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Medicaid Update

Presentation to the Legislative Health & Human Services Committee

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May 23, 2016

Today's Topics

- Medicaid Budget Update
  - Enrollment Report
  - Cost Containment Efforts
- Centennial Care Project Highlights
- Behavioral Health Collaborative Report

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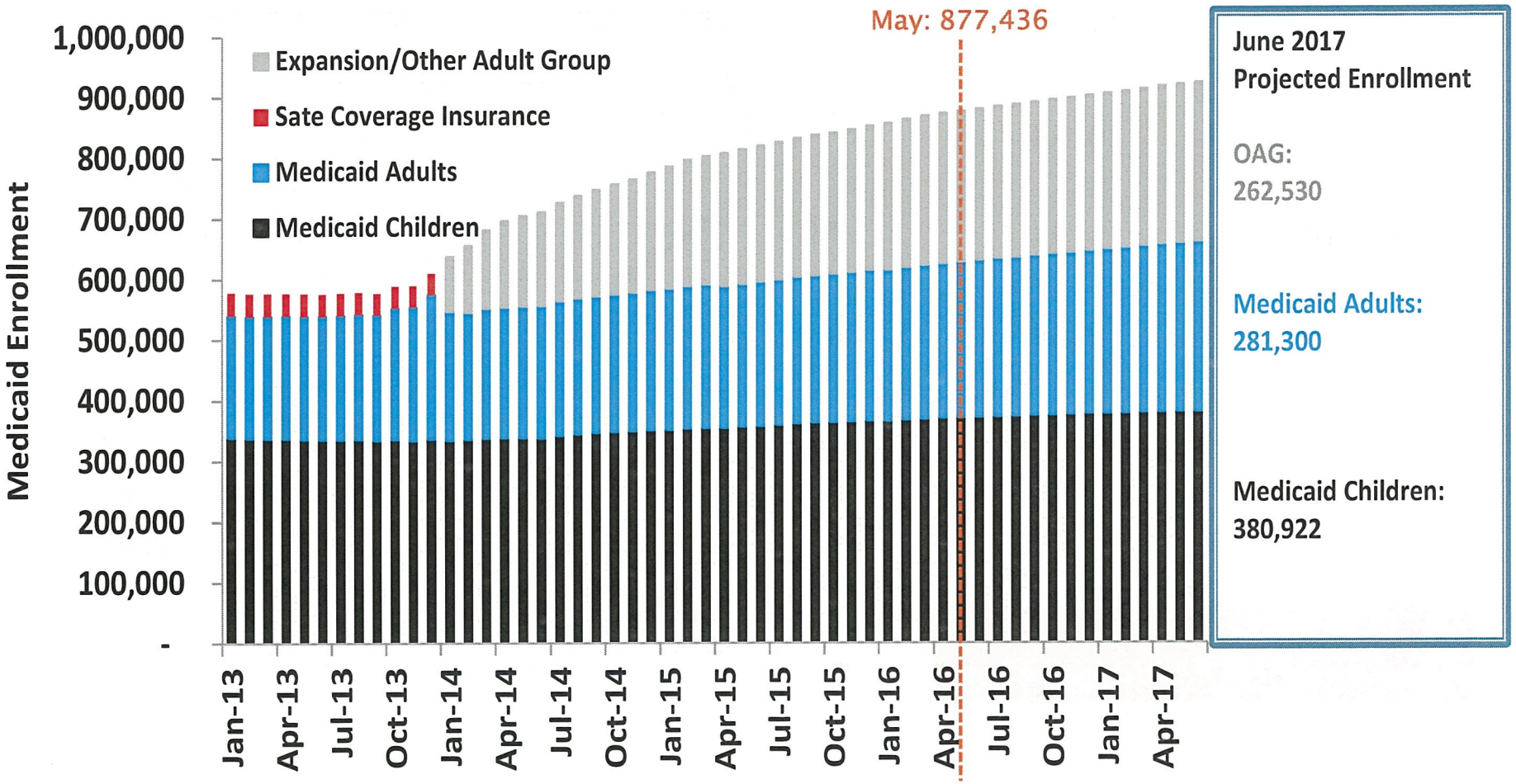
Medicaid Enrollment



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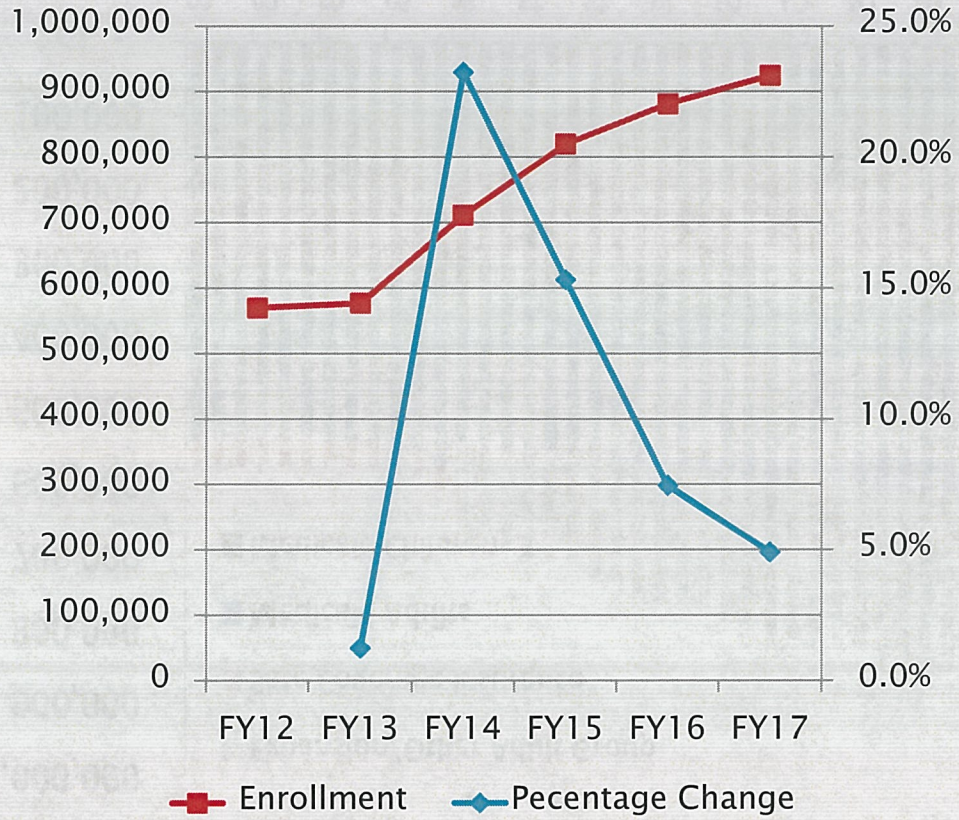

Fiscal Year	Enrollment
FY12	570,054
FY13	577,161
FY14	711,321
FY15	820,271
FY16	881,435
FY17	924,752

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Medicaid Spending

- Total Medicaid spending is increasing, primarily due to enrollment growth.
- The FY17 general fund (GF) appropriation for Medicaid is $913.6 million, an increase of $21.9 million from FY16, but about $63 million less than the FY17 request.

($ in millions)	FY14 Actual	FY15 Projection*	FY16 Projection*	FY17 Request	FY17 Op Bud	FY17 Projection*
Total Budget	$4,200.6	$5,172.3	$5,644.8	$5,916.0	$5,741.9	$5,787.4
General Fund	$901.9	$894.8	$910.2	$976.9	$913.6	$938.0

*Projection data as of March, 2016. The projections include all push forward amounts between SFYs. FY16 general fund includes $18 million supplemental appropriation. These figures exclude Medicaid administration.

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House Bill 2 Requirements

- 2016 House Bill 2 requires the department to take a series of actions to "reduce projected Medicaid spending"
  - Shall reduce reimbursement rates paid to Medicaid providers
  - Shall reduce spending on managed care administrative costs
  - Shall pursue additional cost sharing requirements (e.g., co-pays and premiums)
  - Consider changes to Medicaid benefits and implement processes to enhance eligibility verification

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MAC Cost-Containment Subcommittees

- Provider Payments Cost-Containment Subcommittee
  - Phase 1: Recommendations for reducing provider reimbursement rates effective 7/1/16 in accordance with HB2. Savings goal = $30 million GF.
    - Recommendations received from subcommittee on April 8th.
      - Savings based on recommendations = $18.5-$25 million GF.
    - HSD proposal issued on April 22nd based on subcommittee's recommendations, but with additional reductions to achieve savings goal.
      - Savings = $26-$33.5 million GF.
      - Public comment being accepted through May 31st.
  - Phase 2 merging with the Long-Term Strategies Subcommittee.

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MAC Cost-Containment Subcommittees

- Benefit Package, Eligibility Verification & Recipient Cost-Sharing Subcommittee.
  - Charged with submitting recommendations for achieving cost-savings in Medicaid benefits, eligibility verification measures and recipient cost-sharing, including premiums.
  - Began meeting in mid-April; meetings have been held weekly.
  - Recommendations due June 1; implementation target is 1/1/17.
  - Any implementation requiring a waiver change likely will be delayed and incorporated into the next iteration of the Centennial Care waiver (2018).
- Long-Term Strategies Subcommittee.
  - Currently being appointed; merging with the Provider Payments Subcommittee.
  - Charged with developing recommendations for longer-term innovative strategies, including ways to leverage Medicaid differently.

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Reducing MCO Administrative Costs

- Effective 1/1/16, the MCO capitation rates changed with increases in some cohorts and decreases in others for net reduction of 3.4%

- Additional changes to be implemented on 7/1/16 will result in reductions to administration costs, including:
  - Changes to care coordination program to more effectively target high-needs/high-cost members;
  - Changes to the member rewards program to reduce administrative costs and better align rewards with acuity of Centennial Care population; and
  - Estimated savings: $15-18 million total.

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Cost Containment Implementation Timeframes

- Most cost-containment initiatives require a policy change:
  - Internal review;
  - Tribal and public notice; tribal consultation when requested – 30-60 days;
  - State Plan Amendments (SPAs) – 6 months from start to federal approval;
  - Regulation promulgation – 5-6 months, unless emergency;
  - Waiver approval;
    - New waiver – may take as long as 1 year for federal approval.
    - 1115 waiver amendment – requires opening entire waiver and renegotiation with CMS; may take as long as 1 year.
  - Actuarial rate revision – 30 days; and
  - MCO provider contract changes – 30 days.

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Medicaid: FY 17 Budget Projection

- $938.0 million from the general fund, $38.9 million lower than the Oct. 2015 data projection. The general fund appropriation for FY17 is $913.6 million leaving $24.4 million in GF shortfall.

Component Driver	General Fund Need	GF Change
General Fund Need – Oct. 2015 Data Projection	**$976,970**	
Cost Containment – Provider Rate Reductions *		($32,500)
Federal waiver of Health Insurance Provider Fee **		($18,550)
Care Coordination & Centennial Rewards		($3,512)
Enrollment & Utilization Trends		($3,408)
Federal Match for Family Planning		($2,465)
Net Other Revenue Increase		($1,758)
FY16 Push Forward		$23,263
General Fund Need – March 2016 Data Projection	**$938,042**	

Notes: $ in thousands.
* There was $ 22.4 million as "cost containment" from Oct. 2015 Data projection, and HSD has assumed that the additional revenues from UNMH should cover the expenditures "to be cost contained." Now the additional UNMH IGT of $20 million has been recommended in HB2.
** One time occurrence

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Continuing Medicaid Budget Pressures

- Declining FMAP for Expansion Population
- Federal Rule and Guideline Changes
  - Autism Coverage Requirements
  - Hepatitis C Treatment Requirements
  - Mental Health Parity
  - Managed Care Rules
- Provider Requests for Rate Increases
  - Nursing Facilities
  - PACE
  - ICF-IIDs (formerly known as ICF-MRs)
- Sustainability of Certain Programs Dependent on Medicaid Financing.
  - Health Information Exchange
  - New Mexico Medical Insurance Pool
  - Health Insurance Exchange
  - UNM ECHO Cares

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Centennial Care Projects: 2015 Delivery System Improvement Fund

- Increasing Use of Community Health Workers:
  - All of the MCOs met this target in 2015.
- Increasing members served by Patient Centered Medical Homes (PCMHs):
  - Increased from 200,000 members served in PCMHs at end of 2014 to 250,000 members at end of 2015.
- Reducing non-emergent use of the Emergency Room:
  - 2 MCOs achieved this target and reduced non-emergent use by 14%.
- Increasing Use of Telemedicine "Office Visits":
  - MCOs increased visits by 45% over 2014 visits.

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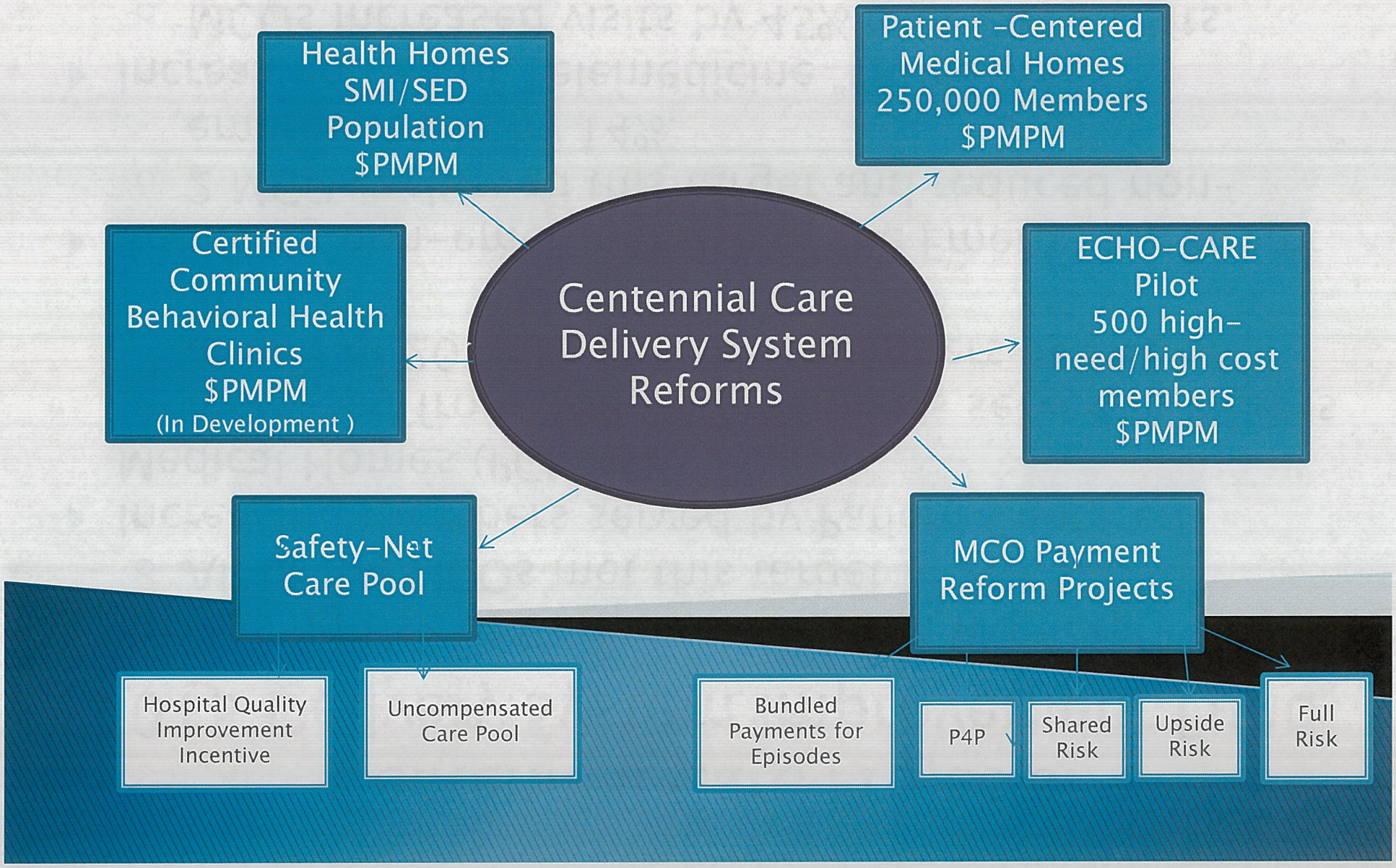
Moving Away from Fee-For-Service Payments



MCO Payment Reform Pilot Projects

MCO payment reform pilots build upon existing efforts to move away from volume-based payments, allow provider incentives and encourage shared risk.

There are a variety of payment structures, from those on the lower-end of a continuum to those that include full-risk sharing:

Provider incentives — Pay-for-Performance — Upside-Risk Only — Full Risk

The MCOs are developing score cards to measure outcomes such as:

- Reductions in ER visits and hospital readmissions;
- Provider performance against several HEDIS measures; and
- Total cost of care for each member.

VBC Provider A - January JOC QUALITY UPDATE

Quality Measure	Relevant Patients (for October)	Open Care Opportunities (for October)	October % Adherent	November % Adherent	December % Adherent	January % Adherent	Quality Threshold Target Score
Breast Cancer Screening **(Medicaid)**	95	51	46%	47%	50%	50%	≥ 78.0%
Diabetes Care- Eye Exam **(Medicaid)**	351	215	38%	42%	43%	44%	≥ 62.0%
Diabetes Care - Kidney Disease Monitoring **(Medicaid)**	351	88	75%	75%	76%	76%	≥ 85.0%
Diabetes Care HbA1c Testing **(Medicaid)**	351	86	75%	77%	77%	78%	≥ 87.3%
Colorectal Cancer Screening	122	67	45%	48%	48%	48%	≥ 60.0%
Asthma Treatment: Appropriate Use of Medications **(Medic**	28	9	68%	71%	69%	70%	≥ 87.3%
Controlling High Blood Pressure*						≥ 60.0%	

*Can only give accurate %'s with chart audits

Health Home Implementation

- Target populations:
  - Serious Mental Illness (SMI) – adults; and
  - Severe Emotional Disturbance (SED) children
- CMS approval of State Plan Amendment – March 2016.
- Implemented April 1, 2016.
- San Juan and Curry Counties.
- Enrolled providers:
  - Presbyterian Medical Services–San Juan; and
  - Mental Health Resource Center – Curry.
- Currently serving 150 members.

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Care Coordination Update

- MCOs developed a standardized Health Risk Assessment (HRA) – Implementation 7/1/2016.
- 40 percent of the Centennial Care members are being served in Patient-Centered Medical Homes.
- 10% of enrollees are assigned to higher levels of care coordination.
- MCOs are partnering with community agencies, such as Albuquerque Ambulance, Addus Homecare and Kitchen Angels to better manage super utilizers.

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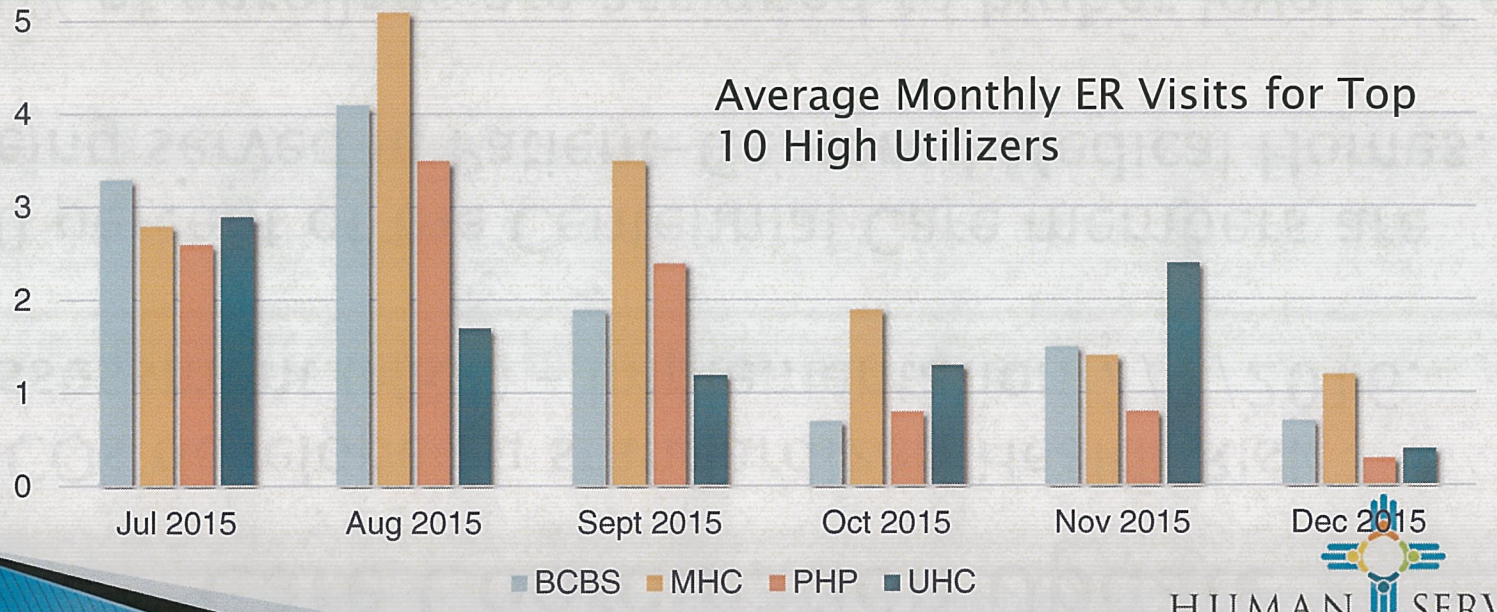
HSD/MAD Pilot Project on Super-Utilizers

- HSD/MAD utilized data that identified the MCOs' highest utilizers of the Emergency Department (ED) over a 15 month period.
- HSD/MAD reviewed the top 10 members for each MCO.
- The MCOs were asked to implement interventions to reduce ED utilization for these members and develop recommendations for better management of super utilizers.
- The following graph illustrates progress in ER reduction for the top 10 super utilizers with each MCO.
- HSD is working with the MCOs on the next group of 25 ED super utilizers.



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Noteworthy MCO Initiatives

- Presbyterian Health Plan:
  - Partnership with Highlands University – Internship program for Social Workers;
  - Partnership with Albuquerque Ambulance to conduct home visits for high ED utilizers to reduce ER usage;
  - Partnership with Healthcare for the Homeless to have behavioral health care coordinators on site to work with members; and
  - Wellness Referral Center – Partnership with Adelante that serves the areas of PMG Isleta, San Mateo, First Choice South Valley and First Nations to connect members with community resources.
- Molina HealthCare:
  - Partnering with Bernalillo County Detention Center to connect incarcerated individuals to care coordinators upon release from the facility; and
  - Partnering with Kitchen Angels to provide up to forty-two (42) home delivered meals per calendar year to homebound members after hospital discharge.

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Noteworthy MCO Initiatives – Continued

- United HealthCare:
  - Partnering with Tribal governments to reimburse for transportation services, translation, and health risk assessment completion;
  - Collaborating with a large PCO provider to help members to better manage their chronic health conditions; and
  - Opened a Resource Center in Shiprock- provides health literacy education, virtual visits, and referrals to other social services.

- Blue Cross Blue Shield:
  - Enhanced Care for Children with Asthma – a collaboration between BCBSNM and the American Lung Association:
    - Data from the initial 12 clinics in NM showed:
      - An 80% reduction in ER visits for asthma; and
      - An 80% reduction in hospitalizations for asthma.
  - Community Paramedicine/EMTs:
    - Conducts home visits to educate members identified as high emergency department utilizers and recent hospital discharges with high risk of readmission.
      - 178 members participating.
      - Reduced ED readmissions by 78%.

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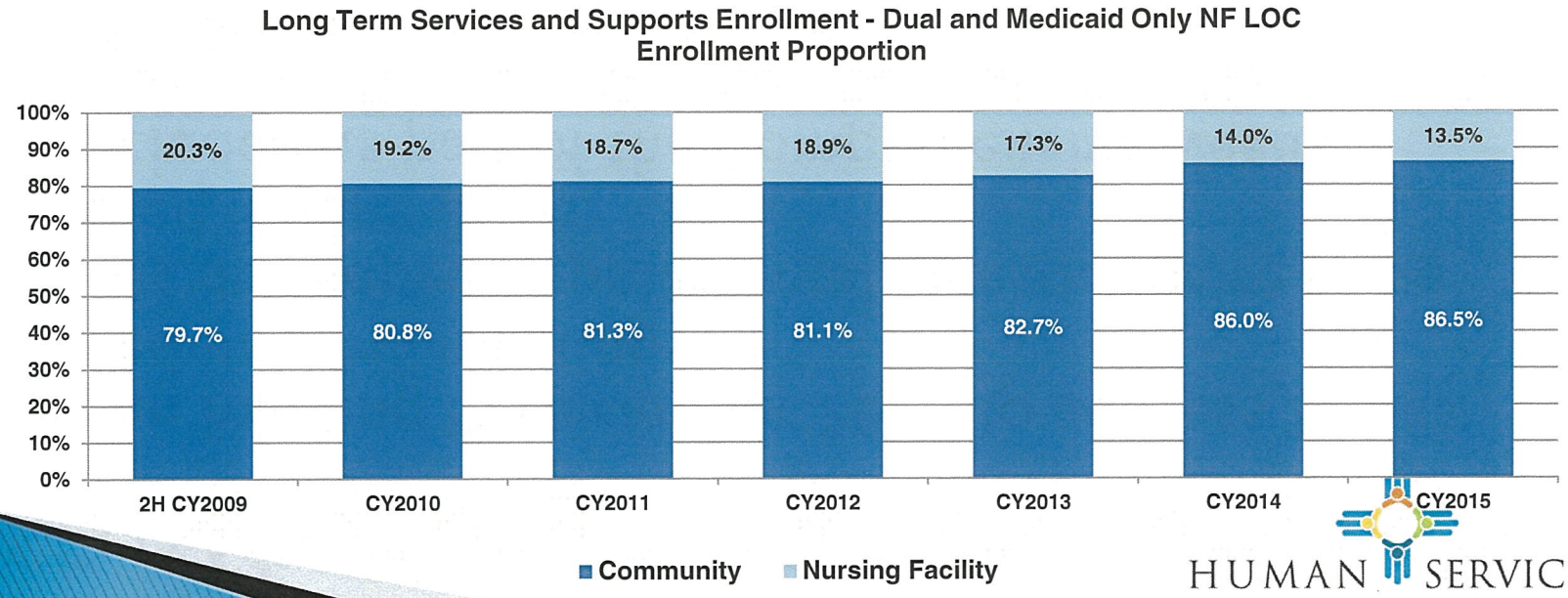
Managed Care and the Long-Term Care Population

- Managed long-term care was implemented in New Mexico in August 2008.
- It continues to have a positive impact on the proportion of members residing in the community vs in Nursing Facilities.
  - As of CY15, 86.5% of members are receiving long-term services at home/in the community vs 13.5% of members in a nursing facility.
- Centennial Care removed the requirement to have a waiver slot in order to access the community benefit.



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HSD/MCO Long Term Care Committee

- Began meeting in December 2015 to address issues raised in LHHS meetings.
- MCOs developed Supplemental Questionnaire to be piloted in June 2016:
  - Included as part of the Comprehensive Needs Assessment to ensure members understand full array of Community Benefits; and
  - Solicited feedback from ALTSD and DRNM.
- HSD and MCOs developed Community Benefit Brochure.
- Implemented changes to Community Benefit section of the Centennial Care Policy Manual to resolve issues identified by stakeholders.
- HSD conducted trainings for MCO care coordinators to re-educate about Community Benefit Services & Policy Manual Changes.

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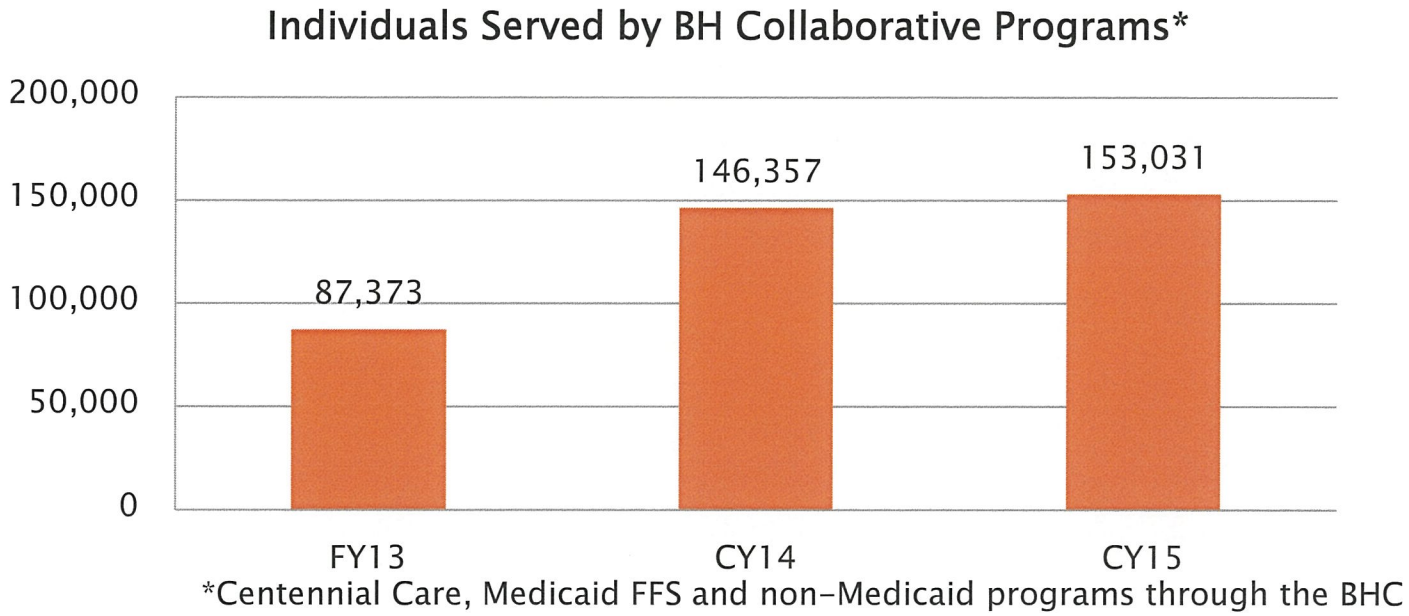
Behavioral Health Collaborative Report

- Utilization of behavioral health services across BHC programs continues to grow



- See Separate BH Collaborative Report

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