Presentation to the Legislative Finance Committee

Brent Earnest, Secretary, HSD

March 21, 2016

Financing Medicaid in FY17 and Beyond

Presentation Topics

- Post Session Medicaid Budget Overview
- Cost Containment: Stakeholder Engagement and Implementation
- Project Snapshots
  - Care coordination
  - Health Homes
  - Telehealth
- Performance Reports
- Payment Reform Projects

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Post Session Medicaid Budget Summary

($ in millions)

FY16			FY17	
Total Projected Expenditures	$5,686.3		Total Projected Expenditures	$5,993.0
Federal Revenue	($4,495.9)		Federal Revenue	($4,746.4)
State Funding Need	$1,190.4		State Funding Need	$1,246.6
Other State Funds	($257.0)		Other State Funds	($270.1)
General Fund Need	$933.4		General Fund Need	$976.5
General Fund Appropriation	($891.7)		HB 2 General Fund Approp.	($913.7)
House Bill 2 Supp Approp.	($18.0)			–
Unfunded General Fund	$23.7		Unfunded General Fund	$62.8
			Total Unfunded General Fund	$86.5
			Total Unfunded Expenditures	$417.9

Notes:

Based on 12.02.2015 Medicaid Projection

Estimated unfunded expenditures calculated with aggregate FMAP of 79.3%

Medicaid Enrollment, Expenditures and Revenues

Medicaid Expenditures/Revenues ($ in Millions): 0 – 7,500

Medicaid Enrollment: – to 1,000,000

	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22
Medicaid Enrollment	576,440	712,349	823,990	883,824	924,709	937,554	950,244	960,961	963,832	965,096
Total Expenditures	3,677	4,201	5,169	5,686	5,916	6,114	6,300	6,481	6,656	6,835
Federal Share	2,560	3,062	4,042	4,496	4,692	4,808	4,933	5,012	5,174	5,320
Other Revenues	250	236	234	257	247	250	251	253	253	253
General Fund Need	868	902	893	933	977	1,055	1,116	1,217	1,229	1,262

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Medicaid Program General Fund FY15-FY22

($ in millions)

$1,370
$1,270
$1,170
$1,070
$970
$870
$770

102%
100%
98%
96%
94%
92%
90%
88%
86%
84%

100% 100% 97.5% 94.5% 93.5% 91.5% 90% 90%

$893 $933 $977 $1,055 $1,116 $1,217 $1,229 $1,262

$910 $914 $987 $1,044 $1,138 $1,150 $1,180

FY 15 FY 16 FY 17 FY 18 FY 19 FY 20 FY 21 FY 22

GF Without Cost Containment
General Fund Appropriation
GF With Cost Containment
Expansion FMAP

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Medicaid Program Total FY15-FY22

($ in millions)

$6,900
$6,700
$6,500
$6,300
$6,100
$5,900
$5,700
$5,500
$5,300
$5,100

FY 15 FY 16 FY 17 FY 18 FY 19 FY 20 FY 21 FY 22

$5,169
$5,686
$5,916
$6,114
$6,300
$6,481
$6,656
$6,835

$5,579
$5,610

$5,784
$5,942
$6,095
$6,281
$6,467

~$415

Total Without Cost Containment
Total Appropriation
GF With Cost Containment

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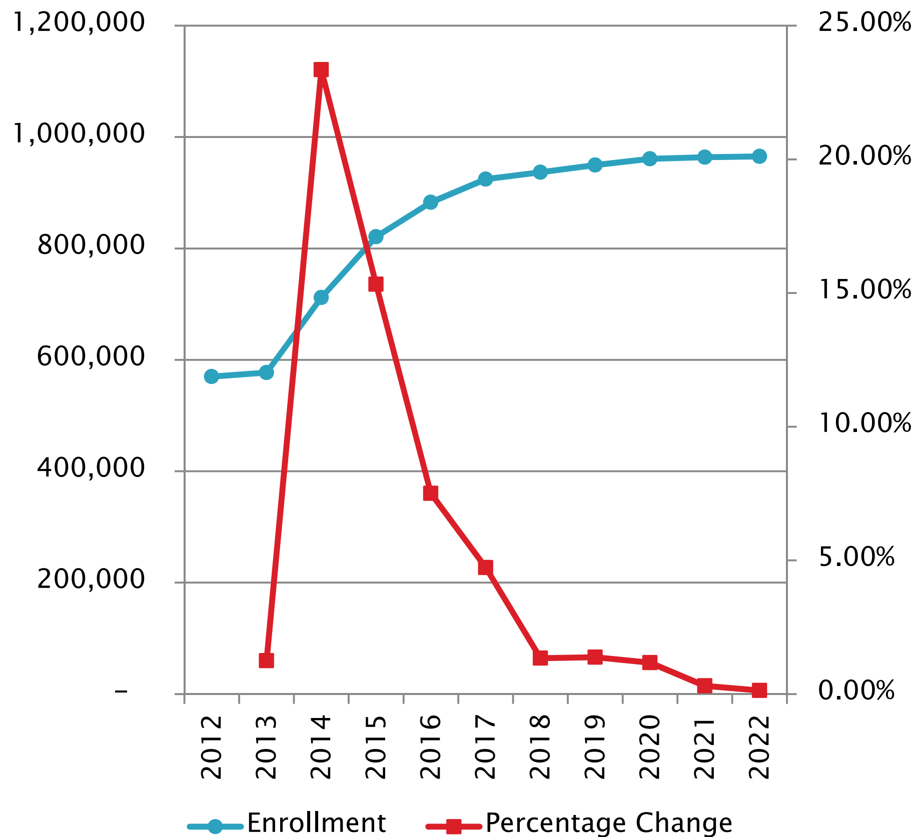
Medicaid Enrollment Projections



Year	Current Projection	Previous Projection
2012	570,054	570,054
2013	577,161	577,161
2014	711,948	712,349
2015	821,077	823,990
2016	882,691	883,824
2017	924,410	924,709

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Variables impacting Medicaid Expenditures

Long Term Impacts

- Medicaid Enrollment increases ↑
- Long Term Services & Supports – growing population with higher setting-of-care needs ↑
- High Cost Drugs ↑
- Medicare Part B premiums ↑
- Health Insurance Exchange Assessment ↑
- Health Insurance Providers Fee (HIPF) ↑
- New Mexico Medical Insurance Pool (NMMIP) Assessment ↑
- Incarcerated Managed Care Recoupments ↓
- Care coordination (reduced utilization trends) ↓

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Variables Impacting Medicaid Expenditures

Short Term Impacts

- CY16 Managed Care Rates ↓
- HIPF moratorium CY 2017 ↓
- Recoupments: Retro-eligibility, Hepatitis C, Risk-Corridor ↓
- Home & Community Based Services Reconciliations ↓

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Variables Impacting General Fund Medicaid Need

- Federal matching rates
  - Title XIX Medicaid program (FMAP – assume current trend) ↓
  - Title XXI CHIP program (EFMAP – 100% through FFY 2019) ↓
    - Subject to Congressional Reauthorization
  - Newly Eligible (Increasing state match until 2020) ↑
- Revenue from UNM and Miners ↓
- Other state fund revenues, such as drug rebates.

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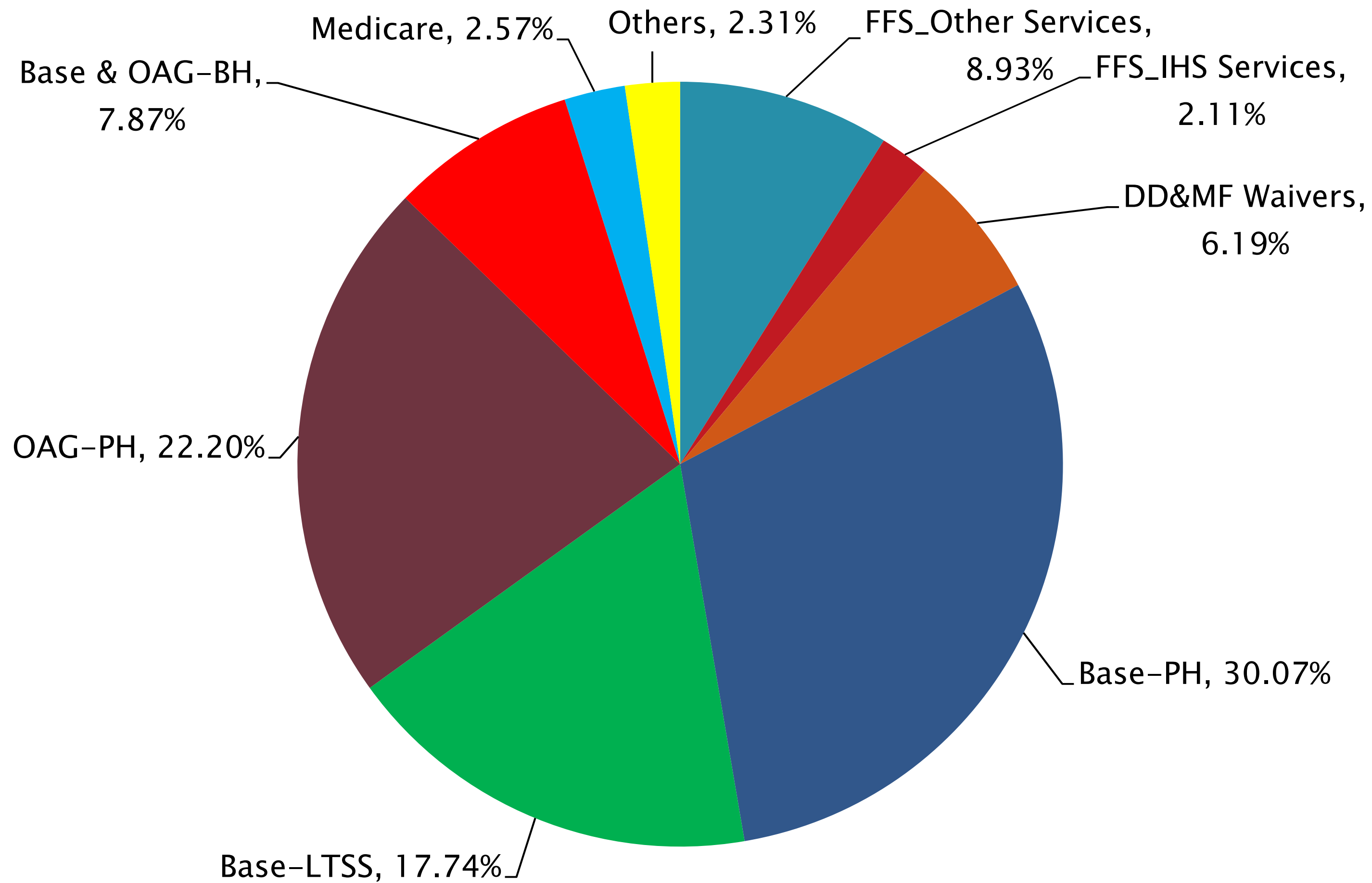
FY15 Budget Projection by Programs



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FY17 Cost Containment Strategies & Implementation

- MAC Subcommittees
  - Provider Payments Cost Containment Subcommittee
    - Phase 1: Recommendations for reducing provider reimbursement rates effective July 1, 2016 in accordance with HB2. Recommendations due by April 8.
    - Phase 2: Recommendations for additional savings related to Medicaid provider payments. Recommendations due this summer.
    - Phase 3: Recommendations for advancing reforms away from fee-for-services payments to more value based reimbursements.
  - Benefit Package, Eligibility Verification and Recipient Cost-Sharing Subcommittee
    - Currently being appointed.
    - Will be charged with submitting recommendations for achieving cost-savings in Medicaid benefits, eligibility verification measures and recipient cost-sharing, including premiums.
    - Implementation target is 1/1/2017 (*any implementation requiring waiver change may be delayed).*

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FY17 Cost Containment Strategies & Implementation cont'd

- Long-Term Strategies Subcommittee
  - Currently being appointed.
  - Charged with developing recommendations for longer-term innovative strategies, including ways to leverage Medicaid differently.
  - Implementation target is 1/1/2017 (*any implementation requiring waiver change may be delayed).*

- Timeline Considerations
  - Internal review.
  - State Plan Amendments, rule promulgation, waiver changes.
  - Tribal and public notice.
  - Actuarial rate revision – Centennial Care.
  - Legislative process.

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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 million total.

- HSD also plans to lower the Medical Loss Ratio in the MCO contracts from 85/15 to 86/14 on 7/1/16, however, does not anticipate savings since the MCOs' administrative costs are currently below 14%.

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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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Care Coordination Update

- 40 percent of the Centennial Care members are being served in Patient-Centered Medical Homes;
- 10 percent of enrollees are assigned to higher levels of care coordination;
- MCOs are partnering with community agencies, such as Albuquerque Ambulance and Kitchen Angels to better manage super utilizers.

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Jail-Involved Care Coordination Pilot Project

- Molina has initiated a pilot project with Bernalillo Detention Center to connect inmates being released with care coordinators.
- It plans to utilize video conference technology so that the care coordinator is able to conduct a health risk assessment with the inmate prior to release and begin scheduling appointments and making referrals.
- The goal is to expand the pilot by the Fall and have all of the MCOs participating.

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MCO Efforts to Reduce Non-Emergent Emergency Room Visits

- The MCOs formed a workgroup to develop initiatives to reduce non-emergent ER use;
- Assigning Community Health Workers to high ER utilizers;
- Piloting programs with Emergency Medical Technicians to visit members;
- Purchasing EDIE software for instant notification when a member is in the ER;
- Patient Navigator program—hospital staff contacts the MCO's navigator who helps triage the member, directing to more appropriate setting such as Urgent Care facility and/or scheduling an appointment with the member's PCP;
- Launch of "Video Visits" with physicians by all MCOs with ability of member to access through a smart phone app.

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Expansion of Telehealth Services

	Baseline			1st Year Results			2nd Year Results			2014 compared to 2015
	2013 Behavioral Health	2013 Physical Health	2013 Total	2014 Behavioral Health	2014 Physical Health	2014 Total	2015 Behavioral Health	2015 Physical Health	2015 Total	Percent Change
BCBS	19	3	22	1,078	91	1,169	1,213	803	2,016	72%
UHC	89	22	111	1,046	96	1,142	1,833	236	2,069	81%
MHNM	7 *	0	7	1,909	32	1,941	2,132	754	2,886	49%
PHP	2,016	4	2,020	3,006	143	3,149	3,809	134	3,943	25%
TOTAL	**2,131**	**29**	**2,160**	**7,039**	**362**	**7,401**	**8,987**	**1,927**	**10,914**	**47%**

* Most telehealth services provided in New Mexico are for behavioral health diagnoses.

In 2013, Medicaid behavioral health services were administered by OptumHealth New Mexico.

Source: MCO 2015 DSIT Results Reporting

MCOs implemented several initiatives to further improve access, including:

- Communication brochures targeted to providers;
- MDLIVE for on-line non-emergent telehealth visits;
- Teledermatology and Telepulmonology;
- Virtual provider visits.

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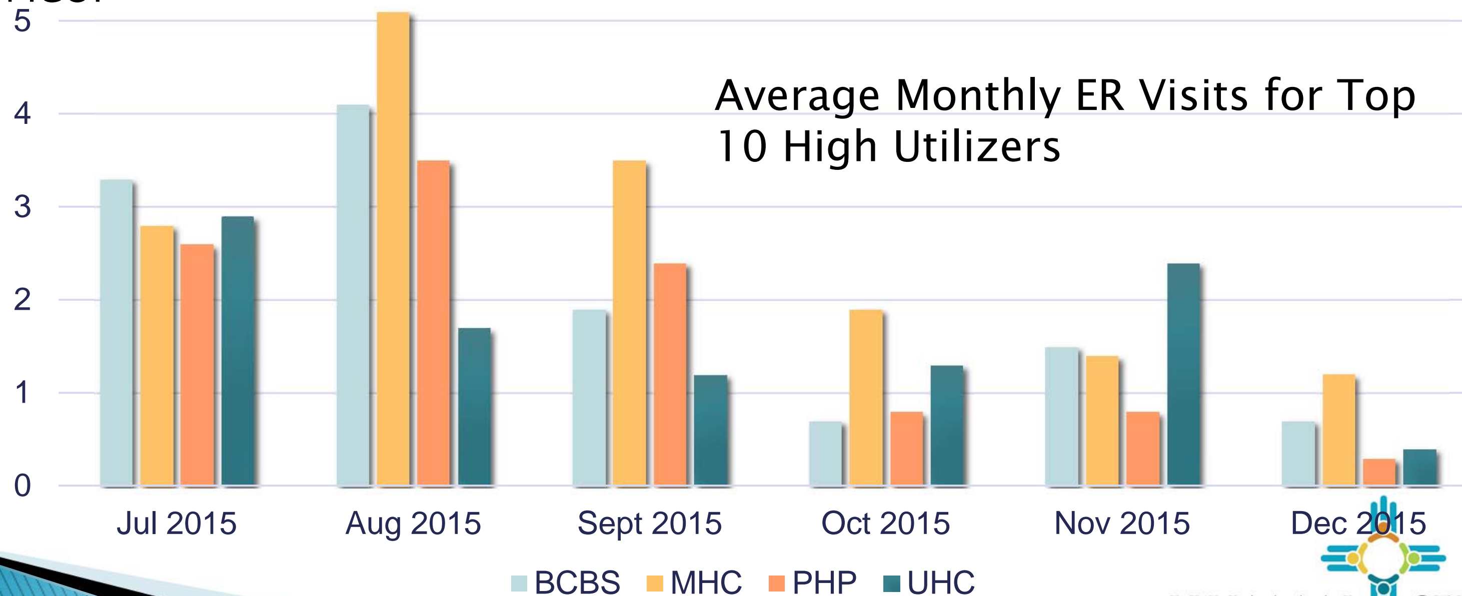
HSD/MAD Pilot Project on Super-Utilizers

- PRISM is an integrated software tool used to support care management interventions for high risk Medicaid patients.
- HSD/MAD utilized PRISM 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:



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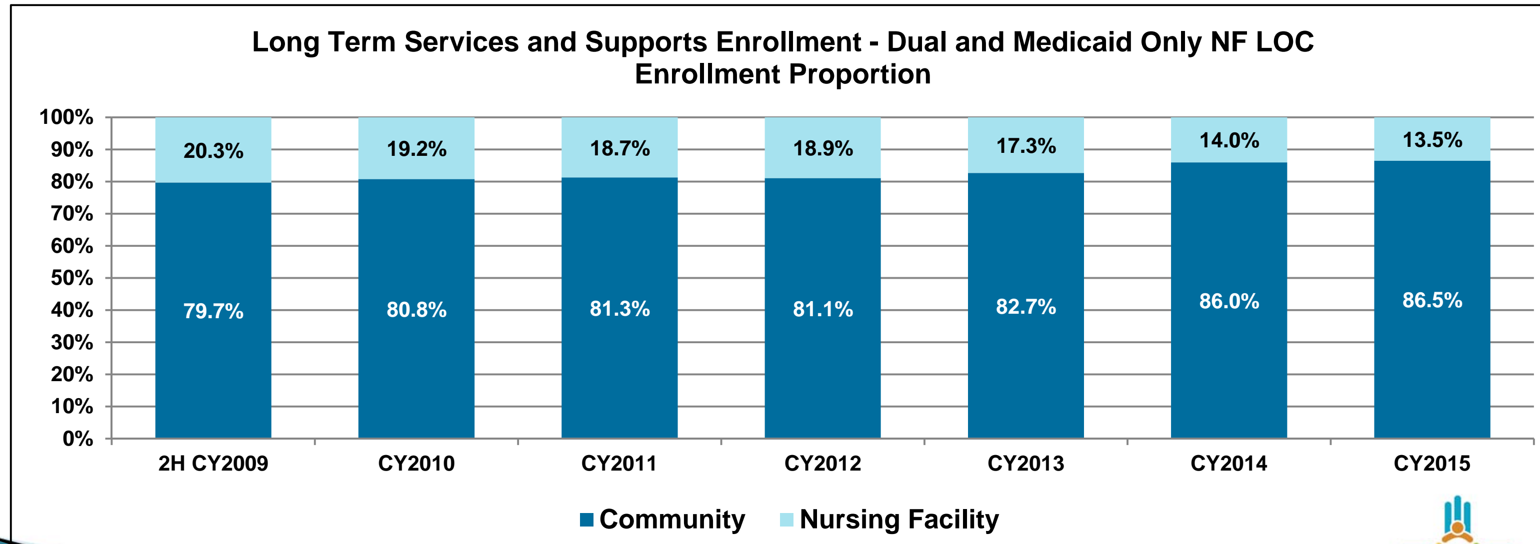
Managed Care and the Long-Term Care Population

- 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 need a waiver slot in order to access the community benefit.



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Health Home Implementation

- Target populations:
  - Serious Mental Illness (SMI) – adults; and
  - Severe Emotional Disturbance (SED) children
- CMS approval of State Plan Amendment – March 2016
- Implementation date April 1, 2016
- San Juan and Curry Counties
- PMS and Mental Health Resources
- Reaching out to potential HH members (letters and telephonically)
- Enrollment estimate by the end of 2016 – 800 members

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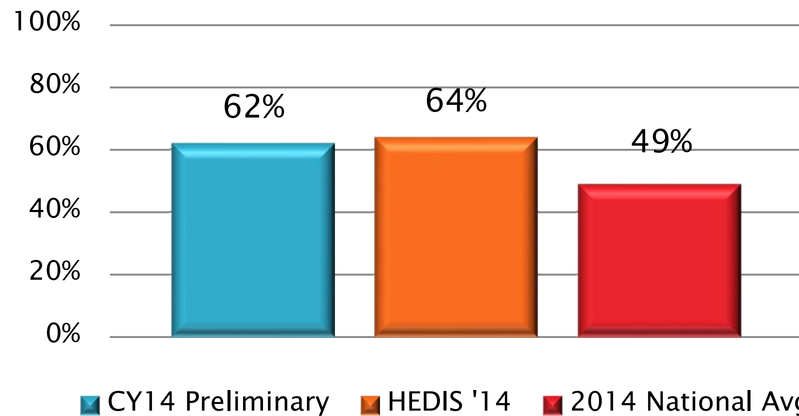
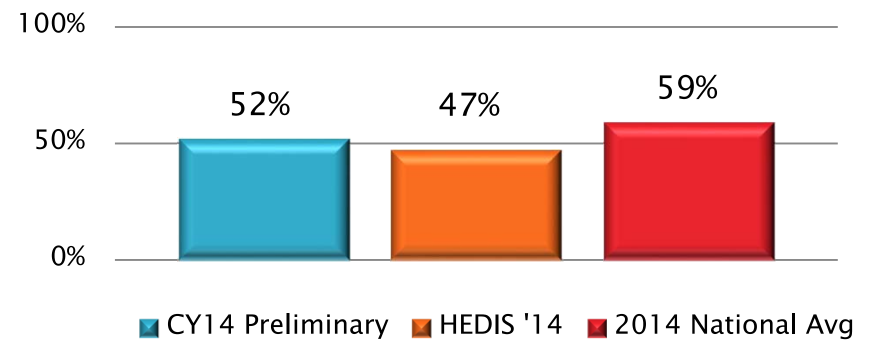
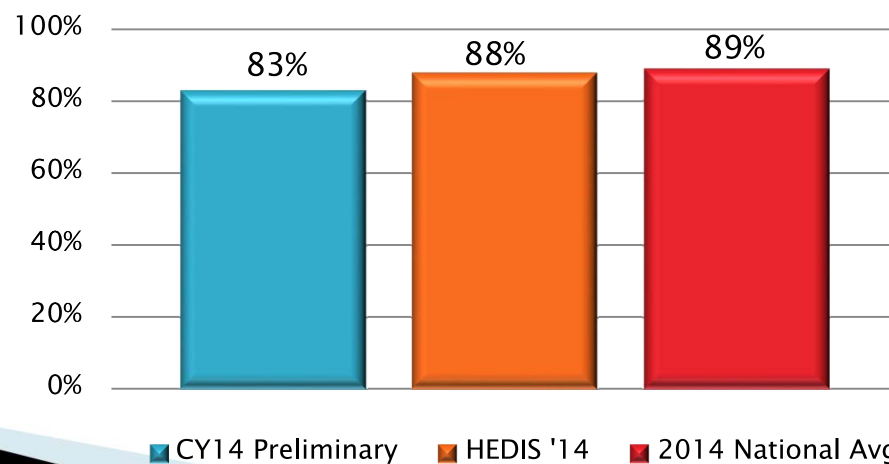
HEDIS Performance Measures







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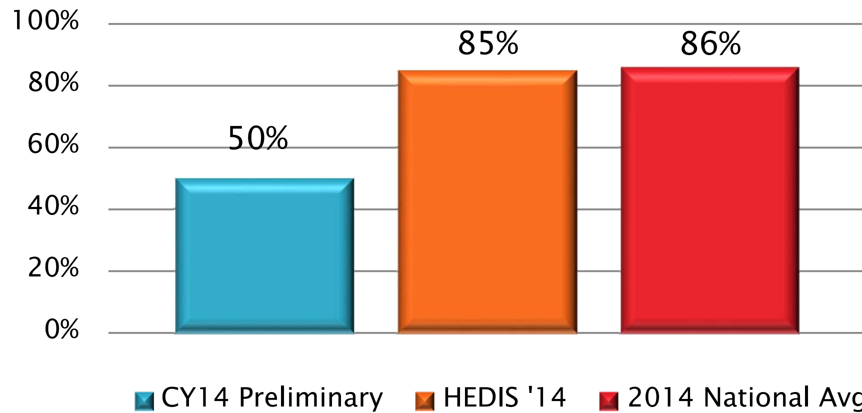
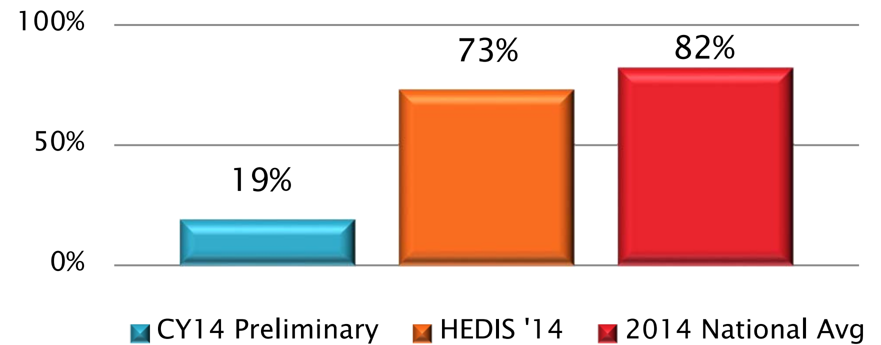
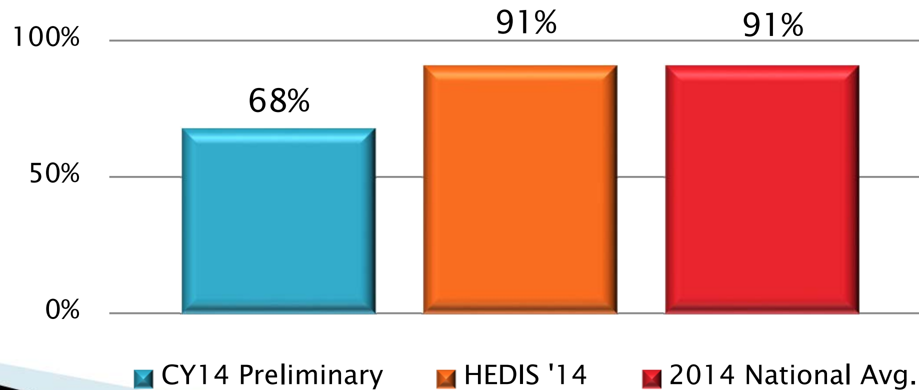
HEDIS Performance Measures







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MCO Efforts to Improve Performance Measures

- MCOs Implemented Strategies to Improve Well-Child Visits and Asthma measures
  - Monitoring visits utilizing administrative reports
  - Newsletters and post cards to members
  - Collaboration with School Based Health Centers
  - Provider education
- MCO workgroup to reduce Emergency Department visits
- MCO initiated Performance Improvement Projects
- Utilization of Care Coordinators and Community Health Workers for outreach and education to members

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HSD Efforts to Improve MCO Performance Measures

- HSD will assess monetary penalties for MCOs that do not meet HEDIS measures for CY16.
- HSD implemented tracking measures for well-child visits.
- HSD monitoring pre-natal rates based on annual audited HEDIS data.
  - Most effective method of tracking progress
- 2015 audited HEDIS is due to HSD on July 1.
- HSD recommends alignment of LFC, Centennial Care contractual and HEDIS measures

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MCO Payment Reform Projects

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

Project	P4P/ACO	Bundled Pay	Description
Accountable Care -Like Models	X		Accountable Care Organization (ACO) model with shared savings for improving quality and reducing total cost of care.
Bundled Payments for Episodes		X	Pursuing bundles for diabetes, bariatric, and maternity.
Emergency Room and Inpatient Reduction Incentives with Behavioral Health Focus	X		Piloting with CSA to reduce ER and inpatient through intensive follow-up, use of peer specialists, crisis visits, and PCP coordination.
Three-tiered Reimbursement for Patient Centered Medical Homes (PCMHs)	X		PMPM increases for base care coordination; data transfer to HIE; telehealth; use of EHRs; and performing HRAs. A total performance incentive per member payment is possible if the targets for every measure are met.
Bundled Payments for Targeted Inpatient Admission Episodes		X	Bundle payments for pneumonia and colonoscopies.
Obstetrics Gain Sharing	X		Reducing unnecessary primary C-sections by developing savings targets that reward appropriate use of C-sections. Under this program, obstetricians can earn enhanced fees for meeting metrics related to reducing unwarranted C-sections.

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Payment Reform Pilot Projects

All of pilots could be considered to be somewhere on the lower end of a continuum-- from allowing provider incentives to fully-shared risk:

The goal is to move toward full risk with providers who have such capacity

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

- Reductions in ER visits and hospital readmissions
- Provider performance against several HEDIS measures
- 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							

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Summary

- Given current state budget, HSD is moving quickly, but carefully, to reduce Medicaid spending in FY17 and future years
- Engaging public and stakeholders
- Seeking to manage short-term cost reductions, while focusing on longer-term strategies that reduce cost and produce better outcomes, e.g.:
    - Expanding payment reform efforts
    - Refining Centennial Care programs

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