2015 Accountability Report

Medicaid

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

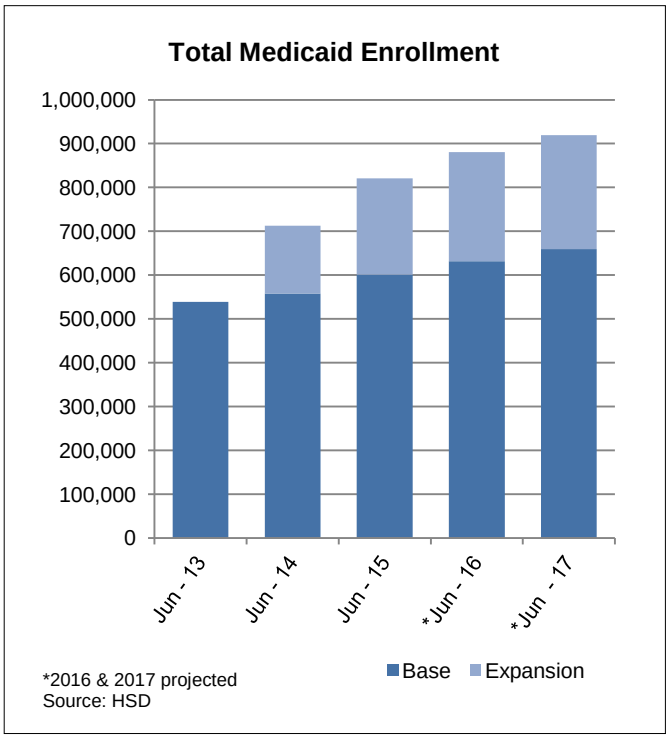
With the implementation of Centennial Care and Medicaid expansion, about 220,000 newly eligible adults are now covered by Medicaid, with a total of over 820,000, or nearly 40 percent of New Mexicans, participating in the program. Expanded coverage and services, improved care coordination and pay-for-performance initiatives should, in time, result in better health outcomes for New Mexicans and greater economic efficiencies for the program.

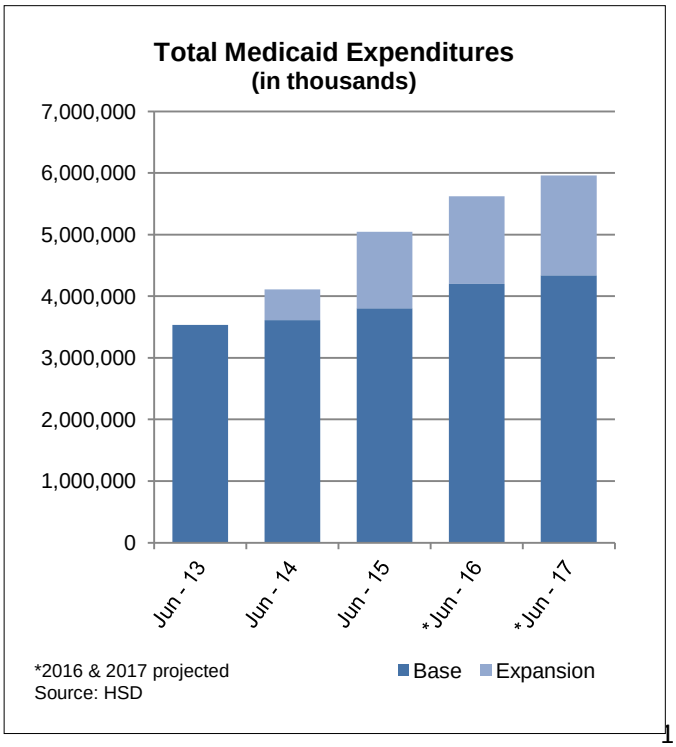
Yet the increased coverage comes at a cost of over a billion in state funds each year; further, with the step-down of federal support beginning in calendar year 2017, the state general fund will pick up an estimated $40 million in FY17. Consequently, advocates and legislators alike are eager for answers regarding cost and performance outcomes for the program.

The Medicaid Accountability Report is intended to provide an in-depth look at key Medicaid quality and cost indicators. In FY13, the department began adding performance measures targeting quality outcomes and focusing less on enrollment; for FY17 the agency has agreed to more such measures. Included here are the standard health quality measures that HSD has reported for several years, as well as new sections that focus on the major areas of Medicaid services: physical health, behavioral health, and long-term care. Data for these sections are drawn from Healthcare Effectiveness Data and Information Set (HEDIS) data and other reports submitted by the MCOs regarding utilization of services and consumer satisfaction.

HSD has routinely used HEDIS measures for Medicaid program oversight. Given the growing importance of Medicaid, this LFC report seeks to expand the amount of performance and cost data available to the Legislature. Because Centennial Care is a new program and just began in 2014, we have utilized National Committee for Quality Assurance (NCQA) benchmarks wherever possible.

Performance-driven Healthcare. The goals of Centennial Care include providing quality healthcare that is also cost-effective. So to measure the success of the program requires considering not just the amount of healthcare delivered, but also the success of preventive care and disease management, both intended to improve health and contain costs by keeping people from getting sick in the first place, and managing the illnesses they do develop as early in the disease process as possible where interventions are generally the most successful and least costly.





Health Quality Measures

These managed care performance measures are part of HSD's regular reporting under the Accountability in Government Act. They are used by the LFC to develop the quarterly report cards for HSD and behavioral health. As part of the change to Centennial Care the department has switched to calendar year reporting for most measures, and the comparisons here are between CY14 actual numbers and CY15 year-to-date numbers. A rating of 'guarded' indicates the measure appears at this time to be trending unfavorably compared to CY14.

HEALTHY CHILDREN	**Percent of newborns whose mothers had prenatal visit during first trimester**	**Percent of infants who had 6 or more well-child visits during first 15 months**	**Percent of children/youth who had one or more well-child visits during the year**	**Percent of children ages 2 to 21 who had at least one dental visit during the year**
	2015 YTD	2015 YTD	2015 YTD	2015 YTD
	20%	44%	56%	39%
	Better	Guarded	Guarded	Guarded
	2014 13%	2014 52%	2014 75%	2014 65%

CARE COORDINATION AND CHRONIC DISEASE MANAGEMENT	**Percent of adults with diabetes who had a HbA1c test during the year**	**Percent of children with persistent asthma appropriately prescribed medication**	**Rate of ER visits per 1,000 member months**	**Percent of hospital readmissions for adults within 30 days of discharge**
	2015 YTD	2015 YTD	2015 YTD	2015 YTD
	51%	52%	41	8%
	Guarded	Guarded	Stable	Better
	2014 63%	2014 65%	2014 42	2014 11%

BEHAVIORAL HEALTH	**Percent of adults with major depression who received continuous treatment with antidepressant medication**	**Percent of individuals discharged from inpatient facilities who receive follow-up services at seven days**	**Percent of individuals discharged from inpatient facilities who receive follow-up services at thirty days**	**Percent of readmissions for children/youth discharged from residential treatment centers and inpatient care**
	2015 YTD	2015 YTD	2015 YTD	2015 YTD
	26%	29.8%	45.6%	7%
	New Measure	Better	Guarded	Guarded
	Target 34%	2014 26%	2014 52.3%	2014 4%

Physical Health

ADULTS AND CHILDREN	Centennial Care Physical Health Expenditures (in billions)	Physical Health Average Cost Per Person Per Month	Medicaid Expansion Physical Health Expenditures (in billions)	Medicaid Expansion* Average Cost Per Person Per Month
2015 YTD	SFY15	SFY15	SFY15	SFY15
596,723	$1.50	$324	$1.15	$552
CY14 612,086	SFY14 $1.29	SFY16 YTD $315	SFY14 $468 million*	SFY16 YTD $564

*Medicaid expansion began mid-way through SFY14 so this is a 6 month figure. Expenditures are HSD capitation payments. Source for this data are HSD Medicaid projections. HSD projections provide a single PMPM for the expansion population and LFC cannot separate out the physical health and behavioral health amounts.

The physical health program includes children and adults and certain special populations such as foster care children. There is also a physical health expansion population consisting of adults not previously Medicaid eligible. Centennial Care MCOs report a variety of measures that can be used to evaluate cost, quality and effectiveness of the healthcare being delivered. Costs as represented by per member per month (PMPM) amounts are projected to decrease for physical health by 2.7 percent and rise for the expansion population by 2.2 percent in SFY16.

Identifying measures that reflect actual health outcomes is difficult, in large part because outcomes involve many factors that are outside the scope of measurement. Some healthcare activities, such as early and ongoing prenatal care, regular monitoring of patients with diabetes, or ensuring access to appropriate medications, are relatively reliable predictors of positive health outcomes. Measures that indicate use or avoidance of costly but not particularly effective procedures, such as use of imaging for low back pain, add the element of efficiency as well as effectiveness. Tracking these measures over time is one way of gauging the effectiveness of the Medicaid program. This is the first set of HEDIS data for the Centennial Care program and we do not have historical data to compare with. HSD has also not established targets for these measures. The data do reveal a notable lag behind available national measures. However there is considerable variation among the Centennial Care MCOs and some come close to or even exceed national benchmarks.

Effectiveness of Care	**Percent of adult patients receiving body mass index assessment**	**Percent of child/adolescent patients receiving body mass index assessment**	**Percent of patients with imaging used to diagnose low back pain**	**Percent of children receiving appropriate treatment for upper respiratory infections**
2014 New Mexico	78.2%	44%	73.5%	86.5%
2014 NCQA 90%	86%	80%	85%	95%
MCO with best rating	Presbyterian 84.4%	BCBSNM 55.4%	UHC 70%	UHC 88.6%
Disease Management	**Percent of patients with poor diabetes control**	**Percent of patients with controlled high blood pressure**	**Percent of patients with COPD managed with corticosteroid medication**	**Percent of patients 75% compliant with asthma medication use**
2014 New Mexico	47.2%	53%	39.2%	22.7%
2014 NCQA 90%	28%	68%	77%	New measure
MCO with best rating	Presbyterian 44%	Presbyterian 56%	Molina 46.6%	UHC 48%
Access to Care	**Percent of children and adolescents with access to primary care**	**Percent of adults with access to preventive & ambulatory care**	**Percent of women completing 81% or greater of expected prenatal care visits**	**Percent of women receiving timely postpartum care**
2014 New Mexico	88%	81.4%	52%	55%
Comparative Measure	HSD 2014 Actual = 75%	n/a	New measure	2014 NCQA 90% Benchmark = 75%
MCO with best rating	Molina 91%	UHC 87.2%	Molina 61%	Presbyterian 62%

Behavioral Health

Centennial Care Members Receiving BH Services	Fee for Service Members Receiving BH Services	Total Medicaid Recipients Receiving BH Services	Average Cost Per Person Per Month
CY14	CY14	CY14	SFY15
18%	13%	16.5%	$55
$210 million	$38 million	$248 million	SFY16 YTD $54

The behavioral health program area was carved into Medicaid under Centennial Care and is now covered by all four MCOs rather than by one (OptumHealth). Enrollees receiving services in physical health or long-term support services can also receive behavioral health services. Fee for service utilization is included above to provide the fullest picture possible of how many Medicaid recipients are accessing behavioral health, as well as cost. The measures below are drawn from 2014 HEDIS reports from the Centennial Care MCOs, and therefore include only managed care recipients.

New Mexico has one of the highest substance abuse rates in the country, so it is notable that New Mexico rates for both initiation and engagement in substance abuse treatment exceed the 2013 national average. Engagement in this measure means that the individual followed up with two or more additional services after initiating treatment. Also notable is that despite considerable well-publicized disruption to New Mexico's behavioral health network that resulted from HSD's audit of providers, the New Mexico Behavioral Health Consumer, Family/Caregiver Annual Satisfaction Survey shows that Medicaid recipients who did receive behavioral health services were in general slightly more satisfied with the services they received than the national average.

Recipients Utilizing Mental Health Services*	**All Services**	**Inpatient**	**Intensive Outpatient/ Partial Hospital**	**Outpatient/ Emergency Department**
2014	13.9%	1%	.08%	13.6%
MCO with highest utilization	UHC 16%	UHC 1.8%	MCOs are statistically similar	BCBSNM 15.4%

* HEDIS reports were submitted prior to finalization of all claims from CY14, so these figures are somewhat lower that the overall picture above.

Effectiveness of Care	**Percent of children with ADHD who had one follow-up visit within 30 days after first prescription***	**Percent of children with ADHD who remained on medication for at least 210 days and had at least two follow-up visits***	**Percent of members with alcohol and other drug dependence (AOD) who initiate treatment within 14 days of diagnosis***	**Percent of members with AOD who had two or more follow-up services within 30 days of initiation***
2014 New Mexico	48%	58%	38.6%	14%
2014 NCQA 90% Benchmark	52%	64%	2013 HEDIS Average 38.2%	2013 HEDIS Average 10.6%
MCO with best rating	Molina 55%	Molina 68%	Molina 39.5%	BCBSNM 14.7%

* UHC did not report data for this measure.

Access to Care	**Behavioral health practitioners**	**Behavioral health facilities**	**Total**	**MCO with most behavioral health providers**
	8,061	953	9,014	Presbyterian = 4,118
Consumer Satisfaction	**Percent of adults generally happy with the services they received**	**US Average 2013**	**Percent of families generally happy with the services provided to their child**	**US Average 2013**
	89%	88%	88%	86%

Long Term Support Services

	Enrollment	Expenditures (in billions)	Average Cost Per Person Per Month
	2015 YTD	SFY15	SFY15
	45,474	$1.27	$1,715
	CY14 44,505	SFY14 $1.25	SFY16 YTD $1,856

The long term support services program, formerly known as CoLTS, consists of enrollees who are dually eligible for Medicare and Medicaid, seniors who are not eligible for Medicare, and Mi Via and other self-directed home and community-based service recipients. On a per person basis, long term services are the most expensive portion of the Medicaid program, with average annual per person costs exceeding $20 thousand. The per member per month (PMPM) is projected to increase by 8.2 percent in SFY16 compared to SFY15. Additionally, the Centennial Care evaluation found that long-term service MCO expenditures slightly outpaced enrollment growth between CY13 and CY14. The biggest cost drivers for long-term services remain personal care services and nursing facilities.

While there are some studies that have found home and community based services (HCBS) can be less costly than nursing facilities and potentially have better health outcomes, the overall evidence is inconclusive. However, national Medicaid spending for HCBS has more than doubled since 1995, indicating a strong consumer preference for remaining in community settings when possible. The Centennial Care program includes an electronic visit verification (EVV) system to confirm that Medicaid recipients receiving personal care services in the community are, in fact, receiving those services in the amount, frequency, duration and scope specified in the recipient's care coordination plan. When fully implemented, the EVV system should provide a new level of accountability for this portion of the Medicaid program.

Care Coordination Levels (All Medicaid Populations*)	**Level One**	**Level Two (includes home health population)**	**Level Three (includes home health population)**
CY2014	471,173	52,653	12,321

*Total figure does not include recipients who declined care coordination or who could not be reached by MCO.

Care Coordination	**Percent of Health Risk Assessments Completed Within 30 Days**	**Percent of Recipients Receiving LTSS Services Within 90 Days of Eligibility**	**Number of Identified Fall Risk Patients 65 and Older Who Received Intervention**
2015 Year to Date	66%	94%	2015 HSD Target 1,600
2014 Actual	41%	97%	New measure
MCO with best rating	UHC 73.7%	n/a	n/a

Low health risk assessment completion rates were identified in the LFC's Centennial Care Program Evaluation as a significant barrier to effective care coordination. By the end of the first year of Centennial Care, the MCOs collectively had reached only 47 percent of their members to complete a health risk assessment. HSD and the MCOs implemented an Unreachable Member Campaign with 5 percent per month improvement targets for all of the MCOs and expanded outreach to Medicaid recipients and providers. As of August, 2015, the completion rate had improved to an aggregate 66 percent, with two MCOs reaching over 70 percent of their members.

Access to Care	**LTC Practitioners**	**LTC Facilities**	**Total**	**MCO with most LTC providers**
	1,411	164	1,575	BCBSNM = 616