



Medicaid Update
Legislative Health and Human Services Committee

Brent Earnest, Secretary
August 24, 2018

Today's Topics

- FY19 Medicaid Changes and Outlook
 - FY19 Budget Update
 - Provider Rate changes
 - Enrollment trends
- Centennial Care Update
- Centennial Care 2.0 Update
- HHS2020 and the Medicaid Management Information System Replacement (MMISR) Project

Medicaid Budget Update

- For FY18, the Legislature appropriated **\$915.6 million**. We are projecting to spend **\$ 907.8 million**, resulting in a general fund surplus of **\$7.8 million** in FY 18.
- The FY19 general fund need for Medicaid is projected to be **\$944.6 million**. The Legislature appropriated **\$933.6 million**, resulting in a projected shortfall of **\$11.0 million** in FY 19.

(\$ in millions)	FY14 Actual	FY15 Actual	FY16 Projection	FY17 Projection*	FY18 Projection*	FY19 Projection*
Total Budget	\$4,200.6	\$5,162.3	\$5,413.9	\$5,607.1	\$5,680.0	\$5,709.8
General Fund Need	\$901.9	\$894.1	\$912.9	\$909.5	\$907.8	\$944.6

*Projection data as of June 2018. The projections include all push forward amounts between SFYs. These figures exclude Medicaid administration.

Medicaid Update:

Provider Rate Increases, 7/1/18

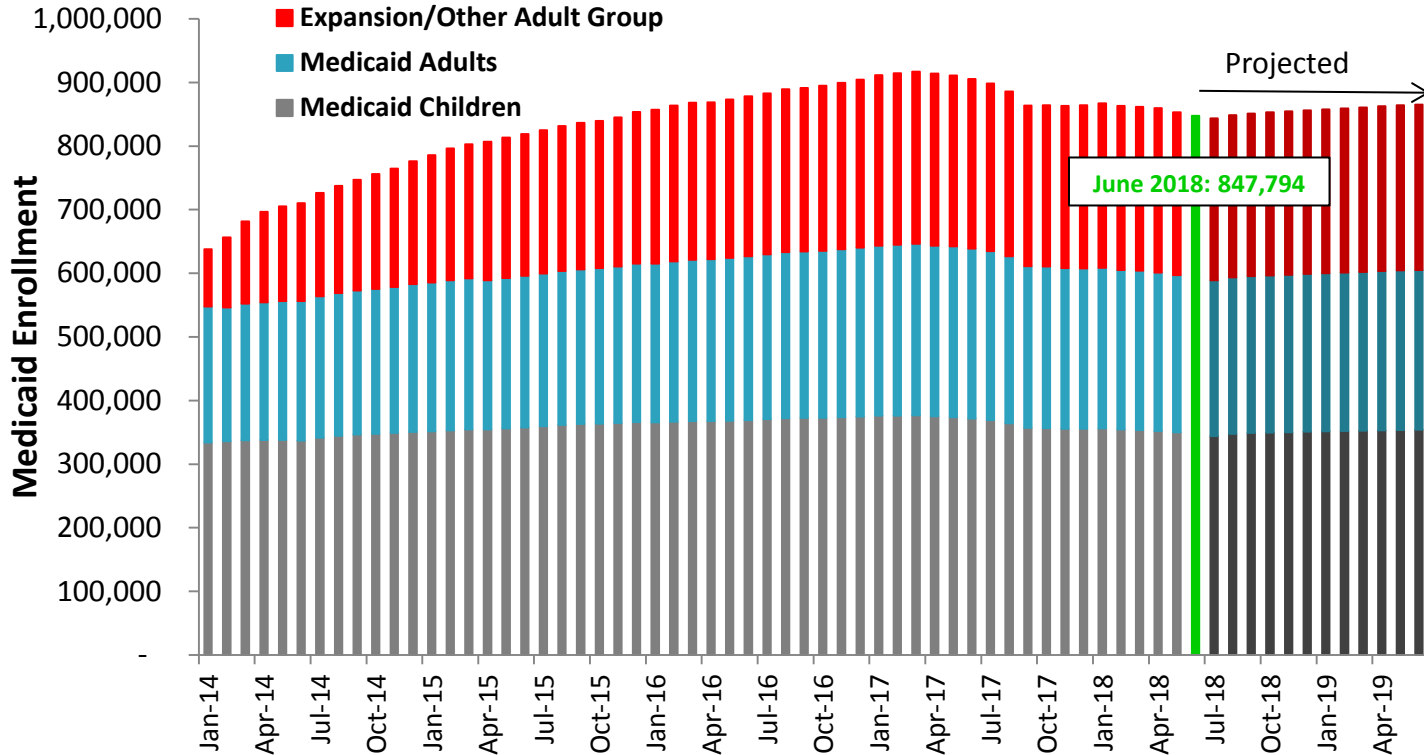
- Increased Evaluation & Management code 99213 from \$50.52 to \$53.19
 - New rate is 75% of the Medicare fee schedule
 - Goal was to ensure that the increase was for primary care office visits
 - Total cost impact of \$2.25 million (state and federal funds)
- Increased the following codes/services targeting LTSS providers:
 - 7.84% increase in payment rates to nursing facilities (6% in July)
 - 1% increase in payment rates to assisted living facilities
 - 3% increase in payment rates for PACE
 - 3% increase in payment rates to ICF/IIDs
 - 38.7% increase in the payment rate for adult day health (from \$2.04 to \$2.83 per 15 minutes)
 - Total cost impact of \$23.3 million (state and federal funds)

Medicaid Update:

Provider Rate Increases, 7/1/18

- Increased behavioral health codes and rates as follows:
 - Increased the payment rate for Assertive Community Treatment (ACT) by 20% and added a modifier for group services to be paid at the new rate
 - Increased the rate for Comprehensive Community Support Services (CCSS) that are provided in the community
 - Increased rates for Treatment Foster Care (TFC) by 20%
 - Increased rates for group psychotherapy by 20%
 - Added modifiers for behavioral health evaluation and treatment codes to allow for a 20% increase in payment rates when services are provided on holidays, weekends, and after-hours
 - Expanded code descriptions for reimbursement of outpatient crisis stabilization services
- Total cost impact of behavioral health changes is \$7.5 million (state and federal funds)
- Additional behavioral health rate and service changes are being planned for implementation in January 2019

New Mexico Medicaid Enrollment and PMPM



**June 2019
Projected Enrollment
Total=865,280
(+2.1% from June 2018)**

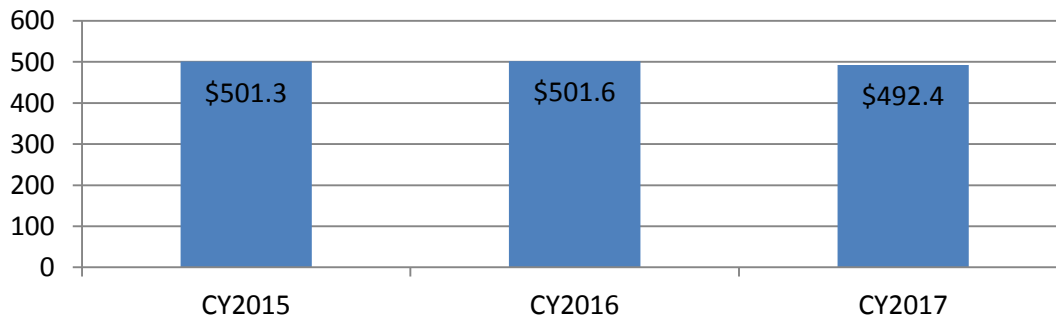
**Expansion/OAG:
260,024**

**Medicaid Adults:
251,005**

**Medicaid Children:
354,330***

*children 19-21 y.o. counted in OAG

Average Per Member Per Month Costs in Centennial Care



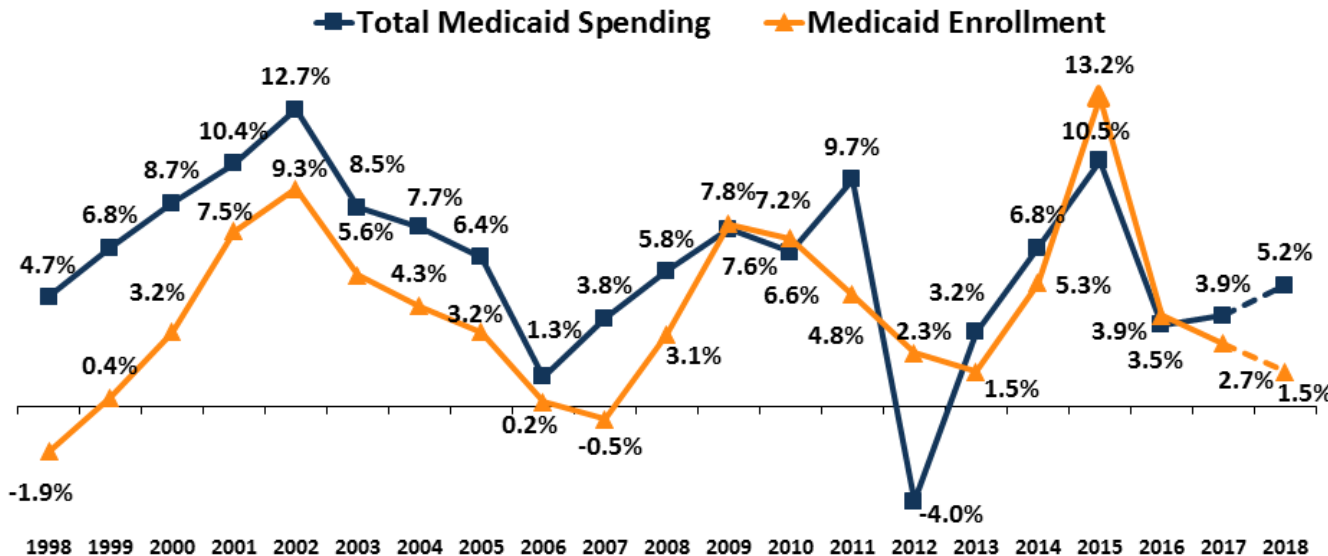
Enrollment Impacts

New Mexico's Improving economy

June 2017 - June 2018: % Changes In Economic Indicators	
	% Change
State Labor Force	+1.2%
Total Employment	+2.5%
Unemployment Rate	-19.7%
Total Personal Income	+2.8%

National Trend of slowing enrollment growth

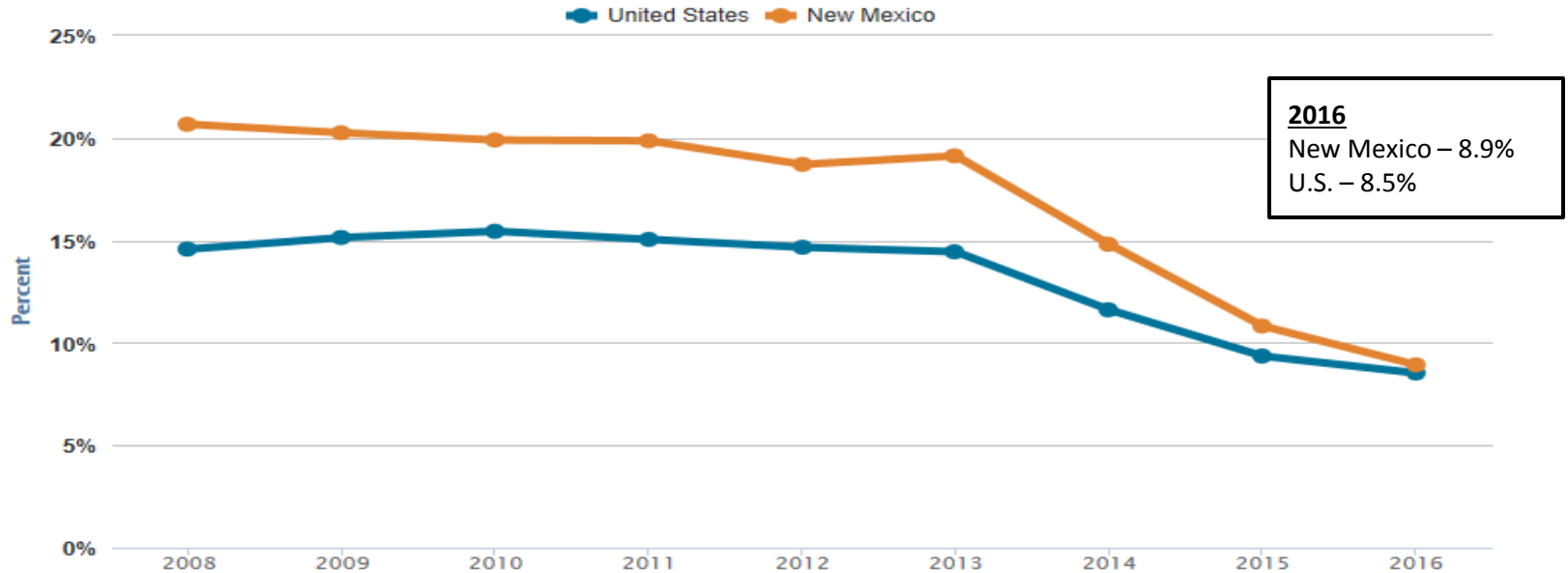
Annual Percentage Changes, FY 1998 – FY 2018



Source: Kaiser Family Foundation

Enrollment Impacts

New Mexico Uninsured Rate



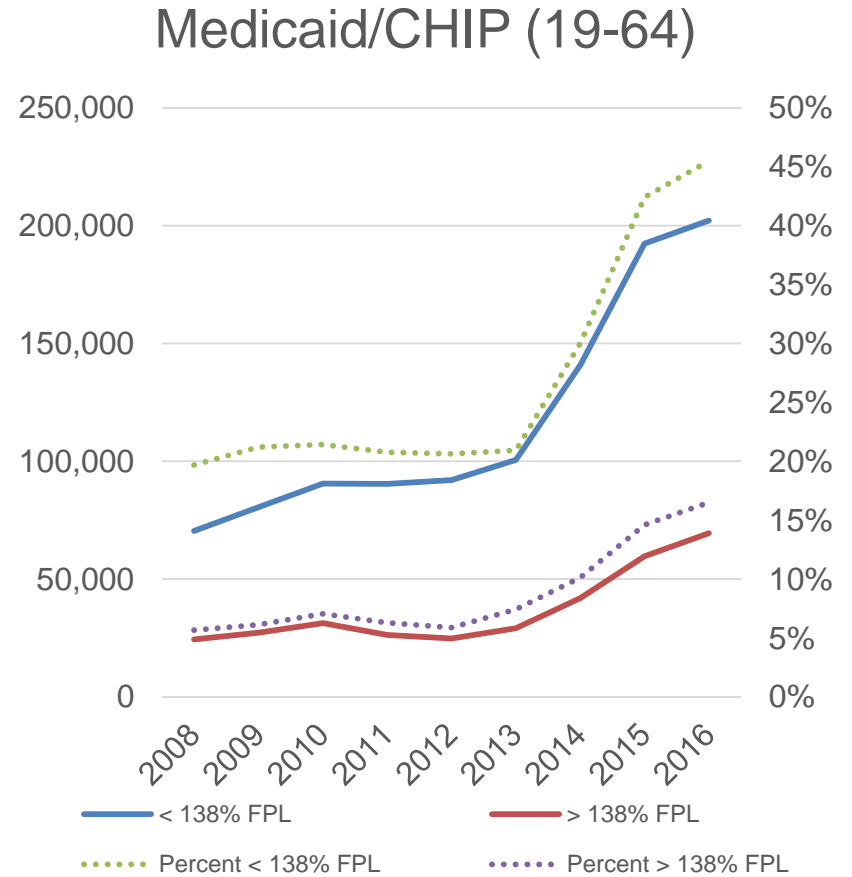
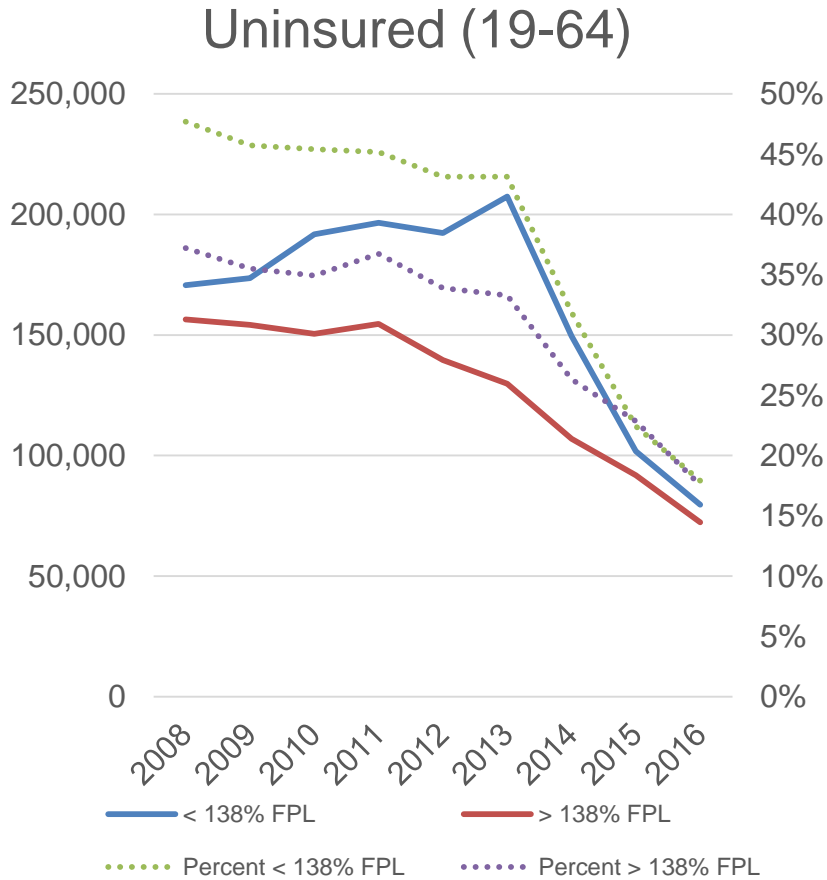
SHADAC is a multidisciplinary health policy research center with a focus on state health policy. SHADAC is supported by the Robert Wood Johnson Foundation and is affiliated with the Health Policy and Management Division of the School of Public Health at the University of Minnesota. For more information, visit www.shadac.org.

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Enrollment Impacts:

New Mexico 19-64 Uninsured and Medicaid-Insured by FPL

2016: 138% FPL, \$16,394 (single), \$33,534 (4-person)



Source: SHADAC State Health Compare, University of Minnesota

Federal Outlook

(FY20 Budget Issues)

- Expansion FMAP steps down again on January 1, 2019, to 93% and on January 1, 2020 to 90%.
- Regular FMAP rates expected to improve slightly for NM.
- CHIP Reauthorization
 - 100% expires in September 30, 2019.
 - Phase-out increased to states' E-FMAP by 11.5% through September 30, 2020.
 - E-FMAP reverts back on October 1, 2020.
- Re-imposition of the Federal Health Insurance Provider Fee

Centennial Care: Reforming Medicaid

- A Comprehensive Service Delivery System
 - Managed Care Organizations are responsible for integrating care to address all health needs of the member through robust care coordination
- Personal Responsibility
 - Engage recipients in their personal health decisions through incentives and disincentives
- Payment Reform
 - Use innovative payment methodologies to reward quality care and improve health outcomes instead of just the quantity of care
- Administrative Simplification
 - Combine all Medicaid waivers (except the Developmental Disabilities and Medically Fragile waivers) into a single, comprehensive Section 1115 waiver

Centennial Care

Principle 1

Creating a comprehensive delivery system

Build a care coordination infrastructure for members with more complex needs that coordinates the full array of services in an ***integrated, person-centered model of care***

- Care coordination
 - 850 care coordinators
 - 37,013 in care coordination L2 and L3
 - Focus on high cost/high need members

- Health risk assessment
 - Standardized HRA across MCOs
 - 753,564 HRAs conducted

- Increased use of community health workers
 - 100 employed or contracted by MCOs

- Increase in members served by Patient Centered Medical Homes
 - Approximately 400,000 members receiving services through a PCMH
- Expanding home and community based services
 - 28,000 members receiving HCBS
 - Implemented electronic visit verification system for personal care services
- Health Homes –Expanded to 10 more counties for adults and kids with co-occurring behavioral health diagnoses

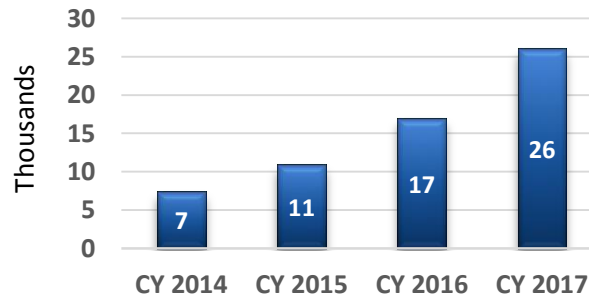
Centennial Care

Principle 1

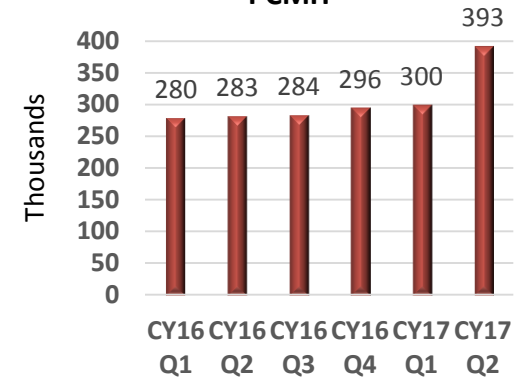
Creating a comprehensive delivery system

Build a care coordination infrastructure for members with more complex needs that coordinates the full array of services in an *integrated, person-centered model of care*

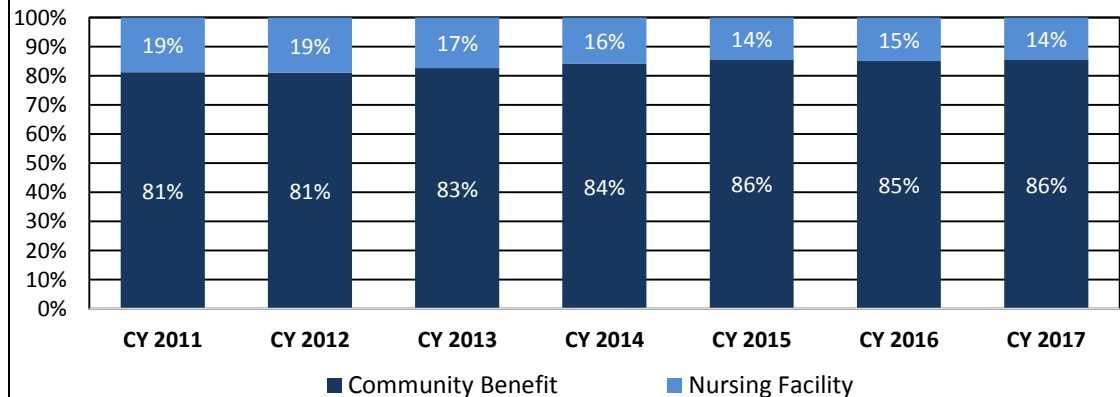
Number of Visits through Telemedicine in Rural and Frontier Counties



Number Served through a PCMH



Long Term Services and Supports: HCBS utilization vs Nursing Facility



Centennial Care: Personal Care Services Spending

Calendar Year	Users	PCS Expenditures	Average Unit Cost	Average Annual Spend per User
2013 (Pre-CC) Long Term Services & Supports (LTSS)/PCS	19,500	\$ 263,072,327	\$13.51	\$13,491
2014 LTSS + Adult Expansion	22,999	\$282,638,083	\$13.93	\$12,289
2015 LTSS + Adult Expansion	26,703	\$310,867,700	\$14.21	\$11,642
2016 LTSS + Adult Expansion	28,364	\$312,100,606	\$14.17	\$11,003

Centennial Care

Principle 2

Encouraging Personal Responsibility

Offer a member rewards program to incentivize members to ***engage in healthy behaviors***

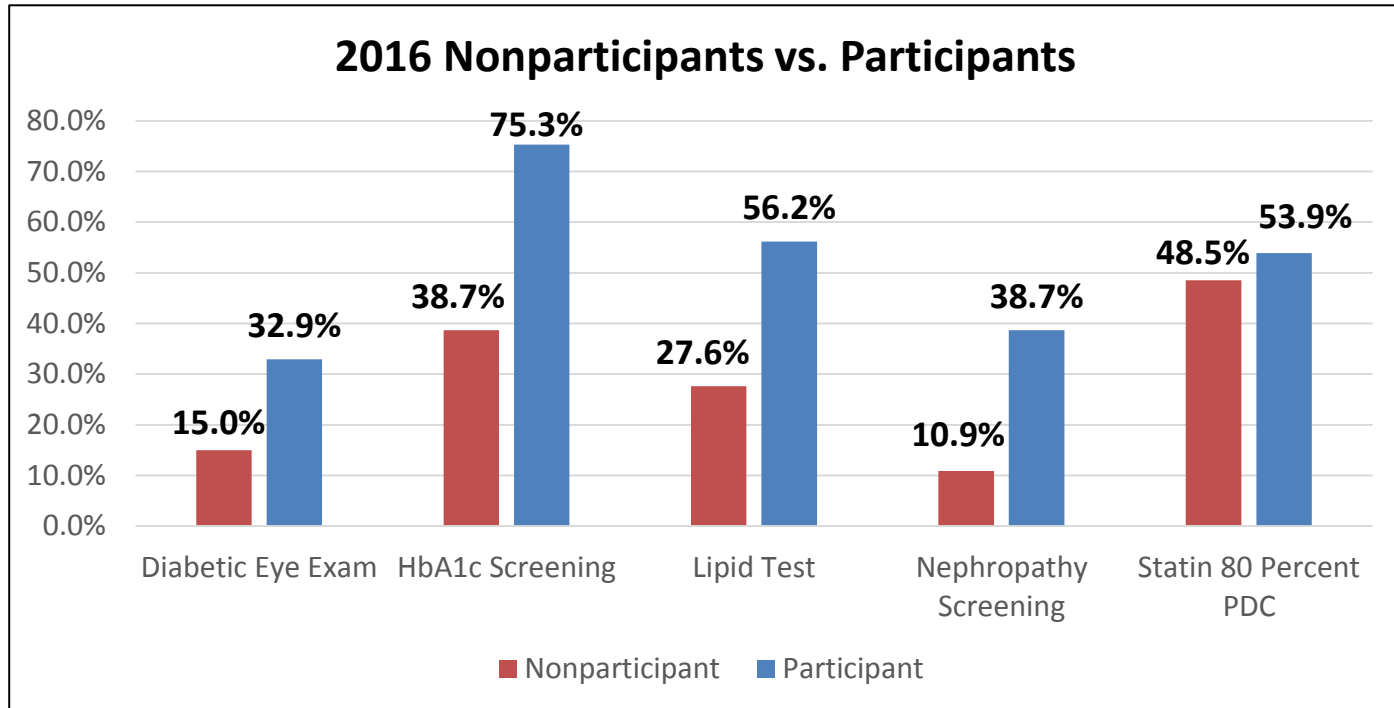
- Centennial Rewards:
 - dental visits
 - bone density screenings
 - refilling asthma inhalers
 - diabetic screenings
 - refilling medications for bipolar disorder and schizophrenia

- 71% participation in rewards program
- 60% participate via mobile devices
- Estimated cost savings in 2016: \$24 million
 - Reduced hospital admissions
 - 35% higher asthma controller refill adherence
 - 40% higher test compliance for diabetes
 - 73% higher medication adherence for individuals with schizophrenia
- 90k members participating in step-up challenge

- Implementing 2 co-pays in 2019: for non-emergent use of the ER and for brand drugs when generic equivalents are available

Centennial Rewards: Participants Compared to Non-Participants

DIABETES MANAGEMENT



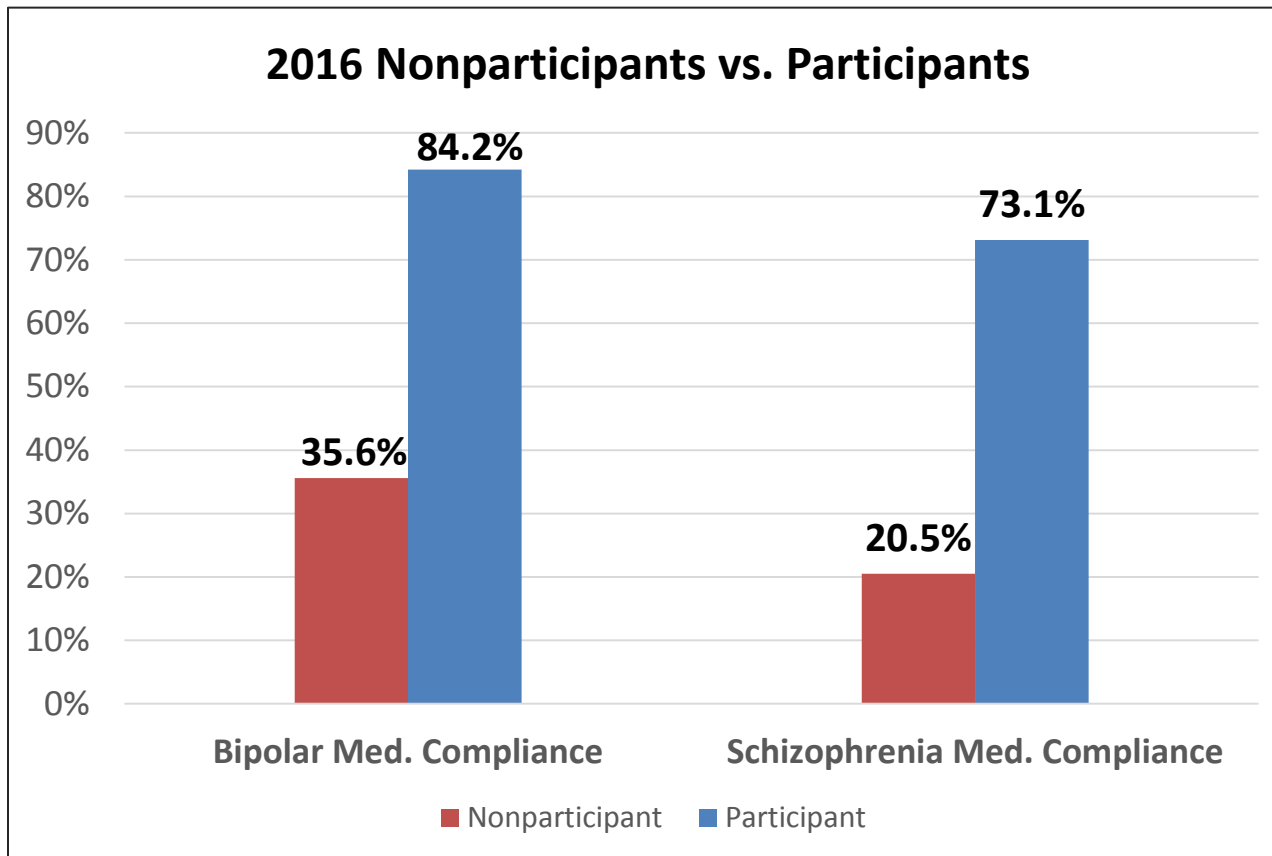
37% Higher HbA1C test compliance

28% Higher nephropathy screening compliance

18% Higher eye exam compliance

Centennial Rewards: Participants Compared to Non-Participants

BIPOLAR & SCHIZOPHRENIA MEDICATION COMPLIANCE

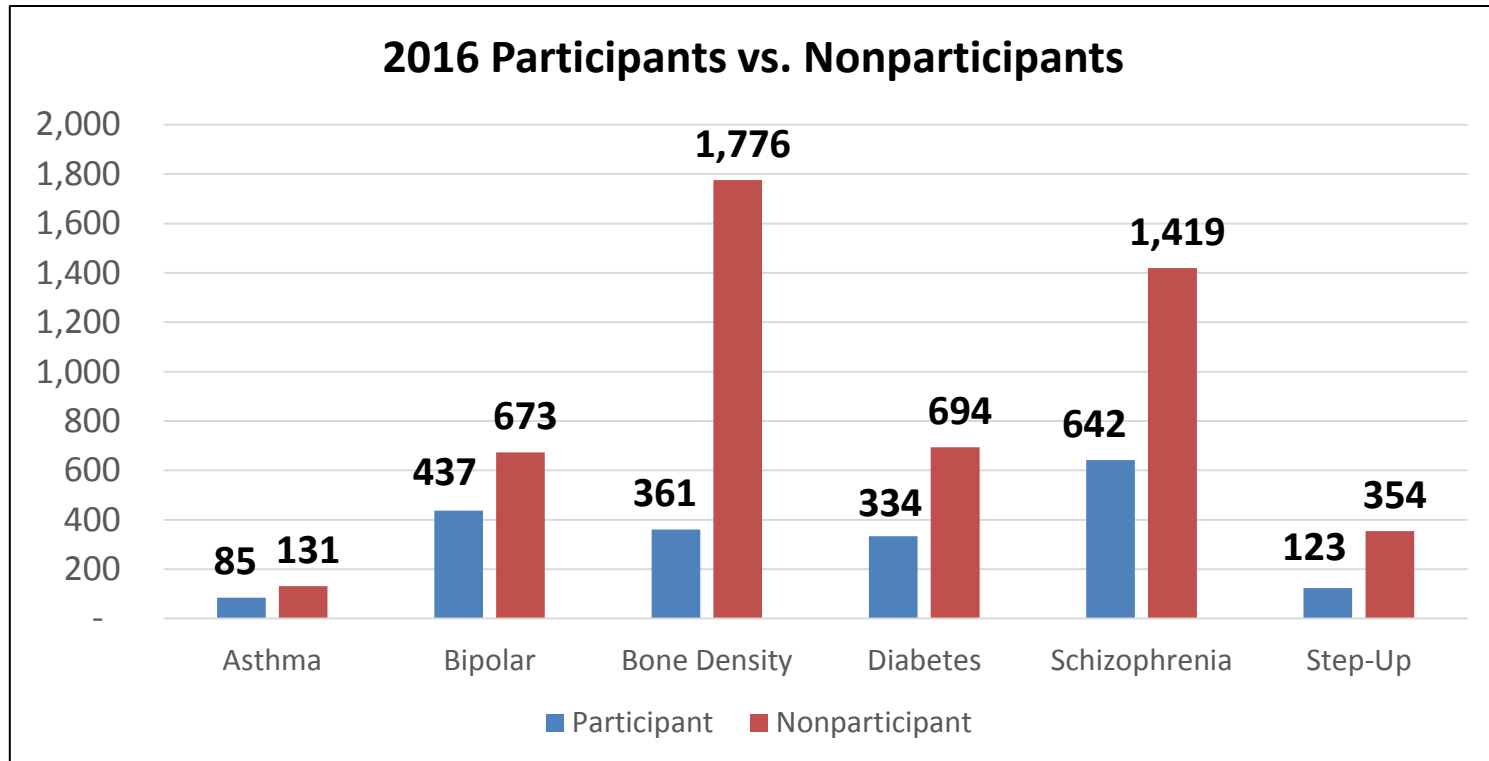


49% higher bipolar medication compliance.

53% higher schizophrenia medication compliance.

Centennial Rewards: Participants Compared to Non-Participants

INPATIENT ADMISSIONS PER 1,000 MEMBERS



Inpatient admissions are lower for participants across all conditions.

Centennial Care

Principle 3

Increasing Emphasis on Payment Reforms

Create an incentive
payment structures
that **reward providers
for high quality of
care to improve
members' health**

- Required the MCOs to have at least 16% of provider payments in value-based purchasing (VBP) arrangements in 2017
 - All of the MCOs met the requirement
 - Increased requirement to 20% for 2018

Delivery System Reform

Health
Homes
(PMPM)

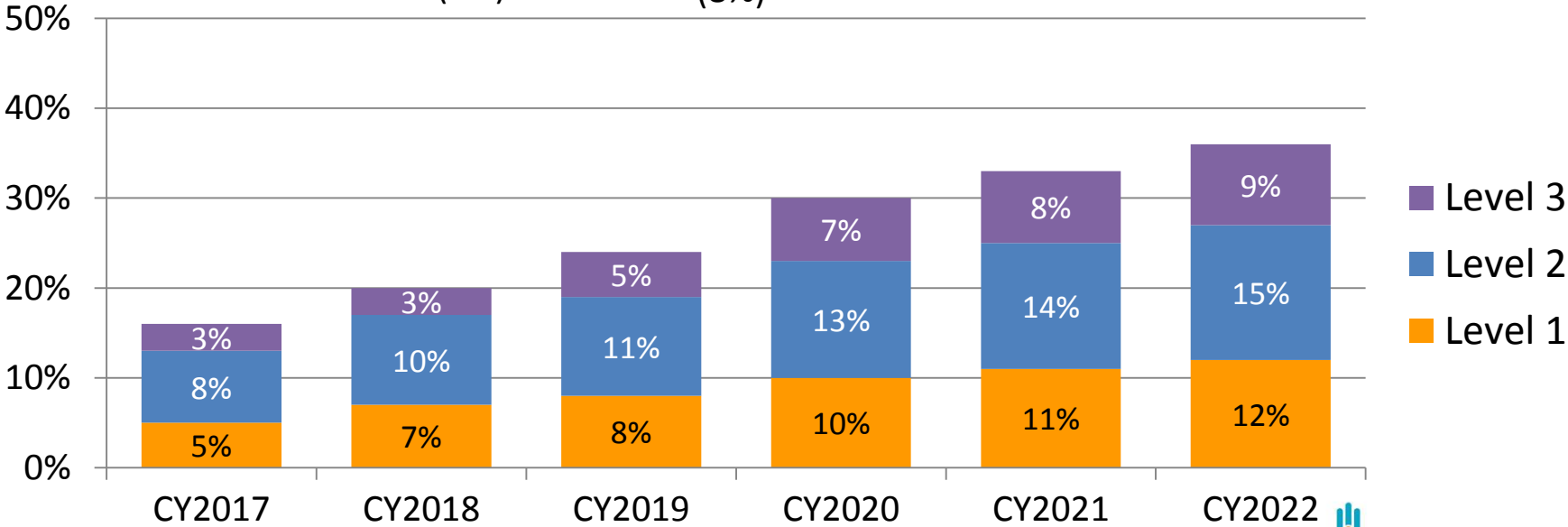
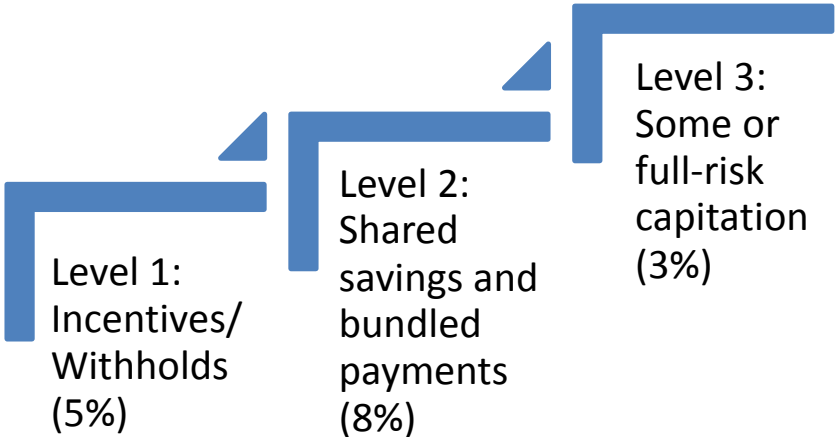
Hospital
Quality
Improvement
Incentives

Shared
Savings with
Patient
Centered
Medical
Homes

Bundled
Payments for
Episodes of
Care

Sub-
capitated
arrangement
for
attributed
members

Centennial Care: Provider Payments in VBP



Centennial Care

Principle 4

Simplify Administration

Create a coordinated delivery system that focuses on **integrated care and improved health outcomes**; increases accountability for more limited number of MCOs and **reduces administrative burden** for both providers and members

- Consolidation of 11 different federal waivers that siloed care by category of eligibility; reduce number of MCOs and require each MCO to deliver the full array of benefits; streamline application and enrollment processes for members; and develop strategies with MCOs to reduce provider administrative burden

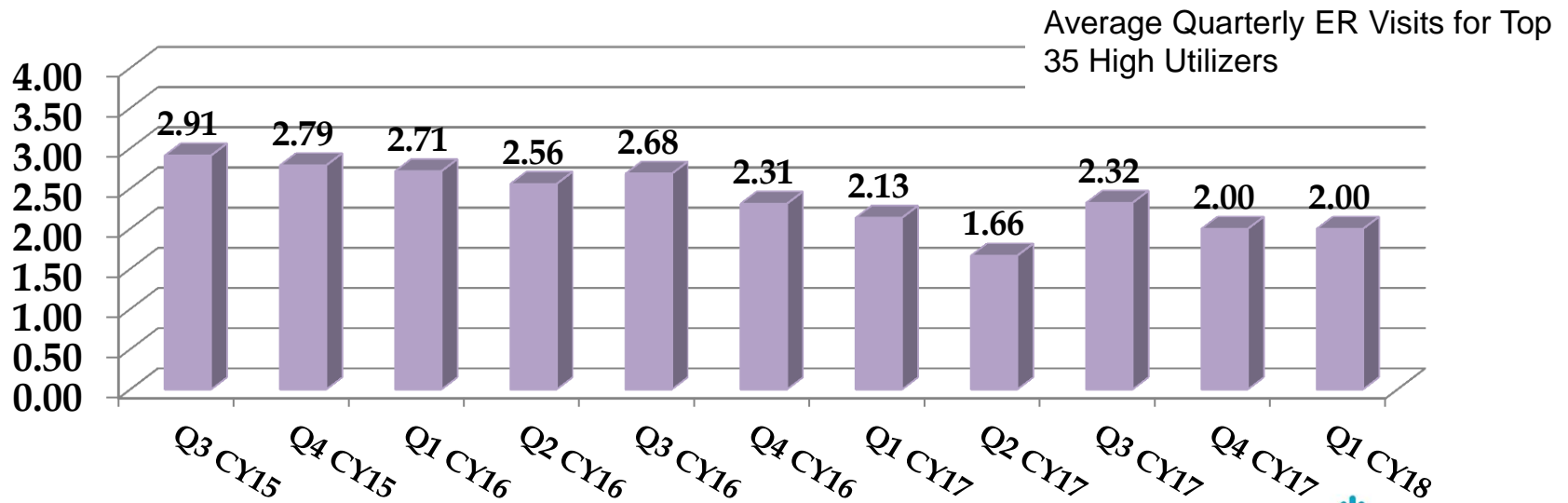
- One application for Medicaid and subsidized coverage through the Health Insurance Exchange Marketplace

- Streamlined enrollment and re-certifications, added more online application tools

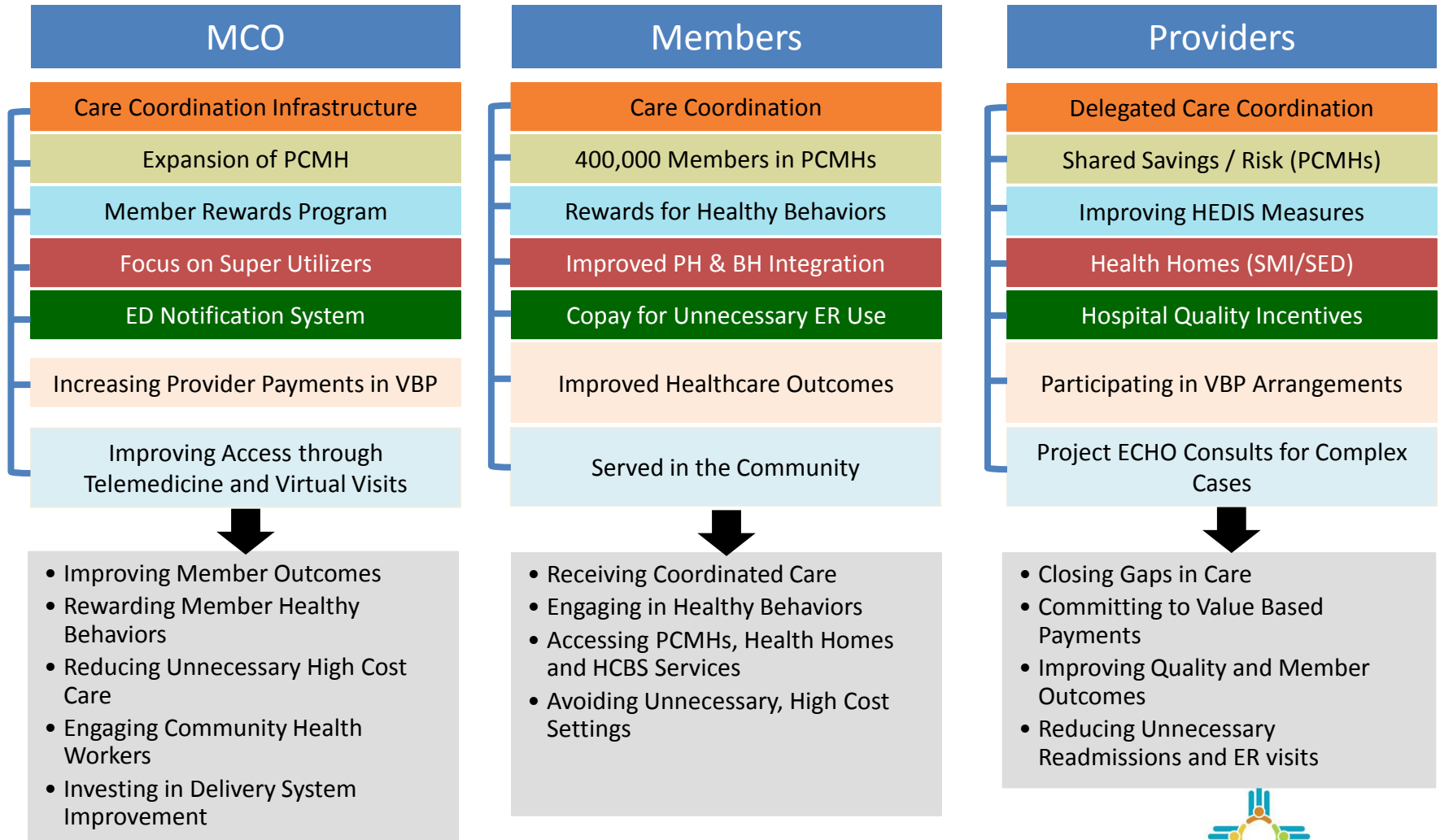
- Fewer Managed Care Organizations
- Standardizing forms and procedures
 - Standardized HRA and Community Benefit Assessment
 - BH Prior Authorization Form for Managed Care and FFS
 - BH Level of Care Guidelines
 - Single Ownership and Controlling Interest Disclosure Form for credentialing.
- Created FAQs for Credentialing and BH Provider Billing

Pilot Project with MCOs on Super-Utilizers

- Identified the MCOs' highest utilizers of the Emergency Department (ED) over a 15 month period.
- HSD/MAD reviewed the top 35 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.
- Led to reduced ER utilization.

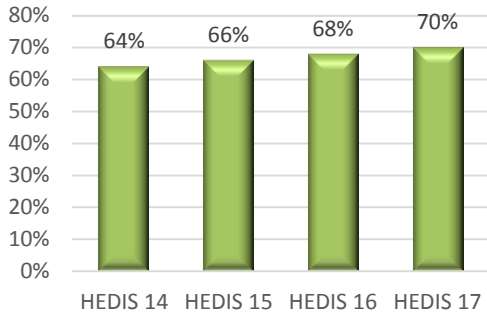


Aligning Policies and Incentives for MCOs, Members & Providers

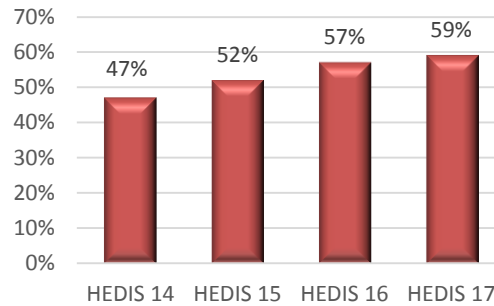


Centennial Care: HEDIS Performance

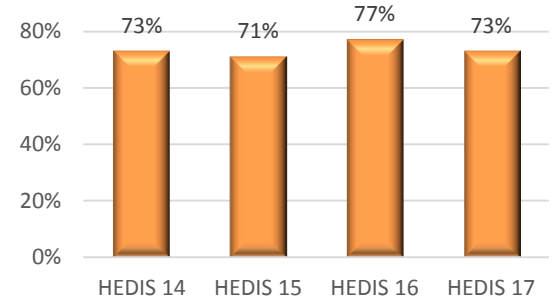
Annual Dental Visits for Children



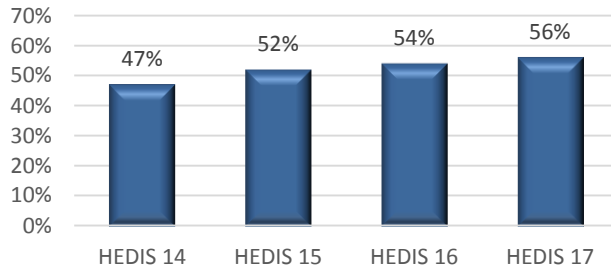
Well Child Visits within 1st 15 mos.



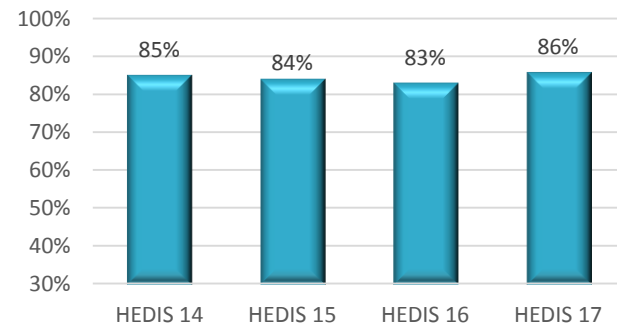
Prenatal Care Visits in the 1st Trimester



Asthma Medication Management for Members 5-64 years, 50% Compliance



Diabetes Testing for 18-75 Years





Vision for the future of Centennial Care

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Behavioral health integration
- Long-Term Services and Supports (LTSS)
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to benefits and eligibility



1115 Waiver Renewal

- 1115 waiver negotiations with CMS are ongoing
- Result of the negotiations will be a new Special Terms and Conditions document that includes all of the federal approvals for Centennial Care 2.0--similar to a contract between the State and CMS
- Hope to have final approval from CMS by end of September/early October 2018



MCO Procurement

HSD is currently contracted with 3 MCOs for services beginning on 1/1/19:

- Blue Cross Blue Shield of NM
 - Presbyterian Health Plan
 - Western Sky Community Care
-
- Molina and United were not selected to provide services after December 31, 2018; however, Molina is appealing the State's decision through its appeal rights with the court.
 - United Healthcare and Presbyterian entered into an agreement to transition United's Medicaid membership to Presbyterian on September 1, 2018. United will not provide Medicaid services after August 31, 2018.



Open Enrollment

- Scheduled to begin in October through end of November;
- Open enrollment letters will be mailed to members beginning the week of September 17th;
- HSD and the CC 2.0 MCOs will conduct statewide outreach events beginning in mid-September.

Proposed Outreach Events

DATE	CITY	LOCATION	EVENT TIME
9/11/2018 Tuesday	Gallup	Main Library - 115 West Hill Avenue Gallup, NM	ALL LOCATIONS/DATES: 5:00 PM - 7:00 PM
9/12/2018 Wednesday	Farmington	Farmington Public Library - 2101 Farmington Ave., Farmington, NM	
9/12/2018 Wednesday	Santa Fe	Santa Fe Public Library - 6599 Jaguar Drive. Santa Fe, NM	
9/17/2018 Monday	Roswell	Roswell Public Library - 301 N. Pennsylvania, Roswell NM.	
9/18/2018 Tuesday	Clovis	Clovis Public Library - 701 N. Main St. Clovis, NM.	
9/19/2018 Wednesday	Las Vegas	NM Highlands University Student Union Building 301 Student Center	
9/19/2018 Wednesday	Albuquerque	Mesa Verde Community Center 7900 Marquette	
9/24/2018 Monday	Silver City	GRC Auditorium/WNMU (Corner of 12th & Kentucky), Silver City	
9/25/2018 Tuesday	Las Cruces	Branigan Library - 200 E. Picacho Las Cruces, NM	
9/26/2018 Wednesday	Albuquerque	Taylor Ranch Community Ctr. - 4900 Kachina NW	

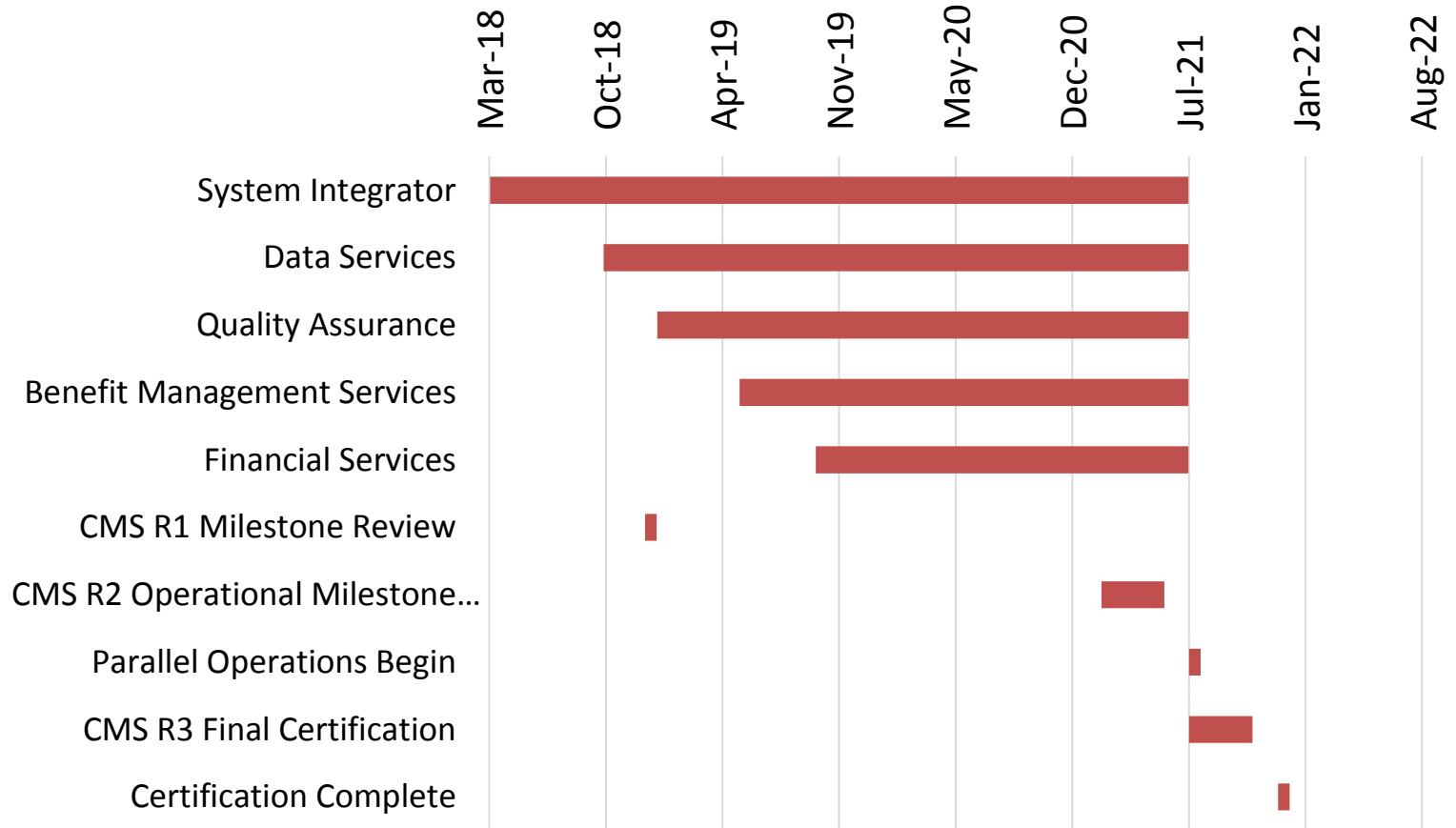
Medicaid and Information Technology

- Medicaid Management Information System (MMIS)
 - Over 10 million transactions per year
 - Responsible for over \$6 billion in Medicaid payments
 - Performs all non-eligibility functions for Medicaid
- MMIS Replacement
 - Multi-year project to replace the current MMIS
 - Modular approach per CMS requirements
 - Multiple procurements and vendors
 - Projected completion by December 2021

Medicaid Management Information System Replacement (MMISR)

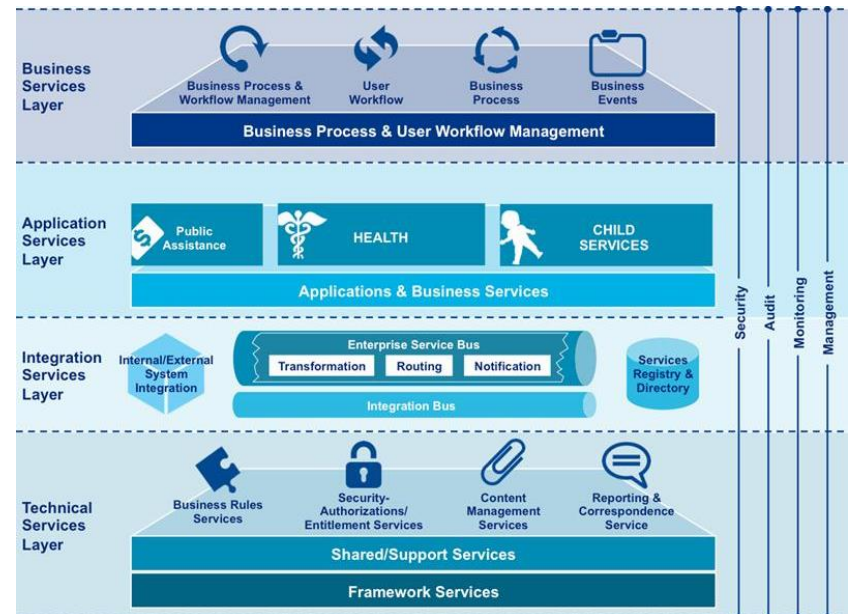
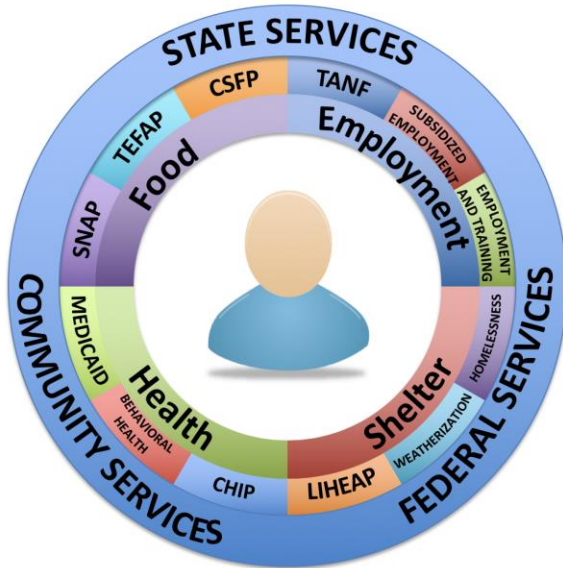
- Part of the HHS2020 initiative
- Creates a client-centric business solution and is the foundation for additional development within New Mexico's Health & Human Services (HHS) enterprise.
- Undertaking multiple procurements to implement MMISR
 - System Integrator (SI) – contract awarded
 - Data Services (DS) – contract in review and signature process
 - Quality Assurance (QA) -- in contract negotiation
 - Benefit Management Services (BMS) -- release RFP in September 2018
 - Financial Services (FS) -- release RFP in November 2018
 - Unified Public Interface (UPI) -- TBD

MMISR Timeline



HHS 2020

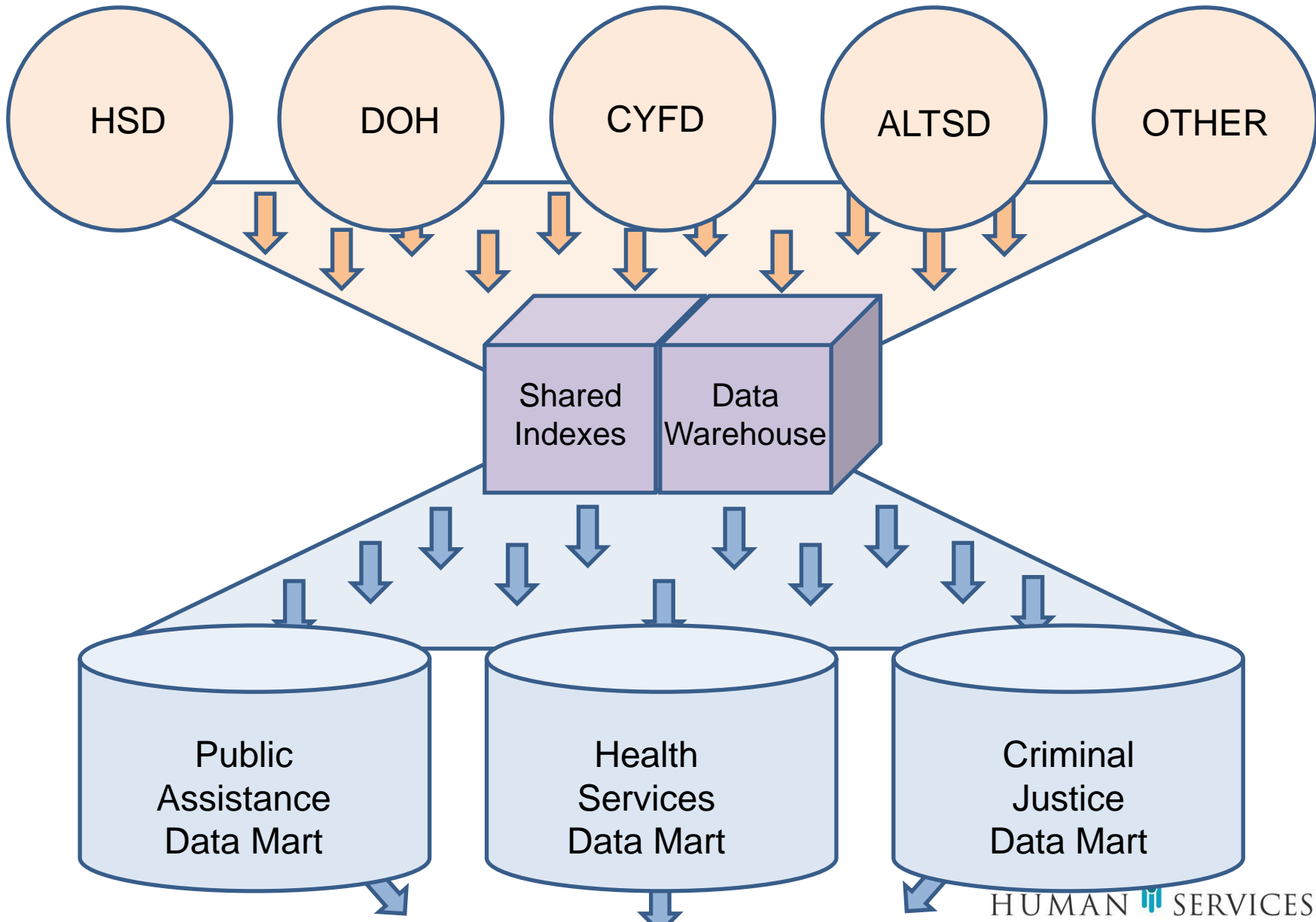
From Program Centric to Person Centric



Leveraging and integrating IT platforms and architecture for multiple business needs (program delivery)



Incorporate data services to measure outcomes and be more responsive to changing needs of populations



360 Degree View of Each Person

HHS2020



HHS2020 Business Transformation Council



Customers



Providers, Contractors, and Employers



MCOs



Financial Management



Organizational Change Management



Communication and Training



Questions?