Mercer

Government Human Services Consulting

Turquoise Care

CY2019 – CY2021 Data Book

State of New Mexico

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Mercer Government

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Contents

Section 1
Introduction

In partnership with the State of New Mexico's Human Services Department, Medical Assistance Division (State), Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, produced the *Turquoise Care Data Book Narrative 20220930.pdf* and the *Turquoise Care Data Book Exhibits 20220930.xlsx* (collectively referred to as the Data Book) with assistance from the State to provide historical encounter and eligibility data summaries from the State's Medicaid Managed Care program that can be used by potential Offerors as part of the on the Turquoise Care (TC) Request for Proposal (RFP) #23-630-8000-0001 with a Go-Live date of January 1, 2024.

Medicaid populations eligible for the Physical Health (PH), Behavioral Health (BH), Long-Term Services and Supports (LTSS) managed care programs are included in the Data Book.

The Data Book does not include claims experience or eligibility for members in the State's fee-for-service program. The Data Book summarizes historical claim-level encounter data processed through the State's Medicaid Management Information Systems (MMIS) with run-out through March 31, 2022 and provided by the State for the following calendar year (CY) time-periods:

- January 1, 2019 through December 31, 2019 (CY2019);
- January 1, 2020 through December 31, 2020 (CY2020);
- January 1, 2021 through December 31, 2021 (CY2021).

The eligibility data summarized in the Data Book is sourced from the State's capitation payment roster (SCR) for CY2019, CY2020, and CY2021 as of March 31, 2022. The Data Book also provides general information on the capitation rate development process, including adjustments that will be considered for the January 1, 2024 through December 31, 2024 (CY2024) capitation rates.

The State intends to contract with no more than four (4) managed care organizations (MCOs) to provide PH, BH, and LTSS benefits for the managed care population.

Aspects of the TC Medicaid managed care program will be described in more detail in subsequent sections of this Data Book. The potential Offerors should also review the Model Contract (Appendix L) for additional information regarding program responsibilities.

In producing this Data Book, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design and financial data, and information supplied by the State and its vendors. The State and its vendors are solely responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the summarized data and information for internal consistency and reasonableness but did not audit it. In our opinion, the data used for the Data Book is appropriate for the intended purpose. However, if the data and information are incomplete/inaccurate, the values shown in this Data Book may

differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this Data Book.

The State and Mercer regularly review the Centennial Care 2.0 MCO-reported encounter and financial data for completeness and accuracy for use in analyses and program management. The State places a high level of importance and value in the collection and submission of complete and accurate encounter and financial data for program management and monitoring purposes. As partners with the State, Offerors who are selected to participate in the Medicaid managed care program are expected to put forth the necessary efforts to submit complete and accurate encounter and financial data.

The user of this Data Book is cautioned against relying solely on the data contained herein. The State and Mercer provide no guarantee, either written or implied, that this Data Book is 100% accurate or error-free.

This Data Book was prepared on behalf of the State and is intended to be relied upon by the State for providing potential Offerors, and any other parties the State deems appropriate as part of the TC RFP process, with information related to the three most recent and complete years of Medicaid managed care experience and general information on the capitation rate development process. It should be read in its entirety and has been prepared under the direction of Stewart Campbell, ASA, MAAA; Brad Diaz, FSA, MAAA; Gina Pompa, FSA, MAAA; and Julie Tang, ASA, MAAA, who are members of the American Academy of Actuaries and meet its US Qualification Standard to issue the information contained herein.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

Mercer expressly disclaims responsibility, liability, or both for any reliance on this Data Book by third parties or the consequences of any unauthorized use or disclosure other than as mutually contemplated when Mercer was first retained to perform this work.

Section 2

Program Background and Services

TC covers services for the PH, BH, and LTSS populations which are described below.

Physical Health

New Mexico has operated a PH Medicaid managed care program since 1997, which was expanded under the Patient Protection and Affordable Care Act (PPACA) to include the Medicaid Expansion population as the Other Adult Group (OAG) as of January 1, 2014. Participation in the program is mandatory for most populations and provides acute care benefits to Temporary Assistance for Needy Families (TANF), Children, Youth and Families Department (CYFD), Children's Health Insurance Program (CHIP), and Social Security Income (SSI) aid categories; pregnant women; and low-income parents and childless adults between 19–64 years of age with income up to 138% of the federal poverty level as determined through the Modified Adjusted Gross Income Test, after adjusting for the 5% income disallowance.

Behavioral Health

New Mexico has included BH services under its Medicaid managed care program since 1997 and expanded to include the OAG as of January 1, 2014. Participation in the program is mandatory for most populations and provides behavioral health benefits to TANF, CYFD, CHIP, and SSI aid categories; pregnant women; individuals in the LTSS program; and low income parents and childless adults between 19–64 years of age with income up to 138% of the federal poverty level as determined through the Modified Adjusted Gross Income Test, after adjusting for the 5% income disallowance.

Long-Term Services and Supports

New Mexico has operated a long-term care Medicaid managed care program since 2008. Participation in the program is mandatory for populations requiring LTSS. This program provides acute care and long-term care benefits for recipients who meet nursing facility level of care (NF LOC) or who are dually eligible for Medicare and Medicaid (Dual Eligible).

Rate Cohort Configuration

The rate cohorts for TC members are consolidated based on aid category and age for purposes of monthly capitation payment. All rate cohorts may be reevaluated in the future and are subject to change. HSD is exploring changes to the rate cohort structure which may include but is not limited to: the implementation of a per-delivery maternity payment separate from monthly capitation payments, consolidation of existing rate cohorts, and/or modifications to risk adjustment.

Children in State Custody

Effective January 1, 2024, one of the selected MCOs will also be designated as a specialized managed care entity to provide services for all Children in State Custody (CISC).

Enrollment for Native American CISC in the CISC MCO will remain optional. Native American CISC who opt-out of enrollment with the specialized managed care entity may be enrolled in a non-specialized managed care entity with either a PH or LTSS rate cohort, and a corresponding BH rate cohort.

The anticipated configuration of the TC rate cohorts for CY2024 is shown below. This configuration is subject to review and change, particularly given the separate identification of the CISC cohorts:

Program	Rate Cohort	Statewide or Regional
PH	TANF, CYFD 0 - 2 months	Statewide
PH	TANF 2 months - 20 years, CYFD 2 months - 21 years	Statewide
PH	TANF, 21+ years	Statewide
PH	SSI & Waiver, 0 - 1 year	Statewide
PH	SSI & Waiver, 1+ years	Statewide
PH	Pregnant Women, 15-49	Statewide
PH	OAG PH 19-64	Statewide
BH	TANF, all ages	Statewide
BH	CYFD, all ages	Statewide
BH	SSI, 0-14 years	Statewide
BH	SSI, 15-20 years	Statewide
BH	SSI, 21+ years	Statewide
BH	LTSS Medicaid Only	Statewide
BH	LTSS Dual Eligible	Statewide
BH	OAG BH 19-64	Statewide
LTSS	Dual Eligible - NF LOC Nursing Facility (Region 1,3,4)	Regional
LTSS	Dual Eligible - NF LOC Community Benefit (Statewide)	Statewide
LTSS	Dual Eligible - NF LOC Nursing Facility (Region 2)	Regional
LTSS	Dual Eligible - NF LOC Nursing Facility (Region 5)	Regional
LTSS	Dual Eligible - Self Direction	Statewide
LTSS	Healthy Dual	Statewide
LTSS	Medicaid Only - NF LOC Nursing Facility (Region 1,3,4)	Regional
LTSS	Medicaid Only - NF LOC Community Benefit (Statewide)	Statewide
LTSS	Medicaid Only - NF LOC Nursing Facility (Region 2)	Regional
LTSS	Medicaid Only - NF LOC Nursing Facility (Region 5)	Regional
LTSS	Medicaid Only - Self Direction	Statewide

Program	Rate Cohort	Statewide or Regional
CISC	PH CISC, 0-21 years	Statewide
CISC	BH CISC, 0-21 years	Statewide

Excluded Populations

There are several distinct populations excluded from the Medicaid managed care program. Populations excluded from the Medicaid managed care program include the following:

- Qualified Medicare Beneficiaries;
- Specified Low Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency medical services;
- Program of All-Inclusive Care for the Elderly;
- Individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities;
- Medically Fragile 1915(c) waiver participants for HCBS;
- Developmentally Disabled 1915(c) waiver participants for HCBS;
- Individuals eligible for family planning services only;
- Mi Via 1915(c) waiver participants for HCBS;
- Supports 1915(c) waiver participants for HCBS; and
- Individuals eligible for the Optional Coronavirus Disease 2019 (COVID-19) Group.

Covered Services

The successful Offerors will be responsible for the coordination and provision of services as described in the Model Contract (Appendix L). The successful Offerors will have the ability to develop creative and innovative solutions to deliver the contractually required Medicaid services. The summarized encounter data in this Data Book includes historical experience reflecting the eligible Medicaid services that the Centennial Care 2.0 MCOs were responsible for covering in each respective calendar year.

The following table lists the medical services for which members are eligible. The successful Offerors will be contractually responsible to provide and effectively coordinate these services. Users of this Data Book seeking more information on services, including more detailed categories of service should refer to the Model Contract (Appendix L).

PH and PH CISC Categories of Service
Inpatient Hospital
Skilled Nursing Facility
Outpatient Hospital
Emergency Room
Physician
Other Practitioner
Clinic
FQHC
Pharmacy
Home Health
Laboratory/Radiology Services
DME/Orthotics/Prosthetics
Dental Services
Hospice
Non-Emergent Transportation
Emergent Transportation
Other Services
Community Benefit/Personal Care Services

BH and BH CISC Categories of Service
RTC, ARTC, Group Homes
Foster Care Therapeutic (TFC I & II) < 21
Skills Training and Development (BMS) < 21
BH Day Treatment < 21
Psychosocial Rehab Services for Adults ≥ 18
Outpatient Therapies & BH Treatment Services
Psychiatric Hospitalization Services
Intensive Outpatient Program Services (IOP)
Autism Spectrum Disorder (ASD) Treatment
BH Pharmaceuticals
School Based Health Center Services
Assertive Community Treatment (ACT)
Multi–Systemic Therapy (MST)
Other
Telehealth
Comprehensive Community Support Services

BH and BH CISC Categories of Service
FQHC or RHC
Core Service Agencies (CSA's)
Medication Assistance Treatment (MAT) Administration
Family Support Services (Waiver)
Recovery Services (Waiver)
Respite Care Services (Waiver)

LTSS Categories of Service
Inpatient Hospital
Physician
Pharmacy
Dental
Non–Emergent Transportation
DME/Medical Supplies
Outpatient
Nursing Facility (NF) State
NF Private
Emergent Transportation
Hospice
HCBS
Home Health
Personal Care Services
Laboratory & Radiology
Other

Section 3

Adjustments in the Capitation Rate Development Process

This section describes the adjustments Mercer anticipates evaluating, as necessary, in the capitation rate development process to ensure capitation rates reflect the State's managed care goals, objectives, and policies. The capitation rates for CY2024 will be developed at a later date.

Adjustments and approaches identified below may be reevaluated in the future and are subject to change.

Rate Development Adjustments

Capitation rates for CY2024 will be based on historical Medicaid managed care experience data (e.g., encounter and financial data for the applicable populations and services). Mercer anticipates using a more recent time-period than the Data Book experience as the underlying base data for the CY2024 capitation rates.

The Data Book only includes experience associated with benefits covered through the Centennial Care 2.0 MCO Contract, and the following list of adjustments have been applied in the Data Book:

- Removal of expenses and eligibility for retroactive-eligible individuals;
- Removal of expenses for HCBS for which providers are reimbursed using Self-Direction member budgets;
- Removal of expenses related to value-added services;
- Removal of Indian Health Service/Tribal Health Providers/Urban Indian Providers (I/T/U);
- Removal of duplicate claims; and
- Removal of claims without paid amounts.

The following section list adjustments that have not been reflected in this Data Book, but will be considered in the capitation rate development process:

- Based on a comparison of reported financial experience and encounter experience by category of service, Mercer may shift expenses among service categories to improve reporting alignment (budget-neutral adjustment).
- Mercer will review encounter data and may adjust the underlying base data as deemed appropriate.
- The following items may be evaluated to determine if an adjustment to the base data is necessary:

  - Net cost of reinsurance (premiums less recoveries) reported within the Annual Supplement Submission financial reports;
  - Subcapitated and/or globally capitated reimbursement arrangements;
  - Appropriate expenditures and/or recoupments captured outside of the claims transaction system;
  - Removal of services or benefit changes effective during the base period;
  - In-Lieu-of services adjustments necessary to comply with Centers for Medicare & Medicaid Services (CMS) requirements; and
  - Removal of CareLink New Mexico Health Home services.
    - CareLink New Mexico Health Home expenditures are included in the capitation rates as a separate per member per month add-on and includes a reconciliation.
- Adjustments to experience data to reflect effective management of member care and efficient service delivery in alignment with State goals. This can include adjustments related to:
  - Potentially preventable inpatient hospital admissions;
  - Avoidable inpatient hospital readmissions;
  - Unnecessary use of emergency room for low-acuity non-emergent visits;
  - Drug utilization management edits;
  - Avoidable costs for drug utilization due to reimbursement inefficiencies; and
  - Removal of drug utilization covered by Medicare Part B/D for dual-eligible members.
- Development of prospective trend factors through a review of variety of data sources including but not limited to historical data, input from the State, Mercer's knowledge of the New Mexico marketplace and health care trends in other states. The resulting trend factors will be annualized and used to project the base data to a future rating period. The number of years the annual trend factors will be applied will be equivalent to the months of movement measured between the midpoint of the base period and the midpoint of the CY2024 period.
- Consideration and evaluation to determine if a prospective adjustment is necessary for any of the following:
  - Programmatic changes originating from State and Federal legislative initiatives;
  - Changes to provider reimbursement rates;
  - Modifications to list of covered services;
  - Provider capacity or utilization changes;
  - Emergence of high cost drugs, treatments, and therapies;

  - Potential impacts of the COVID-19 public health emergency; and
  - Directed payments requiring adjustments to the capitation rates.
    - Separate payment term directed payments are reimbursed outside of the capitation rates.
- Consideration of differences in network and/or provider composition or other risk factors not addressed through other adjustments.
- Rate Adjustments applicable to LTSS only:
  - Blended Rates: Each successful Offeror will be reimbursed for LTSS NF LOC populations through a blended payment rate based on the projected proportion of their NF and community benefit enrollment members enrolled with each successful Offeror.
  - Regional Rates: The capitation rates for LTSS NF LOC cohorts are differentiated by region due to differences in the cost of private and state-owned NFs. The NF regions include the following counties:
    - Region 1, 3, 4: Bernalillo, Chaves, Cibola, Curry, De Baca, Eddy, Lea, Lincoln, Los Alamos, McKinley, Quay, Roosevelt, Sandoval, San Juan, Santa Fe, Socorro, Torrance, Valencia;
    - Region 2: Catron, Dona Ana, Grant, Hidalgo, Luna, Otero, Sierra; and
    - Region 5: Colfax, Guadalupe, Harding, Mora, Rio Arriba, San Miguel, Taos, Union.
- An allowance for non-medical expenses including but not limited to administration for the successful Offerors, care management, and underwriting gain.
- Adjustments for applicable health care taxes, as needed, consistent with federal and/or State policy requirements.

All lists provided above are not considered comprehensive and additional adjustments may be considered in the rate development process.

Risk Mitigation and Withholds

In the development of the capitation rates, the State and Mercer intend to assess the need for adjusting the capitation rates to reflect specific risk for the successful Offerors.

Risk Adjustment Methodology

The State currently uses the “Chronic Illness and Disability Payment System including Pharmacy” (CDPS+Rx) model to further adjust the applicable PH base capitation rates. BH or LTSS rate cells are not currently subject to risk adjustment, however, the State is evaluating the expansion of the risk adjustment process to BH and/or LTSS rate cohorts. The CISC rate cohorts will not be risk-adjusted. The CDPS+Rx model uses both diagnosis data on facility and professional records in addition to pharmacy data to classify individuals into

disease conditions, along with member demographics (e.g., age and sex categories) to measure a population's anticipated health risk. The health risk for each successful Offeror is calculated at the consolidated risk adjustment rating categories level of detail.

Encounter data incurred over a 12-month study period is used to classify recipients into CDPS+Rx disease conditions. This information is then combined with the anticipated cost associated with each of these CDPS+Rx model categories. The CDPS+Rx model is based on national experience from more than 30 Medicaid programs. However, more recent and complete State data was available to develop a State-specific CDPS+Rx model. This State-specific model more closely reflects New Mexico's PH program. A set of cost weights was developed for each of the CDPS+Rx models: TANF Adults and OAG combined, TANF Children, and SSI.

The combination of the CDPS+Rx categories and the appropriate cost weights produces a risk score for each recipient, referred to as an acuity factor. Acuity factors are only developed for recipients with at least six months of Medicaid eligibility (continuous or non-continuous) within the 12-month study period. The recipient-level risk scores will then be aggregated by statewide rate cells and by each Offeror selected by the State. To ensure the risk adjustment process does not increase or decrease the total capitation payments, the aggregated risk scores are adjusted for budget neutrality. The intent of this adjustment is to recalibrate the risk scores for the successful Offerors to yield a population average of 1.000. The State intends to update the individual and risk scores for the successful Offerors on a semiannual basis. The State and Mercer continually discuss innovations and/or alternative approaches to risk adjustment and changes to the State's approach to risk adjustment may occur and will be communicated with the successful Offerors, as needed.

High-Cost Member Risk Pool

Effective January 2022, the State implemented a High-Cost Member Risk Pool (HCRP). The objective of the HCRP is to improve the distribution of funding to align with expenses by the successful Offerors, so that the successful Offerors with a higher share of expenses associated with high-cost members will receive a greater share of the fund. Members are identified as high-cost if their eligible expenditures exceed the attachment point of $175,000 for the calendar year. For these members, the successful Offerors will be at-risk for the incurred medical costs below the attachment point and 20% of incurred medical costs that exceed the attachment point. Additionally, the HCRP will exclude incurred medical costs that exceed $1,000,000 per member to reflect the successful Offerors contract requirement for reinsurance arrangements.

Withhold Arrangements

Withhold arrangements are defined under 42 CFR §438.6(a) as "any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or pre-paid ambulatory health plan (PAHP) and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract." Through the DSIPT included in the Model Contract (Appendix L), the State may impose performance penalties of up to 1.5%, net of premium taxes, New Mexico Medical Insurance Pool (NMMIP) assessments and New Mexico Health Insurance Exchange (beWellnm) assessments, of capitation payments for successful Offerors who fail to meet certain Delivery System Improvement Performance Targets (DSIPT). Currently, Centennial Care 2.0 MCO performance is evaluated on four DSIPT objectives for CY2022 which are equally weighted

at one-fourth of the total withhold amount of 1.5%. The DSIPT objectives for CY2024 will be determined at a later date.

Actuarially Sound Capitation Rates

At the conclusion of the capitation rate development process, Mercer will provide the State with capitation rates that are certified as actuarially sound for each PH, BH, LTSS, and CISC rate cohort, which may vary for each successful Offeror.

Mercer is defining actuarially sound as follows: Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For the purpose of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, cost of capital, and government mandated assessments, fees, and taxes.[1]

Under 42 CFR §438.4(b)[2], the CMS requires that actuarially sound rates meet several criteria for approval, including the following:

- Have been developed in accordance with generally accepted actuarial principles and practices.
- Are appropriate for the populations to be covered and the services to be furnished under the contract.
- Have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and the Actuarial Standards Board.

[1] Please see page 2 of the Actuarial Standard of Practice (ASOP) No. 49: Medicaid Managed Care Capitation Rate Development and Certification, from the Actuarial Standards Board http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf

[2] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4#p-438.4(b)

Section 4

Exhibit Descriptions

The exhibits included in this Data Book provide historical data on the populations included in the Medicaid program. These exhibits reflect managed care data only. The exhibits included within this Data Book, as well as a brief description of the information included, are described below.

Encounter and Risk Adjustment Summary Exhibits

The Centennial Care 2.0 Medicaid managed care data provided in Exhibits 1-3 have been adjusted as described in Section 3. The data is as reported by the Centennial Care 2.0 MCOs as of March 31, 2022. The Centennial Care 2.0 MCOs report data pursuant to the State's encounter reporting requirements. Data from all Centennial Care 2.0 MCOs were aggregated for display purposes.

Users of this Data Book are advised to review the information in Section 1 regarding the sources of data and Section 3 regarding adjustments and exclusions applied to the data, which will be considered in the capitation rate development process.

The Encounter and Risk Adjustment Summary Exhibits include:

- **Exhibits 1a, 1b, and 1c**: CY2019 – CY2021 summarized PH, BH, and LTSS managed care encounter and eligibility experience, exclusive of CISC managed care experience. For each program, annual Member Months (MMs), dollars, and units are summarized across all Centennial Care 2.0 MCOs in aggregate by cohort and category of service.
- **Exhibits 2a, 2b, and 2c**: CY2019 – CY2021 summarized CISC managed care encounter and eligibility experience. For each program, annual MMs, dollars, and units are summarized across all Centennial Care 2.0 MCOs in aggregate by category of service.
- **Exhibit 3**: Prevalence reports from the four most recent CDPS+Rx risk adjustment cycles for applicable TC populations. These exhibits show the diagnostic and pharmaceutical condition categories for each population as well as the current New Mexico-specific cost weights.
  - A separate exhibit is provided for the following population groups:
    - Exhibit 3a — TANF Children
    - Exhibit 3b — TANF Adult
    - Exhibit 3c — SSI
    - Exhibit 3d — OAG

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