Medicaid Advisory Committee-MAC meeting
Monday, April 23, 2018
MINUTES

Time: Start-1:03pm End-3:27pm Location: Garrey Carruthers State Library, 1205 Camino Carlos Rey, Santa Fe, 87507

Chair: Larry A. Martinez, Presbyterian Medical Services

Recorder: Alysia Beltran, Medical Assistance Division

Committee Members:
Sylvia Barela, Santa Fe Recovery Center
Michael Batte, Public Member
Natalyn Begay, Ohkay Owingeh
Jim Copeland, NM Department of Health
Ramona Dillard, Pueblo of Laguna
Jeff Dye, NM Hospital Association
Mary Eden, Presbyterian Healthcare Services
Michael Hely, NM Legislative Council Service
Daniel Bourgeois, Medicaid Population
Ruth Hoffman, Lutheran Advocacy Ministry NM
Gary Housepian, Disability Rights
Monique Jacobson, NM Children, Youth and Families Department
Mark Freeland, Navajo Nation
Kim Jevertson, Public Member
KyKy Knowles, Aging & Long Term Services Department
Meggin Lorino, NM Association for Home and Hospice Care
Carol Luna-Anderson, The Life Link/Behavioral Health Planning Council
Richard Madden, NM Chapter of the American Academy of Family Physicians
Rodney McNease, UNM Hospital
Carolyn Montoya, UNM College of Nursing
Eileen Goode, NM Primary Care Association
Linda Sechovec, NM Health Care Association
Laurence Shandler, Pediatrician
Gene Varela, AARP New Mexico
Dale Tinker, NM Pharmacists Association

Absent Members:
Michael Batte, Public Member
Mark Freeland, Navajo Nation
Monique Jacobson, NM Children, Youth and Families Department
Natalyn Begay, Ohkay Owingeh
Gene Varela, AARP New Mexico

Staff & Visitors Attending:
Nancy Smith-Leslie, Medicaid Director
Mike Nelson, HSD Deputy Secretary
Russ Toal, Consultant
Marilyn Bennett, New Vistas
Jenny Felmly, Legislative Finance Committee
Brian M., HSD
Jason Espinosa, NMHCA
Mary Kay Pera, NMASBHC
Desbah Farden, HSD
Jody Harris, UNMH
Jeff Jarjoura, Optum
Elena Rubinfeld, Southwest Women's Law Center
Jason Sanchez, HSD/MAD
Linda Gonzales, HSD/MAD
Mark Sawaya, OTSUKA
Raymond Mensack, United Healthcare
Abuko D. Estrada, NM Center on Law & Poverty
Chuck Milligan, United Healthcare
Martha Gragg, Western Sky Community Care
Nancy Rodriguez, NMASBHC
Joie Glenn, Advocacy for Home and Hospice Care
Cindy Keiser, HSD/ BHSD
Liz Lacouture, PHP
Kari Armijo, HSD/MAD
Wayne Lindstrom, BHSD
Bianca Gutierrez
Margaret White, Health Insight NM
Sun Vega, Hyde & Associates
Heather Ingram, Presbyterian Health Plan
Nathan Cogborn, Western Sky Community Care
Stefany Goradia, Versatile MED Analytics
David Nater, UHC
Mike Renand, Presbyterian Medical Services
Jordan E., Presbyterian Health Plan

DISCUSSION ITEM		OUTCOME	FOLLOW-UP ACTION	RESPONSIBLE PERSON/ DEPARTMENT	EXPECTED OR REQUIRED COMPLETION DATE
I.	Introductions	Larry Martinez convened the meeting and led the introductions. Larry introduced appointed members, staff and guests as they arrived during the meeting.	None	Larry Martinez, MAC Chairperson	Completed
II.	Approval of Agenda	The agenda for this meeting was approved by all committee members in attendance, with no recommended changes.	None	Larry Martinez, MAC Chairperson	Completed
III.	Approval of Minutes	The minutes from the January 29, 2018 meeting held at State Capitol Roundhouse, Room 326 were approved by the committee with no corrections.	Finalized minutes will be posted on the HSD website.	HSD/MAD Director's office	Completed
IV.	Medicaid Budget Projections	**Jason Sanchez presented the Medicaid Budget Projection:** **Enrollment Projection**- Not too many changes since last budget projection presentation. At the end of Fiscal Year (FY) 2018 Medicaid enrollment is projected to be at 872,676 individuals, a decrease of just under 5,000 from the previous projection, due to lower than expected growth in the full benefit and family benefit populations. On a percentage decrease basis, it is less than half of a percent. We continue to build the projection with one and a half percent growth in enrollment throughout FY19. There is not a significant change in managed care enrollment from previous projections. The Physical Health population grew slower than previously projected. HSD is tracking slower growth in physical health. The Medicaid expansion population has also grown. Overall there is a shift in the distribution of our population; which results in members transitioning into higher cost cohorts. **FY17 Budget Lag Model** - Fee-for-Service expenditures have decreased by about $6.2 million. Developmental Disabilities & Medically Fragile Waivers (DD & MF) line items have no significant changes. We pushed Department of Health expenditures forward from FY17 to FY18 because there was insufficient funds for this expenditure level. Expenditures related to Centennial Care physical health have increased by $1.6 million. CC Long-Term Services and Supports expenditures have also increased by $35 million. This increase is attributed to a reconciliation with the MCOs for the community benefit program. The community benefit reconciliation was overestimated by $24 million. **FY18 Budget Projection Lag Model** - FY18 Expenditures: The Fee-for-Service projection for Indian Health Services (IHS) is reduced by	None	Jason Sanchez, Deputy Director, Medical Assistance Division, Human Services Department	Completed

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	just under $3 million. The number reflects a decrease in expenditures related to recipients' use of IHS. Developmental Disabilities & Medically Fragile Waiver expenditures have a projected increase of about $2.1 million. We are continuing to see higher authorized budgets for DD clients as well as higher utilization of those authorized budgets. Centennial Care managed care lines reflect a total net change of $6.4 million with a decrease in Physical Health expenditures that is tied to a lower projected enrollment than previously projected. LTSS expenditures increased by $11.2 million, which includes the change in the community benefit reconciliation as well as overall higher costs. The adult expansion population reflects a $2.4 increase in expenditures. Medicare Part D increased by $1.1 million. Overall, the general fund need for FY18 is $943,722, and we received an appropriation of $933,625 which results in a shortfall of about $10.1 million. **FY19 Budget Projection Trend Model** – This is a trend model based upon the lag model for FY18. There is a $3 million change for Fee-for-Service in Indian Health Services (IHS) expenditures. In line 14, Developmental Disabilities & Medically Fragile Waiver expenditures are projected to have an increase of $3 million. The managed care line items reflect a shift of members moving to higher cost cohorts and reflect a projected $21.8 million. In line 30, we have built in provider fee increases as well as a projected increase in pharmacy fees. HSD has not finalized what is to be included in the managed care lines. The bottom line is a projected overall increase in expenditures of $41.5 million with an associated projected GF increased need of $10.1 million.			
V. Director's Update	**Nancy Smith-Leslie presented a Director's update to the NM Medicaid Advisory Committee:** **Centennial Care 2.0 MCO RFP updates:** A year-long readiness review process in underway. Centennial Care 2.0 MCOs must be certified as ready to accept new enrollment in mid-September. The open enrollment period for Medicaid members begins in October 2018 through the end of November 2018. **Centennial Care 2.0 Timeline:** Notice of Award for MCO contracts for calendar year 2019 was on January 19, 2018. The deadline to file protest (must be 15 calendar days after Notice of Award) was February 5, 2018. There are four active protests. System testing for file transfers, encounters, etc., and on-site readiness audits with MOCs will take place in July 2018. Final determination for readiness will be in Sep-	None	Nancy Smith-Leslie, Director, Medical Assistance Division, Human Services Department	Completed

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	tember 2018. Statewide outreach events will begin mid-September 2018. Open Enrollment will be October – December 2018 with a 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, comply with specific time-lines for transition activities, identify and track high risk members and members with complex behavioral health needs. HSD and MCOs will form a transition workgroup to monitor activities. **Centennial Care 2.0 1115 Waiver Update:** HSD submitted its 1115 Waiver Renewal application to CMS in December 2017, and CMS conducted its 30-day public comment period through January 2018. Waiver negotiations are underway for the next six to eight months. HSD requested to prioritize negotiations to focus on new initiatives that will require system and regulation changes. A draft rule promulgation with public comments will be in September/October 2018 for an effective date of January 1, 2019. **Pharmacy Updates:** CMS approved the State Plan Amendment (SPA) that revises fee-for-service payment methods for outpatient drugs in accordance with federal rules. It only applies to Medicaid Fee-For-Service payments and reimbursement using an Actual Acquisition Cost (AAC) methodology. Reimbursement is the lowest of Affordable Care Act (ACA) Federal Upper Limit (FUL) plus dispensing fee, National Average Drug Acquisition Cost (NADAC) plus dispensing fee, Wholesaler's Average Cost (WAC) plus 6% plus dispensing fee, pharmacy's reported ingredient cost plus dispensing fee, and the Usual and Customary (U&C) charge. Implements a dispensing fee of $10.30. 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 out to all providers. MCOs are adjusting procedures but are primarily already in compliance with Senate Bill 11 (Prescription Drug Coverage) and will be in full compliance by January 1, 2019. HSD received concerns from community pharmacies about underpayment that could lead to access problems for members. HSD has issued a Letter of Direction to the MCOs establishing new polices for reimbursements to community pharmacies effective April 1, 2018. The Community pharmacy policy establishes that the MCOs MAC pricing for ingredient cost for generic drugs can be no lower than the current National Average Drug Acquisition Cost (NADAC) price. The policy does not establish a dispensing fee for managed care, which must			

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	continue to be negotiated between the pharmacy and the MCO. It ensures payment for administration, compounding, assembling, consultations, or prescribing fee for Naloxone kits and oral contraceptives. It also improves the process for pharmacies to submit price challenges and receive decisions from the MCOs. **Health Home Update:** The health homes for serious chronic behavioral health conditions expanded to eight more counties on April 1, 2018, which are: NM 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, and Guidance Center of Lea County in Hobbs; University of New Mexico Hospital and clinics will launch on July 1, 2018. **Value-Based Purchasing Update:** In 2017 the MCOs were required to have at least 16% of all provider payments in VBP arrangements and all MCOs met this requirement. A new initiative for Value-Based Purchasing (VBP) with nursing facilities is beginning now. A steering committee is being formed to design the program and build the needed infrastructure. The plan is to select eight to ten nursing facilities review and select about four or five quality metrics and agree on readmission definition. The initiative will be launch in 2019. **CC Interim Evaluation Findings:** Deloitte Consulting is conducting the independent evaluation of the 1115 waiver as required by CMS. The interim findings were submitted with the waiver renewal that covered Calendar Years 2014, 2015 and preliminary data from 2016. A summary of findings in key areas includes: improvements in Care Coordination and Integration, improvements in quality of care, reduction in expenditures and a shift to less costly services, increased member engagement and member satisfaction, and improvement in access to care. Additional improvements were found in the percentage of the state population enrolled in Medicaid, the ratio of providers to members, access to telemedicine, the percentage of members utilizing new Behavioral Health services, and the rate of flu vaccination. Declines were found in the percentage of members who had an annual dental visit, the percentage of members who had a primary care provider visit, and childhood and adolescent immunization rates. HSD is evaluating these initial findings to identify potential initiatives to continue to make improvements in the coming years. **Dash Boards:** Total Centennial Care Monthly Enrollment has tapered off. Total Centennial Care costs have increased by one percent for the current year; however, per capita costs have decreased by two percent.			
VI. MMISR Update	**Linda Gonzales presented the MMISR Update**	None	Linda Gonzales, Deputy Director	Complete

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	Medicaid Management Information System Replacement (MMISR) Approach: Health and Human Services (HHS) 2020 is a transformational approach to the way HHS services and programs are delivered. It features a modular, enterprise-wide approach that is person centric. It expands the vision to include an enterprise solution for multiple State agency partners. **MMIS Background:** NM Medicaid has a 20 year old MMIS solution that cannot be renewed as it no longer meet federal requirements. Federal funding depends on a certified solution. Demands and expectations on serving Medicaid recipients are increasing. **Framework:** There are six modules: System Integrator (SI), Data Services (DS), Quality Assurance (QA), Benefit Management Services (BMS), Financial Services (FS), Unified Public Interface (UPI), and Outcomes Based Management (OBM). For each module, there are multiple components, with one prime vendor. **What has been done:** Visioning, Medicaid Information Technology Architecture State Self-Assessment (MITA SSA), approval by CMS, approval by DoIT, and legislative approval for Sate funds for MMISR. **Where we are now:** Independent Verification and Validation (IV&V)-CSG was contracted in August 2016 as the IV&V vendor. The System Integrator vendor- Global solutions was contracted in March 2018.An RFP was released on March 16th for the Data Services vendor and this contract is in final negotiation. The Quality Assurance RFP was released and a vendor is being recommended. The Benefit Management Services RFP was submitted to CMS for review. The Financial Services RFP is in the information gathering stage. The RFPs for a Unified Portal (UPI) and for a Consolidated Customer Service Center are in development.			
VII. Value Based Purchasing	**Jordan E. with Presbyterian Health Plan (PHP) presented the PHP Value Based Purchasing (VBP) Successes:** **Presbyterian's VBP Programs:** PHP has three Levels of VBP Programs; Level 1: Provider Quality Incentive Program and Obstetrics Gainsharing. Provider Quality Incentive Program is a bonus based on achievement of physician quality measures tied to Healthcare Effectiveness Data and Information Set (HEDIS) and Human Services Department (HSD) requirements. Obstetrics Gainsharing is a shared savings program with facilities to incent improvement in cesarean section	None	Jordan Presbyterian Health Plan	Complete

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	rates. Level 2: PCMH with Shared Savings, is an upside only shared savings model that also includes monthly financial support payments and requirements around quality and utilization. This program is similar in many ways to the Medicare ACO Advanced Payment and Shared Savings Model. Level 3: Multi-Specialty Sub-Capitation and Behavioral Health Provider Two-Sided Risk Sharing. Multi-Specialty Sub-Capitation is a PHP's global risk capitation programs for primary care provider groups; there are two arrangements currently in operation—one with a related medical group and another with a large Federally-Qualified Health Center (FQHC). Behavioral Health Provider Two-Sided Risk Sharing is a program that includes enhanced payments to a BH provider in exchange for two-sided risk; thus far results on both sides have been positive. **Data Sharing:** Currently there are different levels of Data Sharing.. Level 1: Provider Quality Incentive Program, and PCMH with Shared Saving and Obstetrics Gainsharing. Provider Quality Incentive Program is shared data that consists of monthly reports of quality achievements for associated members against defined targets. PCMH with Shared Savings is a full report provided monthly with quality and utilization statistics for assigned members, as well as detailed rosters; the financial data is provided quarterly. Obstetrics Gainsharing is a quarterly report on progress annual targets. Level 3: Multi-Specialty Sub-Capitation and Behavioral Health Provider Two-Sided Risk Sharing. Multi-Specialty Sub-Capitation requires PHP to share monthly claims extracts for all assigned members with related delivery system Admission Discharge Transfer files provided daily. Behavioral Health Provider Two-Sided Risk Sharing includes a monthly attributed member roster and claims summaries at the member level for attributed members. **VBP Successes & Challenges:** Some of PHP's successes are general provider satisfaction and feeling of alignment with PHP goals with the PCMH program. The arrangement with the FQHC has proved to be a financial success under the program. PHP has provided technical assistance in data and system setups coupled with clear expectations on deliverables. A few challenges are related to data sharing agreements with providers. Also, teaching provider groups some of the more technical concepts of managing and accounting for risk in the more advanced VBP levels; i.e. IBNR accruals, stop loss, premium adjustments, trend over time, etc. Standardization of data sharing and standardized training were lessons learned in 2017 and applied in 2018. **Mike Renaud with Presbyterian Medical Services presented PMS**			

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	VBP Update: **Presbyterian Medical Services VBP:** A small portion of patients account for a disproportionate share of costs. Employ a methodology to identify these and other high-risk patients. Develop a care management program. Align PMS care teams to goals of program and relentless focus on Quality Measures. High-Risk, High-Cost Group is first priority and ensuring the sickest, most costly patients are well managed, then leveraging analytics to support a comprehensive primary care strategy and using data to unearth opportunities for systematic improvements. PMS is participating in nine successful VBP projects. Hybrid with care teams are comprised of: patients and families, PCP, primary care clinical support staff, centralized care coordination, BH professionals, dental professionals, pharmacists, and HIT staff. Lessons Learned: numerous success stories, increased organizational resources, improved care team, improved Clinical Quality, positive financial results, and improved relationship with MCOs. Challenges include significant up-front investment/ capital intensive, developing partnerships and the complexity of those agreements; need for organizational sophistication, human element, and having feet in two worlds.		Mike Renaud, Presbyterian Medical Services	
VIII. Public Comment	Nancy Rodriguez asked all MCOs to remember all adolescents in the upcoming changes being implemented for the program.	None		Complete
IX. Adjournment	The meeting adjourned at 3:27pm. Date for the next regular meeting was not announced.	See HSD website for upcoming meeting date(s)	Larry Martinez, MAC Chairperson	Completed

Respectfully submitted: Alysia Beltran — June 6, 2018

Recorder — Date