Update to the NM Medicaid Advisory Committee

Nancy Smith-Leslie, Director

April 23, 2018

Centennial Care 2.0 MCO RFP Update

- A year-long readiness review process is underway

- Centennial Care 2.0 MCOs must be certified as ready to accept new enrollment in September
  - Blue Cross/Blue Shield of New Mexico
  - Presbyterian Health Plan
  - Western Sky Community Care (Centene)

- Open enrollment period for Medicaid members begins in October 2018 through first week of December 2018

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Centennial Care 2.0 Timeline

Finalization of Contract/Signatures	January 19, 2018
Notice of Award	January 19, 2018
Deadline to file Protest (15-calendar days after Notice of Award)	February 5, 2018 (ongoing)
Desk Audit	March – May 2018
System Documentation, Share File Layouts, Design & Development	March – April 2018
System Testing (File Transfers, Encounters, etc.)	July 2018
On-Site Readiness Audits with MCOs	July 2018
Final Determination for Readiness	September 1, 2018
Statewide Outreach Events	September 2018
Open Enrollment	October – December 2018
Go-Live	January 1, 2019

Transition Management Agreement

- Current MCOs and the CC 2.0 MCOs have signed a transition management agreement that requires:
  - Each MCO to establish a transition team;
  - Compliance with specific timelines for certain transition activities, such as data transfers;
  - Identification and tracking of high risk members and special populations such as members receiving SUD services, members in health homes and CSAs, members in out-of-home placements and members with complex behavioral health needs.
- HSD and the MCOs will form a transition workgroup to monitor required activities

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Centennial Care 2.0 1115 Waiver Update

- HSD submitted its 1115 Waiver Renewal application to CMS in December 2017
- CMS conducted its 30-day public comment period through January 2018
- Waiver negotiations are underway and will continue over next 6-8 months
- HSD has requested to prioritize negotiations and focus on new initiatives that require system and regulation changes
- Draft rule promulgation with public comment in September/October 2018 for 1/1/19 effective date

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Pharmacy Updates

- CMS recently approved SPA that revises fee-for-service payment methods for outpatient drugs in accordance with federal rules:
  - Applies only to Medicaid Fee-for-Service payments;
  - Establishes reimbursement using an Actual Acquisition Cost (AAC) methodology – reimbursement is the lowest of:
    - ACA Federal Upper Limit (FUL) plus dispensing fee
    - National Average Drug Acquisition Cost (NADAC) plus dispensing fee
    - Wholesaler's Average Cost (WAC)+6% plus dispensing fee
    - Pharmacy's reported ingredient cost plus dispensing fee
    - The Usual and Customary (U&C) charge

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Pharmacy Updates

- Implements a professional dispensing fee of $10.30
- Also includes reimbursement methods for 340B drugs, clotting factor, federal supply schedule, drugs purchased at nominal price, and compounding fees
- A supplement explaining these changes will be sent to providers

Senate Bill 11– Step Therapy Protocols:

- MCOs are adjusting policies and procedures but primarily already in compliance with SB 11
- Will be in full compliance by January 1, 2019

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Community Pharmacy Adjustment

- HSD received concerns from several community pharmacies about underpayment that could lead to access problems for members
- A community pharmacy is defined as: not government- or hospital-owned, not an extension of a medical practice or specialty pharmacy, and not owned by a corporate chain
- HSD issued Letter of Direction (LOD) to the MCOs establishing new policies for reimbursement to community pharmacies- effective 4/1/18

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Community Pharmacies

- Establishes that the MCO's Maximum Allowed Cost (MAC) for ingredient cost for generic drugs can be no lower than the current NADAC price
- Does not establish a dispensing fee for managed care; must be negotiated between the pharmacy and MCO
- Ensures payment of an administration, compounding, assembling, consultation, or prescribing fee for Naloxone kits and oral contraceptives
- Clarifies the source of pharmacy price ranges, and improves the process when a price change is initiated by an MCO
- Improves the process for pharmacies to submit price challenges and receive decisions from the MCOs

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Health Home Update

- The health homes for serious chronic behavioral health conditions expanded to 8 more counties on April 1, 2018:
  - New Mexico Solutions in Albuquerque
  - Presbyterian Medical Services in Rio Rancho
  - Kewa Pueblo Health Corporation in Santo Domingo Pueblo
  - Hidalgo Medical Services in Silver City and Lordsburg
  - Guidance Center of Lea County in Hobbs
  - Mental Health Resources in Tucumcari, Portales, and Fort Sumner
- UNM Hospital & clinics will launch on 7/01/18

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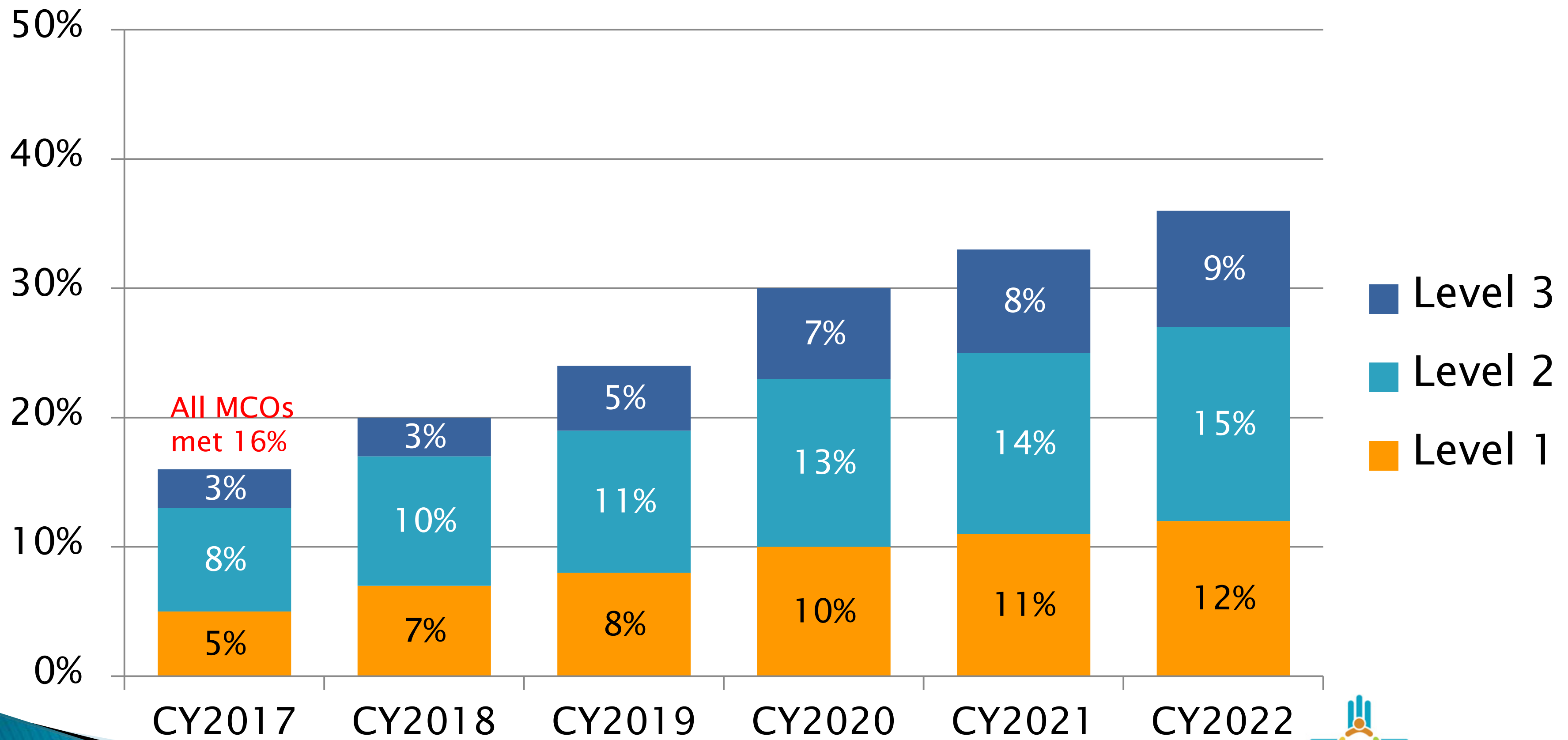
Value-Based Purchasing Update

In 2017, the MCOs were required to have at least 16% of all provider payments in VBP arrangements-- all of the MCOs met this requirement.



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VBP Requirements in CC 2.0 RFP (2019-2022)

Aggregate VBP Targets			
Contract Period 1 (Jan 1 – Dec 31, 2019)	**Contract Period 2** (Jan 1 – Dec 31, 2020)	**Contract Period 3** (Jan 1 – Dec 31, 2021)	**Contract Period 4** (Jan 1 – Dec 31, 2022)
• Level 1: 8% • Level 2: 11% • Level 3: 5% • **Total: 24%**	• Level 1: 10% • Level 2: 13% • Level 3: 7% • **Total: 30%**	• Level 1: 11% • Level 2: 14% • Level 3: 8% • **Total: 33%** ***HSD reserves the right to modify the percentage in Year 3 increasing 5% from Contract Period 2.***	• Level 1: 12% • Level 2: 15% • Level 3: 9% • **Total: 36%** ***HSD reserves the right to modify the percentage in Year 4 increasing 5% from Contract Period 3.***

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VBP with Nursing Facilities: 2018

- Convene steering committee to design the program
- April – June:
  - Build infrastructure
  - Select 8 – 10 NFs
  - Select four *existing* quality metrics
  - Agree on readmission definition
- July – December:
  - Design VBP strategy with 2.0 MCOs

Erica Archuleta	**HSD/ Medical Assistance Division**	Physical Health Unit Centennial Care Contracts Bureau
Karisa "Risa" Berry	**Genesis**	Executive Director, San Juan Center in Farmington
Martha Carvour	**UNM**	ID Fellow
Shannon Cupka	**HealthInsight**	Project Manager
Jim Kaehr	**GE, Aircrafts**	QI Expert / Consultant
Thomas Kim	**Genesis**	Senior VP, Medical Affairs
Steven Littlehale	**Point Right**	Chief Clinical Officer and Executive VP
Cynthia Olivas	**ECHO Institute**	Nurse Manager
David Scrase	**UNM GCOE**	Medical Director
Tracy Smith	**ECHO Institute**	Program Manager
Jason Spaulding	**Genesis, Albuquerque**	Practice Development / Infection Control Manager
Kevin Traylor	**Genesis**	Executive Director, Rio Rancho
Pat Whitacre	**NM HCA**	Director of Quality and Clinical Services
Vanessa Rodriguez	**Genesis**	Center Nurse Executive, Genesis Healthcare at Sandia Ridge

NF VBP Project Timeline 2018-2023

	Project Management	Quality Improvement	Readmission Avoidance	VBP
2018	Training, recruit/convene CAB, Strategic Plan, choose metrics, oversee pilot kickoffs	Start QI Pilot ECHO (10 NFs)	Start RA Pilot ECHO (10 NFs)	Convene CC 2.0 MCOs, Develop VBP Strategic Plan
2019	Transition from pilot to ongoing ECHOs	QI ECHO: 18 NFs	RA ECHO: 18 NFs	Recontracting, Implement Phase 1 VBP
2020	Implement needed changes for RA, VBP (all NFs in at least one ECHO)	2 QI ECHOs: 38 NFs	RA ECHO: 18 NFs	Implement Phase 2 VBP
2021	Reassess metrics for all 3 areas	Continue QI, revise metrics	2 RA ECHOs: 38 NFs	Implement Phase 3 VBP
2022	Reassess metrics for all 3 areas	Continue QI, revise metrics	Continue RA, revise metrics	Refine VBP plan
2023	Reassess metrics for all 3 areas	Continue QI, revise metrics	Continue RA, revise metrics	Continue VBP Plan

CC Interim Evaluation Findings

- Deloitte Consulting is conducting the independent evaluation of the 1115 waiver as required by CMS.
- Interim findings submitted with the waiver renewal that covered CY 2014, 2015 and preliminary data from CY 2016
- Summary of findings in key areas include:
- **Improving Care Coordination and Integration** –indicated general progress in both care coordination and integration activities with improvements noted in:
  - the percentage of members engaged by the MCOs, including increases in
  - the percentage of members for whom Health Risk Assessments were completed and the percentage of Level 2 members who received telephonic and in-person outreach; and
  - decreases in emergency room visit rates among members with BH needs.

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CC Interim Evaluation Findings

- **Improving Quality of Care –** The Evaluation found continued improvements in quality of care with improvements in:
  - the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening rates;
  - Increases in monitoring rates of Body Mass Index (BMI) for adults, children and adolescents;
  - Increases in asthma medication management;
  - Decreases in hospital admission rates across all five ambulatory care sensitive (ACS) measures; and
  - Decline in the percentage of ER visits that were potentially avoidable.

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CC Interim Evaluation Findings

- **Reducing Expenditures and Shifting to Less Costly Services** – The Evaluation found that the program continued to demonstrate significant savings in comparison to the waiver budget neutrality threshold through DY3.
- Total program expenditures for DY3 were 21.8% below the budget neutrality limits as defined by the Special Terms and Conditions of the waiver, including per member per month (PMPM) costs, uncompensated care costs, and Hospital Quality Improvement Incentive (HQII) pool amounts.

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CC Interim Evaluation Findings

- **Increased Member Engagement** – There was a significant increase in the number of members enrolled in the Centennial Rewards program and engaging in various wellness-related activities designed to earn rewards under the program.
- At the end of DY1, approximately 47,000, or 7.1% of eligible members, were registered for the program. At the end of DY2, approximately 156,000, or 20.2% of eligible members were registered for the program.
- There are over 40 activities members can perform to earn rewards from adhering to refilling monthly prescriptions to getting an annual dental visit. In all 40 categories, the percentage of members earning rewards (i.e. performing a health/wellness activity) increased throughout DY2.

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CC Interim Evaluation Findings

- **Increased Member Satisfaction** – The Evaluation found that member satisfaction results largely improved from the baseline to DY2.
- Measures that exhibited improvements included the percentage of expedited appeals resolved on time and the percentage of appeals upheld.
- Satisfaction rates for care coordination and customer service satisfaction rates also increased for members from the baseline to DY2.

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CC Interim Evaluation Findings

- **Improving Access to Care –** The Evaluation noted mixed progress in timely access to care related to several measures as compared to the baseline year.

Increases were found in:

- the percentage of the state population enrolled in Centennial Care;
- the ratio of providers to members;
- access to telemedicine;
- the percentage of members utilizing new BH services (BH respite, family support, and recovery services); and
- rate of flu vaccinations.

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CC Interim Evaluation Findings

Declines were found in:

- the percentage of members who had an annual dental visit (although the NM rates are higher than the national averages);
- the percentage of members who had a PCP visit; and
- childhood and adolescent immunization rates.

HSD is evaluating the initial findings to identify potential initiatives to make improvements in coming years, including whether certain declines were potentially affected by external factors such as the expansion of Medicaid and the influx of enrollment of these members in the initial years.

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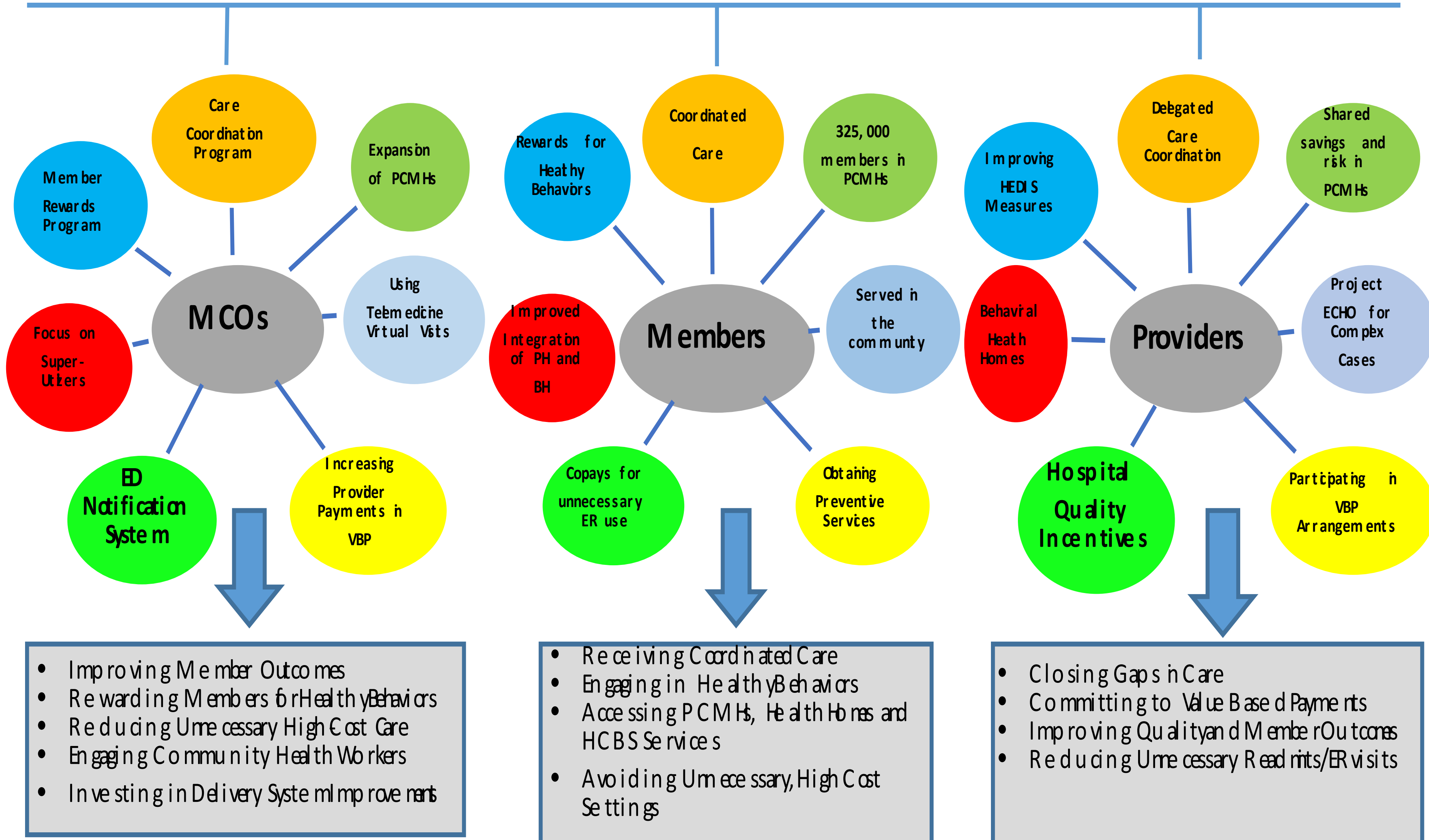
Centennial Care:

Aligning Policies and Incentives for MCOs, Members & Providers



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Centennial Care: Managing Cost Growth

2. Total Centennial Care Dollars and Member Months by Program

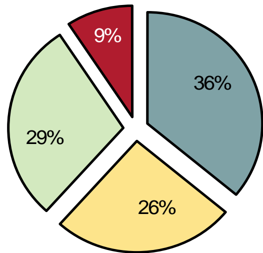
Population	*Aggregate Member Months by Program* Previous (12 mon)	Current (12 mon)	% Change
Physical Health	4,849,767	4,942,490	2%
Long Term Services and Supports	587,197	594,753	1%
Other Adult Group	2,663,852	2,832,882	6%
Total Member Months	**8,100,816**	**8,370,125**	**3%**

Enrollment up 3%; Per capita costs down 2%

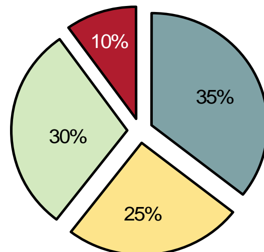
Programs	*Aggregate Medical Costs by Program* Previous (12 mon)	Current (12 mon)	% Change	*Per Capita Medical Costs by Program (PMPM)* Previous (12 mon)	Current (12 mon)	% Change
Physical Health	$ 1,267,457,482	$ 1,273,876,100	1%	$ 261.34	$ 257.74	-1%
Long Term Services and Supports	$ 902,395,324	$ 888,165,627	-2%	$ 1,536.78	$ 1,493.34	-3%
Other Adult Group Physical Health	$ 1,023,220,261	$ 1,062,072,935	4%	$ 384.11	$ 374.91	-2%
Behavioral Health - All Members	$ 327,439,490	$ 354,484,096	8%	$ 40.42	$ 42.35	5%
Total Medical Costs	**$ 3,520,512,557**	**$ 3,578,598,757**	**2%**	**$ 434.59**	**$ 427.54**	**-2%**
Aggregate Non-Medical Costs	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Admin, care coordination, Centennial Rewards	$ 371,761,396	$ 362,167,729	-3%	$ 45.89	$ 43.27	-6%
NMMIP Assessment	$ 54,111,675	$ 63,516,589	17%	$ 6.68	$ 7.59	14%
Premium Tax - Net of NIMMP Offset	$ 148,322,403	$ 131,246,264	-12%	$ 18.31	$ 15.68	-14%
Total Non-Medical Costs	**$ 574,195,473**	**$ 556,930,582**	**-3%**	**$ 70.88**	**$ 66.54**	**-6%**
Estimated Total Centennial Care Costs	**$ 4,094,708,031**	**$ 4,135,529,340**	**1%**	**$ 505.47**	**$ 494.08**	**-2%**

Centennial Care Medical Expenditures

Previous (October 2015 - September 2016)



Current (October 2016 - September 2017)



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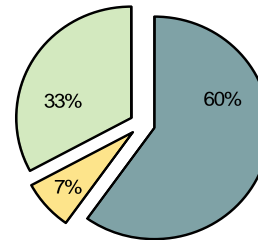
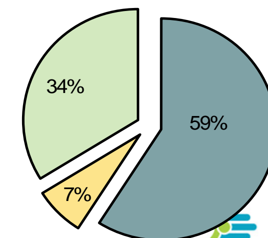
Centennial Care Member Months

Previous (October 2015 - September 2016)



Current (October 2016 - September 2017)



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