Report
to
The LEGISLATIVE FINANCE COMMITTEE

Human Services Department
Program Evaluation: Medicaid Coordination of Long-Term Services Program
February 14, 2011

Report # 11-04

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David Abbey
Director

January 28, 2011

Ms. Sidonie Squier, Secretary-Designee
Human Services Department
2009 S. Pacheco - Pollon Plaza
Santa Fe, New Mexico 87505

Ms. Retta Ward, Secretary-Designee
Aging and Long-Term Services Department
2550 Cerrillos Rd.
Santa Fe, NM 87505

Dear Secretary-Designee Squier and Secretary-Designee Ward:

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the *Medicaid- Coordination of Long-Term Services Program Evaluation.* The evaluation team assessed the Coordination of Long-Term Services (CoLTS) program's costs, performance, and state oversight of managed care organizations to ensure clients receive cost-effective, high quality services. An exit conference was conducted with Human Services Department and Aging and Long-Term Services Department staff to discuss the contents of the report. The Committee would like a plan to address the recommendations within this report within 30 days.

I believe this report addresses issues the Committee asked us to review and hope the CoLTS program benefits from our efforts. We very much appreciate the cooperation and assistance we received from the staff from each agency.

Sincerely,

David Abbey, Director

DA:CS/svb

cc: Representative Luciano "Lucky" Varela, Chairman, LFC
Senator John Arthur Smith, Vice-Chairman, LFC

Table of Contents

Page No.

EXECUTIVE SUMMARY

CoLTS was implemented to provide better care and save money.

Medicaid - CoLTS Spending FY09-FY12
(in millions)

FY09 based on partial year implementation.

* Projected
Source: HSD

In FY10, the CoLTS program cost almost $800 million, delivering services to about 37,500 elderly and disabled New Mexicans per month.

MCO administration, profit and taxes increased program costs by an estimated $68 million.

The Human Services Department (HSD) and the Aging & Long-Term Services Department (ALTSD) implemented the Coordination of Long-Term Services (CoLTS) program on August 1, 2008 to provide better care and save money. The program coordinates the financing of physical health care with long-term care services, including nursing home, community-based services, and personal care option. The state has contracted with two managed care companies to implement the program which is designed to address the following:

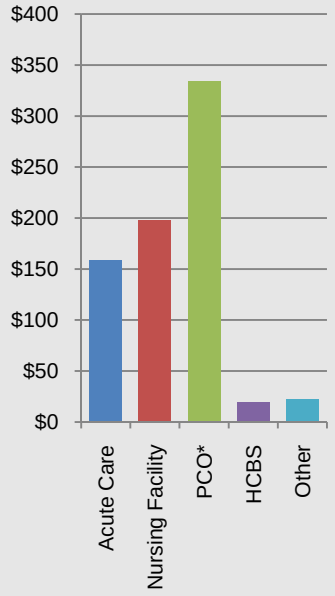
- the fragmented mix of Medicaid financed nursing home, state plan and home and community based services to certain Medicaid recipients;
- help clients delay or avoid the need for higher cost nursing home care, and
- coordinate acute care benefits for people receiving Medicaid and Medicare.

In FY10, the CoLTS program cost almost $800 million, delivering services to about 37,500 elderly and disabled New Mexicans per month. The Legislative Finance Committee program evaluation sought to assess the early implementation of this program, its costs, performance and oversight by HSD and ALTSD, and to provide a baseline analysis of services and whether they are cost-effective and high quality. A follow-up analysis of the 2009 evaluation of Medicaid Salud! was also an objective.

Overall, CoLTS holds promise for delivering better care, but costs have far outpaced original projections and continue to increase. However, the Legislature needs to play a greater role in reviewing the potential fiscal impact of Medicaid waiver and state plan changes, such as CoLTS, before their implementation. For FY12, HSD has projected spending at over $900 million, or about $110 million higher than CoLTS spending in its first full year of implementation in FY10.

The program's structure and oversight needs streamlining to ensure future affordability. A redesign of CoLTS, including consolidating state oversight at HSD, is necessary to improve the program and save money. These changes are needed to allow MCOs to seamlessly manage the full continuum of care, provide community-based services to those most at risk of nursing home placement, and change MCO capitation rate structures to ensure minor changes in services do not result in large scale costs to the state.

CoLTS Selected Service Spending FY07-FY10
(in millions)

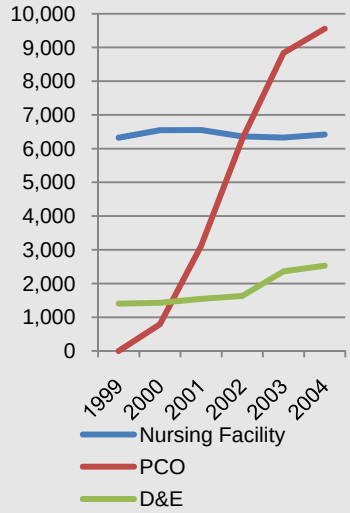


*PCO includes Home Health Services. Other category includes sub-capitations and hospice.

Source: LFC Analysis of HSD/MCO

In FY08, New Mexico ranked 1st nationally in having the most balanced long term care system.

Long-Term Care Services Avg. Enrollment



Source: HSD

<u>Growth in CoLTS spending is unsustainable; assuming no changes, costs in FY12 will be 60 percent higher than FY07</u>. In FY10, CoLTS cost taxpayers almost $800 million to deliver services to 37,500 New Mexicans. Full implementation of CoLTS in FY10 cost about $235.5 million, or about 40 percent more than FY07 spending on the same services. HSD reported spending an estimated $564.6 million on clients that would move into CoLTS in FY07. In both aggregate and per member per month, CoLTS exceeded HSD's original cost estimates to the federal government between 12 percent and 19 percent.

HSD cost projections for CoLTS have continued to climb and pose challenges for budget writers due to large fluctuations. HSD did not provide detailed cost estimates of proposed state plan changes or Medicaid waivers to LFC to review their potential fiscal impact.

Cost increases appear driven by growth in the use of personal care option services (PCO), changes in enrollment, and new costs associated with managed care. Increased spending on services was likely with or without CoLTS but questions remain whether managed care will in fact be able to effectively control these increases. Since FY07, total PCO spending has increased 35 percent to $334 million in FY10 and continues to cause cost pressures for Medicaid. However, the estimated savings from using a managed care model were insufficient to cover the new managed care organization (MCO) administration, profit and taxes and increased program costs by an estimated $68 million.

In FY09, enrollment in CoLTS exceeded projections by about 26 percent, or 6,800 clients per month, including in client groups with higher per member per month rates. Likewise, the FY10 projection experienced a $42 million increase during the fiscal year. Overall enrollment stabilized in FY10, but larger than expected growth continued in expensive client groups and underperformed in inexpensive "healthy" client groups. The wide disparity in rates between healthy and other groups may create an incentive for movement of clients into a nursing facility level of care, which can include minimal service levels delivered through the personal care option.

New Mexico has been a national leader in providing Medicaid community-based services as an alternative to nursing homes, prior to CoLTS. In FY08, New Mexico ranked 1st nationally in having the most balanced long term care system. However, the state has made clear its intention to further "rebalance" the system away from nursing home care and thus continue the decline in Medicaid financed nursing home care by helping people move back into the community through managed care CoLTS. Studies indicate that community-based services, such as personal care option (PCO), are only cost effective if they truly help avoid nursing facility placement.

Since FY07, total PCO spending has increased 35 percent to $334 million in FY10.

Central to managed care is the ability to ensure clients receive the right care, in the right amounts and at the right time.

The CoLTS program operates under a maze of federal and state regulations and two federal waivers that complicate efficient management of care.

Community-based services, such as personal care option (PCO), are only cost effective if they truly help avoid nursing facility placement.

CoLTS' multiple waivers & programs complicate cost-effective managed care; state oversight needs streamlining. Central to managed care is the ability to ensure clients receive the right care, in the right amounts and at the right time. However, the CoLTS program operates under a maze of federal and state regulations and two federal waivers that complicate efficient management of care. The CoLTS c waiver services (formerly D&E waiver) maintain a structure that hampers efficient use of resources toward high risk Medicaid clients.

Growth in PCO enrollment and spending necessitates a total reevaluation of the service's role within the system, its delivery structure and unit cost, and implementation of more aggressive options to contain spending. Other states with PCO and support services have structured their programs differently, including using individual spending caps, operating PCO under a waiver to allow better cost controls, and offering a more limited benefit.

Fragmented state oversight between HSD and ALTSD unnecessarily complicates the CoLTS program. While ALTSD has taken a more public role in promoting CoLTS, the actual program budget, contract and program management resides in HSD. In fact, per federal requirements HSD must not only oversee MCO performance, but also ALTSD. This level of complexity is not necessary, nor affordable. As such, oversight should be concentrated in HSD.

HSD has made progress implementing previous LFC Medicaid Salud! recommendations, resulting in tens of millions in savings. HSD has implemented, or is in the process of implementing, almost 80 percent of significant recommendations. HSD disagreed with the previous LFC report that over a three year period $107 million in managed care savings had accrued to Salud! MCOs that should be returned to the state. However, HSD has reduced rates to the lower end of the actuarial rate range, and has realized an estimated savings of $43 million in FY10. HSD anticipates further savings from implementation of other recommendations, including about $140 million from adopting new payment methodologies for outpatient hospital services.

Throughout this project HSD made available all requested information to LFC, including capitation rates, full actuarial studies and federal waiver calculations for its managed care programs. In December, the HSD notified LFC that it now considers this information public.

Key Recommendations.

Legislature

Amend state law to require HSD to submit fiscal impact reports to the Legislative Finance Committee and the Department of Finance and Administration at least 60 days prior to submitting state Medicaid plan changes or Medicaid waiver applications or amendments.

Transfer CoLTS responsibilities, $1.2 million in all funds and 13 FTE, from ALTSD to HSD through the General Appropriation Act. HSD should integrate staff within existing bureaus in the Medical Assistance Division.

Human Services Department

HSD, in its budget request to LFC and DFA, should consider enrollment increases for Medicaid waiver services, state plan changes or waivers expanding services as expansion requests. This process would require HSD to better justify the costs and benefits of major program changes or enrollment increases.

HSD should continue a managed care approach but redesign CoLTS to allow for a comprehensive system of long term care – including the following:

- consider removing PCO from a state plan service to a capped waiver, and limit enrollment and service hours;
- cap individual D&E waiver spending;
- create a new combined waiver between PCO and D&E that would provide more flexibility for service level based on need and risk for nursing home placement; and
- consider ways to further enhance the use of clients non-Medicaid financed natural supports.

GROWTH IN CoLTS SPENDING IS UNSUSTAINABLE; ASSUMING NO CHANGES, COSTS IN FY12 WILL BE 60 PERCENT HIGHER THAN FY07.

In FY10, the Medicaid Coordination of Long-Term Services managed care program cost taxpayers almost $800 million to deliver services to 37,500 New Mexicans. The Human Services Department and the Aging & Long-Term Services Department implemented the Coordination of Long-Term Services (CoLTS) program on August 1, 2008 to provide better care and save money. CoLTS is a managed care program intended to provide a seamless and coordinated array of long-term care services designed to address the following:

- the fragmented mix of Medicaid financed institutional, state plan and home and community based services to certain Medicaid recipients;
- help clients delay or avoid the need for higher cost nursing home care, and
- coordinate acute care benefits for people receiving Medicaid and Medicare.

According to HSD, the primary goal of CoLTS "is to improve the health of New Mexico Medicaid members by expanding health care choices, improving access to quality health care, increasing coordination of care, improving health outcomes, and decreasing the rate of growth in Medicaid program expenditures."

Table 1. CoLTS – Fast Facts

Monthly Average Enrollment FY09* – 24,225 (based on 11 months) FY10 – 37,565 FY11* – 38,274 (based on 7 months of data)	**Avg. Per Member Per Month (PMPM)** Cost** FY09* – $1,683 FY10 – $1,775 FY11* – $1,844
State Agencies Human Services Department – fiscal, contract management, quality assurance, oversight of ALTSD Aging & Long term Services Department – administers CoLTS c waiver (formerly D&E) and PCO, quality assurance, oversight, central registry, information and referral	**Contractors** MCOs: Amerigroup Community Care of New Mexico Inc., Evercare of New Mexico Inc. (a division of United Healthcare) Utilization Review/Eligibility Determination Contractor: Molina Healthcare Inc.
Services • Acute care – hospital, physician, prescription drugs • Home and community based services – respite, adult day care, home modifications • Nursing facility – short-term skilled nursing, long term nursing home care • Personal care option – meals, household assistance, grooming/bathing • Assisted living • Maintenance therapies • Private duty nursing • Community transition services	**Medicaid Eligibles** • Nursing home residents • Personal Care Option (PCO) participants • CoLTS c Waiver (formerly the Disabled & Elderly (D&E) Waiver) participants, • Healthy Medicare and Medicaid (dual eligible) individuals • Mi Via Waiver participants

Source: HSD.

*Represents eight months during FY09 and seven months of data for FY11**.** **PMPM represents a weighted average.

New Mexico has been a national leader in providing Medicaid community-based services as an alternative to nursing homes, prior to CoLTS. In FY08, New Mexico ranked 1st nationally in having the most balanced long term care system, spending the highest proportion of long-term care funding on community-based services, according to the Hilltop Institute. In addition, AARP identified the state as having "one of the most balanced LTC systems for older people and adults with disabilities in the nation."

Between FY99 and FY04, HSD reported a 136 percent increase in people receiving long-term care services through the state's Medicaid program. Expenditures on these services increased during this time period 186 percent, from $177 million to more than $505 million. These increases in clients and expenditures were primarily due to the expansion of Medicaid community-based services, including implementation of personal care option services (PCO), which provide support for personal care and household tasks. Between FY00 and FY04, the average number of people in nursing homes funded by Medicaid decreased by 131. By FY04, the number of people receiving PCO had increased to more than 9,500, far in excess of those in nursing homes.

However, Medicaid could experience explosive spending increases on long-term care services given New Mexico's projected demographic shifts towards more aged people eligible for services. Theoretically, the use of managed care through CoLTS will help ensure the growing Medicaid population is steered towards lower cost community-based services first, and delay or possibly avoid the need for extended nursing home stays. In addition, the state has made clear its intention to further "rebalance" the system away from nursing home care and thus continue the decline in Medicaid financed nursing home care by helping people move back into the community. The state, through either HSD or ALTSD, have yet to quantify or set goals for the "right size" of Medicaid financed nursing home beds or how many people are currently inappropriately placed in nursing homes.

HSD has designed the managed care rate structure specifically to encourage the two managed care organizations (MCOs) to steer clients to lower cost community services as opposed to nursing facility care. Almost all of the services provided through CoLTS previously were provided through the Medicaid fee-for-service portion of the program. Some clients did receive acute care services through the Salud! program.

Further, the state anticipated opportunities to curb spending on people dually-enrolled in Medicaid and Medicare. Nationally, this population poses challenges on how best to coordinate acute care, paid predominately by Medicare, and long term care, financed by state Medicaid programs. Often spiraling costs begin with a Medicare financed hospital stay followed by skilled nursing care, but a long-term nursing facility stay may ensue if services to transition the person back into their home are not available through Medicaid. However, the federal government financing rules for Medicaid limit the use of community-based services and favor institutional care – which is an entitlement. According to the Hilltop Institute, Medicare and Medicaid administrators accuse each others' programs of cost shifting as a result of this dilemma.

Managed care companies have pushed to provide a fully integrated service model. The Lewin Group studied the potential benefits of this arrangement and found much of the early cost savings would accrue to the Medicare program, while state Medicaid programs would experience

near term cost increases. New Mexico started implementation of CoLTS around the time of this report's release, but estimated cost increases to the state were not included in the report.

Full implementation of CoLTS in FY10 cost about $235.5 million, or about 40 percent more than FY07 spending on the same services. HSD reported spending an estimated $564.6 million on clients that would move into CoLTS in FY07. These clients received services mostly through the fee-for-service program, but also Salud!, the primary physical health managed care program. HSD used these baseline costs to develop program cost projections for FY10. The total projected spending for FY10 increased to $793 million, and the department reported actual spending at about $799 million. The total spending amounts were the cost of the program for Medicaid and do not reflect the actual service or administrative overhead cost experience for the MCOs. These data reflect the underlying assumptions for building capitation rates and funding needs from the Legislature.

An estimated $83 million of the projected program spending increase was for enrollment and programmatic changes, such as state-authorized provider fee increases for nursing homes. For example, HSD projected increases in PCO clients between FY07-FY10 of about 26 percent. The estimated increase also included adjustments made in the amount of about $16.5 million due to underreporting of Medicaid Salud! encounter data for clients that would move into the CoLTS program. Another $71.5 million of the increase was from projected increases in medical costs, either fees paid or the amount of services used.

Table 2. CoLTS – Estimated Cost Increases
FY07 Baseline - FY10 Full Implementation

Enrollment/Program Changes/Data Adjustments	$83,382,173
Medical Spending & Utilization Trend Estimate	$71,551,430
MCO Overhead	$68,037,416
Mi Via	$6,327,357
Capitation Payments Above Projections	$5,174,582
Total Estimate	$234,472,958

Source: LFC Analysis of HSD – Actuarial Estimates

Assumptions for building capitation rates included a net increase cost to Medicaid for CoLTS overhead of about 10.5 percent or an estimated $68 to $71 million. HSD assumed the net effect of estimated savings from managed care were insufficient to offset new overhead costs of MCOs, including premium taxes and assessments for the New Mexico Medical Insurance Pool. As a result, an estimated $68 million in increased costs were built into the capitation rate estimates for MCOs overhead.

In addition, reviewing HSD projections that are used to develop the Medicaid budget show about a $71 million difference between the adjustments HSD was making to reduce other services that would be moved into the new CoLTS program over FY09 and FY10. HSD moved about $685 million from other parts of the Medicaid program into the new CoLTS projection. The total CoLTS projection in May 2009 right before full implementation was $756 million.

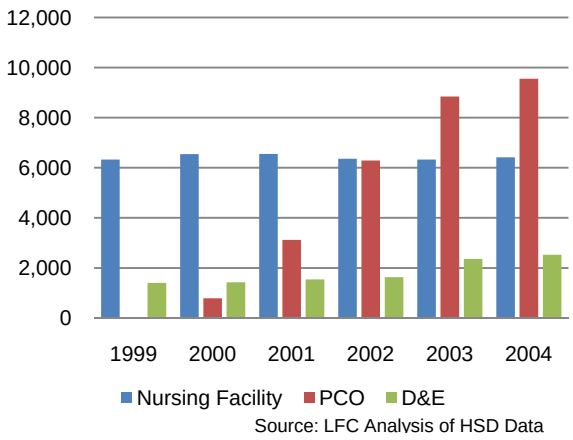
Some of these increased overhead costs from CoLTS do return to the state general fund in the form of premium taxes. And having another MCO paying NMMIP assessments offsets some of the Medicaid liability paid by other MCOs, which HSD appears to have taken credit for, into the other managed care rate development process.

Another cost item to be further analyzed is the expense paid to MCO parent companies for services related to administration of their managed care programs, including CoLTS. In calendar year 2009, Evercare reported paying $17.2 million and Amerigroup paid $18.8 million to their respective parents for these administrative services. These expenses are not negotiated within the CoLTS contract, yet represent between 34 percent and 47 percent of all administrative expenses for the MCOs. LFC recommends including negotiation of these expenses as part of the total administration charge for the program.

Beyond cost, efficiencies related to claims processing and timely payment need to be analyzed. Currently, MCO reporting on claims processing focuses solely on percentage of claims processed. Reporting should go further to indicate when claims were initially received, and how many times they were rejected back to providers before being processed. Most importantly, tracking the time interval from when a claim is received to when payment is remitted to the provider should be a key performance metric for MCOs. Currently, this data is not being reported to HSD.

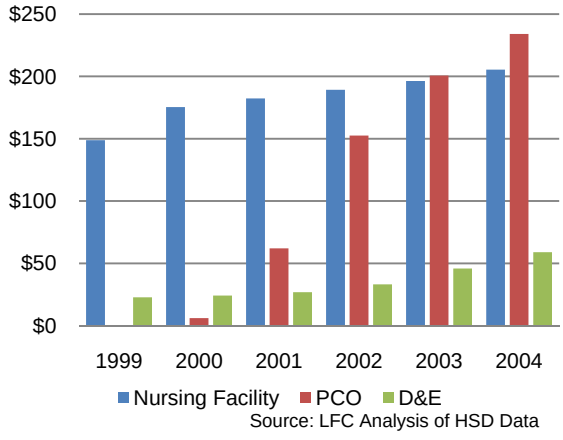
Trends for this Medicaid population were increasing with or without managed care and moderating these increases, while ensuring better outcomes from coordinated care, is the promise of CoLTS. Much of the pre-CoLTS increases were due to implementation of PCO as an entitlement Medicaid state plan amendment. This represented a significant expansion of community-based alternatives to institutional care, assuming that people would have otherwise ended up in a nursing home without the service. Enrollment and spending on community-based services (PCO and D&E) far outpaced nursing homes between FY99 and FY04, according to HSD.

Graph 1. Long-Term Care Services Avg. Enrollment by Service



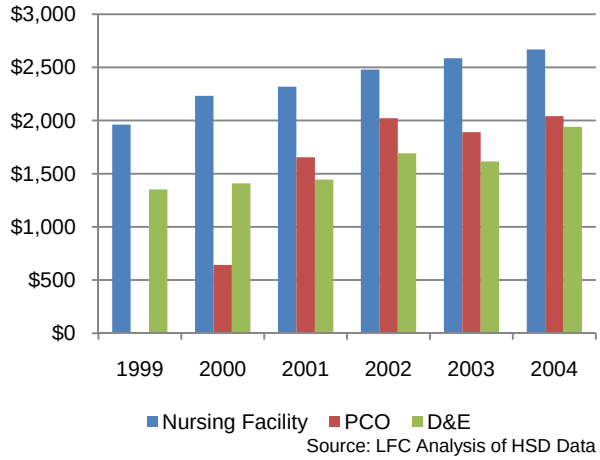
Source: LFC Analysis of HSD Data

Graph 2. Long-Term Care Services Spending
(in millions)



Source: LFC Analysis of HSD Data

Graph 3. Long-Term Care Services Per Member Per Month Expense



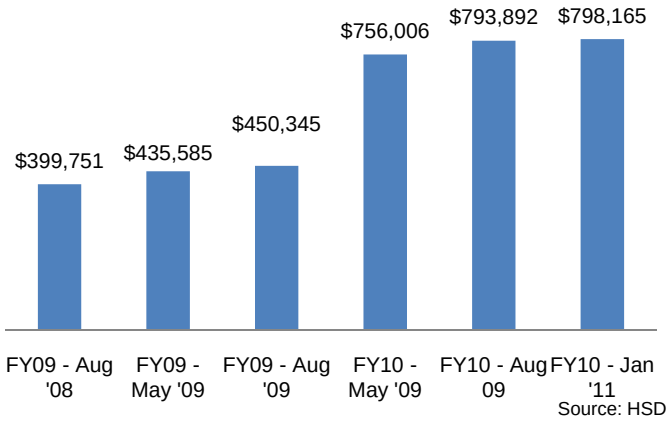
Source: LFC Analysis of HSD Data

A Hilltop Institute report found that home and community-based services in Maryland's Medicaid program cost significantly more than Medicaid costs for similarly situated clients not receiving services, but far less than nursing home care. According to the report, community-based services are only cost effective if they truly help avoid nursing facility placement. This points to a need to ensure a robust screening and assessment process that awards slots based on risk of nursing home placement, not first-come-first-served. According to ALTSD, before CoLTS, about 33 percent of people on the waiting list for D&E waivers services are actually eligible for the program, and about 23 percent already receive some other Medicaid services, including nine percent receiving PCO.

Costs have continued to increase under CoLTS, as have projected costs, which are not sustainable. HSD cost projections for CoLTS have continued to climb and pose challenges for budget writers due to large fluctuations. Initial cost estimates for the first year of CoLTS showed an increase from almost $400 million to over $450 million, an almost 13 percent increase from program implementation, based on a partial year of expenses. In FY09, actual enrollment in CoLTS exceeded projections by about 26 percent, or 6,800 clients per month. Much of this increase occurred in client groups with higher per member per month rates.

Likewise, the FY10 projection experienced a $42 million increase during the fiscal year. While overall enrollment stabilized in FY10, larger than expected growth continued in expensive client groups and underperformed in inexpensive "healthy" client groups. For example, there were about 500 fewer healthy clients per month less than projected. These clients cost the state about $180 per month in FY10 and the lower enrollment resulted in estimated savings of about $1 million. By comparison, clients meeting a nursing facility level of care exceeded projections by almost 460 per month. These clients cost the state almost $3,150 per month, and accounted for an estimated $17.5 million in additional capitations payments. This wide disparity in rates may create an incentive for movement of clients into a nursing facility level of care, which can include minimal service levels delivered through the personal care option.

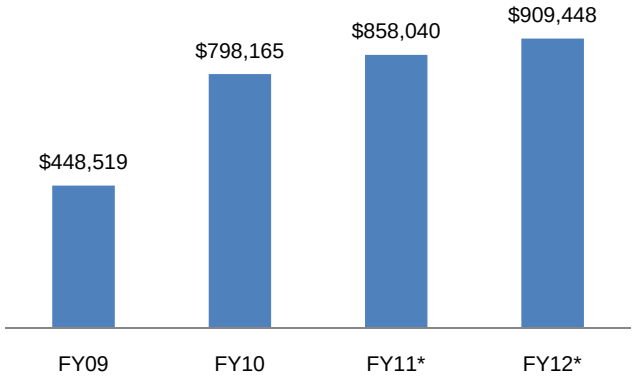
Graph 4. CoLTS - Cost Projection Changes
FY09-FY10
(in thousands)



Source: HSD

According to the most recent Medicaid projections, CoLTS spending will top out at about $858 million in FY11 and almost $910 million in FY12. Assuming no changes, spending will have increased over 60 percent for this group of Medicaid clients in five years (FY07-FY12). An estimated $128 million of the FY12 projected cost would be available for MCO administration, profit and taxes.

Graph 5. Medicaid - CoLTS Spending
FY09-FY12
(in thousands)



* Projected

Source: HSD

Costs have increased beyond the state's original federal waiver projections required to demonstrate cost effectiveness. CoLTS operates under a Medicaid waiver to implement a managed care model of services. The federal waiver requires Medicaid to project future costs of the program and monitor whether the state achieves expenditures within those projected costs. In both aggregate and per member per month terms, the CoLTS program exceeded HSD's original cost estimates by between 12 percent and 19 percent. The federal waivers no longer require states to demonstrate whether managed care costs less than fee-for-service and, as such, HSD does not perform this analysis. Again, services now provided through CoLTS were

increasing in cost prior to the program, but questions remain whether managed care will in fact be able to effectively control these increases.

Table 3. CoLTS
Projected versus Actual Costs

	Projected Original	Actual
FY09	$382,050,132	$448,497,185
FY10	$699,461,187	$799,050,887

Source: Projected figures from HSD CoLTS (b) and (c) waiver - Appendix D, 2008. Actual from HSD.

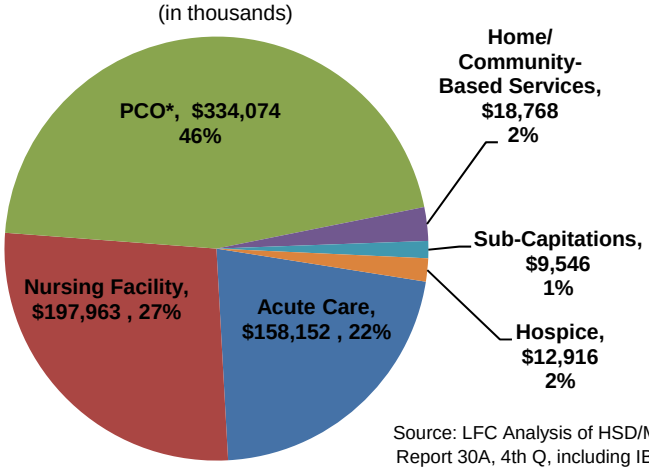
Table 4. CoLTS
PMPM Cost Effectiveness

	Projected-Original	Actual
FY09	$ 1,519	$1,683
FY10	$ 1,548	$1,775

Source: Projected figures from HSD CoLTS (b) and (c) waiver - Appendix D, 2008
Actual from HSD-MAD

Spending on services by MCOs has continued to increase under CoLTS, primarily driven by PCO. Spending on medical services for FY10 topped $732 million. The largest cost category is PCO and home health services at over $334 million, followed by home and community-based services and nursing facilities. Medical costs increased about $96 million, or 16 percent, from FY08 spending of $636 million. These increases in spending are likely to result in higher future capitation rates due to federal rate guidelines.

Graph 6. CoLTS - FY10 Services Spending
Total: $732 million
(in thousands)



Source: LFC Analysis of HSD/MCO Report 30A, 4th Q, including IBNR.

[1]

[1] Acute Care Services category includes inpatient, outpatient, physician, therapy, pharmacy, dental and vision, clinic, and transportation service categories.

Major cost drivers between pre-CoLTS and the program's first full year of implementation include PCO, nursing facilities, and inpatient hospital. However, PMPM costs in virtually all service categories and across all member cohorts increased. While utilization in some major categories of service, including PCO, appears to drop off at the end of FY10, these cost increases will continue to place additional burden on the state as more New Mexicans become eligible to receive services. The CoLTS program differs from Salud!, where in almost all cases, once a client is enrolled into CoLTS, they will continue to utilize services in some capacity until death. So while utilization of certain services can be reduced in the early years of the program, this trend may level off once the member has achieved a best case scenario health outcome, where they will remain for the duration of their time in the CoLTS program. Therefore, primary variables to minimize spending growth in the program include provider costs, service coordination costs, and administration costs. Continued attention to provider rates, as well as overhead at the MCOs, would allow the state greater control over costs of the CoLTS program.

PCO spending, at $334 million in FY10, continues to increase and cause cost pressures for Medicaid. Aggregate costs, as well as PMPM costs for PCO, have been increasing since FY07. Figures for PCO in this report have been adjusted from those reported by MCOs to include the home health category from their medical cost reports submitted to HSD. This adjustment was made to fully account for PCO providers hired by clients directly, as well as PCO services delivered by home health agencies, and could change after HSD reviews MCO cost reports.

PCO cost increases do not appear to be the result of changes in what was formerly the D&E waiver. PCO is both a service category and a discrete sub-population of Medicaid recipients. As part of CoLTS implementation, the state revamped parts of the previous D&E waiver. Specifically, the D&E waiver used to pay for homemaker services, which were similar to PCO. However, the current waiver, CoLTS c, eliminated homemaker services and in its place, the state made PCO services available to waiver clients. Spending on PCO services for D&E clients decreased under CoLTS by almost eight percent relative to FY08.

D&E equivalent waiver costs under CoLTS appear to have declined, even after adding PCO expenditures, compared to baseline spending in FY08. This may be due to enrollment restrictions as the reported number of people covered has declined slightly.

Table 5. PCO/Homemaker Expenditures FY07-FY10

	FY07	FY08	FY10	Change FY08-FY10
PCO – Only^	$200,142,667	$231,306,692	$275,893,932	38%
PCO - D&E*	$46,823,914	$58,777,684	$54,244,118	16%
PCO-Other	-	-	$3,935,721	
Total PCO	$246,966,581	$290,084,376	$334,073,771	35%

Source: HSD

*Homemaker Services in FY07/FY08. FY07/FY08 from MMIS. FY10 as reported by MCOs, including IBNR.

^Includes adjustment for MCO reporting in FY10 to include PCO and home health expenditures. Home health spending totaled less than $1.5 million in FY07 and FY08.

Table 6. CoLTS c (formerly D&E) Waiver Expenditures, Including Homemaker/PCO
FY07-FY10

Year	Member Months	D&E Waiver Expenditures	Avg. PMPM
FY07	35,159	$58,636,823	$1,667.76
FY08	38,748	$73,149,271	$1,887.82
FY10	32,005	$66,718,529	$2,084.64

Source: HSD
FY10 includes PCO expenditures on CoLTS c (formerly D&E) clients.
FY07-FY08 Data from MMIS. FY10 as reported by MCOs, including IBNR

Another primary service category of the CoLTS program is long term care facilities (LTC), accounting for $198 million of total program dollars. This would include private and state inpatient nursing facilities as well as skilled nursing facilities (SNFs.) Looking specifically at LTC facilities, costs continue to increase in this category, up 27 percent from FY09 to FY10. When broken down into a PMPM total to account for changes in utilization, the cost increased 21.7 percent, indicating again in this category that increases are being fueled by service costs as opposed to increased utilization. In fact, LTC facility utilization has decreased an average of 46 percent from FY09 to FY10.

HSD has not regularly provided detailed cost estimates of proposed state plan changes or Medicaid waivers to the Legislative Finance Committee or the legislature to review their potential fiscal impact. State plan amendments do not require statutory change and thus circumvent the normal process for the Legislature to weigh in on major policy changes and assess their fiscal impact. In addition, implementation of CoLTS was not considered a program expansion during the budget development, despite the addition of new costs to the Medicaid program in the form of managed care.

Given the appropriation pattern for Medicaid, the Legislature is further limited in its ability to prioritize among competing services within the program due to its block grant nature. An effort was made to break up Medicaid appropriations for FY10, but it has not been continued due to complaints over administrative reporting problems by HSD.

RECOMMENDATIONS

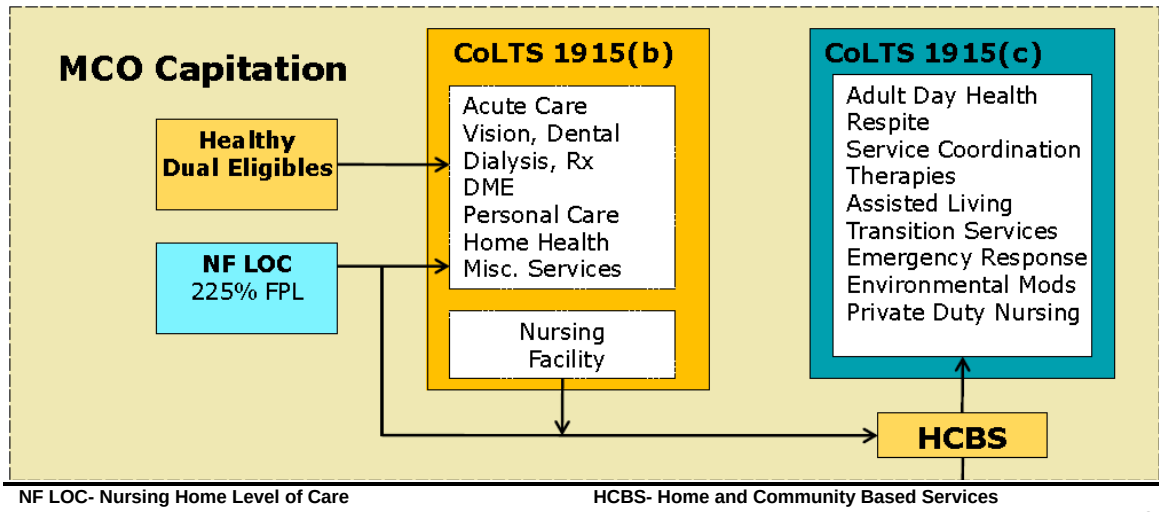
The Legislature should consider requiring HSD to submit fiscal impact reports to the Legislative Finance Committee and the Department of Finance and Administration at least 60 days prior to submitting state Medicaid plan changes or Medicaid waiver applications or amendments.

HSD, in its budget request to LFC and DFA, should consider enrollment increases for Medicaid waiver services, state plan changes or waivers expanding services as expansion requests. This process would require HSD to better justify the costs and benefits of major program changes or enrollment increases.

CoLTS' MULTIPLE WAIVERS & PROGRAMS COMPLICATE COST-EFFECTIVE MANAGED CARE; STATE OVERSIGHT NEEDS STREAMLINING.

The CoLTS program operates under a maze of federal and state regulations and two federal waivers that complicate efficient management of care. Central to managed care is the ability to ensure clients receive the right care, in the right amounts and at the right time. CoLTS operates under two separate waivers, requiring separate reporting and oversight requirements, in addition to various optional state plan services. Some long term services are capped (CoLTS c waiver), while others are entitlement-based (PCO), which makes management of enrollment and cost challenging. For example, a client may need only one D&E waiver (CoLTS c) service to significantly reduce the risk of nursing home placement. But because that program's enrollment is capped, unless the person goes into the nursing home, then the MCO cannot provide the service. In addition, multiple state agencies overseeing the same MCOs and services further complicates the program and adds unnecessary administrative costs.

Exhibit 1.



NF LOC- Nursing Home Level of Care HCBS- Home and Community Based Services

Source: HSD

The CoLTS c waiver (formerly D&E waiver) maintain a structure that hampers efficient use of resources toward high risk Medicaid clients. The D&E waiver structure, brought into the CoLTS program as the CoLTS c waiver, provides a range of home and community based services to help keep people in the community, including respite, adult day care and home modifications. The program has an enrollment and total spending cap. In FY10, the spending cap was about $61.6 million.

Total spending, excluding Mi Via clients, increased 56 percent between FY06-FY08, from about $47 to $73 million. This increase was primarily driven by the use of homemakers services, similar to PCO, within the D&E waiver. In FY09, the state transitioned into a new CoLTS c waiver, which excluded homemaker/PCO services from the waiver and instead made those available through the traditional PCO state plan services.

Table 7. CoLTS c (formerly Disabled and Elderly Waiver) [1]

Fiscal Year	Traditional Waiver Expenses	Homemaker/PCO	Unduplicated Clients Served
SFY06	$13,444,800	$34,012,701	2,831
SFY07	$16,001,893	$43,647,629	3,542
SFY08	$19,023,557	$54,959,076	2,727
SFY09 [2]	$26,361,700	$42,600,268 [4]	2,712
SFY10 [3]	$9,486,187	$43,670,502 [4]	2,318

Source: HSD/ALTSD NM MMIS Data Warehouse. 1 Includes admin costs, excludes Homemaker/PCO & Mi Via. 2 Based on claims through 10/2010 and average of unduplicated clients between FFS/MCO. 3 MCO reported encounters through 1/3/11.4. PCO services not included in waiver expenses in FY10 and partial FY09.

The highest spending category of the D&E waiver, homemaker services, has been moved out of the CoLTS program, and now these clients can access comprehensive PCO services instead. This waiver change created a significant void in available service dollars, without a corresponding increase in enrollment. For example, HSD projected waiver spending for FY10 to be about $61.6 million in its federal waiver. However, MCOs reported spending about $9.5 million on D&E waiver equivalent services under CoLTS. Some of these expenditure differences could have been used for MCO overhead and service coordination since the total authorized waiver amount of $61.6 million was intended to cover capitation payments to MCOs. Again, in FY10 PCO services are not part of the CoLTS c authorized expenditure levels under the federal waiver.

There are no spending caps for individual clients, resulting in some clients costing far in excess of nursing home care. For example, before implementation of CoLTS in FY07, 86 D&E clients had waiver expenditures in excess of average nursing home care. Per person nursing home costs in FY07 were $40,437. Most clients with expenditures in excess of nursing home costs had D&E expenditures between $40 thousand and $50 thousand. Another 16 had expenditures between $60-$99 thousand and five in excess of $100 thousand. One client had D&E expenditures totaling almost $268 thousand. In all, these 86 clients accounted for about $4.75 million in D&E expenditures, not including other Medicaid costs, or about eight percent of the $58.4 million in total D&E expenditures. In total, 3,548 individuals had at least one service in FY07. However, most of the 3,548 clients were not enrolled for the entire 12-month fiscal year; over 1,200 had expenditures less than $10 thousand. Further study should focus on the average cost per person with a 12-month fully enrolled experience for FY10.

Growth in PCO enrollment and spending necessitates a total reevaluation of the service's role within the system, its delivery structure and unit cost, and implementation of more aggressive options to contain spending. PCO is one of several community services central to the CoLTS program, as a primary goal of the program is keep participants in their homes as members of the community. PCO is an entitlement benefit as part of the Medicaid state plan, unlike the CoLTS c waiver, which has total spending and enrollment caps. Any fully Medicaid eligible person over twenty-one years of age who meets the nursing facility level of care requirement, and requires assistance with two or more activities of daily living (ADL), can access personal care option services. PCO provides services ranging from assistance with

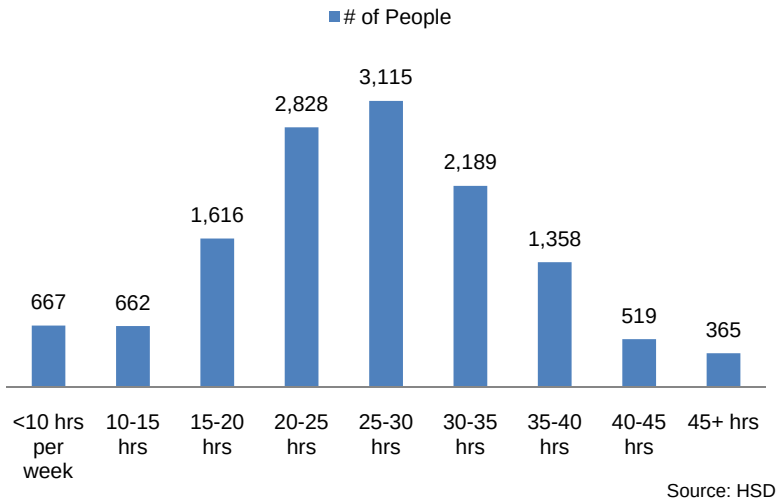
household tasks such as cooking and cleaning to personal care services such as bathing and feeding.

The structure of PCO makes it a higher risk service for fraud and abuse. The majority of complaints in our sample of fraud referrals referenced suspicion of time sheet fraud by overbilling hours or billing for services not rendered. For example, in one case a provider billed for services while the PCO client was allegedly in jail. In another case, a provider billed for services while the provider was allegedly in jail.

State regulations define how PCO services are managed and administered, separating service delivery into two categories: consumer-delegated and consumer-directed. Both service models allow the recipient to choose a caregiver, such as a relative, friend, or neighbor. Further analysis could focus on the costs associated with operating two service models within the PCO program, as well as whether controls within both options are strong enough to prevent additional costs to the state. In addition, comparison of underlying direct provider hourly rates should be undertaken to compare regionally to ensure these base unit costs remain reasonable.

Other states with PCO and support services have structured their programs differently, including using individual spending caps, operating PCO under a waiver to allow better cost controls and offering a more limited benefit. In FY09, people accessed PCO services on average between 26-27 hours per week, according to HSD. Over 4,400 clients used the services in excess of 30 hours per week. Nine other states reviewed by HSD have limits of around 30 hours per week. If New Mexico implemented this limit, it could have saved an estimated $27 million in FY11, even assuming enrollment growth of five percent. Capping enrollment and weekly hours, which would require a new federal waiver, could save an estimated $50 million. Other options include requiring a minimum number of hours, while ensuring MCOs conduct thorough assessments of needs. Many clients using little amounts of services may not be at high risk for nursing home placement and thus add potentially unnecessary costs to the program.

Graph 7. PCO Utilization - FY09



Source: HSD

State oversight is complicated by having multiple agencies overseeing a single program and set of contractors. During the 2010 interim, extensive analysis was conducted on whether to consolidate administrative oversight over CoLTS at HSD, or keep a split responsibility among HSD and ALTSD. The LFC budget recommendation includes a reduction and consolidation of CoLTS administration and oversight at HSD. Given this program evaluation of CoLTS, the reduction and consolidation appears warranted and would streamline oversight and administration of the program.

CoLTS now includes the full continuum of Medicaid services, well beyond the historic scope of responsibility for ALTSD. The departments have not substantially updated their respective responsibilities since implementation of CoLTS. ALTSD has been responsible for administering the D&E and PCO programs, many of which are now performed by the MCOs. Other program areas are duplicative, such as having two agencies conducting activities related to federal waiver development and reporting, rulemaking and fiscal oversight, particularly given ALTSD's limited scope in the program.

Finally, fiscal and performance accountability is fragmented between the two departments, and program costs are buried in Medicaid. Each has separate performance measures for CoLTS and programs within CoLTS in the General Appropriations Act. While ALTSD has taken a more public role in promoting CoLTS, the actual budget for the program resides imbedded in the larger Medicaid block grant. This further reduces accountability to the Legislature.

In FY11, ALTSD Long-Term Services Program adjusted budget was about $8 million ($4.2 million from the general fund) with 59 FTE. Of the 59 FTE, 30 FTE work in the Elderly Disabilities Services Division in some capacity on CoLTS and related waiver services, such as Mi Via and Medicaid's program for people with traumatic brain injury. Given the duplication and overlap of administrative services between ALTSD, HSD and the MCOs not all of the 30 FTE are necessary. As a result, consolidating services at HSD would require no more than 13 FTE of the 30 FTE for an all funds cost of about $1.2 million, for an estimated all funds savings of $5.2 million. This estimate is lower than assumed in the LFC budget recommendation, which include a transfer of $1.4 million ($705 thousand from the general fund). The 13 FTE should be integrated into existing bureaus with responsibility for contract and program oversight, which would also include the Mi Via waiver and the Traumatic Brain Injury program. The remaining 29 FTE and $1.5 million in the Long-Term Services Program would move to another program in ALTSD.

Continued monitoring and focused study is needed to ensure CoLTS delivers cost effective, high quality care through a stable network of providers. HSD has a broad framework for monitoring performance and quality, and should use it to demonstrate whether coordinated care and other program elements are leading to better outcomes.

Service coordination is a key component of CoLTS, but the program lacks clear accountability around the amount of service provided, associated outcomes and cost. A main component of the CoLTS program was the addition of a broader service coordination function into the long term care system. Service coordination is carried out by the MCOs and includes needs assessments, service planning, and referral and case monitoring. Both MCOs have implemented, what appears to be a sophisticated assessment and case monitoring system. Further quality

improvement studies could focus on the value-added benefit of service coordination for clients other than traditional D&E clients and the previous case management model. Furthermore, the state does not receive specific cost or utilization data for service coordination because it is considered administrative and part of the larger overhead spending category of the MCOs.

The state has implemented performance-based contracts for CoLTS services and should soon be ready to implement pay-for-performance incentives. The state has collected baseline performance information during FY10 on a range of performance measures. Measures include emergency room visits for high risk clients, hospital readmission rates, nursing home admission rates, and community reintegration. Appendix C includes a listing of associated reported performance. However, better reporting is needed to monitor the prompt payment of providers.

Because CoLTS is somewhat unique nationally, few evidence-based measures have been developed for MCOs delivering long-term care services. However, additional measures are being studied nationally, and when available, should be integrated into the CoLTS program.

Medicaid regulations and contracts require MCOs to perform targeted performance improvement projects and quality assurance studies. These efforts provide an opportunity for the state to gather additional information on whether CoLTS is achieving its desired goals and if not, how to improve.

Vigilant monitoring is needed to ensure financial and performance data reported by MCOs is accurate. During FY09, HSD sanctioned Evercare for over $2.9 million for encounter data reporting problems. Encounter data provides claims costs and service utilization to the department for analysis, program oversight and rate setting. In addition, at the end of this evaluation, HSD expressed concerns over data accuracy of MCO financial cost and utilization reports, also used for rate making and analysis. HSD did not provide specifics on the nature of data concerns, nor a margin of error. As a result, some of the data contained in this report may need revision upon further review by HSD. LFC made adjustments to these unaudited data sets to account for clearly identified areas requiring adjustment and reviewed multiple data sets to ensure consistency. Previous LFC evaluations have expressed concern over the lack of auditing of data that will be used to determine billions in future payments to Medicaid MCOs.

RECOMMENDATIONS

HSD should continue a managed care approach but redesign CoLTS to allow for a comprehensive system of long-term care – including considering removing PCO from a state plan service to a capped waiver, limiting enrollment and service hours; capping individual D&E waiver spending; creating a new combined HCBS waiver between PCO and D&E that would provide more flexibility for service level based on need and risk for nursing home placement; and consider ways to further enhance the use of clients non-Medicaid financed natural supports.

The Legislature should transfer CoLTS responsibilities, $1.2 million in all funds and 13 FTE from ALTSD to HSD through the General Appropriation Act. HSD should integrate staff within existing bureaus in the Medical Assistance Division.

HSD HAS MADE PROGRESS IMPLEMENTING PREVIOUS LFC MEDICAID SALUD! RECOMMENDATIONS, RESULTING IN TENS OF MILLIONS IN SAVINGS.

HSD has made progress improving the Salud! program and has implemented, or is in the process of implementing, almost 80 percent of significant recommendations. Table 8 shows the implementation status of significant recommendations.

HSD disagreed with the previous LFC report that over a three year period $107 million in managed care savings had accured to Salud! MCOs and that it should be returned to the state. However, HSD has been reducing Salud! rates. By reducing rates to the lower end of the actuarial rate range, the state has realized an estimated savings of $43 million in FY10, or about 3.7 percent of total program costs for the year at $1.13 billion. Further reductions are anticipated due to implementation of other recommendations, including adopting new payment methodologies for outpatient hospital services. Full implementation of this new payment methodology, along with associated rate reductions for cost containment, is estimated to save the state about $140 million in state and federal funds across Medicaid in FY12.

Throughout this project HSD made available all requested information to LFC, including capitation rates, full actuarial studies and federal waiver calculations for its managed care programs. In December, the department notified LFC that it now considers this information public.

Table 8. Status of 2009 LFC Program Evaluation Significant Recommendations

Recommendation	Fully Implemented	Partially Implemented/ In Progress	Not Implemented
Make available to LFC information on Medicaid managed care contract rates.	HSD made available all requested data on Salud!, CoLTS, and behavioral health during this evaluation.		
Cap non-medical expenses, admin, and profit at 15%, then at 14% for FY11, and 13% for FY12.		Admin capped at 15%. Further savings realized by moving all Salud! programs to low end of actuarially sound rate range.	
Increase MCO performance-based premiums (challenge funds) to 1% in FY10 and 2% in FY11.	2009-2010 contract amended to raise performance-based premiums to 1%. Also, MCOs returned $2 million in challenge funds to HSD in 2009.		
Require MCOs to provide more data on sub-capitation arrangements with PCPs, assess whether practice and utilization patterns.		HSD requires detailed reporting on cost and utilization of sub-capitations but has not fully evaluated their use as recommended.	

Recommendation	Fully Implemented	Partially Implemented/ In Progress	Not Implemented
Transition to Medicare's payment methodology for outpatient services.	This recommendation was due to take effect in November 2010.		
Provide Medicaid clients with comparative information on MCO cost and quality.			Tabled due to lack of resources, and HSD deferred to MCO quality rankings on the department's website.
Modify the auto-assignment algorithm to steer more Medicaid members not choosing a plan to the lowest priced plans.	HSD implemented in FY09. For FY10, all rates were equal and at the low end of the allowable rate range.		
Extend Medicaid regulations requiring providers to submit claims electronically	HSD implemented by amending MCOs contracts.		
Conduct a staffing and efficiency review of MAD to determine whether staffing levels, organization, and expertise require modification to effectively oversee a changed Medicaid delivery system.			HSD responded that while it agrees with this recommendation, the department commented that they do not foresee having the available resources in the Internal Audit Bureau in the near future due to other critical functions being currently performed by the bureau.
Total Recommendations: 9	Fully Implemented: 5	Partially Implemented/ In Progress: 2	Not Implemented: 2

New Mexico Human Services Department

Susana Martinez, Governor
Sidonie Squier, Secretary-Designate

Medical Assistance Division
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Santa Fe, NM 87504-2348
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January 28, 2011

Mr. David Abbey, Director
Legislative Finance Committee
325 Don Gaspar Avenue, Suite 101
Santa Fe, New Mexico 87501

RE: HSD and ALTSD Management Response to LFC Program Evaluation Report on Coordinated Long-Term Services (CoLTS)

Dear Mr. Abbey:

The following outlines the Human Services Department's (HSD's) and Aging & Long-Term Care Department's (ALTSD's) response to the LFC staff's draft evaluation report. We have learned a great deal through this process and we agree with many of the recommendations in the draft report. With the goal of providing clarification, we offer the following information in response to data included in the report.

The State's goals for implementation of CoLTS include the following:

- Rebalance Medicaid long-term supports and services system from a primary reliance on nursing facility services to support the increased use of community-based supports and services;
- Increase coordination between Medicaid and Medicare services;
- Improve and expand coordination of acute care and community-based supports and services for all;
- Offer seamless access to a choice of culturally responsive, appropriate, and quality long-term services;
- Provide a system of services that minimizes stays in institutional settings, such as a nursing home, by increasing access to less restrictive home- and community-based services;
- Promote improved health status and quality of life and reduce dependency on institutional care;
- Use best practices from other states seeking to improve coordination and reduce fragmentation.

New Mexico has always been at the forefront of implementing new initiatives that improve quality outcomes for low-income adults receiving long-term supports and services. In fact, New Mexico was one of the original states that began putting together Medicaid waiver programs in the mid- to late 1970s. These efforts, pre-dating the establishment of CoLTS, have made a positive impact on realigning the entitlement of the core state Medicaid service for nursing home care to place greater emphasis on home and community based alternatives. New Mexico is one of only nine states in the U.S. that has implemented a managed long-term care (LTC) program, and not all of the programs in those states are statewide like New Mexico's CoLTS program.

New Mexico's CoLTS program began on August 1, 2008 with a nine month phase-in process. By April 2009 all New Mexico counties were incorporated into the CoLTS program. Therefore, FY09 data does not represent a full year of implementation. Comparisons in the LFC's draft report of gross costs for FY09 (July 2008–June 2009) to FY10 (July 2009–June 2010), the first full year of the CoLTS program, inflate the growth of the program in that the charts do not recognize the partial nature of the first year.

Prior to CoLTS, acute and LTC services were never combined into a single managed care or fee-for-service (FFS) program in New Mexico. LTC services were primarily FFS while acute care services were primarily provided through SALUD! managed care. The LFC report's comparisons of FY07 and FY08 to FY09 or FY10 are rarely applicable because Medicaid FFS and Medicaid SALUD! clients/expenses were not accurately compared to specific service areas in CoLTS. The following table provides clarification on data listed throughout the report:

Page Number/Section	Report Language	Agency Clarification
1/Intro Statement	Growth in CoLTS spending is unsustainable- assuming no changes cost in FY12 will be 60% higher than FY07	The comparison of FY07 to FY12 is not applicable because pre-CoLTS Medicaid fee-for-service and Medicaid SALUD! clients/expenses are not accurately compared.
1/Paragraph 1	In FY10, the Medicaid Coordinated Long-Term Services managed care program cost taxpayers almost $800 million to deliver services to 37,500 New Mexicans.	The number of unique New Mexicans served in FY10 is 42,915. The 37,500 enrollee figure represents average count of CoLTS member months per month during the year.
2/Paragraph 4	Almost all of the services provided through CoLTS previously were provided through the Medicaid fee-for-service portion of the program.	While we agree that the long-term care services provided through CoLTS were previously provided through Medicaid FFS, the physical health services received by many CoLTS members were provided through Medicaid SALUD! managed care as well as FFS. Because of this, when reviewing pre-CoLTS baseline expenditures, consideration needs to be given to properly identify these populations and their previous SALUD! and FFS expenditures.
3/Table 2	Total Estimate $234,472,958	From the perspective of a reader who may not be familiar with the CoLTS program, this chart may lead to the conclusion that the CoLTS program is generating $234 million more in expenditures than the prior program. Please note that many of the expenditures presented on this chart would have occurred with or without the implementation of the CoLTS program. • $83,382,173 in expenditures due to enrollment trends and program changes would still exist. • $71,551,430 in expenditures would probably be higher without the CoLTS program due to the unmanaged nature of FFS. • Managed Care Organization (MCO) overhead costs are less than the costs that would have been incurred in FFS.
3/Final Paragraph	Assumptions for building capitation rates included a net increase cost to Medicaid for CoLTS overhead of about 10.5 percent of an estimated $68 to $71 million.	Based on the information that has been shared with the LFC CoLTS evaluation team, the assumptions made by that team in this report overstate the overhead percentage. The actual overhead amount is 9.1% instead of 10.5% or an estimated $58 to $61 million.

Page Number/Section	*Report Language*	Agency Clarification
4/Paragraph 3	These expenses are not negotiated within the CoLTS contract, yet represent between 34 and 47 percent of all administrative expenses for the MCOs.	The administrative expenses are contractually limited to 15% in SFY10 and 14% in SFY 11 – this includes profit margins to the MCOs. Corporations provide marketing, billing, legal, legislative and policy services to the local operations of both MCOs.
6/Paragraph 1	Initial costs estimates for the first year of CoLTS showed an increase of from almost $400 million to over $450 million, an almost 13% increase from program implementation, based on a partial year of expenses.	The re-calibration was a budget neutral adjustment which took the equivalent money from one MCO and gave it to the other MCO. The projected budget increases were due to higher FY09 Member Months (MM) and more high need enrollees than were originally projected. Originally, 211,000 MM were estimated but approximately 266,000 MM were realized in FY09. This is not uncommon in new programs such as CoLTS.
5/Bar Graph	CoLTS – Cost Projection Changes FY09-FY10	As rates were held flat and/or slightly decreased, the growth in expenditures in FY10 was due to the full year of enrollment which occurred in FY10 after the FY09 phase-in. This is not evident in the chart.
7/Last two tables	CoLTS Table 3 and Table 4	The CoLTS program continues to meet the cost effectiveness requirements of the waiver. Comparing the original projections from 2008 and the final rates is not an "apples to apples" comparison due to waiver projection amendments and the membership mix distribution between actual and projected. In evaluating the waiver, the federal Centers for Medicare & Medicaid Services (CMS) does recognize the potential impact/distortion on the PMPM due to case mix between the projected and the actual. The revised waiver projections for FY09 and FY10 were $1,861.42 and $1,972.70 respectively (waiver dated 4/21/2010).
12/Paragraph 3	Related to D&E waiver homemaker expenditures- "This waiver change created a significant void in available service dollars, without a corresponding increase in enrollment. For example, HSD projected waiver spending for FY10 to be about $61.6 million in its federal waiver. However, MCOs reported spending about $9.5 million on D&E waiver services under CoLTS. Some of these expenditure differences could have been used for MCO overhead and service coordination since the total authorized waiver amount of $61.6 million was intended to cover capitation payments to MCOs."	CMS required that these services be shifted from the waiver into solely state plan PCO. Hence, the difference is a cost neutral switch in category of service expenditure (waiver to state plan), not a reduction of service expenses. D&E waiver expenditures were not available for MCO overhead. Clients who received homemaker services under the waiver now receive comparable PCO services outside of the waiver.

Page Number/Section	Report Language	Agency Clarification
13/ Paragraph 2	***The structure of PCO makes it a higher risk service for fraud and abuse.*** The majority of complaints in our sample of fraud referrals referenced suspicion of time sheet fraud by overbilling hours or billing for services not rendered.	We share these concerns and have taken proactive steps to ameliorate the associated areas. For example, the Medical Assistance Division (MAD) and the ALTSD collaborated in performing audits of all PCO providers in FY 2007-2008. As the result of those audits, a number of actions were taken to more effectively monitor personal care services. Action steps included immediate referrals to the Medicaid Fraud and Elder Abuse Division (MFEAD) of the Office of the New Mexico Attorney General who then investigated and prosecuted several of the providers referred for investigation. MFEAD continues to work with MAD in monitoring the PCO program.
16/ Paragraph 1	Previous LFC evaluations have expressed concern over the lack of auditing of data that will be used to determine billions in future payments to Medicaid MCOs.	HSD wants to audit all the MCO organizations we contract with. We are inhibited by are lack of staff to perform these functions.
18/Item 4	Requires MCO to provide more data on subcapitation arrangements with PCPs, assess whether practice and utilization patterns	HSD staffing prohibits us from doing the sub-capitations audit.
18/Item 7	Modify the auto-assignment algorithm to steer more Medicaid members not choosing a plan to the lowest price plans	The auto assignment algorithm is currently at 25% per SALUD! MCO.
Page 20/Graph		The weighted PMPM is affected by increases in member months and case mix.

Recommendation	Response
The Legislature should consider requiring HSD to submit fiscal impact reports to the LFC and DFA at least 60 days prior to submitting state Medicaid plan changes or Medicaid waiver applications or amendments.	We do not concur with this recommendation because enacting it would limit the State's ability to provide Medicaid State Plan Amendments (SPA) and Medicaid Waiver Applications/Amendments to CMS in a timely fashion and it creates unnecessary administrative burden. Also, information about SPA and Medicaid Waiver Applications/Amendments is readily available to the public and is posted on HSD's website.

Recommendation	Response
HSD should continue a managed care approach but redesign CoLTS to allow for a more comprehensive system of long-term care- including considering removing PCO from a state plan service to a capped waiver, limiting enrollment and service hours; capping individual D&E waiver spending; creating a new combined HCBS waiver between PCO and D&E that would provide more flexibility for service level based on need and risk for nursing home placement; and consider ways to further enhance the use of clients non-Medicaid financed natural supports.	The Department agrees that some LTC redesign is needed and we will explore all options mentioned in this recommendation.
The Legislature should transfer CoLTS responsibilities, $1.2 million in all funds and 13 FTE from ALTSD to HSD through the General Appropriation Act. HSD should integrate staff within existing bureaus within the Medical Assistance Division.	HSD is in agreement with this recommendation to transfer staff and resources to HSD for the CoLTS program; however bureau reorganization may be necessary to accomplish effective program management.

The growth of LTC is expected to continue due to the increasing number of older individuals with an overall increased trend of chronic conditions (obesity, high blood pressure, heart disease, and others). Both of these factors will contribute to an increase in demand for LTC services over the next 10 to 15 years. Programs such as CoLTS are designed to meet the healthcare needs and long term support of the individuals in settings outside of institutional care when possible while being cost effective. While it is too soon to quantify and understand the overall impact of the CoLTS program, there are visible indications of utilization of less expensive settings of care under the MCOs. While these initial indicators do not guarantee a positive financial impact with respect to the CoLTS program, it is evident that without such a program the State will be unable to meet the LTC needs of its citizens.

The State continues to explore innovations for delivering LTC that save money, better coordinate care, and improve the health and quality of life for older adults and other individuals living with disabilities in NM. Currently, HSD is working with the MCOs to remove barriers to statewide enrollment in Medicare Special Needs Plans (SNPs) for New Mexicans enrolled in CoLTS. Many of the costs for these SNP-eligible individuals could appropriately be paid by the federal government under Medicare, thus relieving the State of the associated Medicaid costs. Moving healthcare coverage for individuals eligible for both Medicare and Medicaid to one integrated and coordinated set of benefits avoids the current cost-shifting between the programs.

We thank the LFC evaluation team members for their assistance with the on-going analysis and evaluation of our programs. We are proud of the steps that have been taken by the Human Services and Aging & Long-Term Care departments, with the support of our legislative partners, to implement essential healthcare services for our citizens while being mindful of budgetary constraints. This administration will continue to address the difficulties of strengthening our essential healthcare programs in these challenging economic times.

Sincerely,

Sidonie Squier
Secretary-Designate

Evaluation Objectives.

- Review the costs of the Medicaid CoLTS managed care program and related performance outcomes.
- Assess both departments' oversight of the CoLTS program and its managed care organizations to ensure clients' access to cost-effective, high quality services.
- Review the implementation status of recommendations for the *Physical Health Medicaid Managed Care* evaluation.

Program Evaluation Activities (Scope and Methodology).

- Reviewed state and federal laws, regulations and policies; HSD & ALTSD reports, Medicaid plans, waivers, correspondence with CMS, including CMS audit reports; and MCO contracts, list of required reports and reviewed selected sample;
- Reviewed public (CMS, GAO, other states, etc.) and private research and evaluations of long-term care issues, health care quality, managed care, Medicaid managed care and costs of long-term care and health care in general;
- Reviewed financial, encounter, enrollment, utilization, performance and quality data from HSD, MCOs and PRC-Insurance Division for FY00-11 for Medicaid as a whole and individually by MCO.
- Interviewed staff from HSD, ALTSD, MCOs among others.

Evaluation Authority. The Committee has authority under Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political sub-divisions, the effect of laws on the proper functioning of these governing units, and the policies and costs of government. Pursuant to its statutory authority, the Committee may conduct performance reviews and inquiries into specific transactions affecting the operating policies and costs of governmental units and their compliance with state law.

Evaluation Team.

Charles Sallee, Deputy Director
Maria D. Griego, Program Evaluator
Lawrence Davis, Program Evaluator

Exit Conference. The contents of this report were discussed with Ms. Sidonie Squier, Secretary-Designate, HSD, Mr. Mathew Onstott, Deputy Secretary, ALTSD and senior staff from each department, and LFC staff on January 19, 2011.

Report Distribution. This report is intended for the information of the Office of the Governor, the Human Services Department, Aging and Long-Term Care Services Department, the Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report which is a matter of public record.

Charles Sallee
Deputy Director for Program Evaluation

APPENDIX B: CoLTS Spending & Utilization Data

Medicaid Long-Term Services Expenditures - FY07-FY10

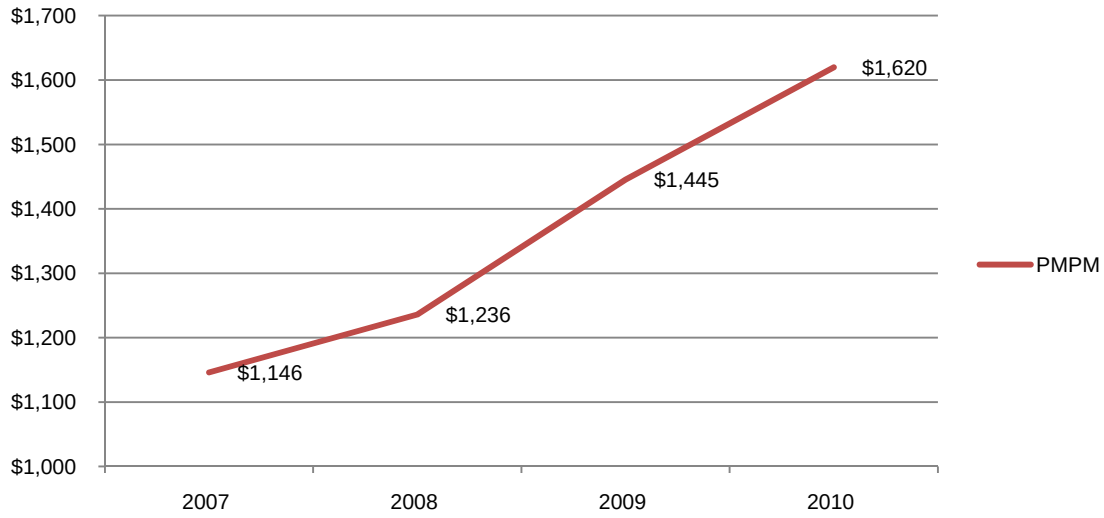
	FY07	FY08	FY10	Change
Category of Service	Expenditures	Expenditures	Expenditures	FY08-FY10
Dental	$3,491,626	$3,681,875	$3,025,489	($656,386)
Emergency Transportation	$1,191,102	$1,750,208	$2,472,347	$722,140
HCBW *	$58,812,141	$73,173,895	$18,768,139	($54,405,756)
Hospice	$11,330,600	$12,286,734	$12,916,414	$629,679
Inpatient Hospital	$30,979,043	$32,732,289	$39,697,870	$6,965,581
Medical Supplies	$6,885,046	$9,611,061	$12,395,160	$2,784,098
Nursing Facilities	$175,179,399	$184,239,374	$197,963,277	$13,723,902
Non-Emergent Transportation	$7,851,360	$7,893,399	$7,135,963	($757,436)
Other**	$105,170	$73,989	$29,438,585	$29,364,596
Outpatient	$25,672,917	$30,266,780	$31,210,727	$943,947
Personal Care Services	$200,142,667	$231,306,692	$334,073,771	$102,767,079
Pharmacy	$19,443,809	$23,074,618	$21,081,768	($1,992,850)
Physician	$22,223,962	$26,087,239	$22,304,444	($3,782,795)
Grand Total - Medical	***$563,308,842***	***$636,178,153***	***$732,483,954***	***$96,305,801***
MCO Administration***	-	-	$66,566,933	
Total HSD Payments for LTS	***$563,308,842***	***$636,178,153***	***$799,050,887***	***$162,872,734***

Source: LFC Analysis of HSD Baseline Data - FY07-FY08 & MCO Report 30A FY10-4thQ including IBNR.

*FY07-FY08 includes Homemaker, which was moved into PCO in FY10. **Includes subcapitations, dialysis, clinics, etc.
***Admin Calculation = Total Capitations Paid - Medical Expenses.
^Includes adjustment for MCO reporting in FY10 to include PCO and home health expenditures. Home health spending totaled less than $1.5 million in FY07 and FY08.

The data in the following tables and graphs includes cost and utilization information submitted by both MCOs to HSD, specifically Reports 30A & 30B from as reported FY10 4th quarter adjusted to include incurred but not received (IBNR) claims. In addition, adjustments were made to the data to better reflect the cost and use of personal care option services delivered through providers, by including home health as agreed upon with the Human Services Department.

Overall Weighted Medical PMPM Spending
FY07-FY10

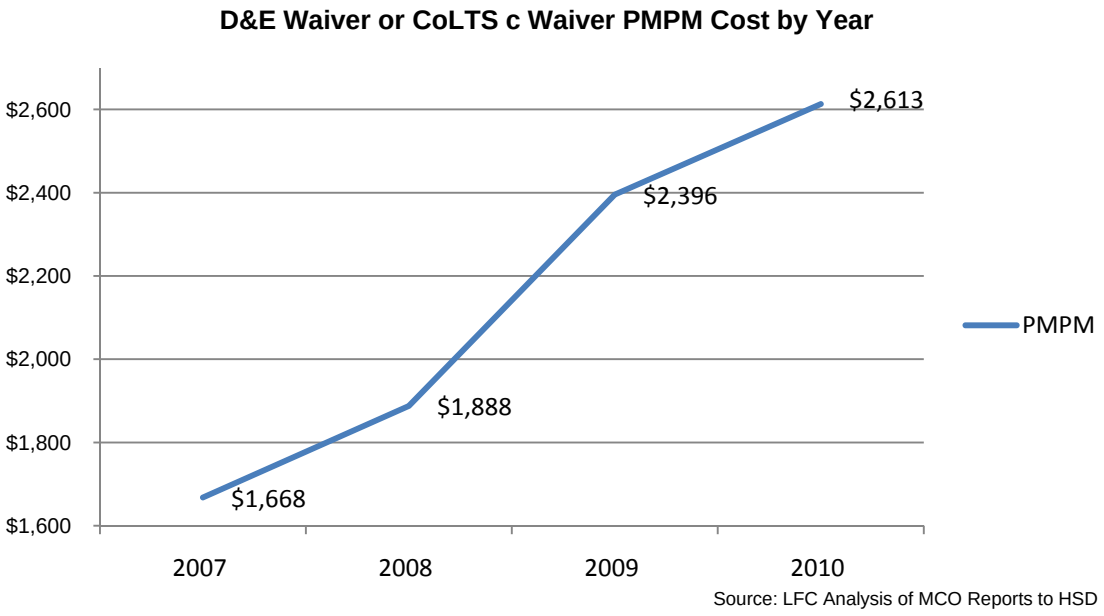


Source: LFC Analysis of HSD Baseline Data & MCO Reports

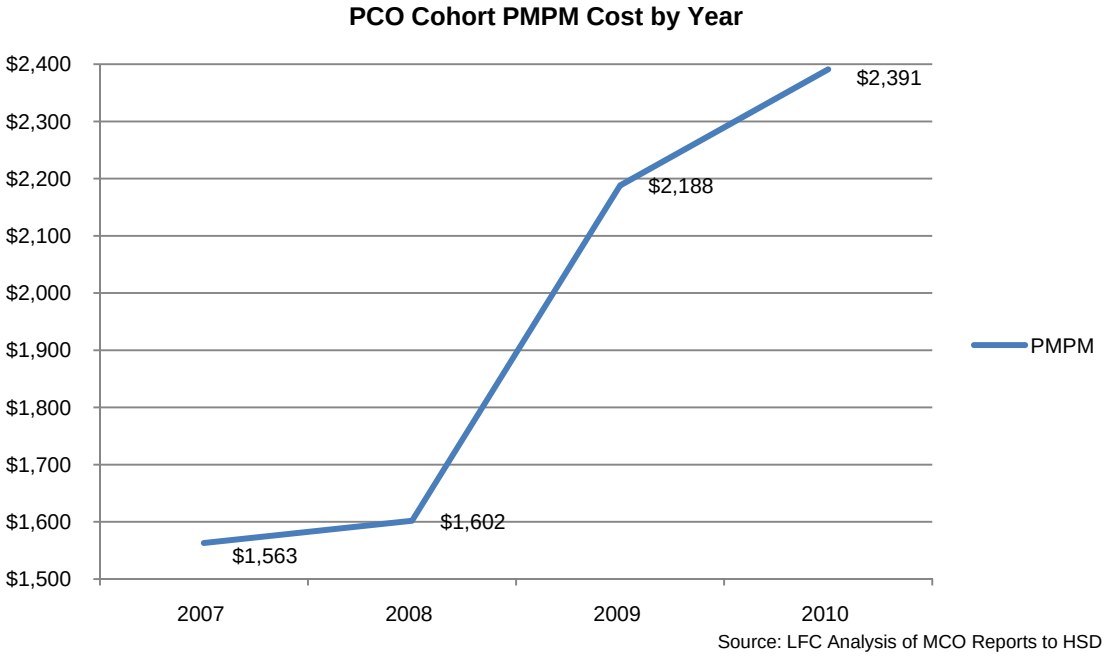
PMPM Medical Cost by Cohort

All MCOs	2009	2010	% Change
Dual - Disabled and Elderly Waiver	$ 2,250.97	$ 2,481.77	10.3%
Dual - Nursing Facility(Phase 1,3,4)	$ 3,612.40	$ 3,857.71	6.8%
Dual - Nursing Facility(Phase 2)	$ 4,222.73	$ 4,567.68	8.2%
Dual - Nursing Facility(Phase 5)	$ 4,902.41	$ 5,047.75	3.0%
Dual - Personal Care Option	$ 1,756.21	$ 1,920.29	9.3%
Dual Mi Via	$ 176.57	$ 195.27	10.6%
Healthy Dual	$ 195.73	$ 175.75	-10.2%
Non dual - Disabled and Elderly Waiver	$ 3,626.38	$ 3,693.61	1.9%
Non dual - Nursing Facility(Phase 1,3,4)	$ 5,561.37	$ 5,932.43	6.7%
Non dual - Nursing Facility(Phase 2)	$ 6,459.33	$ 7,928.93	22.8%
Non dual - Nursing Facility(Phase 5)	$ 8,351.62	$ 8,088.41	-3.2%
Non dual - Personal Care Option	$ 3,055.69	$ 3,236.29	5.9%
Non-dual Mi Via	$ 1,110.38	$ 1,615.67	45.5%

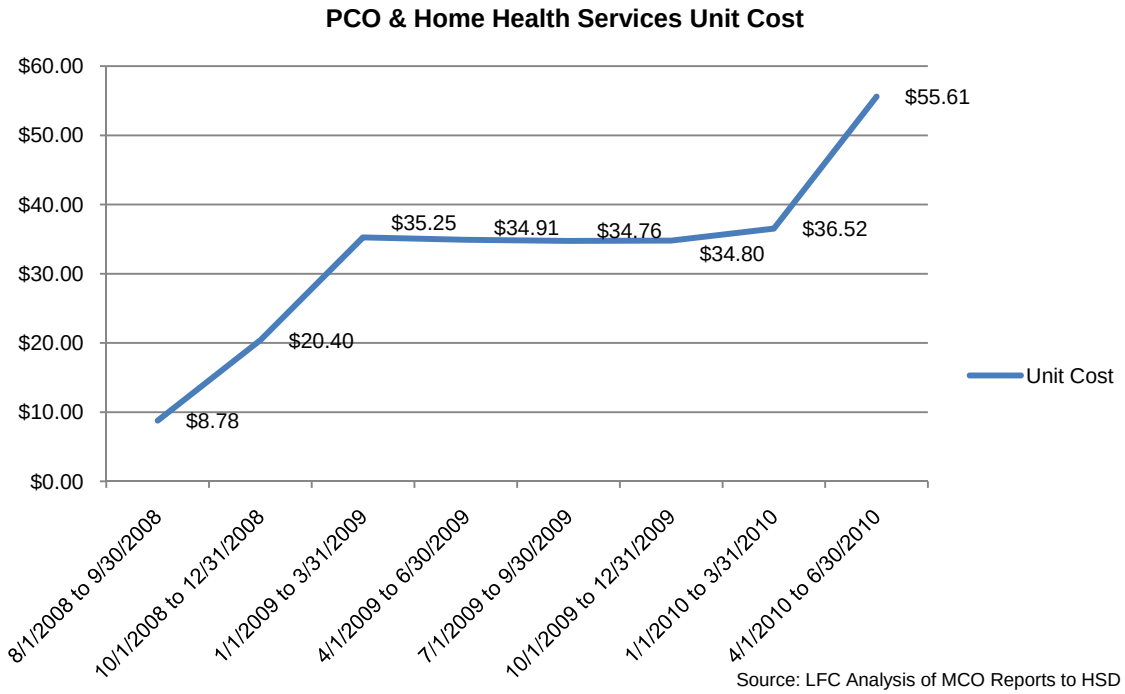
Source: LFC Analysis of MCO Reports



Source: LFC Analysis of MCO Reports to HSD



Source: LFC Analysis of MCO Reports to HSD

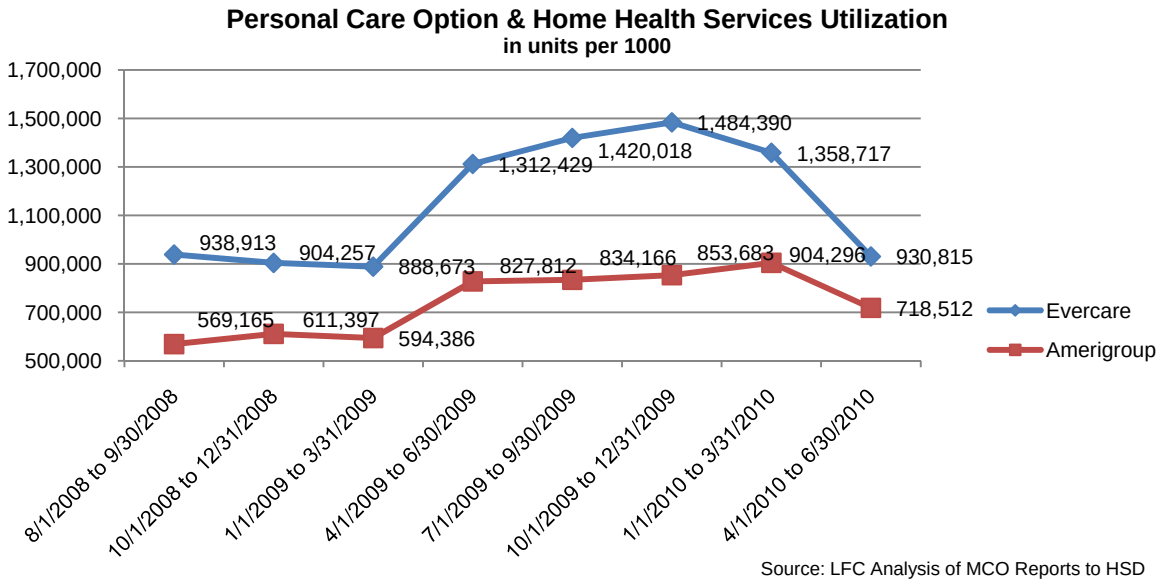


Source: LFC Analysis of MCO Reports to HSD

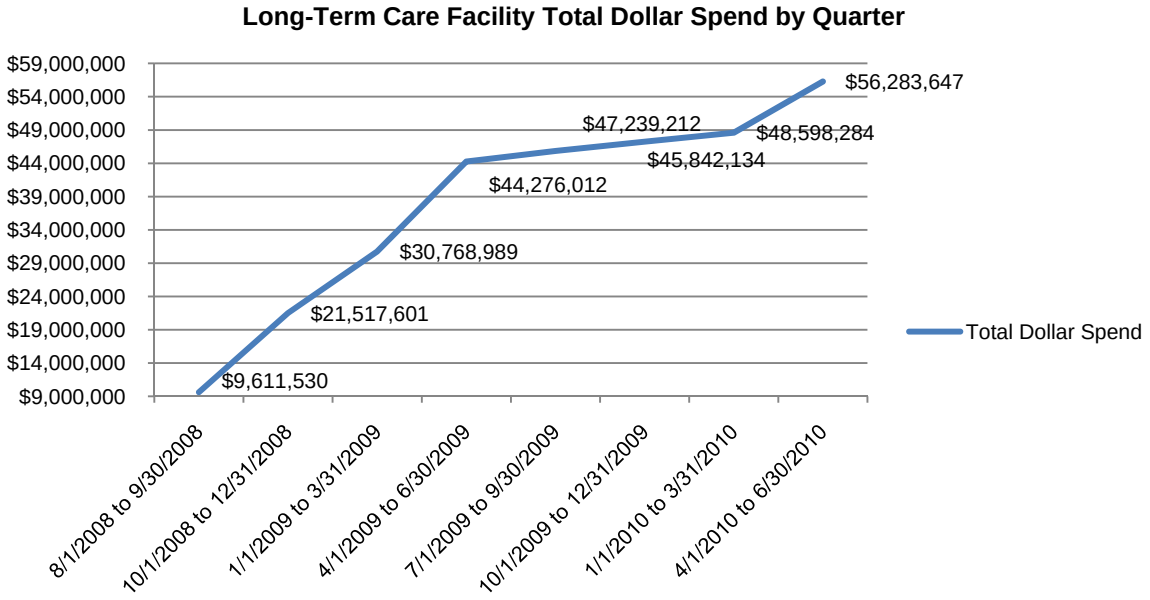
PCO & HHS PMPM Cost by Cohort

All MCOs	2009	2010	% Change
Dual - Disabled and Elderly Waiver	$ 1,516.08	$ 1,713.16	13.0%
Dual - Nursing Facility(Phase 1,3,4)	$ 32.40	$ 63.26	95.2%
Dual - Nursing Facility(Phase 2)	$ 41.76	$ 28.86	-30.9%
Dual - Nursing Facility(Phase 5)	$ 10.09	$ 25.07	148.5%
Dual - Personal Care Option	$ 1,473.09	$ 1,632.63	10.8%
Dual Mi Via	$ 0.84	$ 12.18	1352.8%
Healthy Dual	$ 5.30	$ 4.71	-11.2%
Non dual - Disabled and Elderly Waiver	$ 1,527.49	$ 1,544.01	1.1%
Non dual - Nursing Facility(Phase 1,3,4)	$ 43.92	$ 93.40	112.6%
Non dual - Nursing Facility(Phase 2)	$ 10.63	$ 58.79	453.0%
Non dual - Nursing Facility(Phase 5)	$ -	$ 20.42	100%
Non dual - Personal Care Option	$ 1,660.11	$ 1,707.82	2.9%
Non-dual Mi Via	$ 85.37	$ 101.30	18.7%

Source: LFC Analysis of MCO Reports to HSD.



Source: LFC Analysis of MCO Reports to HSD



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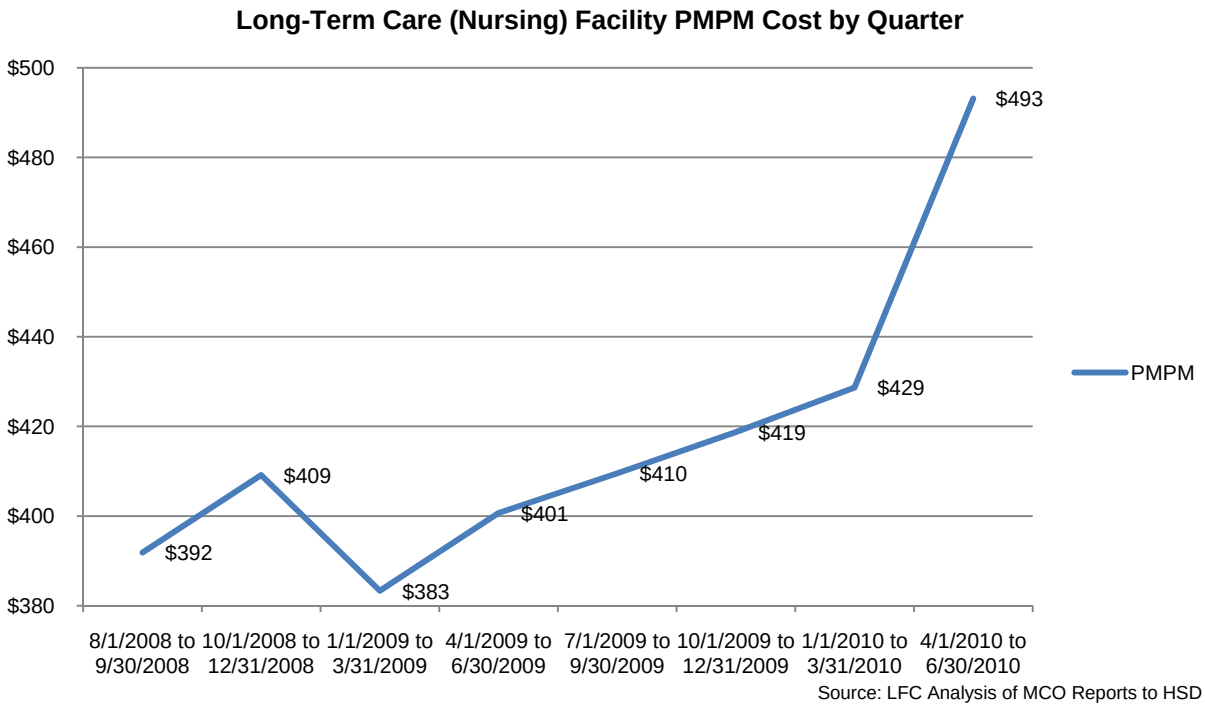

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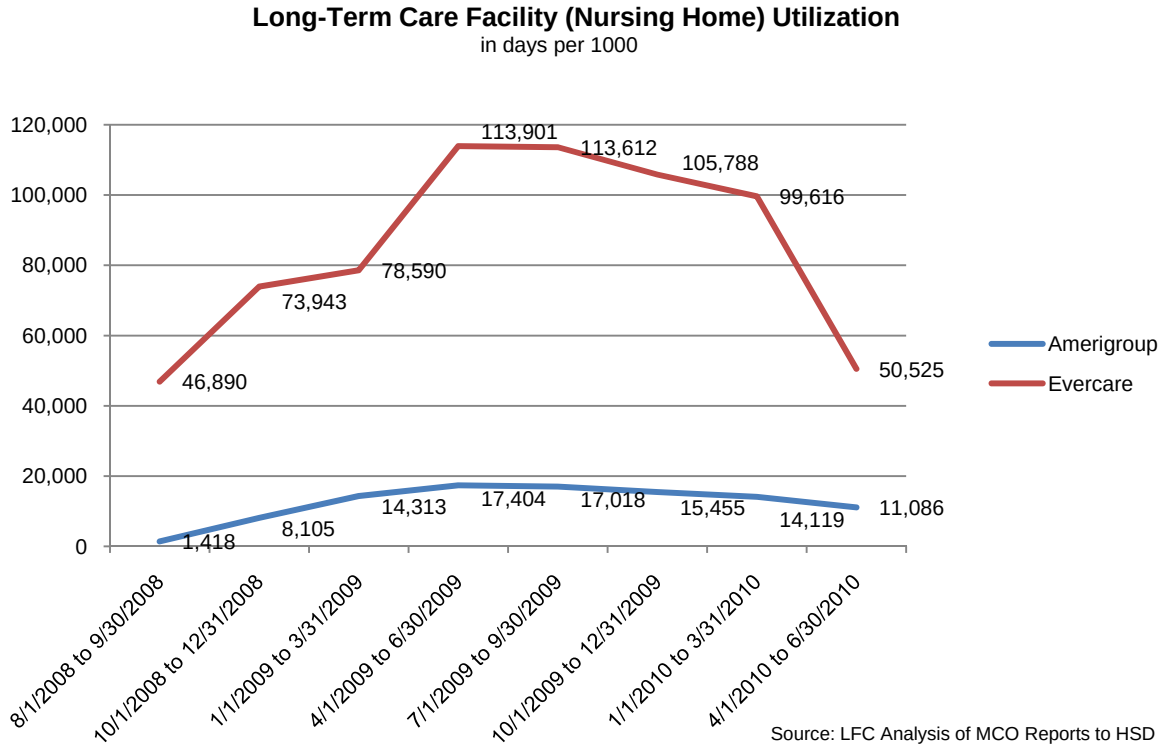

Source: LFC Analysis of MCO Reports to HSD

CoLTS Baseline Performance
FY10

PERFORMANCE MEASURE	ACTUAL PERFORMANCE	
	Amerigroup	**Evercare**
Flu shots for older adults	0.12	0.15
Pneumonia vaccination for older adults	0.03	0.08
# of members stratified as high, moderate, low risk	High: .64 Moderate: 14 Low: .22	High: .51 Moderate: .055 Low: .12
# of members with ED visits for Diabetes Mellitus, COPD (including Asthma, Chronic Bronchitis)	Total ER Visits: 35846 All COPD: 984, 3% of total ER visits Diabetes: 635, 2% of total ER visits	Total ER Visits: 23752 All COPD: 982 4.1% of total ER visits Diabetes: 1547 6.5% of total ER visits
Nursing Home admissions stratified by long and short term; readmissions to SNF following short-term admit	Short Term: 518 Long Term: 540 Readmissions to SNF within 30 days of discharge: 93	Short Term: 518 Long Term: 540 Readmissions to SNF within 30 days of discharge: 333
# of members with inpatient acute care hospitalizations	Acute Hosp: 4546 CHF: 659 Dehydration: 305 Cellulitis: 632	Acute Hosp: 4182 CHF: 637 Dehydration: 283 Cellulitis: 268
PCP visits	Total PCP visits: 66283 Annual visits per mbr/ 3.3	Total PCP visits: 45069 Annual visits per mbr/ 2.7
Comprehensive Diabetes Care	HbA1c Testing: 80% HbA1c Poor Control (>9.0%): 38% Eye Exam: 48% LDL-C Screen: 60% LDL-C Level <100 mg/dL: 36% Medical Attention for Nephropathy: 78%	HbA1c Testing: 97% HbA1c Poor Control (>9.0%): 50% Eye Exam: 40% LDL-C Screen: 83% LDL-C Level <100 mg/dL: 53% Medical Attention for Nephropathy: 93%

CoLTS Baseline Performance
FY10

PERFORMANCE MEASURE	AMERIGROUP	EVERCARE
Hospital Readmissions within 30 days of discharge	T Discharges: 7528 T Readmissions: 233 Readmission rate: 3%	T Discharges: 5063 T Readmission: 981 Readmissions rate: 19.3%
Use of high risk medications in the elderly	One Rx: 13% Two + Rxs: 0%	One Rx: 16.6% Two+ Rxs: 0%
Call Answer Timeliness	89% Total Calls: 110008	86% Total Calls: 51979
Call Abandonment	2% Total Calls: 110008	3.1% Total Calls: 51979
Number of home safety evaluations	17030	350
Percent of home safety evaluations requiring follow-up for safety issues	17%	100% (reported)
# of persons age 75 or older and other members at risk for falls who have been asked at least annually about the occurrence of falls and treated for related risks	> 75 years-old: 5279 Others at risk: 11751	> 75 years-old: 943 Others at risk: 2155
# of consumers who transition from NF placement who are served and maintained with community-based services for six months	# Transitioned: 90 Maintained for 6 mo: 42	# Transitioned: 109 Maintained for 6 mo: 24

Source: HSD