HUMAN SERVICES DEPARTMENT

Medicaid Update

Presentation to the New Mexico Association of Counties

Mike Nelson, Deputy Secretary, HSD

June 23, 2016

Today's Topics

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

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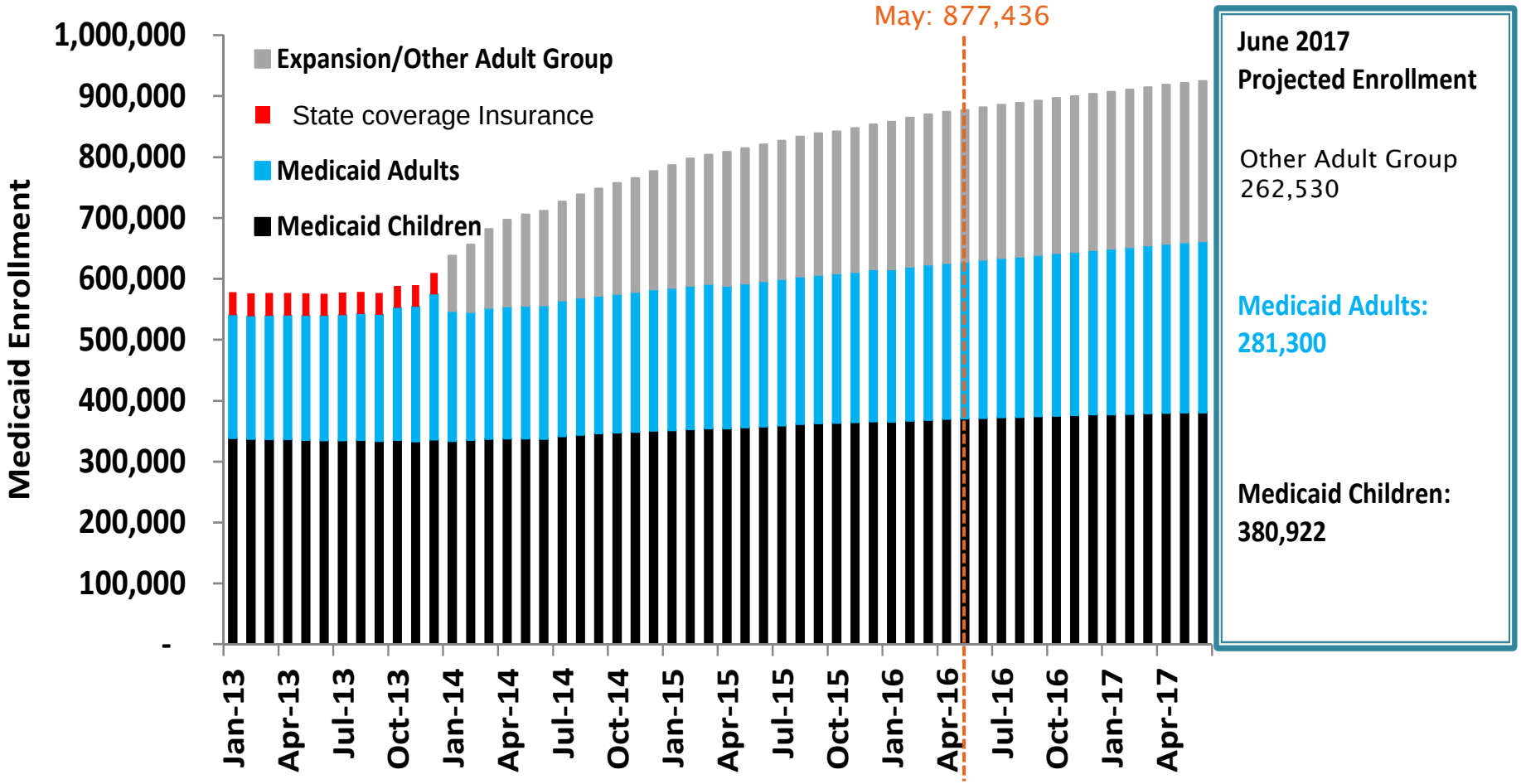
Medicaid Enrollment



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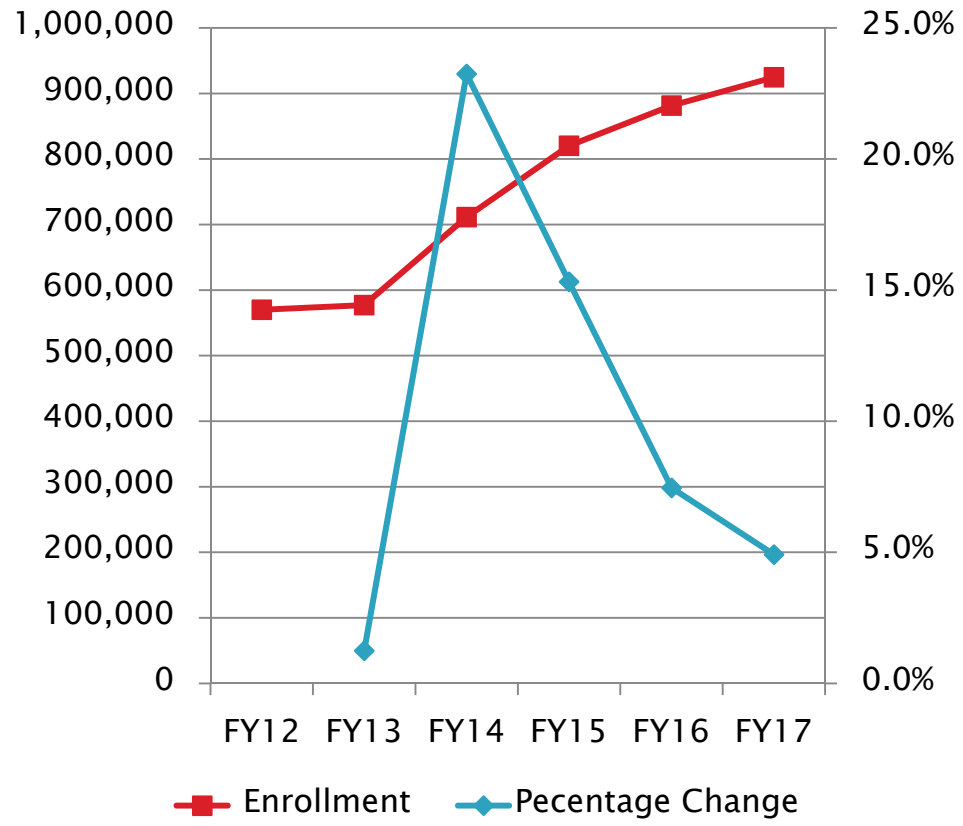
Medicaid Enrollment



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 accepted through May 31st.
  - **Phase 2**: merging with the Long-Term Leveraging Medicaid Subcommittee.

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Proposed Medicaid Rate Changes

- Terminate Primary Care Provider Enhanced Payments
  - Propose to discontinue the PCP Enhanced Payment Program implemented under the Affordable Care Act; effective 7/1/16
  - Program originally put in place for 2013-2014 with enhanced federal funding to support
  - Enhanced federal funding ended in 2015; HSD opted to continue program
  - Affects approximately 2,000 providers statewide
  - Total Savings = $24-$26 million total ($5-$6 million GF)

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Proposed Medicaid Rate Changes

- Outpatient Hospital Reimbursement Reduction
  - Hospitals have benefited significantly from the Adult Expansion of Medicaid
  - Propose to reduce hospital outpatient payments as follows:
    - 3% reduction to outpatient services at acute care, critical access and outpatient rehabilitative hospitals
    - 5% reduction to outpatient services at UNM Hospital
  - Effective 7/1/16
  - Savings = $12.5-$17 million total ($3-$4 million GF)

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Proposed Medicaid Rate Changes

- Inpatient Hospital Reimbursement
  - Propose to reduce hospital inpatient payments as follows:
    - 5% reduction at acute care and critical access hospitals
    - 8% reduction at UNM Hospital
  - Propose to reduce SNCP hospital enhanced rates to the level of matching funds available from counties and the $10 million general fund appropriation in HSD's base budget
  - Effective 7/1/16
  - Inpatient savings = $38-$45million total ($8-$10 million GF)
  - SNCP savings = $28-$33 million total ($3-$4 million GF)
    - Note: GF savings lower due to contribution of state matching funds by UNM Hospital

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Proposed Medicaid Rate Changes

- Practitioner and Dental Reimbursement
  - Propose to reduce payments to physicians and other practitioners paid by fee schedule:
    - 2% reduction for codes currently paid below 90% of the Medicare fee schedule
    - 4% reduction for codes currently paid between 90-100% of the Medicare fee schedule
    - 6% reduction for codes currently paid at greater than 100% of the Medicare fee schedule
    - Any code remaining above 94% of Medicare was reduced to 94% of the Medicare rate
    - 5% increase for EPSDT Well-Child screens
    - 3% reduction for dental services paid by fee schedule

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Proposed Medicaid Rate Changes

- Maternity care, delivery and obstetric codes exempt; specialized BH services exempt
- Effective 7/1/16
- Provider reduction savings = $29-$33 million total ($6-$7.5 million GF)
- Dental reduction savings = $3-$4.5 million total ($600,000-$1 million GF)

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Proposed Medicaid Rate Changes

- Community Benefit Reimbursement
  - Propose to reduce Medicaid payments to Community Benefit providers and agencies by 1%
  - These services are reimbursed by the Centennial Care managed care organizations (MCOs) at rates determined by the MCOs
  - Savings =$3-$4 million total ($850,000-$1.2 million GF)

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Access Monitoring Plan

- HSD establishing a method for studying provider access for Medicaid recipients
  - CMS requirement
  - Baseline study for Medicaid access as of July 2015
  - Access Monitoring Plan will be focused on FFS recipients and FFS providers
  - Will be available for public and tribal comment prior to submission to CMS
- Detailed model in development to detect changes in provider access due to rate reductions
  - Both FFS and Centennial Care
  - Baseline will be established for June 2016, the month before reductions are implemented
  - Study to be conducted every three months and compared against baseline to identify trends

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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 received from subcommittee on June 15; savings based on recommendations are being calculated; 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 Leveraging Medicaid Subcommittee.
  - Has recently been appointed; many members of the Provider Payments Subcommittee, and additional members based on need and interest.
  - 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 – 30-60 days; tribal consultation was conducted June 6, 2016
  - 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 a year for federal approval.
    - 1115 waiver amendment – requires opening entire waiver and renegotiation with CMS; may take as long as a 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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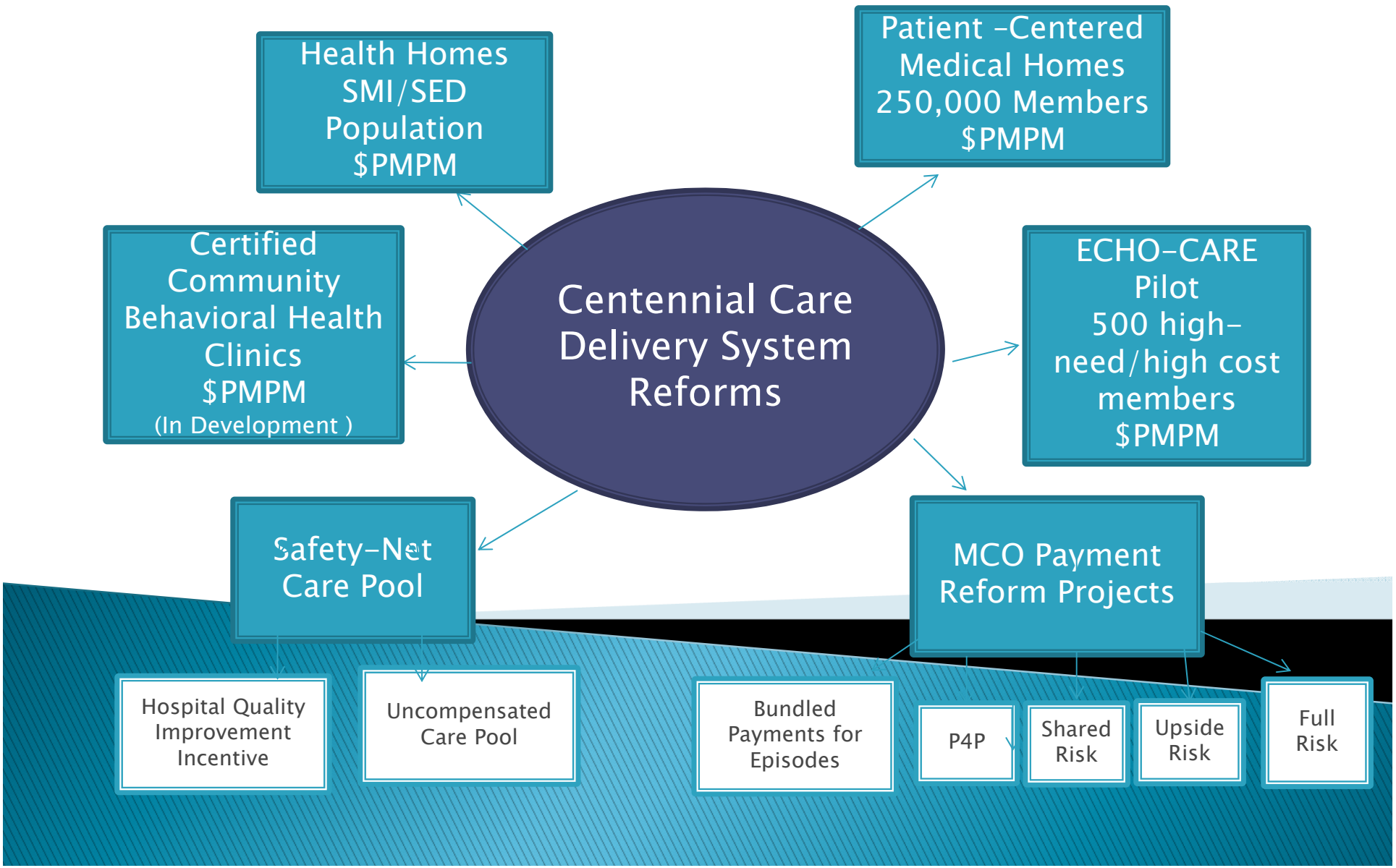
Moving Away from Fee-For-Service Payments



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 **(Medi**	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 286 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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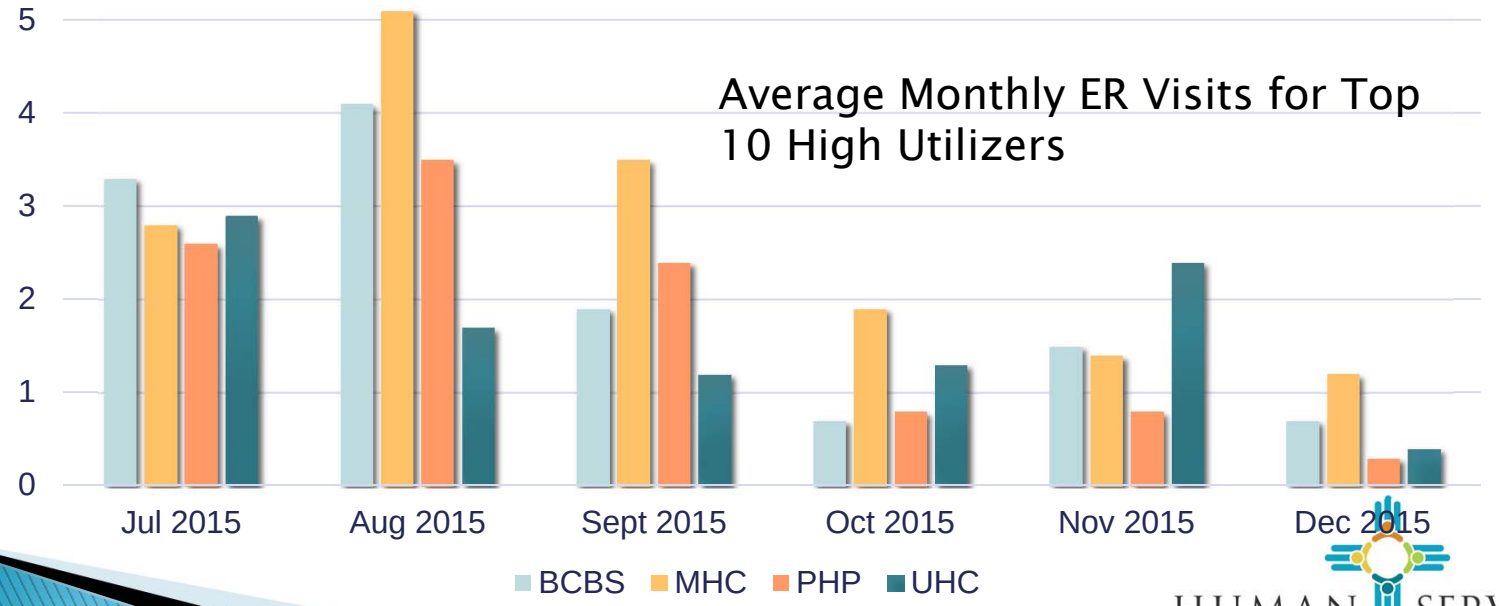
HSD/MAD Pilot Project on Super-Utilizers

- 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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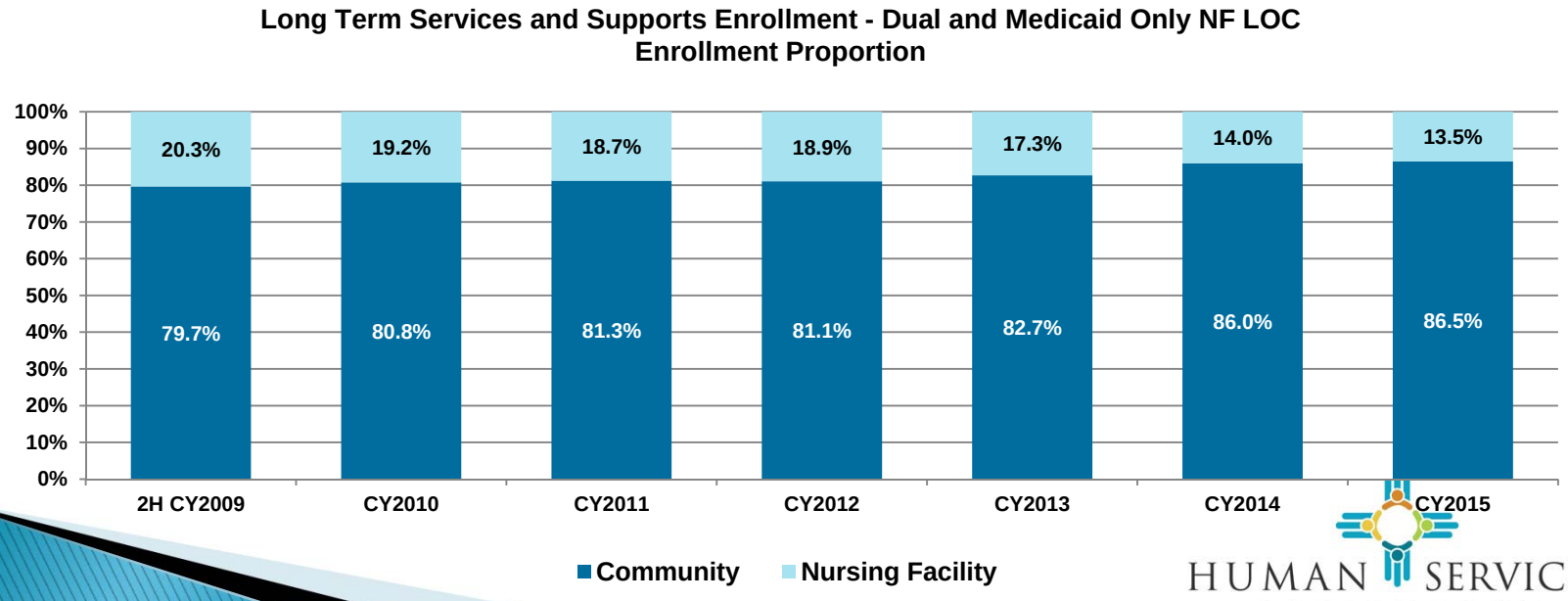
Managed Care and the Long-Term Care Population

- 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 –piloting 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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Community Benefit Supplemental Questionnaire

- Questionnaire is being piloted with approximately 300 members across all MCOs in June 2016
- Members and care coordinators will be surveyed on their experiences with the questionnaire.
- The LTC Committee will meet in July 2016 to review pilot and survey data and to make improvements prior to full implementation.

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Medicaid for Incarcerated Individuals Program (MIIP)

- HSD began implementing the Medicaid for Incarcerated Individuals Program (MIIP) under Senate Bill 42 in October 2015 with the New Mexico Corrections Department (NMCD).
- Enrolled over 1,200 NMCD inmates into Medicaid.
- MIIP allows inmates enrolled into Medicaid to keep their eligibility while in prison/jail and have their benefits reactivated when released so they can get timely physical and behavioral health services/prescriptions.
- Goal is to help inmates make a successful reintegration into society and potentially reduce recidivism.

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Medicaid for Incarcerated Individuals Program (MIIP)

- System automation target completion is June 2016.
- Expanding MIIP to other county jails in a phased approach.
- Beginning July 1, we will be implementing MIIP with the Metropolitan Detention Center in Bernalillo County.
- Starting in September, we will begin MIIP implementation with CYFD, Santa Fe County and Rio Arriba County.
- Working with Sandoval, Sierra, Valencia and Dona Ana counties to implement MIIP.
- Goal is to implement MIIP statewide in the coming months.

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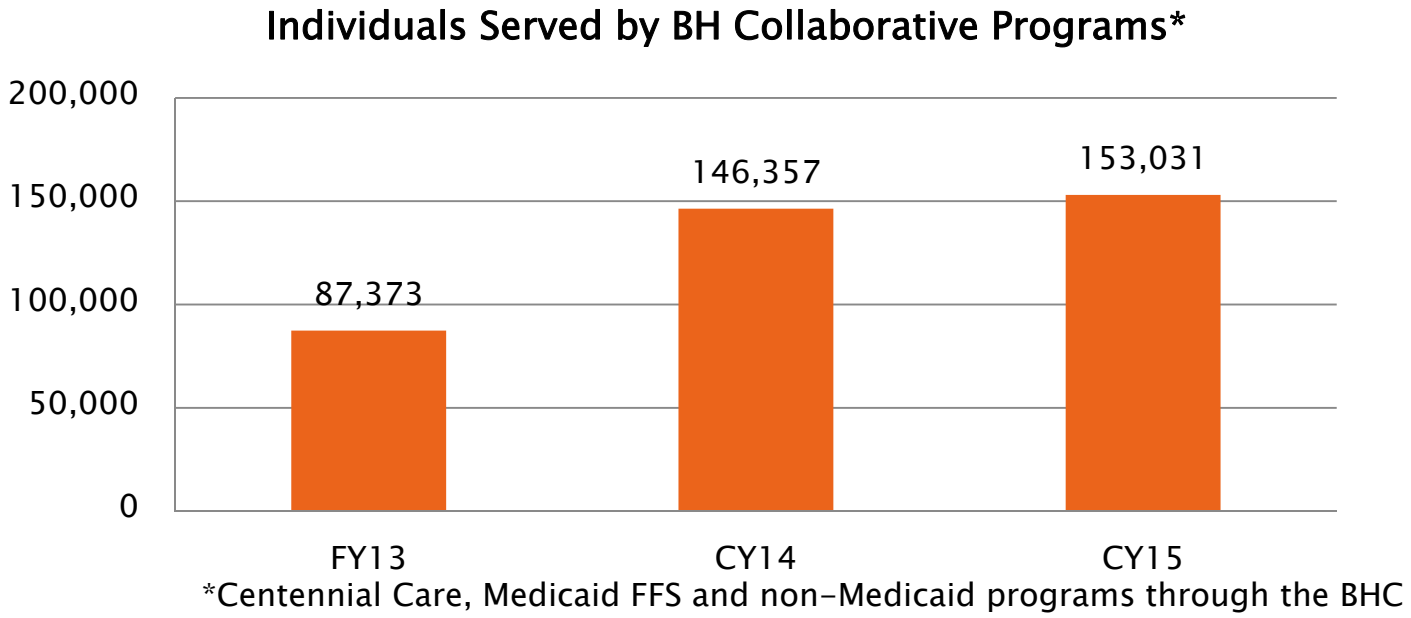
Behavioral Health Report

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



- See Separate BH Collaborative Report

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