2018 Accountability Report

Medicaid

The October 2018 Medicaid projection from the Human Services Department (HSD) once again significantly revised the department's enrollment and expenditure projections. HSD reports that Medicaid enrollment probably hit its lowest point in September 2018, at 833,611, and is projected to begin to rise again slowly, increasing by 1.4 percent to 844,967 between now and the end of FY19. As a result, the $10.9 million FY19 general fund shortfall HSD was projecting in July has now dropped to $8.1 million.

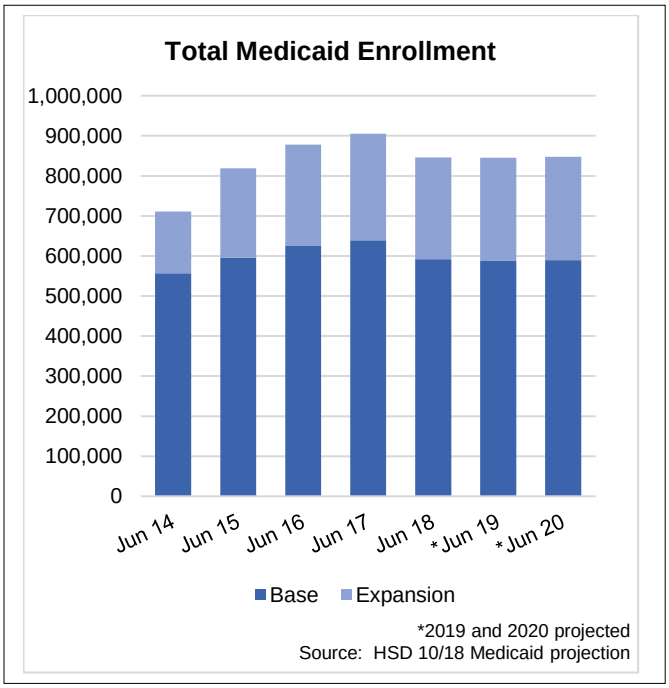
HSD reports that enrollment declines are due primarily to falling enrollment in family planning Medicaid, a relatively small program that is not a Medicaid cost driver. The only eligibility criteria for family planning Medicaid has been its income limit of 250 percent of the federal poverty level, which led to many Medicaid applicants essentially defaulting into the program due to incomes too high for any other category. As recipients discover how limited the benefit package is, many choose not to recertify. HSD reports the Centennial Care 2.0 waiver renewal will limit family planning eligibility to individuals under 50 years old, and anticipates this will lead to further declines in enrollment.

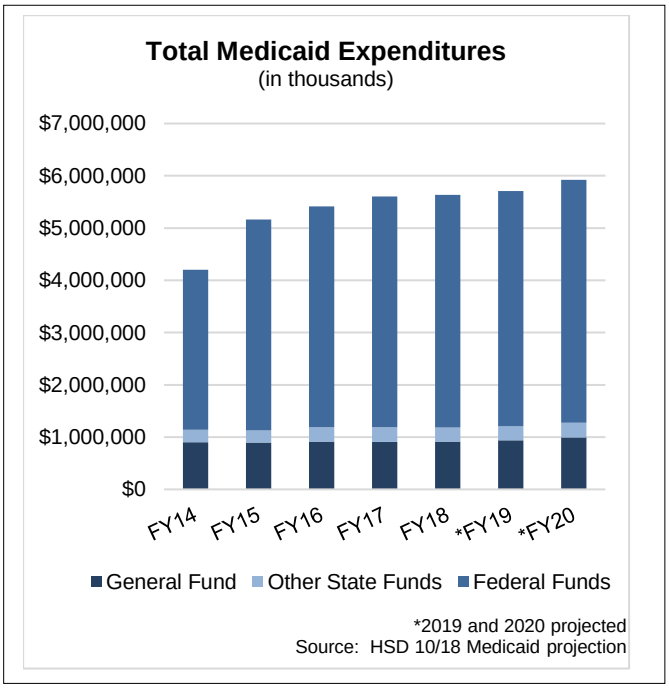
Other factors driving enrollment declines include a generally improved economy and jobs picture, and annual eligibility redeterminations.

Despite enrollment declines and slowing growth, HSD is projecting FY19 Medicaid expenditures will be $81 million greater than FY18. HSD projects total expenditures of $5.7 billion for FY19, including state funds slightly over $1.2 billion. The department reports a primary driver for increasing reliance on the state's general fund is the third and final reduction to the federal matching rate for the Medicaid expansion population, which will drop from 93 percent in 2019 to 90 percent in 2020. In addition, increased reimbursement rates for behavioral health providers are projected to offset any savings from slower growth in the behavioral health programs.

Performance driven health care. Medicaid in New Mexico is a nearly $6 billion dollar program, providing health care coverage to approximately 40 percent of the state's citizens. With so much at stake, the LFC, legislators and advocates have an interest in understanding how well the state's Centennial Care Medicaid program is performing.

This annual Accountability Report seeks to bolster the program's limited quarterly report by presenting annual audited National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) national averages for Medicaid, side by side with information on program expenditures and consumer satisfaction.





Health Quality Measures

The performance measures on this page have historically been part of HSD's reporting under the Accountability in Government Act, used by the LFC to develop its quarterly report cards. HSD, however, has reduced its quarterly reporting so this report primarily focuses on annual performance outcomes. The chart below compares audited HEDIS data for calendar years 2016 and 2017, along with unaudited preliminary data from the first two quarters of calendar year 2018. Benchmark ratings of *better*, *good*, or *worse* indicate state performance for calendar year 2017 compared with 2017 NCQA national averages.

HEALTHY CHILDREN	Newborns whose mothers had prenatal visit during first trimester (or within 42 days of enrollment)	Infants who had 6 or more well-child visits during first 15 months	Children/youth who had one or more well-child visits during the year	Children ages 2 to 20 who had at least one dental visit during the year
2018 Preliminary (first 2 quarters only)	**Not reported**	44%	71%	65%
	Worse	Good	Better	Better
2017 Actual	73%	59%	84%	70%
2016 Actual	77%	57%	85%	68%
2017 National Average	81%	59%	71%	54%

CARE COORDINATION AND CHRONIC DISEASE MANAGEMENT	Adults with diabetes who had a HbA1c test during the year	Patients with persistent asthma prescribed and maintained on appropriate medication	Rate of non-emergency ER visits per 1,000 members	Hospital readmissions for adults within 30 days of discharge
2018 Preliminary (first 2 quarters only)	62%	44%	504	7%
	Worse	Worse		
2017 Actual	77%	57%	467	7%
2016 Actual	83%	54%	458	12%
2017 National Average	88%	61%	*Not a HEDIS measure*	*No NCQA benchmark*

BEHAVIORAL HEALTH	Adults with major depression who received continuous treatment with antidepressant medication	Individuals discharged from inpatient facilities who received follow-up services at seven days	Individuals discharged from inpatient facilities who received follow-up services at thirty days	Readmissions for children/ youth discharged from residential treatment centers and inpatient care
2018 Preliminary (first 2 quarters only)	30%	45%	63%	6%
	Worse	Better	Better	
2017 Actual	34%	38%	62%	8%
2016 Actual	35%	42%	62%	11%
2017 National Average	39%	37%	58%	*Not a HEDIS measure*

Physical Health

ADULTS AND CHILDREN*	Centennial Care Physical Health Expenditures *(in billions)*	Physical Health Average Quarterly PMPM	Medicaid Expansion Physical Health Expenditures *(in billions)*	Medicaid Expansion Average Quarterly PMPM
2018 October	FY18	FY18	FY18	FY18
726,316	$1.48	$305	$1.26	$453
2017 743,468	FY17 $1.50	FY17 $301	FY17 $1.25	FY17 $468

*Total Medicaid enrollment, managed care and full benefit FFS. Source: Medicaid enrollment reports. Expenditures are HSD capitation payments, not the actual MCO expenditures. Source: HSD Medicaid projection, 10/26/18.

The physical health program includes both the base Centennial Care population of children, parents, and certain special populations such as foster care children, and the expansion population of adults. For about the last year HSD has been projecting growth in spending for this portion of the Medicaid program largely based on trends that suggested healthier Medicaid recipients were leaving the program while sicker, and more costly, recipients remain. However, with the October 2018 Medicaid projection, the department reported lower-than-expected average costs across physical health cohorts. Combined with enrollment decreases, HSD now projects FY19 physical health costs will be 0.5 percent less than FY18 spending for the Centennial Care base population, and increase by only 2.4 percent for the expansion population. For FY20, HSD anticipates the trend of lower average per person costs will continue, but nonetheless projects 3.2 percent and 3.8 percent increases, respectively, in spending for both programs as enrollment rises slowly.

Centennial Care MCOs report on a variety of HEDIS measures that can be used to evaluate the cost, quality and effectiveness of the health care they provide. As has been the case in previous years' reports, the data reveal a notable lag behind available national measures, although there are a couple of measures where the state on average, or an individual MCO, meets or exceeds the NCQA Medicaid benchmark. Green arrows indicate improvement from last year, while red arrows indicate declining performance. Nine of the 12 measures show some improvement between 2016 and 2017, such as the three point improvement for lead screening for children and a nine point improvement for COPD management.

Effectiveness of Care	**Adult patients receiving body mass index assessment**	**Child/adolescent patients receiving body mass index assessment**	**Patients with lower back pain who did not have an imaging study for diagnosis**	**Children receiving appropriate treatment for upper respiratory infections**
2017 New Mexico	80%↑	61%	71%↑	89%↑
2016 New Mexico	79%	61%	70%	88%
2017 National Average	85%	73%	72%	89%
MCO with best rating	PHP 84%	PHP 64%	UHC 72%	UHC 91%
Disease Management	**Patients with poor diabetes control (lower is better)**	**Cardiovascular patients with controlled high blood pressure**	**Patients with COPD managed with corticosteroid medication**	**Patients 75% compliant with asthma medication**
2017 New Mexico	46%↑	50%↓	52%↑	31%↑
2016 New Mexico	48%	54%	43%	29%
2017 National Average	41%	57%	68%	37%
MCO with best rating	UHC 46%	Molina 50%	UHC 67%	UHC 42%
Access to Care	**Children ages 1 – 6 years with access to primary care**	**Children screened for lead poisoning by their second birthday**	**Adults with access to preventive & ambulatory care**	**Women receiving timely postpartum care**
2017 New Mexico	86%↑	39%↑	80%↑	57%↓
2016 New Mexico	84%	36%	76%	58%
2017 National Average	91%	68%	80%	64%
MCO with best rating	Molina 89%	Molina 45%	PHP 79%	BCBS 61%

Behavioral Health

Centennial Care Members Receiving BH Services	Centennial Care BH Expenditures *(in millions)*	Fee for Service Recipients Receiving BH Services	Fee for Service BH Expenditures *(in millions)*	Behavioral Health Average Quarterly PMPM
CY17	FY18	CY17	FY18	FY18
16%	$444.9	42%	$38.5	$56
CY16 14%	FY17 $458.9	CY16 48%	FY17 $36.6	FY17 $52

Spending on the Centennial Care behavioral health program increased by approximately 8.7 percent between FY18 and FY19. The largest proportion of the increase was for behavioral health services for the expansion population, which made up 28 percent of total behavioral health costs in FY19. Behavioral health expenditures are projected to increase by another 4 percent for FY20. Despite the same lower enrollment trend as physical health, HSD projects behavioral health spending FY19 and FY20 will be driven by provider rate increases and expanded Centennial Care 2.0 benefits.

There were several new HEDIS measures related to substance use disorder for the 2017 reporting year: the measures for initiation and engagement in substance use disorder treatment expanded to distinguish alcohol, opioids, and other drugs, and new measures track high dose opioid use, multiple opioid providers, and opioids obtained from multiple pharmacies. The New Mexico Department of Health reports 68 percent of drug overdose deaths in the state in 2016 involved prescription opioids, so although there are not yet national averages for these new measures the data provide useful insights about factors that contribute to the opioid epidemic in New Mexico. Centennial Care contracts authorize MCOs to 'lock in' members who seek opioids from multiple sources, limiting their access to one pharmacy when appropriate. For Centennial Care 2.0 HSD is revising how the MCOs report lock ins, adding detail that may help the program address potential opioid overuse.

Substance abuse or dependence	Members with alcohol abuse or dependence who		Members with opioid abuse or dependence who		Individuals receiving opioids from four or more providers for 15 or more days[1]
	initiated treatment within 14 days of diagnosis	had two or more additional visits within 30 days	initiated treatment within 14 days of diagnosis	had two or more additional visits within 30 days	
2017 New Mexico	38%	12%	48%	26%	219 per 1,000 members
2017 National Average	*Separate alcohol and opioid measures are new, as is the multiple opioid prescribers measure; no benchmarks yet.*				

[1]UHC did not report data for this measure

Access to Care	Individuals receiving substance abuse or mental health services, fee for service and managed care	Behavioral Health Providers (providers may be counted more than once if enrolled with multiple MCOs)			MCO with highest ratio of behavioral health providers to members
		Behavioral health practitioners	Behavioral health facilities	Total behavioral health providers	
2017	159,297	12,660	1,235	13,895	UHC 1:19
2016	161,158	12,078	1,238	13,316	PHP 1:52

Note: LFC staff has questions about the accuracy of UHC's network adequacy report and has requested HSD investigate.
Source: BHSD performance report FY18 Q4; MCO network adequacy reports CY17 Q4; Medicaid enrollment report 12/17.

Consumer Satisfaction	Adults generally happy with the services they received	Families generally happy with the services provided to their child	Adults feel they can manage their daily activities better	Families feel their child is better able to do the things they want to do	Adults feel they have good access to the services they need
2017	89%	83%	74%	76%	82%
2016	86%	84%	72%	78%	82%
2017 US Average	91%	88%	78%	73%	89%

Source: 2018 BH Consumer Satisfaction Surveys (report data collected during prior calendar year).

Long Term Services and Supports

Centennial Care Enrollment	Managed Care LTSS Expenditures *(in billions)*	LTSS Waiver Expenditures *(in millions)*[1]	Centennial Care Average Quarterly PMPM
2018 October	FY18	FY18	FY18
48,914	$1.05	$385	$1,767
2017 48,554	FY17 $1.08	FY17 $365	FY17 $1,777

[1]Waiver expenditures include spending for the developmentally disabled, medically fragile, and Mi Via waivers.
Source: HSD Medicaid projection, 10/26/18.

On a per person basis, the long term services and supports (LTSS) program is the most expensive portion of the Medicaid program, with average annual per person costs exceeding $29 thousand. Total spending for all long term services, combining the Centennial Care population and the waiver population, grew 4.4 percent between FY18 and FY19, and is projected to increase by another 3 percent in FY20. Increased spending for the Centennial Care LTSS population continues at a faster pace than enrollment growth: enrollment is projected to increase by 2 percent for FY19 and FY20, but spending increased 3.8 percent between FY18 and FY19, and is projected to increase by another 3.8 percent in FY20. The biggest cost drivers for long-term services remain personal care services and nursing facilities.

Spending for the long term care waivers – the developmentally disabled (DD), medically fragile and Mi Via populations – rose 6.2 percent between FY18 and FY19 and is projected to increase by another one percent in FY20. HSD reports cost-drivers for this group of people are 80 new DD waiver allocations, DOH plans for greater attrition replacement, increased provider rates, and new services and procedures in the DD waiver renewal.

As noted in the last Medicaid Accountability Report, HSD has discontinued all three LTSS performance measures because they no longer provided an accurate reflection of the program's performance, particularly now that community based services are available to all Medicaid recipients who meet the required level of care. One new measure was introduced, leaving this important and costly program with a single accountability measure for which there are no benchmarks. The National Committee for Quality Assurance (NCQA) has announced four new LTSS HEDIS measures for 2019, none of which, unfortunately, are outcome oriented. All four simply track the creation and updating of assessments and care plans. Four new non-HEDIS measures that NCQA encourages states to adopt are somewhat more focused on outcomes, including successful discharges and transitions back to the community from nursing facilities. HSD reported it is considering the new HEDIS measures, but has not reviewed the others yet.

LTSS Quality Measure	Members with a nursing facility level of care who are being served in the community	CAHPS fall risk questions	
		Did you fall in the past 6 months?	Has your health provider done anything to help prevent falls?
2018	86%	20% *about 265 respondents*	37% *about 388 respondents*
2017	*New Measure*	21% *about 292 respondents*	31% *about 367 respondents*
2017 National Average	*Not a HEDIS measure, no national benchmark.*		

Sources: HSD Performance Report Annual FY 2018 and 2018 annual CAHPS.

The annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey includes several questions about falls and problems with walking or balance. Survey results are limited to relatively few respondents and cannot be generalized across the whole Medicaid population. But in the absence of meaningful performance measures, they provide a little more information about long term care in the state. Similarly, the MCO network adequacy reports offer a glimpse into whether New Mexicans are able to access LTSS services when they need them.

Access to Care	LTC Practitioners	LTC Facilities	Total	MCO with most LTC providers
2017	1,482	302	1,784	BCBS = 590
2016	1,496	270	1,766	BCBS = 591

Source: MCO network adequacy reports, CY16 and CY17 Q4.

Care Coordination

Care coordination is a key aspect of the Centennial Care program, meant to achieve both better health outcomes and lower costs by assessing and coordinating care for recipients, particularly those with complex medical needs. Health risk assessments (HRAs) were initially required for all recipients, but since 2016 MCOs have only been required to conduct HRAs for new Medicaid enrollees and existing recipients who have a change in health status. That change resulted in a 41 percent decrease between 2016 and 2017 in the number of HRAs for MCOs to complete. Care coordination, including more advanced comprehensive needs assessments (CNAs) as well as regular calls and face-to-face visits, is required only for members who meet a level two or level three need.

Care Coordination Levels	Level One (healthy individuals)	Level Two (nursing facility level of care; low to moderate care needs)	Level Three (nursing facility level of care; moderate to high care needs)	Client declined care coordination	Client unreachable
2017	522,199	34,208	3,419	33,498	39,782
2016	529,194	40,109	5,205	26,159	80,307
MCO with highest proportion in CY17	Molina 92%	UHC 15%	UHC 1%	BCBS 10%	UHC 20%

Source: HSD MCO utilization reports: 2016 4th quarter (some updated data from HSD), and 2017 ad hoc annual.

However, even with fewer HRAs to complete and despite a notable 25 percent improvement in timely completion, the aggregate completion rate for all four MCOs is only 65 percent. Further, LFC staff was not able to validate 2017 data provided by HSD; the quarterly MCO care coordination report has been on hold pending modification since the second quarter of 2017 and the ad hoc annual report for 2017 provides for limited comparison.

Care Coordination Indicators	Number of HRAs required	HRAs completed within 30 days	Level 3 members who received quarterly in-person visits	ER visits for non-emergency conditions
2017	50,303	65%	54%	23%
2016	84,566	40%	52%	24%
MCO with highest proportion in CY17	n/a	PHP 83%	Molina 89%	BCBS 36%

Source: HSD MCO care coordination reports: 2016 4th quarter and 2017 2nd quarter and ad hoc annual.

The change to the HRA requirements were, at least in theory, meant to allow greater focus of MCO care coordination efforts on higher need members. Yet MCO reports indicate Medicaid recipients in the higher care coordination levels are not consistently receiving more focused MCO attention. In 2017, the MCOs completed only an average of 47 percent of the required quarterly in-home visits with level three care coordination members, an improvement over 2016's average of 52 percent but lower than 2015's average of 68 percent. The range of MCO success in this area is quite broad, from a low of 20 percent to a high of 89 percent.

MCO care coordination may be showing more success in another measure, the extent to which members with non-emergency conditions are re-directed away from emergency rooms. A number of factors largely outside the control of Medicaid MCOs contribute to persistent ER use by Medicaid recipients, including the state's lack of sufficient primary care providers. But a key rationale HSD offers for the costs of care coordination is its ability to encourage members, through monitoring, education, and incentives, to select lower cost care when available and appropriate. In 2017, 23 percent of all Centennial Care emergency room visits were for non-emergency conditions, a slight improvement from 2016's 24 percent and six points better than 2015's 29 percent.

Centennial Care members classified as 'unreachable' – people an MCO has been unable to reach despite three or more attempts, by various means and at various times of day – are also a persistent, but improving, challenge to the program. In 2015, the MCOs reported over 106 thousand people in this category, which made up over 15 percent of the non-emergency ER visits that year, reflecting at best members who have not been educated about how to use the managed care system and, at worst, a sign of potential problems with access to primary care providers. However, by 2017 the MCOs reported fewer than 40 thousand unreachable members, representing 10 percent of non-emergency ER visits.