



HUMAN SERVICES
DEPARTMENT

**Medicaid Reform, Controlling Costs and Improving Quality
Hearing before the Legislative Finance Committee
August 16, 2017**

Brent Earnest, Secretary, HSD



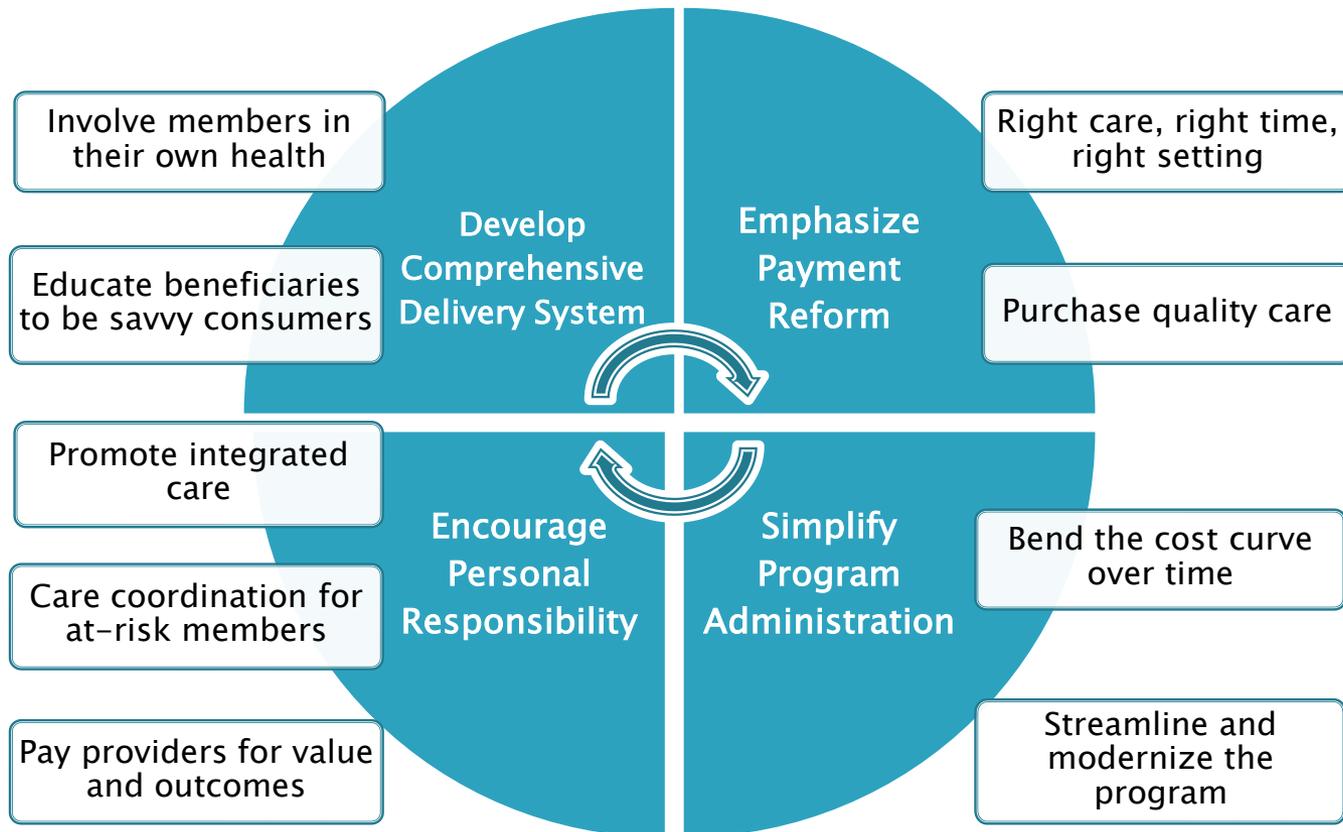
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Today's Topics

- ▶ Centennial Care
 - Medicaid reforms reducing per person costs, expanding access, driving performance and quality improvements
- ▶ Centennial Care 2.0
 - Opportunities and process for the second five-year waiver agreement
- ▶ Federal Outlook
 - Health care reform legislation
 - Possible FY19 Budget Impacts

Centennial Care

Guiding Principles for Medicaid Reform



Centennial Care: Reforming Medicaid

- ▶ A Comprehensive Service Delivery System
 - Managed Care Organizations are responsible for integrating care to address all health needs of the member through robust care coordination
- ▶ Personal Responsibility
 - Engage recipients in their personal health decisions through incentives and disincentives
- ▶ Payment Reform
 - Use innovative payment methodologies to reward quality care and improve health outcomes instead of the quantity of care
- ▶ Administrative Simplification
 - Combine all Medicaid waivers (except the Developmental Disabilities waiver) into a single, comprehensive 1115 waiver

Centennial Care: Reforming Medicaid

Principle 1

Creating a comprehensive delivery system

Build a care coordination infrastructure for members with more complex needs that coordinates the full array of services in an ***integrated, person-centered model of care***

- Care coordination
 - 950 care coordinators
 - 60,000 in care coordination L2 and L3
 - Focus on high cost/high need members

- Health risk assessment
 - Standardized HRA across MCOs
 - 610,000 HRAs

- Increased use of community health workers
 - ~100 employed by MCOs

- Increase in members served by Patient Centered Medical Homes
 - 334,000 members now receiving services through a PCMH
- Health Homes – Two pilot sites for adults and kids with co-occurring behavioral health diagnoses
- Expanding home and community based services
 - Implemented electronic visit verification for personal care services
- Reduction in the use of ER for non-emergent conditions

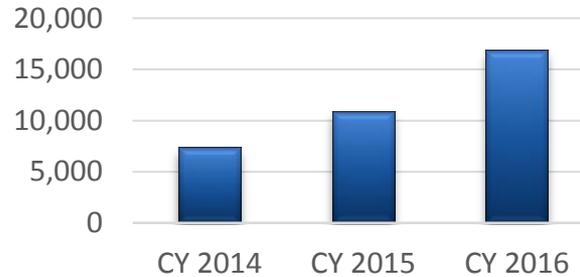
Centennial Care: Reforming Medicaid

Principle 1

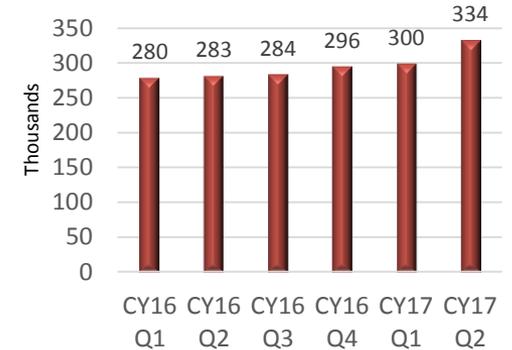
Creating a comprehensive delivery system

Build a care coordination infrastructure for members with more complex needs that coordinates the full array of services in an *integrated, person-centered model of care*

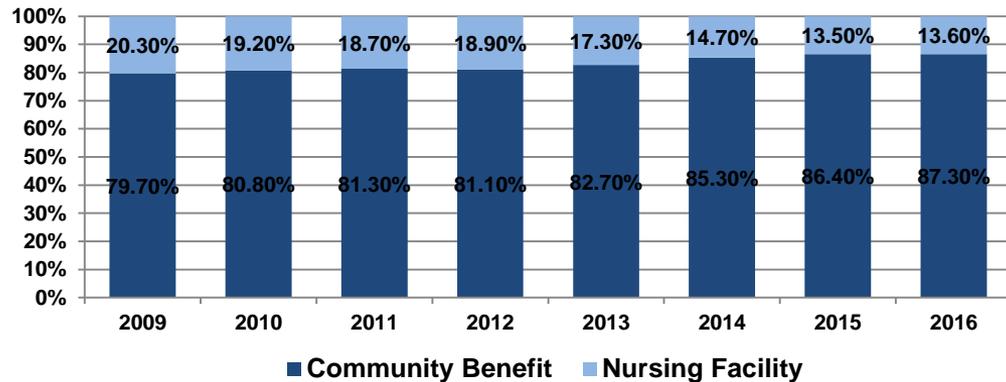
Number of visits through Telehealth in rural and frontier counties



Number Served Through a PCMH



Long Term Services and Supports Enrollment – Setting of Care



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Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer a member rewards program to incentivize members to ***engage in healthy behaviors***

- Centennial Rewards
 - health risk assessments
 - dental visits
 - bone density screenings
 - refilling asthma inhalers
 - diabetic screenings
 - refilling medications for bipolar disorder and schizophrenia

- 70% participation in rewards program
- Majority participate via mobile devices
- Estimated cost savings in 2015: \$23 million
 - Reduced hospital admissions
 - 43% higher asthma controller refill adherence
 - 40% higher test compliance for diabetes
 - 76% higher medication adherence for individuals with schizophrenia
- 70k members participating in step-up challenge

- Co-pays to drive better health care decisions

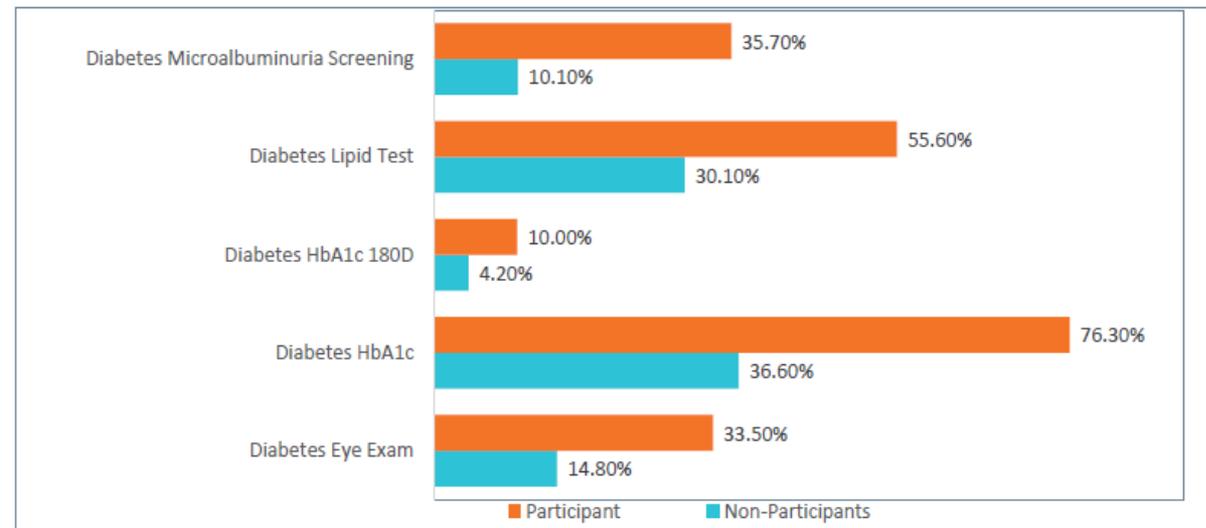
Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer a **member rewards program** to incentivize members to *engage in healthy behaviors*

Quality/Compliance Summary – Diabetes



- 39.7% higher HbA1c test compliance
- 25.4% higher lipid test compliance
- 18.8% higher eye exam test compliance

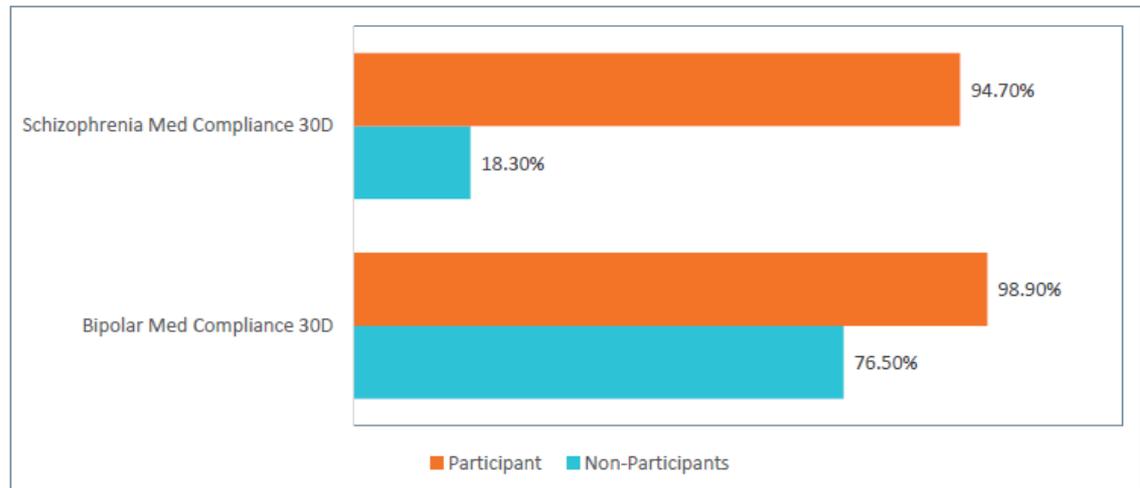
Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer a **member rewards program** to incentivize members to *engage in healthy behaviors*

Quality/Compliance Summary – Behavioral Health



Medication adherence is substantially higher for participants in the bipolar and schizophrenia programs compared to non-participants.

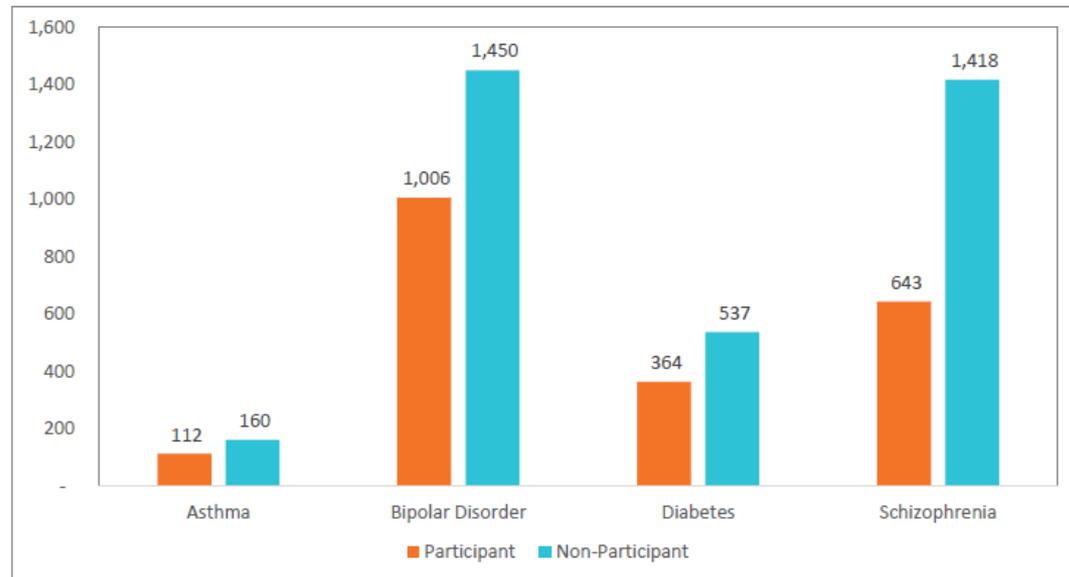
Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer a **member rewards program** to incentivize members to ***engage in healthy behaviors***

Inpatient Visits per 1,000 Members



Inpatient admits are lower for all conditions.

Finity, Inc.

9

Centennial Care: Reforming Medicaid

Principle 3

Increasing Emphasis on Payment Reforms

Create an incentive payment structures that **reward providers for high quality of care to improve members' health**

- July 2015, 10 pilot projects approved
 - Accountable care organization (ACO)-like models
 - Bundled payments for all services related to a condition
 - Shared savings

- Developed quarterly reporting templates and agreed-upon set of metrics that included process measures and efficiency metrics

- Sub capitated Payment for Defined Population
- Three-tiered Reimbursement for PCMHs
- Bundled Payments for Episodes of Care
- PCMH Shared Savings
- Obstetrics Gain Sharing

- Implemented minimum payment reform thresholds for provider payments in CY2017 in MCO contracts

Centennial Care: Reforming Medicaid

Principle 4

Simplify Administration

Create a coordinated delivery system that focuses on **integrated care and improved health outcomes**; increases accountability for more limited number of MCOs and **reduces administrative burden** for both providers and members

- Consolidation of 11 different federal waivers that siloed care by category of eligibility; reduce number of MCOs and require each MCO to deliver the full array of benefits; streamline application and enrollment processes for members; and develop strategies with MCOs to reduce provider administrative burden

- One application for Medicaid and subsidized coverage through the Health Insurance Exchange Marketplace

- Streamlined enrollment and re-certifications, added more online application tools

- Fewer Managed Care Organizations
- Standardizing forms and procedures
 - BH Prior Authorization Form for Managed Care and FFS
 - BH Level of Care Guidelines
 - Facility/Organization Credentialing Application
 - Single Ownership and Controlling Interest Disclosure Form for credentialing.
- Created FAQs for Credentialing and BH Provider Billing

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	4,763,194	4,918,215	3%
Long Term Services and Supports	572,988	589,577	3%
Other Adult Group	2,536,906	2,757,481	9%
Total Member Months	7,873,088	8,265,273	5%

Programs	Aggregate Medical Costs by Program		
	Previous (12 mon)	Current (12 mon)	%Change
Physical Health	\$ 1,245,916,497	\$ 1,262,498,696	1%
Long Term Services and Supports	\$ 883,544,015	\$ 898,665,309	2%
Other Adult Group Physical Health	\$ 955,821,072	\$ 1,054,867,891	10%
Behavioral Health - All Members	\$ 319,161,964	\$ 335,419,279	5%
Total Medical Costs	\$ 3,404,443,548	\$ 3,551,451,175	4%

Programs	Per Capita Medical Costs by Program (PMPI)		
	Previous (12 mon)	Current (12 mon)	%Change
Physical Health	\$ 261.57	\$ 256.70	-2%
Long Term Services and Supports	\$ 1,541.99	\$ 1,524.25	-1%
Other Adult Group Physical Health	\$ 376.77	\$ 382.55	2%
Behavioral Health - All Members	\$ 40.54	\$ 40.58	0%
Total	\$ 432.42	\$ 429.68	-1%

Programs	Aggregate Non-Medical Costs		
	Previous (12 mon)	Current (12 mon)	%Change
Admin, care coordination, Centennial Rewards	\$ 371,292,953	\$ 351,377,344	-5%
NM MIP Assessment	\$ 53,676,377	\$ 61,948,430	15%
Premium Tax - Net of NIM MIP Offset	\$ 133,873,146	\$ 142,065,842	6%
Total Non-Medical Costs	\$ 558,842,476	\$ 555,391,616	-1%

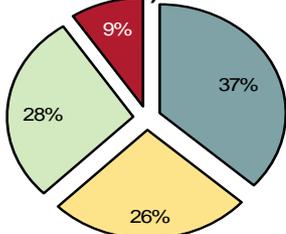
Programs	Per Capita Non-Medical Costs by Program (PMNPI)		
	Previous (12 mon)	Current (12 mon)	%Change
Admin, care coordination, Centennial Rewards	\$ 47.16	\$ 42.51	-10%
NM MIP Assessment	\$ 6.82	\$ 7.50	10%
Premium Tax - Net of NIM MIP Offset	\$ 17.00	\$ 17.19	1%
Total	\$ 70.98	\$ 67.20	-5%

Estimated Total Centennial Care Costs	\$ 3,963,286,024	\$ 4,106,842,791	4%
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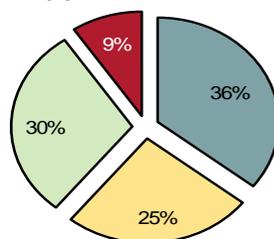
Estimated Total Per Capita Centennial Care Costs	\$ 503.40	\$ 496.88	-1%
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Centennial Care Medical Expenditures

Previous (April 2015 - March 2016)



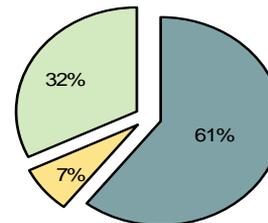
Current (April 2016 - March 2017)



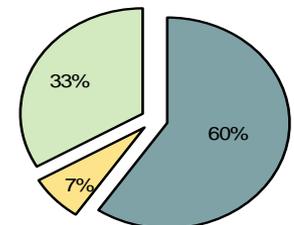
*See above for legend.

Centennial Care Member Months

Previous (April 2015 - March 2016)

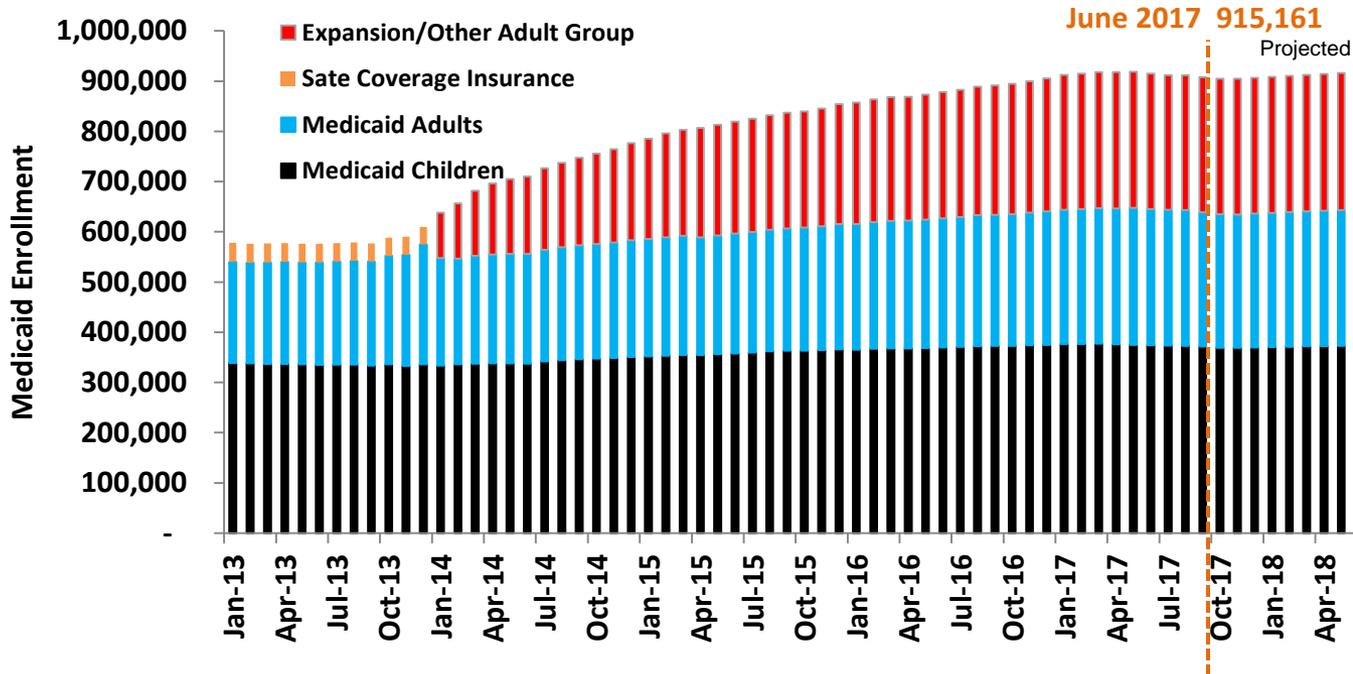


Current (April 2016 - March 2017)



*See above for legend.

Medicaid Enrollment



**June 2018
Projected Enrollment**

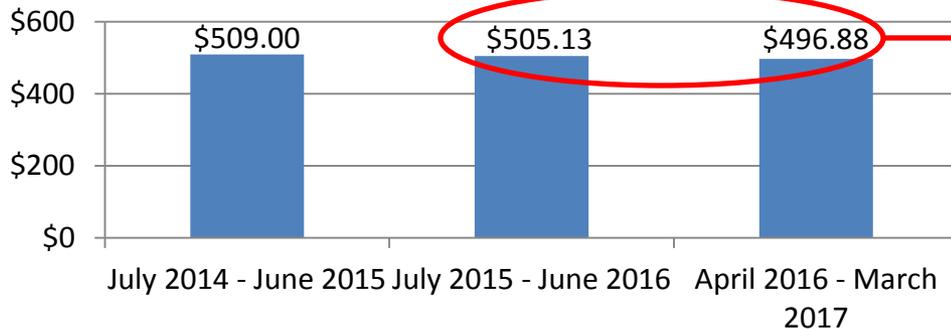
OAG:
272,954*

Medicaid Adults:
271,609

Medicaid Children:
373,390*

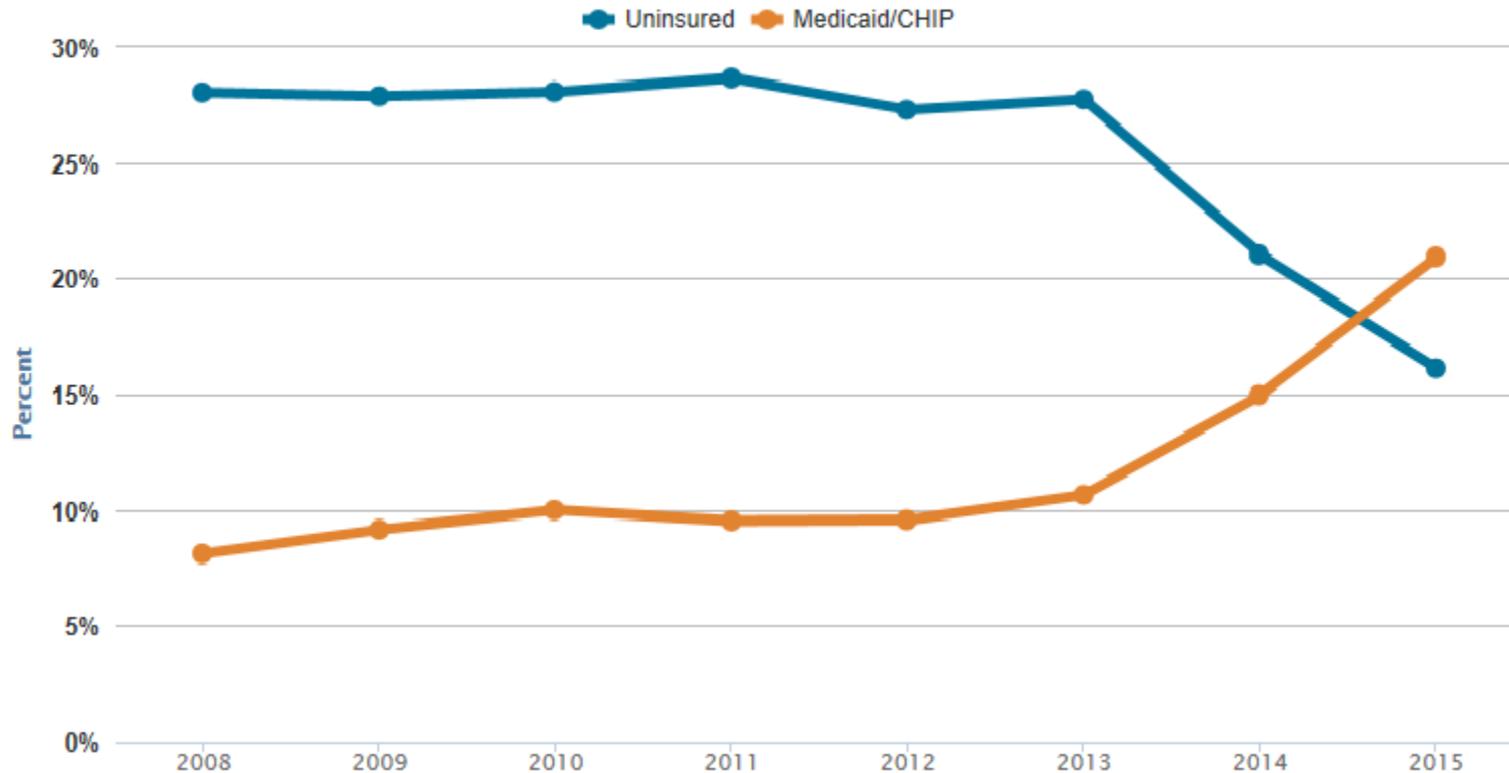
*children 19-21 y.o. counted in OAG

Average Per Member Per Month Costs in Centennial Care



Reduced spending by \$68.2 million

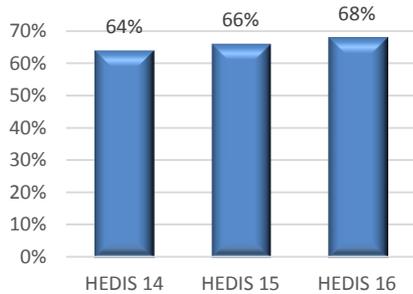
New Mexico Uninsured and Medicaid–Insured (19–64 population)



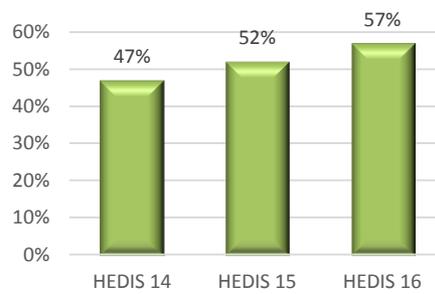
Source: SHADAC State Health Compare, University of Minnesota

Centennial Care: HEDIS Performance

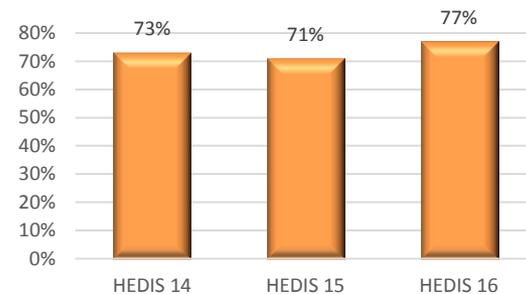
Annual Dental Visits for Children



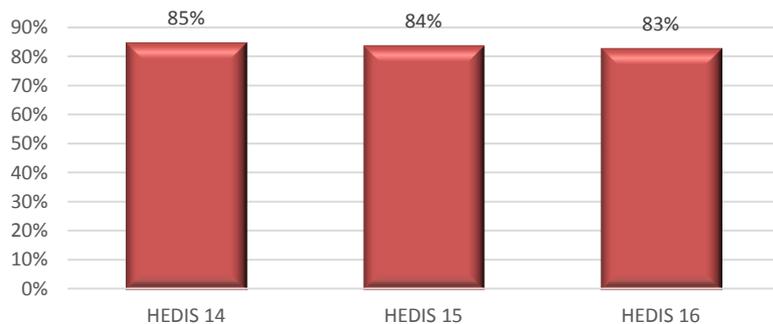
Well Child Visits within 1st 15 mos.



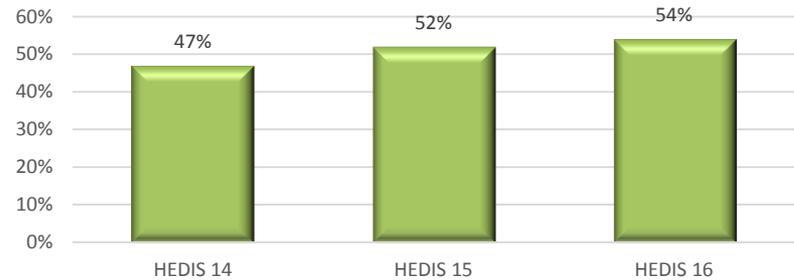
Prenatal Care Visit in the 1st Trimester



Diabetes Testing 18-75 yrs.



Medication Management for Asthma for 5-64 yrs, 50% Medication Compliance







Vision for the future of Centennial Care

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Behavioral health integration
- Long-Term Services and Supports (LTSS)
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to benefits and eligibility

Care Coordination 2.0

Identified Opportunities

#1: Increase care coordination at the provider level

#2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

#3: Expand programs working with high needs populations:

- First Responders, wellness centers, personal care agencies and Project ECHO;
- Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists
- Pilot a home visiting program; and
- Expand supportive housing.

Behavioral Health Integration 2.0

Opportunities

Opportunity #1: Expanding Health Homes (CareLink NM)

Opportunity #2: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

Long-Term Services and Supports 2.0

Opportunities

#1: Allow for one-time start-up goods for transitions when a member transitions from agency-based to self-directed care

#2: Increase caregiver respite hours (from 100 to 300 hours).

#3: In order to continue to provide access to the Community Benefit services for all eligible members who meet a NF LOC, establish some limits on costs for certain Community Benefits

#4: Implement an automatic NF LOC approval for members whose condition is not expected to change

#5: Include nursing facilities in Value Based Purchasing (VBP) arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff.

Payment Reform 2.0

Opportunities

Opportunity #1: Pay for better quality and value by increasing percentage of providers payments that are risk-based

- Expand requirements for MCOs to shift provider payments from fee-for-service to paying for quality and improved outcomes.

Opportunity #2: Use Value Based Purchasing (VBP) to drive program goals, such as:

- Increasing care coordination at provider level, improving transitions of care, increasing physical and behavioral health integration and improving member engagement.



Member Engagement and Personal Responsibility 2.0

Opportunities

#1: Advance the Centennial Rewards Program

#2: Allow providers to charge small fees for three or more missed appointments

#3: Premiums for populations with income that exceeds 100% FPL (applies only to three categories of eligibility)

- Adults in the Expansion with income greater than 100%
- CHIP program (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
- Working Disabled Individuals

FPL Range	Annual Income (Household of 1)	Monthly Premium
101-150% FPL	\$11,881-\$16,404	\$20
151-200% FPL	\$16,405-\$23,760	\$30
201% FPL and up	\$23,761-\$29,700	\$40

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#1: Cover most adults under one comprehensive benefit plan

- HSD proposes to consolidate the two different plans under a single comprehensive benefit package that more closely aligns with private insurance coverage
 - similar to the Alternative Benefit Plan we have today for the Other Adult Group (a.k.a., expansion population)
- Individuals who are determined “medically frail” may receive the standard Medicaid benefit package

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#2: Develop buy-in premiums for dental and vision services for adults (if necessary)

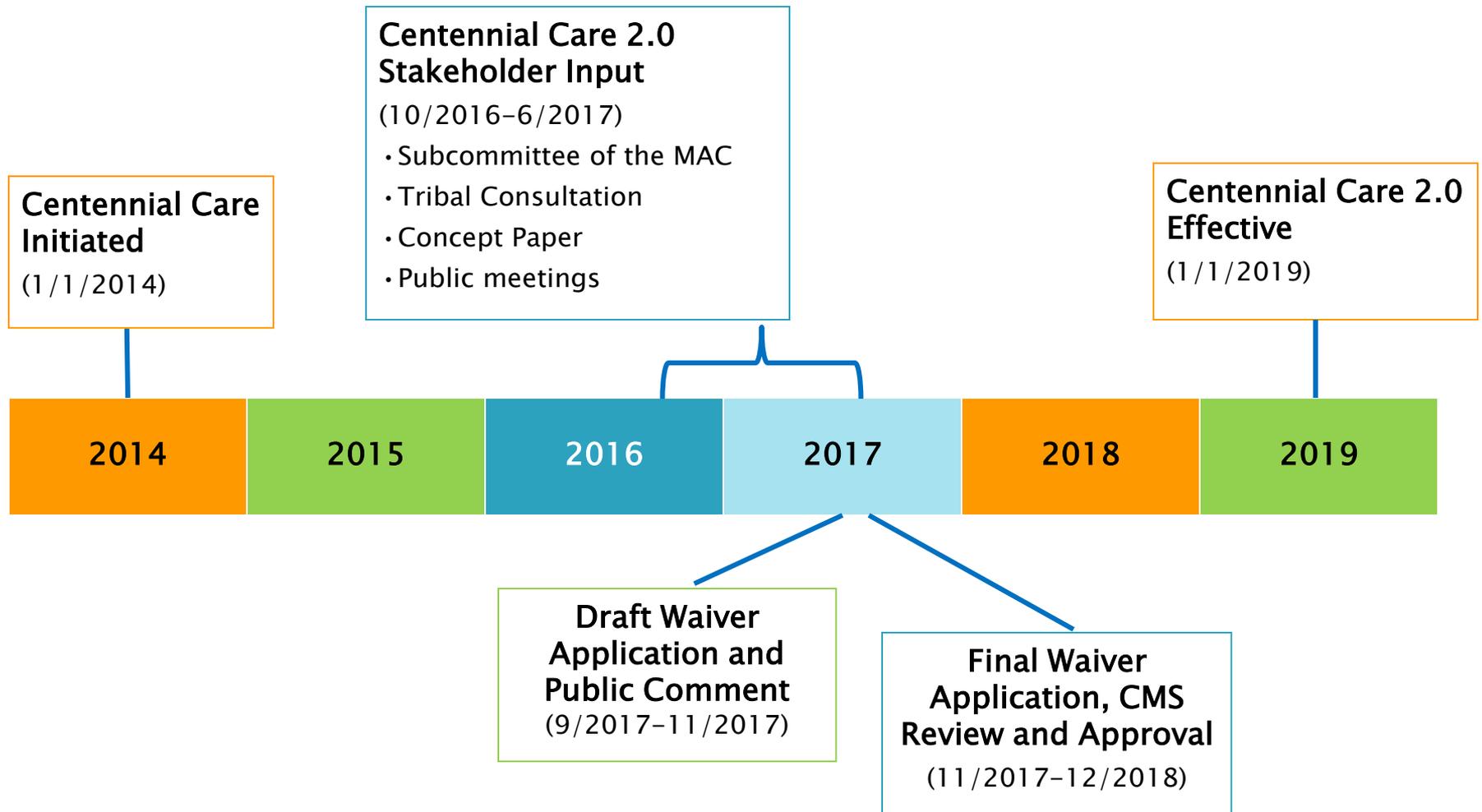
#3: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Populations covered in FFS would be exempt from this change
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services

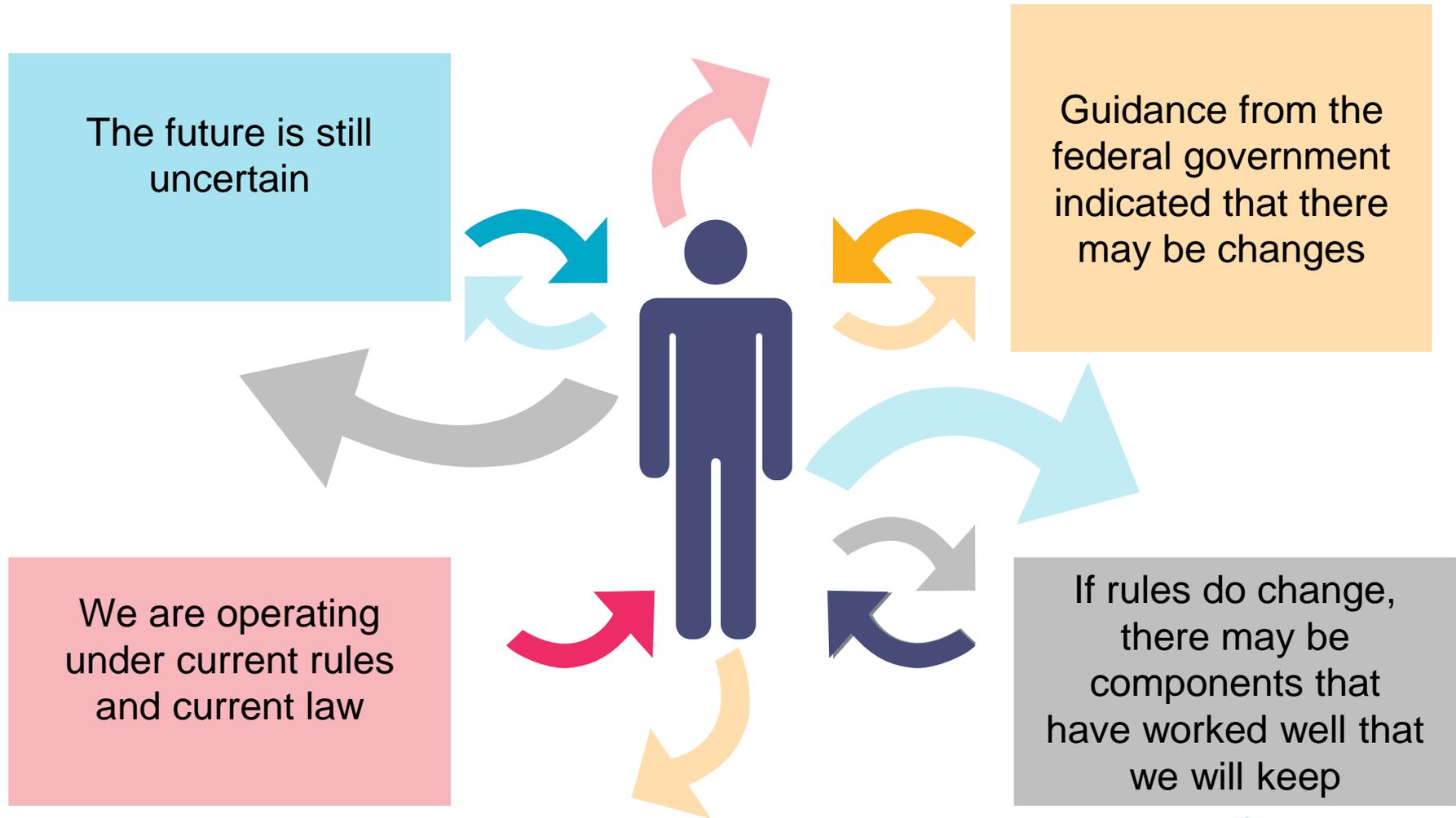
#4: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that put them over the eligibility guidelines

- Use of the category dropped from 26,000 individuals to 2,000
- Individuals with income above the Adult Group guidelines may receive subsidies to purchase coverage through the Exchange

Centennial Care Timeline



Federal Medicaid Changes



Federal Outlook

- ▶ AHCA, BCRA, “Skinny” BCRA, Other proposals
 - Application of Per Capita Caps / Block Grants
 - Reduced federal spending for Medicaid
 - Budget impacts are more significant in the out years (three to six years)
- ▶ Changes in policy and practice likely at CMS
- ▶ Federal budget likely vehicle for other changes
- ▶ Efficient programs like NM’s do not have a large margin to absorb health care cost inflation changes in a per capita cap or block grant proposal

Federal Outlook

(FY19 Budget Issues)

- ▶ Expansion FMAP steps down again on January 1, 2018, to 93%
- ▶ Regular FMAP rates expected to improve slightly for NM
- ▶ CHIP Reauthorization “up in the air”
 - Expires September 30, 2017
 - Scenarios:
 - No action/reauthorization
 - Full reauthorization (including higher ACA matching rate)
 - Reauthorization at regular or lower FMAP rates

Other State Responses and Options

- ▶ Restructure financing and responsibility for state and county health care services
 - With the expansion of Medicaid, counties' responsibility for indigent health care has been reduced while the state's responsibility has increased
 - Financing and funding has not followed this change
- ▶ Reduce Medicaid's responsibility for other care programs for higher income populations
 - Health Insurance Exchange
 - NM Medical Insurance Pool (High Risk Pool)

Questions?