2017 Accountability Report

Medicaid

In November 2017, the Human Services Department (HSD) significantly revised its enrollment and expenditure projections. HSD now reports that Medicaid enrollment likely peaked in March of 2017, at 916,767, and had dropped to 854,942 by October, 2017. As a result, the $22.6 million FY18 budget deficit HSD was projecting as recently as August has now evaporated, and the department has lowered its budget projection for FY19.

The decrease in enrollment is primarily due to fewer individuals recertifying for Medicaid than HSD had projected, something that became clear as the department caught up with the back-log of annual re-certifications that had built up while it shifted priorities to attend to the back-log of SNAP cases. The SNAP cases were, at least temporarily, a higher priority due to the ongoing litigation in the Debra Hatten-Gonzales case.

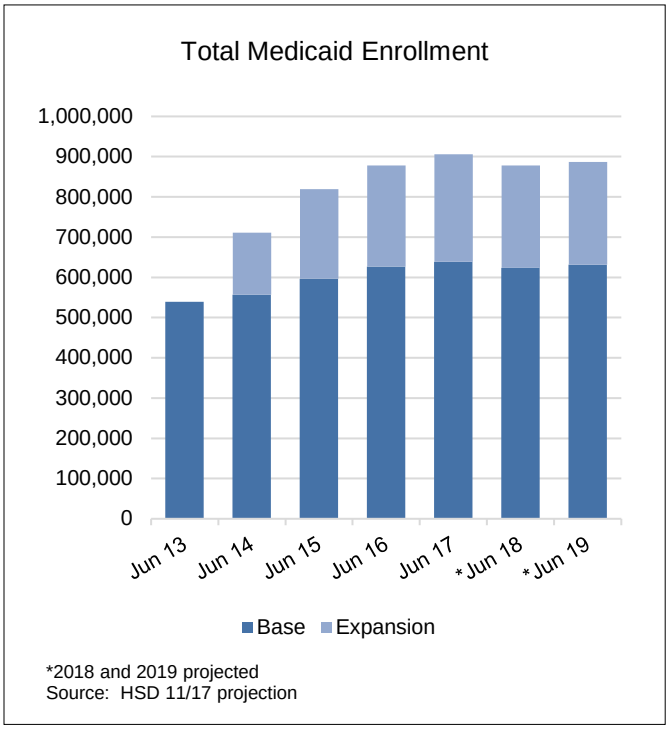
With enrollment down, FY18 Medicaid expenditures are also now projected to drop. For FY17, total costs for Medicaid were $5.62 billion, with approximately $1.17 billion of state funds. HSD projects total expenditures of $5.68 billion for FY18, the state's share of which is estimated to be over $1.25 billion.

For 2019, HSD expects both enrollment and expenditures to rise slowly, as the charts below show.

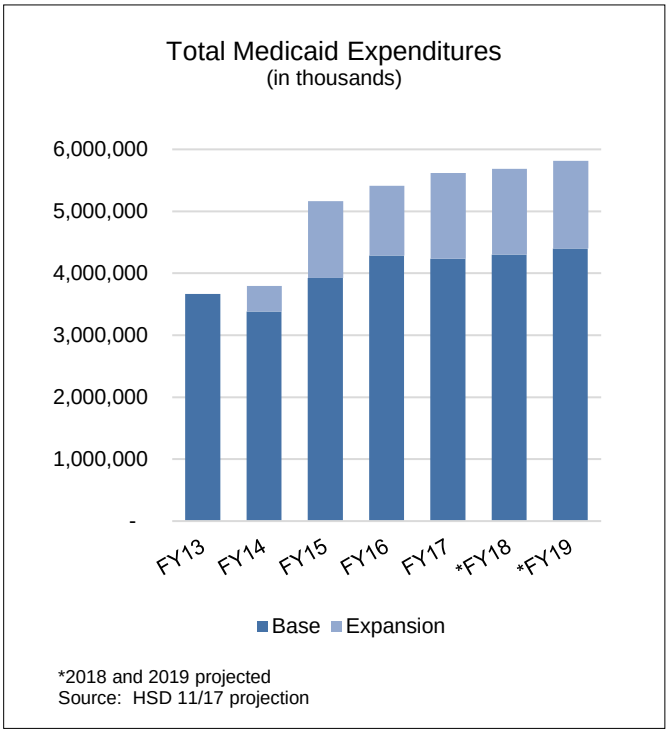
NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

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. The Medicaid program has always lacked somewhat in timely reporting of meaningful outcome measures that offer useful information about the quality and cost-effectiveness of the program. HSD says delays are largely due to factors such as the time needed to audit data reported by the MCOs to ensure accuracy, but the Legislature needs timely information to effectively perform its oversight function. HSD's decision over the last couple of years to drop some measures and to change a number of quarterly measures to annual reporting moves the program in the wrong direction in terms of performance measure reporting.

This annual Accountability Report seeks to bolster the program's reduced routine 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.



*2018 and 2019 projected
Source: HSD 11/17 projection



*2018 and 2019 projected
Source: HSD 11/17 projection

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 calendar year 2015 and 2016 audited HEDIS data, along with unaudited preliminary calendar year 2017 data. Initial trends for 2017 are noted as stable, better or worse. 2016 NCQA national averages are provided for benchmarking purposes.

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
2017 Preliminary (first 2 or 3 quarters only)	77%	57%	85%	65%
	Stable	Stable	Stable	Worse
2016 Actual	77%	56%	85%	68%
2015 Actual	71%	49%	85%	66%
2016 National Average	82%	62%	90%	53%

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 ER visits per 1,000 member months	Hospital readmissions for adults within 30 days of discharge
2017 Preliminary (first 2 or 3 quarters only)	60%	54%	45	10%
	Worse	Stable	Better	Better
2016 Actual	84%	54%	50	12%
2015 Actual	84%	52%	50	12%
2016 National Average	87%	*Retired by NCQA in 2015*	*Not a HEDIS measure*	19%*

*NCQA does not have a Medicaid benchmark; this is the Medicare national average

BEHAVIORAL HEALTH	Adults with major depression who received continuous treatment with antidepressant medication	Individuals discharged from inpatient facilities who receive follow-up services at seven days	Individuals discharged from inpatient facilities who receive follow-up services at thirty days	Readmissions for children/ youth discharged from residential treatment centers and inpatient care
2017 Preliminary (first 2 or 3 quarters only)	35%	43%	64%	7%
	Stable	Better	Better	Better
2016 Actual	35%	42%	62%	9%
2015 Actual	38%	39%	62%	8%
2016 National Average	38%	44%	61%	*n/a*

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
2017 October	FY17	FY17	FY17	FY17
854,942	$1.51	$301	$1.27	$468
2016 October 884,735	FY16 $1.51	FY16 $317	FY16 $1.03	FY15 $533

*Total Medicaid enrollment, managed care and FFS. Source: Medicaid enrollment reports. Expenditures are HSD capitation payments, not the actual MCO expenditures. Source: HSD Medicaid projection, 11/15/17.

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 FY18, physical health costs are projected to increase by 0.7 percent for the Centennial Care base population, and decrease by 0.3 percent for the expansion population. This time last year, HSD was projecting 4 and 5 percent increases, respectively; estimates are reduced now due to projected decreases in enrollment.

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 few exceptions where the state on average, or an individual MCO, exceeds the NCQA Medicaid benchmark. Green arrows indicate improvement from last year, while red arrows indicate declining performance.

One important measure not included in the chart is lead screening for children. The Center for Medicare and Medicaid Services (CMS) requires that all Medicaid-eligible children be screened for lead in their blood when they are one and two years old. New Mexico is far from reaching this requirement but has seen some improvement over the last year: in 2015, an average of 30 percent of children were tested; in 2016, the number increased to almost 36 percent. NCQA national average for 2015 was 67 percent.

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**
2016 New Mexico	79% ↑	61% ↑	70% ↓	88% ↓
2015 New Mexico	76%	53%	83%	89%
2016 National Average	80%	70%	71%	89%
MCO with best rating	PHP 83%	Molina 62%	PHP 72%	UHC 89%
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**
2016 New Mexico	48% ↑	54%	43%	29% ↑
2015 New Mexico	50%	54%	44%	27%
2016 National Average	43%	56%	66%	35%
MCO with best rating	Molina 41%	Molina 58%	Molina 65%	UHC 41%
Access to Care	**Children ages 1 – 6 years with access to primary care**	**Adults with access to preventive & ambulatory care**	**Women receiving at least 81% of recommended prenatal visits**	**Women receiving timely postpartum care**
2016 New Mexico	84%	76% ↓	56% ↑	58% ↑
2015 New Mexico	85%	78%	46%	51%
2016 National Average	91%	80%	58%	64%
MCO with best rating	Molina 91%	PHP 79%	Molina 57%	PHP 59.5%

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
CY16	FY17	CY16	FY17	FY17
14%	$457.8	47%	$40	$54
CY15 14%	FY16 $442.3	CY15 42%	FY16 $34.4	FY16 $55

Source for dollar amounts: HSD Medicaid projection, 11/15/17. Expenditures are for combined base and expansion population and represent HSD capitation payments, not the actual MCO expenditures. HSD projections provide a single PMPM for behavioral health and do not provide a PMPM for expansion behavioral health. Source for percent of population: CC: MCO utilization reports; FFS: Medicaid enrollment reports, 12/15 and 12/16, and BHC Performance Report FY17 annual.

Spending on the Centennial Care behavioral health program increased by approximately 3.5 percent between FY16 and FY17, with the largest proportion of the increase going to behavioral health services for the expansion population; expenditures on the expansion cohort have increased from 23 percent of total costs in FY16 to a projected 26 percent in FY18. Behavioral health expenditures are projected to decrease by 2.5 percent for FY18, reflecting anticipated lower enrollment in both the base and expansion populations.

In the context of on-going concerns about the stability of New Mexico's network of behavioral health providers, one way to measure access is as a ratio of MCO providers to members, which for the first quarter of CY17 ranged from one MCO with one behavioral health provider for every 52 members to another MCO with one provider for every 127 members.

The effectiveness of care measures below are drawn from 2016 HEDIS reports from the Centennial Care MCOs, and therefore include only managed care recipients. New Mexico has one of the highest substance abuse rates in the country, so it is notable that the state is slightly better than the national averages for initiation and engagement in substance abuse treatment, but unfortunate that New Mexico rates for both remain stagnant. Objective outcome measures for behavioral health services can be difficult to determine and HSD does not report any such measures. However, the annual consumer satisfaction report includes several questions regarding recipients' perspectives on improved functioning and satisfaction. The state scored lower than the national average on measures of access and general satisfaction for both adults and children, but at or higher than the national average for other measures including improved outcomes and social connectedness.

Effectiveness of Care	**Children with ADHD who had one follow-up visit within 30 days after first prescription**	**Children with ADHD who remained on medication for at least 210 days and had at least two follow-up visits**	**Members with alcohol and other drug dependence (AOD) who initiate treatment within 14 days of diagnosis[1]**	**Members with AOD who had two or more follow-up services within 30 days of initiation[1]**
2016 New Mexico	50%	62%	39% ↑	14%
2015 New Mexico	50%	62%	38%	14%
2016 National Average	44%	55%	41%	13%

[1]UHC did not report 2015 data for these measures.

Access to Care	**Behavioral health practitioners**	**Behavioral health facilities**	**Total behavioral health providers**	**MCO with highest ratio of behavioral health providers to members**
2017 *(1st quarter)*	9,365	1,225	10,590	BCBS 1:52
2016 *(1st quarter)*	10,131	1,310	11,441	PHP 1:46

Source: MCO network adequacy reports; CY17 Q1 is most recent available from HSD. MCO enrollment from March 2017 (end of Q1) enrollment reports.

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**
2016	86%	84%	72%	77%
2015	88%	87%	74%	79%
2016 US Average	88%	88%	74%	73%

Source: 2016 and 2017 BH Consumer Satisfaction Surveys (report data collected during prior calendar year).

Long Term Services and Supports

Centennial Care Average Quarterly Enrollment	Total Expenditures *(in billions)*[1]	Centennial Care Average Quarterly PMPM
FY17	FY17	FY17
49,651	$1.41	$1,766
FY16 48,375	FY16 $1.42	FY16 $1,807

[1]Expenditures include spending for the developmentally disabled, medically fragile, and Mi Via waivers, as well as Centennial Care LTSS.
Source: HSD Medicaid projection, 11/15/17.

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 $28 thousand. In FY17, the average quarterly per member per month (PMPM) cost for LTSS recipients was $1,766, compared to a physical health average of only $301 PMPM for the Medicaid base population and $468 for the expansion population. The biggest cost drivers for long-term services remain personal care services and nursing facilities. Spending on the LTSS program decreased by just under 1 percent from FY16 to FY17, but is projected to increase by approximately 1.4 percent for FY18.

LTSS expenditures continue to grow more quickly than enrollment. For FY18, HSD projects a 2.5 percent drop in enrollment for LTSS, driven by the closure earlier this year of approximately 800 cases where individuals lost their federally-determined eligibility for supplemental security income (SSI). The relatively smaller decline in the LTSS population, compared to other Medicaid categories, is of some concern, given that LTSS per person expenditures are higher and CY19 MCO payment rates were developed using older projections of the expected proportions of LTSS and other population groups. For FY19, the department expects LTSS enrollment to rise between 2 and 3 percent. The population mix for Medicaid appears to be shifting, with potentially more high-cost LTSS recipients and fewer less-expensive recipients in other categories; if it materializes, this shift would pose clear challenges for the program.

As noted in the last Medicaid Accountability Report, HSD shifted all three of the LTSS quarterly performance measures to annual reporting for FY17 and discontinued them entirely for FY18. One of the discontinued measures, the number of Medicaid recipients who receive services in the community after transitioning from a nursing facility, will be replaced by a new measure, the percent of recipients with a nursing facility level of care who are being served in the community. HSD discontinued the other two measures because it felt they did not accurately reflect the program's performance. If the discontinued measures were flawed, however, the fact that HSD has not yet identified more appropriate replacement measures leaves this important and costly program with a single new measure for which the LFC will have no longitudinal data. There is on-going national discussion about appropriate measures for LTSS, and HSD reports that it is participating in that discussion.

LTSS Quality Measures	Recipients who transition from nursing facilities and are served and maintained with community-based services for six months *(Discontinued for FY18)*	Recipients receiving LTSS services within 90 days of eligibility *(Discontinued for FY18)*	Identified fall risk patients 65 and older who received intervention *(Discontinued for FY18)*
2016	124	86%	22%
2015	72	98%	16%
2015 National Avgerage	*Not a HEDIS measure*	*Not a HEDIS measure*	54%[1]

[1] NCQA does not have a Medicaid benchmark for this measure, 54% is the national Medicare average.
Sources: HSD Performance Report Annual FY 2017.

Access to Care	LTC Practitioners	LTC Facilities	Total	MCO with most LTC providers
2017 *(1st quarter)*	1,613	318	1,931	BCBS = 591
2016 *(1st quarter)*	1,591	249	1,840	BCBS = 602

Source: MCO network adequacy reports; CY17 Q1 is most recent data available from HSD.

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 all recipients, particularly those with complex medical needs. Health risk assessments (HRAs) were initially required for all recipients, with annual updates for all members who were not assigned a care coordination level two or three. After two years of experience with the program, HSD determined the MCOs should focus on members who wanted and needed care coordination, rather than continuing to pursue contact with 'hard to reach' members. Centennial Care contract amendments in July 2016 reduced care coordination requirements and HRAs are now only conducted for new Medicaid enrollees and existing recipients who have a change in health status. In addition, the MCOs review overutilization and underutilization for level one members to monitor potential changes to their need for care coordination activities. Care coordination is required only for members who meet a level two or level three need.

However, while the changes reflect a reasonable reallocation of resources, all four MCOs still struggle to complete even this smaller number of HRAs in a timely manner, as the tables below show.

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 could not be contacted
2017*	555,132	35,985	3,749	24,589	62,282
2016	529,194	46,945	6,275	23,173	80,307
2015	475,232	49,307	9,497	24,774	106,112
MCO with highest proportion in CY17	Molina 36%	Molina 34%	PHP 34%	Molina 66%	Molina 47%

Source: HSD MCO utilization reports: 2015 and 2016 4th quarter, 2017 1st quarter.

Furthermore, 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 quarterly reports indicate Medicaid recipients in the higher care coordination levels are not consistently receiving more focused MCO attention. In the second quarter of CY17, the MCOs completed only an average of 61 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 36 percent to a high of 80 percent.

Care Coordination Indicators	Number of HRAs required	HRAs completed within 30 days	HRAs not completed	Reason for no HRA: Client not contacted	Reason for no HRA: Client refused or unreachable
2017*	48,526	25%	50%	45%	55%
2016	94,071	36%	45%	28%	72%
2015	116,452	34%	43%	42%	58%
2014	185,342	23%	50%	26%	74%
MCO with highest proportion in CY17	n/a	Molina 88%	UHC 74%	BCBS 73%	PHP 97%

Source: HSD MCO care coordination reports: 2014, 2015 and 2016 4th quarter, 2017 2nd quarter.

Unreachable Centennial Care members continue to make up a sizable, though decreasing, proportion of Medicaid recipients who go to the emergency room with non-emergency conditions. In the first quarter of CY17, an average of approximately 11 percent of non-emergent ER visits were made by unreachable members. This is an improvement from 15 percent in 2015 and 13 percent in 2016, the result of HSD's efforts to work with the MCOs to reduce non-emergent ER use across all populations. That said, ER use by unreachable members remains a concern, 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, as well as a cost-driver for the program. In 2017, the MCOs collaborated with various hospitals to implement the Emergency Department Information Exchange (EDIE) which notifies the MCOs when a member accesses the emergency department.