSD adopted two-thirds of the recommendations from the 2015 program evaluation. Progress on the recommendations can be found on page 16.

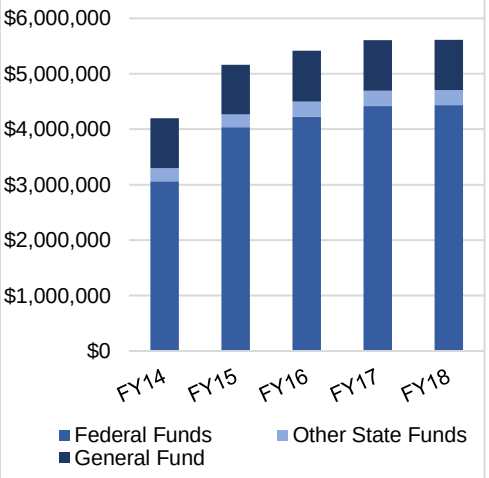
Background

Since the 1980s, state and federal policymakers have looked to managed care to provide quality care for Medicaid beneficiaries while also stabilizing healthcare costs. Managed care organizations (MCOs), contracted entities charged with establishing healthcare networks, seek to vertically integrate members' healthcare treatment through coordination of care, as well as reduce costly acute care (e.g., emergency department visits and hospitalizations). MCOs are paid a fixed monthly capitation rate per enrollee and assume the risk of cost for providing covered services.

Centennial Care, launched on January 1, 2014, consolidated previously separate Medicaid managed care programs through a Centers for Medicare and Medicaid Services (CMS) Section 1115 demonstration waiver. Centennial Care aimed to modernize the Medicaid program by improving the efficiency and effectiveness of health delivery, advancing person-centered models of care, and slowing the rate of Medicaid program costs. Four MCOs were competitively sourced to provide Centennial Care coverage to eligible New Mexicans: Blue Cross Blue Shield, Molina Healthcare, Presbyterian Health Plan, and United HealthCare. The Centennial Care program consists of five Medicaid programs: physical health, behavioral health, long-term supports and services, physical health for the Medicaid expansion population, and behavioral health for the Medicaid expansion population.

The implementation of Centennial Care also coincided with the expansion of Medicaid in New Mexico under the Affordable Care Act (ACA) to all people earning up to 138 percent of the federal poverty level. Under the ACA, the federal government paid 100 percent of the cost of care for the new enrollees through 2016, followed by a gradual step down of support until stabilizing at 90 percent in 2020.

Chart 1. Total Medicaid Expenditures by Revenue Source
(in thousands)



Source: LFC Files

Overall Medicaid expenditures increased from $4.2 billion in FY14 to $5.6 billion in FY18. The general fund portion of the Medicaid program remained similar over this time period at around $900 million. Both Centennial Care enrollment and expenditures have accounted for around 80 percent to 90 percent of total Medicaid enrollment and spending.

While this Progress Report focuses on the first iteration of Centennial Care (2014-2018), Centennial Care 2.0 is currently in its second demonstration year and runs through 2023.

Key Medicaid Terms:

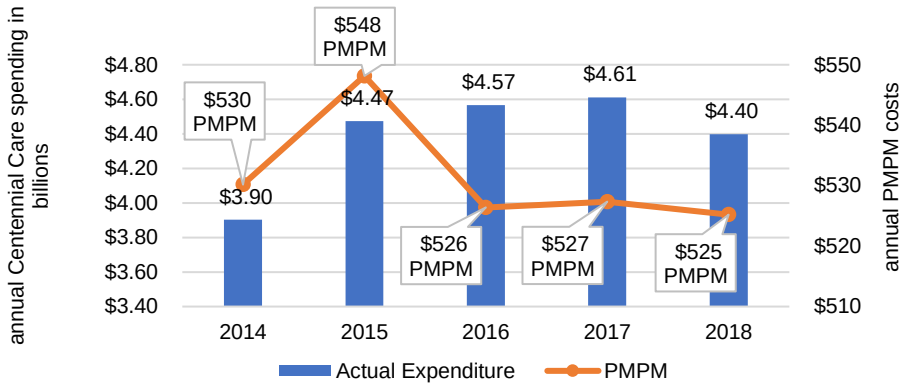
- Capitation payment – a monthly fixed payment by HSD to managed care organizations (MCO) on behalf of each Medicaid beneficiary.
- Centers for Medicare and Medicaid Services (CMS) – the agency in the Department of Health and Human Services (DHHS) with responsibility for administering the Medicaid, Medicare, and State Children's Health Insurance (CHIP) programs at the federal level.
- Managed care organization (MCO) – entities that serve Medicaid beneficiaries through a network of employed or affiliated providers on a risk basis to provide a specified package of benefits to enrollees in exchange for monthly capitation payments.
- Medicaid eligibility groups (MEGs) – HSD defined population groups, by eligibility characteristics, who comprise the Centennial Care program
- Medical loss ratio (MLR) – a provision requiring health insurance issuers to spend a minimum percentage of premium dollars on medical care with limits on the proportion spent on administration, marketing, and profits.
- Per-member, per-month (PMPM) – the average per-member, per-month amount in capitation payments HSD pays to MCOs.
- Supplemental security income (SSI) – a federal entitlement program that provides cash to low-income aged, blind, and disabled individuals. Individuals with SSI benefits are eligible for Medicaid coverage.
- Temporary Assistance for Needy Families (TANF) – a block grant program that makes federal matching funds available to states for cash and other assistance to low-income families with children.

Provider Rates and Enrollment Makeup Drove Centennial Care Costs

The Human Service Department (HSD) initiated rate freezes and rate cuts in FY17, which stabilized Centennial Care spending.

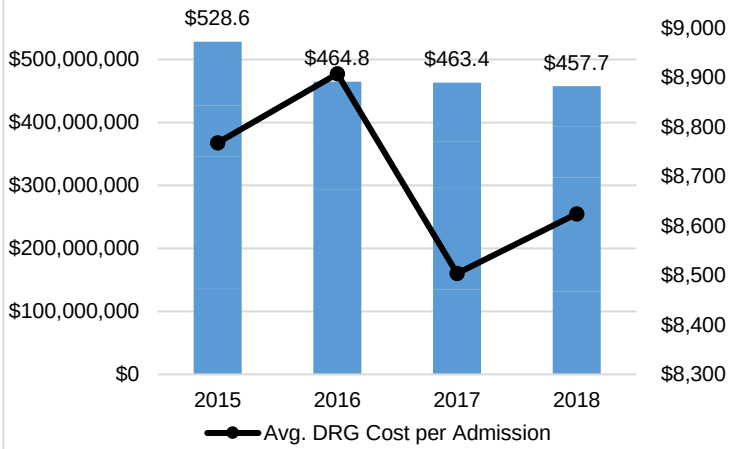
After a 3.4 percent increase in overall per-member, per-month costs between Centennial Care's first and second years, PMPM costs significantly decreased beginning in 2016 following provider rate cuts. While overall Centennial Care spending increased from $4.47 billion in 2015 to $4.61 billion in 2017, PMPM costs decreased from $548 PMPM to $527 PMPM. This PMPM cost stabilization is largely attributed to cost-containment measures taken by HSD at the direction of the Legislature in the 2016 legislative session, when New Mexico's budget situation worsened. HSD lowered or froze rates for inpatient hospital stays, primary care physicians, specialists, and dentists.

Chart 2. Centennial Care Overall Spending and PMPM Costs



Source: LFC analysis of MCO financial reports

Chart 3. DRG Hospital Stay Expenditure



Source: LFC analysis of MCO financial reports

Inpatient hospitalization expenditures between 2015 and 2018 show the direct impact of provider rate cuts.[1] In 2015, MCOs spent nearly $530 million on diagnosis-related group (DRG) hospitalizations – a payment system where hospitals assign admission events a code based on care provided during the hospitalization and are paid a fixed amount for that DRG. In 2015, these hospital stays accounted for 22 percent of all MCO healthcare spending. As provider rate cuts were implemented in FY17 (the last six months of 2016) overall cost decreased by 12 percent and inpatient hospitalization costs decreased by over $63 million. The full effect of reduced inpatient admission

[1] 2014 data omitted due to utilization data accuracy concerns in Centennial Care's first year of operation.

rates is seen in 2017 when average DRG cost decreased by 5 percent to about $8,500.

Centennial Care enrollment and program makeup drive overall program costs.

Centennial Care program costs generally followed Centennial Care enrollment. At the end of 2014, Centennial Care had around 595 thousand members, and program costs totaled $3.9 billion. The concurrent implementation of Centennial Care and Medicaid expansion in New Mexico led to significant enrollment increases in Centennial Care. At the end of 2016, enrollment increased to nearly 690 thousand and a program cost of $4.6 billion, before gradually decreasing to about 650 thousand at the end of 2018.

In addition to overall enrollment, the sub-populations within Centennial Care significantly impact program spending. Reported costs are broken down into their respective Medicaid eligibility groups (MEGs) – population groups defined by primary eligibility characteristics. Centennial Care costs are driven by two MEGs with the highest enrollment, TANF and related (51 percent of 2018 enrollees) and Medicaid expansion (38 percent of 2018 enrollees). Although the TANF and related group had the highest enrollment, its PMPM was the lowest of all MEGs, $319 in 2018. The Medicaid expansion group had a PMPM of $480 in 2018. The lower PMPM costs of these two MEGs reflect the healthier member populations that comprise them and thus require less costly medical services.

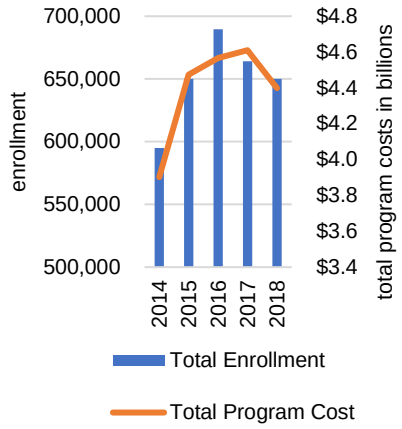
Table 1. 2018 Medicaid Enrollment Group Statistics

MEG	Avg. PMPM	Cost	% Cost	% Membership
TANF & Related	$ 319	$ 1,409,054,435	32.4%	50.9%
SSI & Related - Dual Eligible	$ 1,717	$ 791,312,991	18.2%	5.4%
SSI & Related - Medicaid Only	$ 1,286	$ 552,584,591	12.7%	5.1%
"217 Like" Dual Eligible	$ 3,429	$ 12,001,420	0.3%	< 0.1%
"217 Like" Medicaid Only	$ 2,839	$ 133,736,825	3.1%	0.6%
Medicaid Expansion	$ 480	$ 1,447,565,532	33.3%	38.0%
Total		$ 4,346,255,794	100.0%	100.00%

Source: HSD Centennial Care Annual Report, demonstration year five

The chart also highlights the high PMPM cost and small enrollment associated with the "217 like" groups – individuals who receive home- and community-based services. The 217 dual-eligible group (individuals who are eligible for both Medicare and for full Medicaid coverage) had a PMPM of $3,429 in 2018, but membership was less than 0.1 percent of all Centennial Care members. Similarly, the 217 Medicaid-only group had a $2,839 PMPM but only 0.6 percent membership. While these groups comprise less than 1 percent of Centennial Care enrollees, total expenditure in 2018 was over $145 million. Additionally, the high PMPM costs associated with these groups could lead to significant program spending growth should the number of members in these MEGs increase, a potential trend to watch for as New Mexico's population ages.

Chart 4. Medicaid Managed Care Enrollment 2014 to 2018, End of Year



Source: LFC Files

Table 2. Medicaid Enrollment Group Descriptions

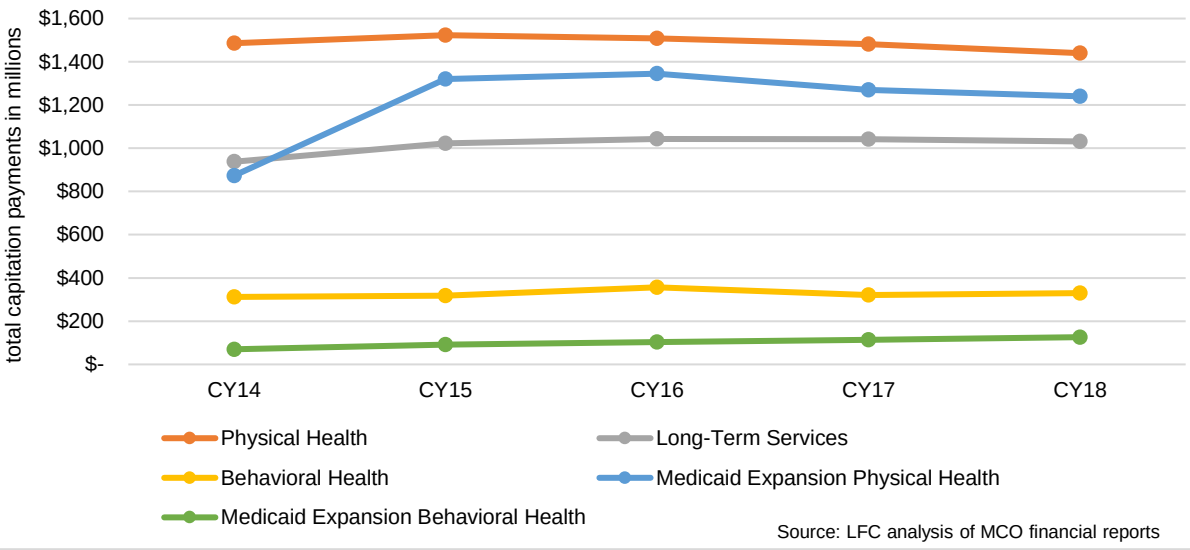
Population Group	Populations
TANF and Related	• Newborns, infants, and children
	• Children's Health Insurance Program (CHIP)
	• Foster children
	• Adopted children
	• Pregnant women
	• Low-income parent(s)/caretaker(s) and families
	• Breast and Cervical Cancer
	• Refugees
	• Transitional Medical Assistance
Supplemental Security Income (SSI) Medicaid	• Aged, blind and disabled
	• Working disabled
SSI Dual Eligible	• Aged, blind and disabled
	• Working disabled
Medicaid Expansion	• Adults between 19-64 years-old up to 133% of Modified Adjusted Gross Income (MAGI) (effectively 138% FPL)
"217 Like"	• Individuals who receive home and community-based services (HCBS)

Source: HSD Centennial Care website

Physical health continues to be the highest cost center for Centennial Care.

Directly related to the MEGs are the specific Centennial Care Medicaid programs, where the physical health program accounts for 35 percent of capitation payments to MCOs. When including the Medicaid expansion population portion of physical health, the physical health program increases to 65 percent of total MCO capitation payments. Long-term services consistently accounted for a quarter of Centennial Care spending, ranging from $937 million to $1.04 billion in total capitation spending. Behavioral health, including the expansion group, comprised between 10 percent and 11 percent of annual spending (see Appendix B for additional program profiles).

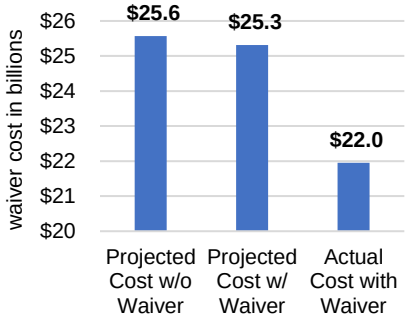
Chart 5. Managed Care Medicaid Total Capitation Payments By Program Area in millions



Source: LFC analysis of MCO financial reports

Centennial Care cost savings are much higher than originally projected, but unlikely reflective of true cost savings.

Chart 6. Centennial Care Waiver Cost, Demonstration Years 1-5 (in billions)



Source: HSD Centennial Care Annual Report, demonstration year five

As measured by CMS, Centennial Care bent the cost curve by 14 percent between 2014 and 2018. The 2015 LFC evaluation noted original cost saving estimates from Centennial Care were reduced to $257 million after an initial savings estimate of $453 million. In the end, cost savings attributed to Centennial Care between 2014 and 2018 amounted to $3.6 billion dollars, far exceeding both estimates. However, these values rely on a CMS established methodology that reflects a negotiation between CMS and HSD about how costs would have increased in the absence of the Centennial Care program. The forecasted cost calculations were done at the Medicaid-eligible group (MEG) level and formalized in a special terms and conditions portion of the demonstration waiver.

In the cost assumptions, each MEG's PMPM received an annual percentage increase between 3 percent and 5 percent, conceivably to account for increasing healthcare costs over time. In actuality, three of the groups averaged negative PMPM growth, one experienced about 1 percent annual growth, and the PMPM for the "217 like" dual-eligible home and community care clients

grew annually by 10 percent. The misalignment of projected values and actual values is greatest, given the compounding nature of the assumptions, in 2018's PMPM values where the group PMPM with the smallest margin of error is still 17 percent.

Table 3. Centennial Care Projected vs. Actual Costs

Medicaid Eligibility Group	CY14-CY18 Projected Cost Annual % Increase	CY14-CY18 Actual Avg. Cost Annual % Increase	CY18 PMPM Projected Cost w/o Waiver	CY18 PMPM Actual Cost	Difference
TANF & Related	3.88%	-0.69%	$ 442.81	$ 318.94	$ 123.87
SSI & Related - Dual Eligible	4.30%	0.97%	$ 2,060.80	$1,716.86	$ 343.94
SSI & Related - Medicaid Only	4.30%	-0.83%	$ 2,053.54	$1,286.37	$ 767.17
"217 Like" Dual Eligible	3.11%	10.17%	$ 2,107.10	$3,428.98	$ (1,321.88)
"217 Like" Medicaid Only	4.30%	-3.09%	$ 5,585.63	$2,838.94	$ 2,746.69
Medicaid Expansion	5.10%	1.54%	$ 705.08	$ 480.16	$ 224.92

Source: HSD Centennial Care Annual Report, demonstration year five

New Mexico is not an anomaly with its differences between projected and actual values. While the PMPM cost caps are informed by historical data and cost trends, a 2017 federal Government Accounting Office report found multiple examples of actual demonstration project spending by state to be far less than projected estimates using budget neutrality thresholds.[2] For example, over a three year period, Tennessee's demonstration accrued an estimated $11.6 billion in savings, while actual demonstration expenditure over the period was around $22 billion.

While the discrepancy between Centennial Care's estimated and actual costs did not negatively, or positively, impact the state, the results of the CMS calculation should not be directly interpreted as cost savings. Looking ahead, Centennial Care 2.0 should draw on past cost measures to establish meaningful benchmarks, which will enable true assessments of program cost savings and help inform targeted program improvements.

Noncompliant MCOs have improved performance on contractually stipulated financial metrics.

Following a 2015 LFC recommendation, HSD changed the Medical loss ratio (MLR) from 85:15 to 86:14 in late 2016. For the first three years of Centennial Care, MCOs were contractually required to achieve an MLR of 85:15, meaning MCOs had to spend at least 85 percent of their Medicaid revenues on direct medical services and quality improvement activities and no more than 15 percent on the administrative activities of running the program. To increase direct spending on healthcare services and encourage greater administrative cost efficiencies by the MCOs, LFC recommended HSD review its MLR requirement as Centennial Care evolved.

In 2014, Presbyterian and United Healthcare both failed to meet the MLR, enabling HSD to recoup portions of its capitation payments. United Healthcare again failed to meet the target in 2015 and 2016. As of 2017, all MCOs achieved the required MLR.

U.S. Department of Health and Human Services, Office of Inspector General Report (February 2019): *New Mexico Did Not Always Appropriately Refund the Federal Share Recoveries from Managed-Care Organizations*

The OIG report stated New Mexico underreported the federal share of MCO recoveries by $15 million and owed the federal government $4.4 million. OIG states this error was the result of New Mexico using incorrectly calculated federal shares for specific Medicaid groups, most notably the expansion population.

In a formal response, HSD agreed with OIG's main finding and stated it would work with CMS to return the $4.4 million.

Additionally, OIG found New Mexico did not perform reconciliations of capitation payments for community-based long-term care services as required. HSD disputed this finding and provided documentation to OIG to support its belief.

[2] United States Government Accountability Office. "Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending." April, 2017. GAO-17-312

Two MCOs consistently exceeded the 3 percent underwriting gain threshold as defined in their Centennial Care contracts. A 3 percent cap is placed on MCO profits, with anything above 3 percent shared 50/50 with HSD. Presbyterian Health Plan and United Healthcare exceeded the 3 percent threshold in each of the years between 2014 and 2017, with 2018 data not yet finalized and released. As detailed in LFC's 2019 *Health Note: Medicaid Spending on Program and Managed Care Administration*, HSD recouped over $102 million in overpayments from the two MCOs.

Table 4. Medical Loss Ratios, Administrative Spending, and Underwriting Gains by MCO, 2014 - 2018

		Legacy Programs			All Programs	
MCO	**Measure**	**2014**	**2015**	**2016**	**2017**	**2018**
Blue Cross Blue Shield	*MLR*	97.1%	94.4%	94.2%	93.7%	Not Yet Released
	Admin	13.4%	10.9%	11.2%	11.1%	
	UG	-10.6%	-5.4%	-4.9%	-4.5%	
Molina Healthcare	*MLR*	91.5%	87.0%	91.5%	89.3%	
	Admin	12.7%	12.6%	11.2%	14.2%	
	UG	-4.2%	0.4%	-2.3%	1.5%	
Presbyterian Health Plan	*MLR*	83.7%	86.1%	90.1%	86.5%	
	Admin	7.0%	8.1%	6.9%	6.9%	
	UG	9.3%	5.9%	3.1%	6.9%	
United Healthcare	*MLR*	83.5%	84.6%	84.9%	87.2%	
	Admin	7.3%	6.1%	7.3%	9.0%	
	UG	9.2%	9.3%	7.9%	4.5%	

Source: Mercer medical loss ratio (MLR) executive summaries

Cost savings of $93 million in general fund dollars were possible if MCOs were paid at lowest actuarially sound rate.

Actuarially sound rates are developed by HSD's actuary, and the calculated range, when combined with investment income and other revenue sources available to the MCO, should cover all "reasonable, appropriate, and attainable costs," including health benefits, administrative expenses, and government fees and taxes. Notably, profit is included as an allowable administrative MCO cost and is built into the rate range development at a margin of 2.25 percent in most cases. In LFC's 2015 evaluation, the recommendation was made for HSD to focus its rate setting on the lower bound estimate of the actuarially sound rate range. Additionally, LFC recommended the Legislature consider amending statute to require HSD to award rates within the actuarially sound rate range and create clawback provisions if rates are paid outside of the range. HSD noted that while some rates may not be at the lowest actuarially sound rates, federal regulations require all rates to be actuarially sound and approved by CMS.

Between 2014 and 2018, HSD could have saved $93 million across all Centennial Care programs if MCOs were paid at the lowest actuarially sound rate. Long-term services comprised 42 percent of potential savings with $38.9 million, followed by physical health at $31.8 million and behavioral health with $21.8 million. The Medicaid expansion populations represented no potential savings to the general fund between 2016 and 2018 because the federal match for that population was 100 percent and savings would have

reverted to the federal government. In 2017 and 2018, the Medicaid expansion population represented $3 million in potential savings to the general fund.

Table 5. Potential General Fund Savings from Lower MCO Payments (in millions)

	Physical Health	Behavioral Health	LTSS	Physical Health - Medicaid Expansion	Behavioral Health - Medicaid Expansion	Total
2014	$12.5	$4.1	$13.2			$29.8
2015	$6.1	$2.4	$3.9			$12.4
2016	$4.4	$4.1	$7.6			$16.1
2017	$4.2	$4.8	$5.6	$1.0	$0.3	$14.6
2018	$4.6	$6.4	$8.6	$1.4	$0.3	$19.6
Total	**$31.8**	**$21.8**	**$38.9**	**$2.4**	**$0.6**	**$92.5**

Source: LFC analysis of MCO rate packages and Mercer actuarial rate range analysis

HSD noted during LFC's original 2015 program evaluation of Centennial Care that, given MCO's different member populations and provider networks, rate parity among MCOs is not possible. Additionally, HSD's actuary does account for MCO specific rate adjustments including member population risk adjustments, broad vs. limited contracting adjustments, health home add-on, as well as others. Nonetheless, to the extent HSD can further lower MCO rates, potential cost savings exist.

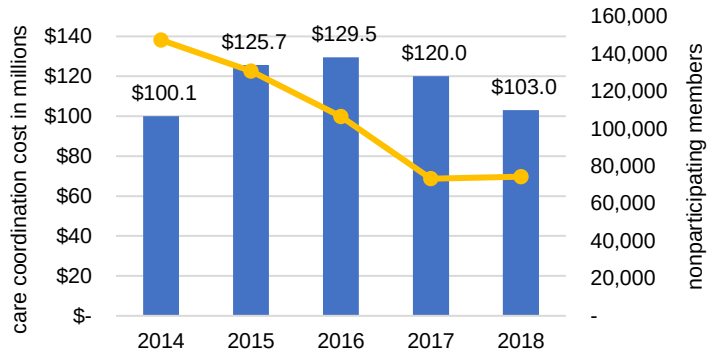
As an example of demonstrating the complexities of overseeing Medicaid programs in other states, Colorado enacted legislation in June 2015 to establish the Medicaid Provider Rate Review Advisory Committee. The committee assists the Department of Health Care Policy and Financing to review provider rate reimbursements in the Medicaid program. The committee is charged with reviewing the statutorily required annual report from the agency and reviewing any rate increase proposals or petitions sent to the agency.

Key Centennial Care Cost-Saving Elements Were not Fully Realized

Care coordination had limited data reporting and continued to have a large number of members not participate.

Total care coordination spending exceeded $575 million between 2014 and 2018. Care coordination was described by HSD in the original waiver application as a fundamental component of the Centennial Care program. Care coordination is defined as the implementation of an individualized, culturally appropriate comprehensive care management plan through appropriate linkages, referrals, coordination, and follow-up to needed services and supports. HSD initially attributed $31 million in cost savings to care coordination, but no direct cost savings amount has been subsequently provided.

Chart 7. Care Coordination Costs and Nonparticipating Care Coordination Members, $ in millions



Source: LFC analysis MCO financial reports and LFC files

The percentage of health risk assessments completed in thirty days significantly increased between 2014 and 2018, but care coordinators still only completed 60 percent of the number of HRAs required, even though the number was lowered. Beginning in 2016, HRAs – basic health assessments conducted by care coordinators to determine levels of care (intensity of care coordination) – were only required for new Medicaid enrollees and existing recipients who had a change in health status. Theoretically, this should have enabled MCOs to dramatically increase the completion percentage, but the overall number of HRAs completed has actually decreased over time.

Health risk assessments (HRAs) are basic health assessments conducted by care coordinators to determine members' intensity of care coordination needed.

Almost 6 percent of Centennial Care members declined care coordination in 2018, with another 6 percent unreachable. While the number of Centennial Care members who are unreachable has significantly improved since the program's inception in 2014, the number of members declining care coordination has steadily increased, growing by nearly 14 thousand over the five-year period. Care coordination is a cornerstone of the Centennial Care program's efforts to contain costs and improve member health outcomes; increasing care coordination participation is central to New Mexico's ability to control Medicaid spending.

Table 6. Health Risk Assessment and Comprehensive Needs Assessment Statistics, 2014 – 2018

	Number of HRAs required	HRAs completed within 30 days	Member declined care coordination	Member unreachable
2014	185,342	23%	22,291	125,134
2015	116,452	34%	24,774	106,112
2016	84,566	40%	26,159	80,307
2017	50,303	65%	33,498	39,782
2018	25,381	60%	35,929	38,388

Source: MCO care coordination reports and HSD MCO annual ad hoc reports, 2017 and 2018.
Note: 2018 HRA data is only for two MCOs.

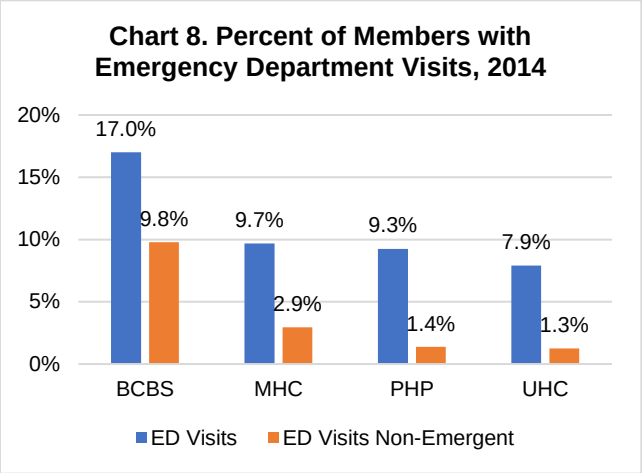
Utilization data reporting improved between 2014 and 2018, but more timely and consistent analyses could have been performed.

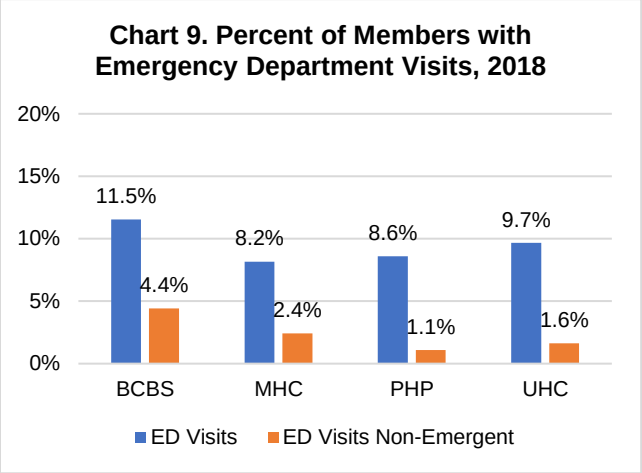
Between 2013 (pre-Centennial Care Medicaid baseline) and 2017, the percentage of Centennial Care enrollees receiving an ambulatory or preventive care visit decreased from 85.5 percent to 76.4 percent. This pattern was true across the three age cohorts analyzed (20-44, 45-64, and 65 plus), but member visit percentage increased with age. This finding is of concern because a 2019 analysis of Medicare beneficiaries shows annual preventive visits are associated with a 5.7 percent reduction in total healthcare costs for the next year.[3] If this cost-savings percentage extended to all members in the physical health, physical health Medicaid expansion, and long-term care programs, annual savings would total around $190 million.

Emergency department visits generally decreased between 2015 and 2018. A goal of care coordination under Centennial Care was to decrease utilization of higher cost healthcare services, such as emergency department visits. All MCOs except United HealthCare saw a reduction in the percentage of members receiving an emergency department visit, as well as the percentage

[3] Beckman, et. al. "Medicare Annual Wellness Visit Association with Healthcare Quality and Costs." *American Journal of Managed Care.* March 2019.

of members seeking emergency treatment for non-emergent needs. However, MCO variation shows some MCOs, most notably Blue Cross Blue Shield, could further reduce member emergency department visits, generating cost savings in the process.





Source: LFC analysis of MCO utilization report data

Original cost saving program elements were delayed and altered.

After delaying the implementation of health homes in the first two years of Centennial Care, in 2016 New Mexico implemented the health home model in two rural counties. New Mexico chose to focus its health homes, CareLink NM, on Medicaid-eligible adults with severe mental illness and children and adolescents with severe emotional disturbances. By 2018, HSD expanded health homes into six additional counties, for eight total, and partnered with seven providers. The health home sites provide for enhanced care coordination and integration of primary, acute, behavioral health, long-term care services, and social supports.

Health homes are a model of healthcare coordination where individuals with more complex and chronic health conditions receive integrated care and connection to services from either individual providers or teams of providers.

Evidence from other states suggests New Mexico can expect some level of cost savings from health homes in coming years. A 2017 report from the Urban Institute for the Department of Health and Human Services evaluated the first 13 health home programs approved in 11 states.[4] While the study found no significant savings for Medicaid enrollees in primary care health homes, Medicaid members enrolled at health homes located at community mental health centers – similar to New Mexico's implemented health homes – showed significant cost savings. Savings were highest for enrollees with greater exposure to the program, highlighting the importance of maintaining enrollee engagement.

[4] Spillman, Brenda C., Allen, Eva H. "Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Evaluation of Outcomes of Selected Health Home Program." *Annual Report – Year Five.* May 2017

Centennial Care Lacked Strong Legislative Oversight, and Limited Quarterly Reporting

Minimal changes to legislative oversight of Medicaid have occurred since the LFC's 2015 program evaluation.

While the 2015 LFC evaluation recommended the Legislature should consider appropriating Medicaid funds by program area, Medicaid continues to be budgeted and appropriated under two line items: physical health ($5.5 billion, FY20) and behavioral health ($531 million, FY20). In terms of general fund dollars, in FY20 this amounted to $873 million under physical health and $110 million under behavioral health.

Chart 10. Medical Assistance - FY20

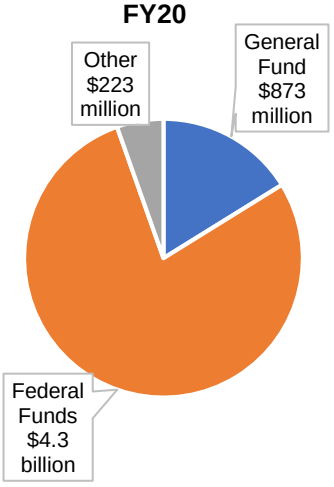
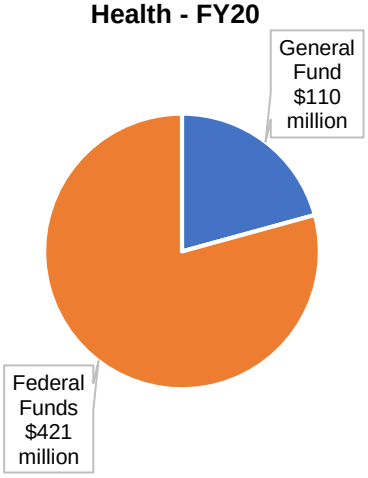


Chart 11. Medicaid Behavioral Health - FY20



Source: LFC Files

In many other states, Medicaid appropriations have greater transparency through more detailed budgeting with subcategory appropriations explicitly referenced. New Mexico, in contrast, relies on performance measures reported as part of the Accountability in Government Act to monitor program performance. Additionally, the Legislature relies on informal processes to communicate the nuances of the Medicaid budget and program, such as quarterly Medicaid projection meetings with Department of Finance and Administration (DFA) and LFC staff.

Performance measures for physical health and behavioral health between 2014 and 2018 remained similar. For FY14, the Medicaid program had eight performance measures, six under physical health and two under behavioral health. In FY18, the number of physical health measure dropped by one and the performance target for children receiving dental care declined noticeably, from 72 percent to 67 percent.[5]

[5] Nationally, dental care visits among children had a decreasing trend, which prompted HSD to request lowering the target percentage.

Table 7. Medicaid Performance Measures, FY14 and FY18

	Performance Measure	Performance Measure Target
FY14	(a) % of children 2 - 21 enrolled in managed care who had at least on dental visit during the measurement year	72%
	(b) % of infants in managed care who had 6 or more well-child visits with a PCP before 15 months	72%
	(c) Average % of children and youth ages 12 months to 19 in managed care who received a visit with a PCP during the measurement year	92%
	(d) % of children in managed care ages 5 - 11 who are identified as having persistent asthma and who are appropriately prescribed medication during the measurement year	95%
	(e) Number of ED visits per 1,000 Medicaid member months	45
	(f) % hospital readmissions for adults 18 and over, within 30 days of discharge	10%
	(a) % of readmissions to same level of care or higher for children or youth discharged from residential treatment centers and inpatient care	7%
	(b) Number of individuals served annually in substance abuse or mental health programs administered through behavioral health collaborative statewide entity contract	85,000
FY18	(a) % of children 2 - 20 enrolled in managed care who had at least on dental visit during the measurement year	67%
	(b) % of infants in managed care who had 6 or more well-child visits with a PCP before 15 months	Explanatory
	(c) Average % of children and youth ages 12 months to 19 in managed care who received one or more well-child visits with a PCP during the measurement year	92%
	(e) Rate of per capita use of ED categorized as non-emergent care	0.25
	(f) % of hospital readmissions for adults in managed care, age 18 and over, within 30 days of discharge	<10%
	(a) % of readmissions to same level of care or higher for children or youth discharged from residential treatment centers and inpatient care	5%
	(b) Number of individuals served annually in substance abuse or mental health programs administered through behavioral health collaborative statewide entity contract	160,000

Source: LFC Files

LFC continues to propose additional performance measures for increased accountability. As part of the FY22 budget process, LFC proposed 12 additional performance measures (shared with DFA as well) related to the New Mexico Medicaid program. Three of these measures are related to long-term services and the remaining nine are related to substance use disorder and treatment. Additionally, LFC has requested for more of the performance measure metrics to be reported on a quarterly, rather than annual, basis. Additional performance measures, coupled with increased frequency of data reporting, allows for enhanced oversight of the $6 billion Medicaid budget and enables the state to more closely monitor and analyze the cost-effectiveness of various program elements.

Table 8. LFC Proposed Medicaid Performance Measure Recommendations

FY22 LFC Performance Measure Recommendations
Percentage of LTSS plan members with a care plan that was transmitted to their primary care practitioner (PCP) or other documented medical care practitioner identified by the plan member within 30 days of its development
Percentage of inpatient discharges of LTSS plan members resulting in updates to the assessment and care plan within 30 days of discharge
Proportion of admissions to an institutional facility among MLTSS plan members age 18 and older that result in successful discharge to the community (community residence for 60 or more days) within 100 days of admission
Members with opioid abuse or dependence who had two or more additional visits within 30 days
Medicaid members rate of compliance with medication-assisted treatment
Medicaid members completing inpatient detoxification; could be ratio of number who start: number who complete
Medicaid members completing residential rehabilitation; could be ratio of number who start: number who complete
Medicaid members completing outpatient detoxification; could be ratio of number who start: number who complete
Medicaid members completing intensive outpatient treatment; could be ratio of number who start: number who complete
Number of Medicaid encounters under IMD waiver exclusion for substance use disorder treatment
Members with alcohol abuse or dependence who initiated treatment within 14 days of diagnosis
Members with alcohol abuse or dependence who had two or more additional visits within 30 days

Source: LFC Files

Finding

Centennial Care estimated cost savings are at risk due to problematic implementation of cost management components.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
1. HSD should amend the state plan amendment application for health homes to include health homes for chronic physical health conditions such as diabetes and cardiovascular disease. HSD should leverage the existing network of patient-centered medical homes to deploy these services.				In 2016, two health home sites were established to provide integrated care coordination services for individuals with serious mental illness and severe emotional disturbance. HSD requires MCOs to address chronic health conditions through performance improvement projects.
2. HSD should consider taking steps to improve the Health Risk Assessment (HRA) completion rates including standardizing HRA procedures and forms.				HSD collaborated with the MCOS to improve the HRA completion rate including standardizing HRA procedures and forms. HSD addressed with each MCO to refine its strategies and processes to reach members to complete an HRA. HSD has continued to monitor HRA completion, CNA/CCP completion with quarterly report submissions.
3. HSD should require in contract that Centennial Care initiatives including care coordination and the member rewards program spend at least 85 percent of funding on direct services leaving up to 15 percent for administrative expenditures.				The Centennial Care contract delineates which expenditures are considered under the MLR, as well as defining medical versus administrative for care coordination expenses in the calculation of the MLR. Neither care coordination nor member rewards are direct services and, therefore, would not be assessed as a separate MLR.
4. HSD should strengthen contract requirements for MCOs to incorporate payment and delivery reforms.				In 2015, HSD approved two to three payment reform projects per each MCO. The MCOs were required to report efficiency metrics, including (1) Total number of patients attributed to the provider for the project; (2) Total cost of care across all attributed patients for all covered services, per member-per-month; (3) Emergency room utilization for all attributed patients; and (4) Inpatient utilization for all attributed patients. Currently, HSD continues to work with MCOs and providers to further develop Value-Based Purchasing.
5. HSD should evaluate the benefits of care coordination to determine if the benefits are outweighing the costs.				HSD collects monthly data from each of the MCOs regarding members' engagement with care coordination, non-emergent ED usage, and housing stability.
6. HSD, in conjunction with LFC and DFA, should develop performance measures specific to Centennial Care initiatives to include in quarterly performance reporting.				HSD submits quarterly reports and an annual report to LFC with Centennial Care data. HSD continues to monitor performance metrics with an approved evaluation plan and the final report from the independent evaluator regarding the performance of the Centennial Care Program. HSD and LFC also establish performance measures as part of the budgeting process.

Finding

A lack of utilization data from Centennial Care limits ability to determine if the Medicaid system is adequate and cost-effective.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
1. HSD should amend MCO contracts to require the 85/15 medical loss ratio per program area on an annual basis, and for non-medical services such as care coordination and member rewards.				Per Centennial Care contracts, MLR is not assessed at a service-level but analyzed at the overall level, and care coordination and member rewards are not defined as direct services.
2. HSD should examine whether the 85/15 MLR requirement is appropriate as efficiencies are gained and economies of scale continue to grow under Centennial Care.				HSD assesses MLR requirement annually. In late 2016, HSD changed the MLR requirement to 86/14.
3. HSD should contractually require MCOs to report utilization data for each cohort and program area as reported prior to Centennial Care.				Report 41 (discontinued under CC 2.0) captured 220 categories of utilization in physical and behavioral health. HSD state it relies on encounter data reporting for analysis of utilization. HSD initiated and completed an encounter data improvement project at the beginning of calendar year 2015.
4. HSD should amend MCO contracts to require sub-capitation agreements to be submitted and approved by HSD.				HSD has the ability to request sub-capitated agreements. It has chosen to request more information from MCOs about sub-capitated arrangements in its financial reporting requirements and is receiving more information about these agreements than it has in the past.

Finding

A lack of utilization data from Centennial Care limits ability to determine if the Medicaid system is adequate and cost-effective.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
1. The Legislature should consider amending statute to require HSD to award rates within the actuarially sound rate range including clawback provisions if rates are paid outside of this range.				No legislative action has been taken. HSD states CMS has regulations about establishing actuarially sound rates. HSD follows this practice and establishes rates within the actually sound rate range prescribed by CMS.
2. HSD should require its actuary to use encounter data for rate setting purposes.				HSD's actuary has always utilized encounter data in its rate setting process. The encounter data used to develop rates is documented in detail in the rate certification letters submitted to CMS.
3. HSD should focus rate setting to the lower bound estimate of the actuarial sound rate range.				HSD notes rates were competitively procured and later performs rate adjustments based on programmatic changes. HSD also notes MCOs have different member populations and delivery systems, which impact rates and make it unreasonable all rates can achieve the lower bound rate.
4. HSD should negotiate a lower rate for pharmaceutical drugs related to high cost treatments such as Hepatitis C such as done by Interagency Benefits Advisory Committee for public employees of New Mexico. HSD should ensure access to clinically effective medications remains intact. HSD should require the actuary to incorporate pharmaceutical discounts into the rate setting process.				All MCOs all have contracts with pharmaceutical benefit managers (PBMs) and have negotiated rate reductions. HSD realizes these drug price reductions through its financial reconciliation process when it recoups the difference between assumed per member treatment versus the actual cost less the supplemental rebates received by the MCOs from the drug manufacturers. This arrangement is basically the same type of arrangement that the IBAC has negotiated but with less administrative burden on HSD staff to have to manage a pharmacy benefit.
5. HSD should incorporate profit margin analysis into rate setting process on an annual basis.				HSD continue to incorporate profit margin analysis into the rate setting process on an annual basis. This analysis is incorporated by the actuary through its analysis of the MCO financial statements.
6. The Office of Superintendent of Insurance (OSI) should amend rules to require all MCOs with interests in New Mexico submit financial statements annually for review and publication on the OSI website.				MCOs annually submit financial statements to OSI and are published to the OSI website. However, many statements do not contain New Mexico specific data, rather rollup amounts of the parent company.

Finding

More detailed information and reporting is needed to leverage Medicaid savings and increase the Legislature's ability to budget at a detailed level.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
1. The Legislature should consider budgeting Medicaid to program area level (physical health, behavioral health, long term services, Medicaid expansion), and requiring reporting on Medicaid spending through other state agencies including CYFD, DOH, etc. along with appropriate performance measures for each part of Medicaid.				Legislative action has not been taken. HSD notes a detailed projection of Medicaid expenditures and enrollment at the program levels are provided to LFC and DFA on a quarterly basis along with a presentation which includes analysis of program component changes.
2. The Legislature should consider requiring HSD to include, as a part of its budget proposal, approved rates and rate ranges for the upcoming budget year.				Legislative action has not been taken. HSD notes the recommendation is problematic given the timeline of budget decision requirements, actuarial analysis timelines, as well as administrative expenses. HSD incorporates all available sources of information when developing the budget proposal. Approved rates available at the time are included in the budget proposal.
3. The Legislature should consider amending statute to require HSD to develop a Centennial Care performance report card inclusive of cost savings measures, quality performance measures, and clinical outcome measures.				Legislative action has not been taken. HSD and LFC review the AGA performance metrics on an annual basis, and HSD provides feedback on metrics in PB1 and PB2 for LFC and DFA review and approval.
4. HSD should work with LFC and DFA to develop a regular reporting format for Medicaid managed care as part of regular projection meetings. Reports should provide, at a minimum, up-to-date cohort level data on enrollment and average PMPM spending compared to beginning of the year projections. HSD should also include projections by major program.				The quarterly projection process continues to be refined and updated. HSD regularly addresses LFC and DFA requests to make sure the data is clear and the detailed level information needed is included. This includes a new presentation format, the expanded enrollment charts/tables, the PMPM sheet, component analysis charts, and the detailed narrative.
5. HSD should institute a set list of performance measures for MCO payment reform to measure performance uniformly across all MCOs. These performance measures should include measurement of cost savings and utilization reduction.				Centennial Care contract amendments changed payment reform project emphasis to value-based purchasing projects. HSD notes it continues to work with MCOs and providers to further advance value-based purchasing.
6. HSD should include actuarial analysis in budgeting and forecasting process and provide line item detail for key program changes within the Medicaid program.				HSD provides detailed budget forecasts and responds to questions from LFC and committees. HSD works closely with the actuarial contractor to set appropriate capitation rates which include program changes.
7. HSD should consider incentivizing lower rates by awarding MCOs with enrollees based on rates.				HSD did not award MCOs with enrollees based on rates. HSD also notes if all MCOs were paid at the lower bound of the rate range, then it would not also be able to award auto-assigned enrollees based on rates.

Appendix A. Total Capitation Payments by Program Area, 2014 – 2018

Table 1. Total Capitation Payments by Program Area, 2014 – 2018 (in millions)

Demonstration Year	Physical Health	Long-Term Services	Behavioral Health	Medicaid Expansion Physical Health	Medicaid Expansion Behavioral Health	Total
2014	$ 1,485.44	$ 937.54	$ 312.05	$ 873.08	$ 69.90	$ 3,678
2015	$ 1,522.80	$ 1,023.06	$ 318.02	$ 1,320.76	$ 91.74	$ 4,276
2016	$ 1,508.39	$ 1,042.80	$ 356.44	$ 1,344.70	$ 102.99	$ 4,355
2017	$ 1,481.65	$ 1,042.39	$ 320.38	$ 1,269.94	$ 113.79	$ 4,228
2018	$ 1,439.86	$ 1,031.14	$ 330.10	$ 1,239.91	$ 125.88	$ 4,167

Appendix B. Managed Care Statistics by Program, 2014 – 2018

Table 1. Behavioral Health Managed Care Statistics, 2014 – 2018

Calendar Year	Member Months	Total Capitation (millions)	Capitation PMPM (Total HSD Capitation Payments / Member Months)	Total MCO expenditures on medical services (millions)	MCO PMPM (Total MCO expenditures on medical services / Member Months)
2014	5,216,545	$ 312.05	$ 60	$ 261.46	$ 50
2015	5,303,015	$ 318.02	$ 60	$ 261.78	$ 49
2016	5,475,737	$ 356.44	$ 65	$ 274.60	$ 50
2017	5,484,653	$ 320.38	$ 58	$ 283.41	$ 52
2018	5,290,104	$ 330.10	$ 62	$ 296.47	$ 56

Table 2. Long-Term Services Managed Care Statistics, 2014 – 2018

Calendar Year	Member Months	Total Capitation (millions)	Capitation PMPM (Total HSD Capitation Payments / Member Months)	Total MCO expenditures on medical services (millions)	MCO PMPM (Total MCO expenditures on medical services / Member Months)
2014	546,669	$ 937.54	$ 1,715	$ 825.97	$ 1,511
2015	569,434	$ 1,023.06	$ 1,797	$ 899.32	$ 1,579
2016	586,547	$ 1,042.80	$ 1,778	$ 945.81	$ 1,613
2017	590,224	$ 1,042.39	$ 1,766	$ 906.30	$ 1,536
2018	577,960	$ 1,031.14	$ 1,784	$ 891.34	$ 1,542

Table 3. Medicaid Expansion Physical Health Managed Care Statistics, 2014 – 2018

Calendar Year	Member Months	Total Capitation (millions)	Capitation PMPM (Total HSD Capitation Payments / Member Months)	Total MCO expenditures on medical services (millions)	MCO PMPM (Total MCO expenditures on medical services / Member Months)
2014	1,662,998	$ 873.08	$ 525	$ 653.44	$ 393
2015	2,428,070	$ 1,320.76	$ 544	$ 956.39	$ 394
2016	2,715,273	$ 1,344.70	$ 495	$ 1,088.52	$ 401
2017	2,816,927	$ 1,269.94	$ 451	$ 1,089.78	$ 387
2018	2,742,872	$ 1,239.91	$ 452	$ 1,109.28	$ 404

Table 4. Medicaid Expansion Behavioral Health Managed Care Statistics, 2014 – 2018

Calendar Year	Member Months	Total Capitation (millions)	Capitation PMPM (Total HSD Capitation Payments / Member Months)	Total MCO expenditures on medical services (millions)	MCO PMPM (Total MCO expenditures on medical services / Member Months)
2014	1,662,998	$ 873.08	$ 525	$ 653.44	$ 393
2015	2,428,070	$ 1,320.76	$ 544	$ 956.39	$ 394
2016	2,715,273	$ 1,344.70	$ 495	$ 1,088.52	$ 401
2017	2,816,927	$ 1,269.94	$ 451	$ 1,089.78	$ 387
2018	2,742,872	$ 1,239.91	$ 452	$ 1,109.28	$ 404

Appendix C. MCO PMPM Expenditures by Program, 2014 – 2018

Table 1. Physical Health MCO Expenditures by Service Type, 2014 – 2018

Calendar Year	Inpatient	Outpatient	Physicians	Pharmacy	Dental	Subcap	Other	Total
2014	$ 80.96	$ 36.91	$ 47.23	$ 21.13	$ 18.64	$ 31.85	$ 40.52	$ 277.23
2015	$ 72.13	$ 37.77	$ 46.08	$ 21.20	$ 20.28	$ 30.72	$ 42.31	$ 270.48
2016	$ 78.86	$ 42.00	$ 51.54	$ 25.78	$ 21.64		$ 54.47	$ 274.28
2017	$ 74.46	$ 41.69	$ 48.62	$ 26.02	$ 20.11		$ 53.75	$ 264.65
2018	$ 77.33	$ 47.67	$ 52.06	$ 26.27	$ 21.01		$ 58.31	$ 282.65

Table 2. Behavioral Health MCO Expenditures by Service Type, 2014 – 2018

Calendar Year	Evaluation / Therapies	Pharmaceuticals	Residential Treatment	Therapeutic Foster Care	Hospital Facility	Skills Training	Other	Total
2014	$ 8.61	$ 7.27	$ 7.21	$ 4.30	$ 5.82	$ 2.40	$ 14.51	$ 50.12
2015	$ 8.49	$ 7.86	$ 9.02	$ 4.37	$ 3.21	$ 1.67	$ 14.75	$ 49.36
2016	$ 8.49	$ 7.65	$ 9.02	$ 3.79	$ 3.82	$ 0.63	$ 16.76	$ 50.15
2017	$ 8.71	$ 7.87	$ 8.55	$ 3.66	$ 4.52	$ 0.40	$ 17.97	$ 51.67
2018	$ 9.22	$ 7.64	$ 9.16	$ 3.81	$ 4.57	$ 0.36	$ 21.28	$ 56.04

Table 3. Long-Term Services MCO Expenditures by Service Type, 2014 – 2018

Calendar Year	Personal Care Option	Nursing Facility	Home Health & Community Service	Inpatient	Outpatient	Physicians	Pharmacy	Subcap	Other	Total
2014	$ 496.96	$ 355.81	$ 142.59	$ 137.65	$ 73.20	$ 54.58	$ 40.00	$ 26.56	$ 183.57	$ 1,510.92
2015	$ 559.17	$ 370.85	$ 104.81	$ 163.49	$ 70.01	$ 55.07	$ 50.65	$ 14.58	$ 190.69	$ 1,579.32
2016	$ 529.02	$ 391.30	$ 121.82	$ 139.66	$ 79.58	$ 58.64	$ 63.36	$ -	$ 229.13	$ 1,612.51
2017	$ 490.12	$ 386.29	$ 121.81	$ 132.32	$ 80.73	$ 54.94	$ 58.17	$ -	$ 211.14	$ 1,535.52
2018	$ 490.26	$ 406.34	$ 125.90	$ 116.13	$ 84.58	$ 51.74	$ 52.74	$ -	$ 214.53	$ 1,542.21

Table 4. Medicaid Expansion Physical Health MCO Expenditures by Service Type, 2014 – 2018

Calendar Year	Inpatient	Outpatient	Physicians	Pharmacy	Dental	Subcap	Other	Total
2014	$ 117.90	$ 72.99	$ 65.29	$ 43.31	$ 14.91	$ 12.12	$ 66.42	$ 392.93
2015	$ 106.01	$ 72.88	$ 62.95	$ 53.23	$ 17.33	$ 7.55	$ 73.94	$ 393.89
2016	$ 104.68	$ 74.90	$ 62.19	$ 63.29	$ 15.19	$ -	$ 80.63	$ 400.89
2017	$ 103.08	$ 72.18	$ 57.82	$ 61.81	$ 13.16	$ -	$ 78.81	$ 386.87
2018	$ 106.76	$ 78.98	$ 62.55	$ 63.33	$ 13.67	$ -	$ 79.12	$ 404.42

Table 5. Medicaid Expansion Behavioral Health MCO Expenditures by Service Type, 2014 – 2018

Calendar Year	Evaluation/ Therapies	Pharmaceuticals	Hospital Inpatient Facility	FQHC's	Methadone & Suboxone Treatment	Hospital Outpatient	Other Professional BH Services	Other	Total
2014	$ 6.26	$ 6.47	$ 4.00	$ 2.31	$ 1.11	$ 1.11	$ 0.94	$ 4.60	$ 26.79
2015	$ 8.61	$ 8.00	$ 3.89	$ 2.81	$ 1.92	$ 0.76	$ 1.18	$ 5.36	$ 32.53
2016	$ 9.72	$ 8.50	$ 4.08	$ 3.88	$ 2.68	$ 0.39	$ 0.84	$ 5.20	$ 35.30
2017	$ 9.64	$ 8.89	$ 5.00	$ 4.03	$ 3.11	$ 0.59	$ 1.39	$ 6.71	$ 39.36
2018	$ 10.22	$ 8.83	$ 5.92	$ 4.74	$ 4.06	$ 0.59	$ 1.68	$ 8.02	$ 44.06