2016 Accountability Report

Medicaid

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

As of January 2017, New Mexico's expanded Medicaid program covered over 898,000 New Mexicans, about 263,000 of whom are in the expansion population. The Human Services Department (HSD) projects a total of over 920,000 Medicaid recipients by June 2017 and over 949,000 by June 2018.

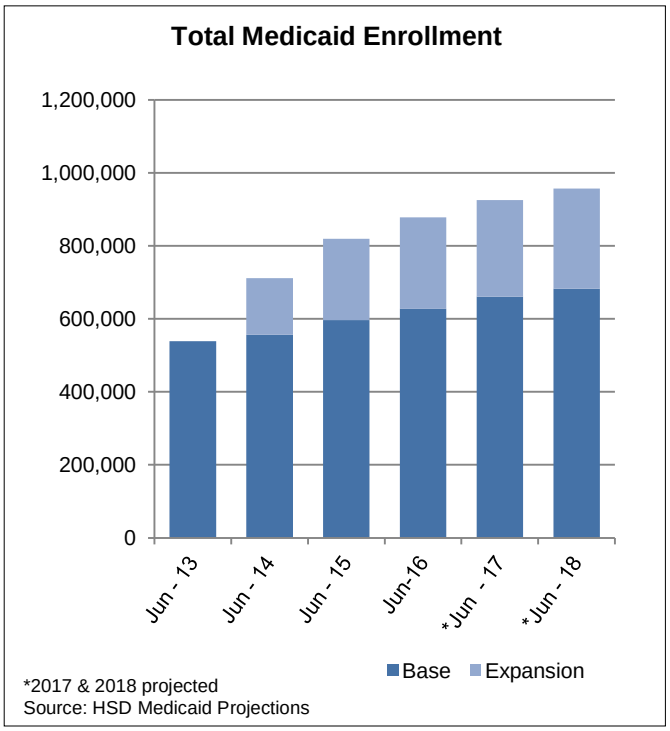
Expenses for the program are also increasing, driven by both enrollment growth and the shifting of a higher portion of the cost of the expansion population from the federal government to the state. For FY16, total costs for Medicaid were over $5.4 billion, with approximately $1.1 billion of state funds. HSD projects total expenditures of $5.8 billion for FY17, the state's share of which is estimated to be over $1.2 billion.

With the health care – and tax dollars – of so many New Mexicans at stake, the LFC, legislators and advocates have an interest in understanding how well the state's Centennial Care Medicaid program is performing. Meaningful measures of the quality and cost-effectiveness of the program take on particular importance in the current context of state-wide austerity and a heightened need to make difficult decisions about how to prioritize spending.

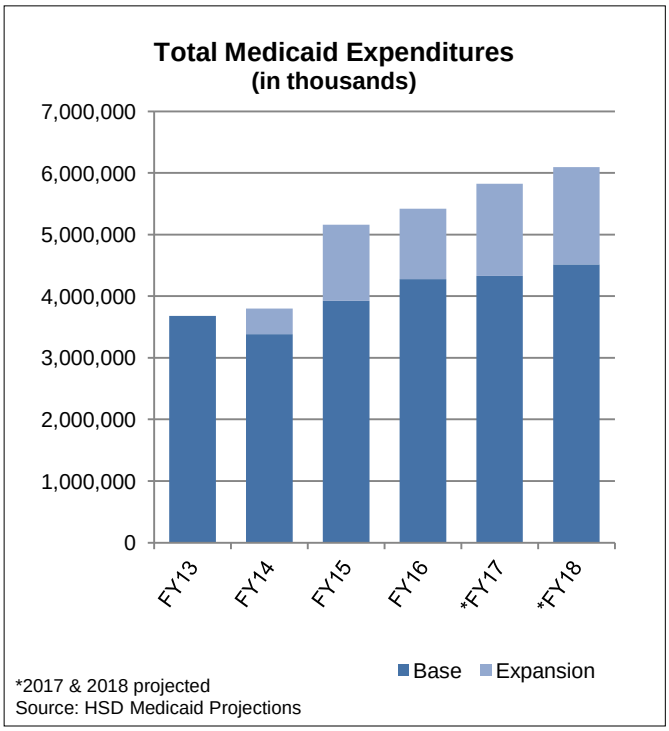
In 2016 LFC and DFA staff conducted a comprehensive review of all agency performance measures and identified a number of less meaningful measures for HSD to stop reporting on in FY18, or to shift from quarterly to annual reporting. However, HSD, like a number of other state agencies, began reducing its quarterly reporting to the LFC in FY17, sooner than anticipated. The LFC remains committed to robust quarterly reporting for all key agencies and measures for which loss of quarterly data is of concern have been highlighted below.

Performance driven health care. The goals of Centennial Care include providing quality health care delivered in the right quantity at the right cost. To measure the success of the program requires considering not just the amount of health care delivered, but also the success of preventive care and disease management.

This annual Accountability Report seeks to bolster the program's routine quarterly report by presenting annual audited Healthcare Effectiveness Data and Information Set (HEDIS) measures, side by side with information on program expenditures and consumer satisfaction.



*2017 & 2018 projected
Source: HSD Medicaid Projections



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Source: HSD Medicaid Projections

Health Quality Measures

The performance measures on this page have historically been part of HSD's reporting under the Accountability in Government Act, used by the LFC to develop its quarterly report cards. As noted above, as of the first quarter of FY17 HSD has reduced its quarterly reporting, resulting in a loss of some meaningful information. For example, the department has decided to report prenatal visits on an annual basis, rather than every quarter, because payments for all pregnancy-related services are bundled and accurate counting of prenatal visits prior to delivery is administratively difficult. However, prenatal care is a key health indicator that HSD requires the MCOs to track, and LFC staff has requested that HSD find a way to continue reporting this data quarterly. Note: The comparisons below are between audited annual data for 2015 and either FY16 fourth quarter data (if HSD elected not to report in FY17) or FY17 first quarter data. The ratings therefore indicate how partial year data is trending at this time when compared to prior year data.

HEALTHY CHILDREN	**Newborns whose mothers had prenatal visit during first trimester (or within 42 days of enrollment)**	**Infants who had 6 or more well-child visits during first 15 months**	**Children/youth who had one or more well-child visits during the year**	**Children ages 2 to 20 who had at least one dental visit during the year**
	FY16 4th Quarter	FY16 4th Quarter	FY16 4th Quarter	FY17 1st Quarter
	71%	43%	71%	65%
	Stable	Worse	Worse	Stable
	2014 73%	2015 49%	2015 84%	2015 66%
CARE COORDINATION AND CHRONIC DISEASE MANAGEMENT	**Adults with diabetes who had a HbA1c test during the year**	**Children with persistent asthma appropriately prescribed medication**	**Rate of ER visits per 1,000 member months**	**Hospital readmissions for adults within 30 days of discharge**
	FY17 1st Quarter	FY16 4th Quarter	FY16 4th Quarter	FY16 4th Quarter
	58%	89%	46	11%
	Worse	Stable	Better	Better
	2015 84%	2015 91%	2015 51	2015 13%
BEHAVIORAL HEALTH	**Adults with major depression who received continuous treatment with antidepressant medication**	**Individuals discharged from inpatient facilities who receive follow-up services at seven days**	**Individuals discharged from inpatient facilities who receive follow-up services at thirty days**	**Readmissions for children/ youth discharged from residential treatment centers and inpatient care**
	FY16 4th Quarter	FY17 1st Quarter	FY17 1st Quarter	FY17 1st Quarter
	29%	37%	55%	7%
	Worse	Better	Better	Better
	2015 37%	2015 31%	2015 53%	2015 9%

Physical Health

ADULTS AND CHILDREN*	Centennial Care Physical Health Expenditures (in billions)	Physical Health Average Quarterly PMPM	Medicaid Expansion Physical Health Expenditures (in billions)	Medicaid Expansion Average Quarterly PMPM
2016 November	FY16 Projected	FY16	FY16 Projected	FY16
896,854	$1.41	$317	$1.04	$533
2015 December 853,864	FY15 $1.47	FY15 $322	FY15 $1.15	FY15 $552

*Total Medicaid enrollment, managed care and FFS; Expenditures are HSD capitation payments. Source: HSD Medicaid projection, 1/11/17. 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, parents 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 the cost, quality and effectiveness of the health care. For FY17, physical health costs are projected to rise by 1.8 percent over FY16 for the Centennial Care base population, and by approximately 33 percent for the expansion population. Some of the increased cost for the expansion population is due to a projected 5.7 percent increase in covered members between June 2016 and June 2017 and corresponding rising utilization, and some is the result of the department's recent determination about how to account for changing eligibility.

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. The data do reveal a notable lag behind available national measures, although there are a few exceptions where the state on average, or an individual MCO, exceeds the National Committee for Quality Assurance (NCQA) Medicaid benchmark. Green arrows indicate improvement from last year, while red arrows indicate declining performance.

Effectiveness of Care	**Adult patients receiving body mass index assessment**	**Child/adolescent patients receiving body mass index assessment**	**Patients with imaging used to diagnose low back pain**	**Children receiving appropriate treatment for upper respiratory infections**
2015 New Mexico	77% ↓	54% ↑	73% ↓	89% ↑
2014 New Mexico	78%	44%	74%	87%
2015 NCQA 90%	86%	80%	85%	95%
MCO with best rating	PHP 83.9%	PHP 63%	PHP 74%	BCBS 91%
Disease Management	**Patients with poor diabetes control (lower is better)**	**Cardiovascular patients with controlled high blood pressure**	**Patients with COPD managed with corticosteroid medication**	**Patients 75% compliant with asthma medication**
2015 New Mexico	50% ↓	54% ↑	46% ↑	29%
2014 New Mexico	47%	53%	39%	29%
2015 NCQA 90%	30%	70%	78%	43%
MCO with best rating	Molina 45%	BCBS 57%	Molina 68%	UHC 37%
Access to Care	**Children ages 1 – 6 years with access to primary care**	**Adults with access to preventive & ambulatory care**	**Women receiving timely prenatal care**	**Women receiving timely postpartum care**
2015 New Mexico	87%	78% ↓	71% ↓	51% ↓
2014 New Mexico	87%	81%	73%	55%
2015 NCQA 90%	n/a	n/a	93%	75%
MCO with best rating	Molina 92%	UHC 83%	Molina 76%	BCBS 58%

Behavioral Health

Centennial Care Members Receiving BH Services		Centennial Care BH Expenditures (in millions)		Fee for Service Medicaid Recipients Receiving BH Services		Fee for Service Medicaid BH Expenditures (in millions)		BH Average Quarterly PMPM	
CY15		FY16		FY15		FY16		FY16	
14.4%		$419.0		22%		$34.7		$55	
CY14	18%	FY15	$390.6	FY14	22%	FY15	$32.4	FY15	$55

Sources: HSD Medicaid projection, 1/11/17. HSD projections provide a single PMPM for behavioral health and do not provide a PMPM for expansion behavioral health. MCO utilization management reports. BHC Performance Report FY16 4th Qtr.

Spending on the behavioral health program increased by approximately seven percent between 2015 and 2016 while utilization decreased slightly. The four Centennial Care MCOs appear to have increased their behavioral health networks, but because the same provider may be enrolled with more than one MCO it is difficult to tell whether this is an actual increase or simply the same provider being counted by multiple MCOs. One way to measure access is as a ratio of MCO providers to members, which currently ranges from one MCO with one behavioral health provider for every 51 members to another MCO with one provider for every 83 members.

The effectiveness of care measures below are drawn from 2015 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 unfortunate that New Mexico rates for both initiation and engagement in substance abuse treatment are stagnant. Also notable is that in the context of on-going disruptions to the state's behavioral health network 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 less satisfied in 2015 with the services they received than they were in 2014, and just below the national average.

Effectiveness of Care	Children with ADHD who had one follow-up visit within 30 days after first prescription[1]	Children with ADHD who remained on medication for at least 210 days and had at least two follow-up visits[1]	Members with alcohol and other drug dependence (AOD) who initiate treatment within 14 days of diagnosis[2]	Members with AOD who had two or more follow-up services within 30 days of initiation[2]
2015 New Mexico	49% ↑	58%	38%	14%
2014 New Mexico	48%	58%	38%	14%
2015 NCQA 90%	53%	64%	n/a	n/a
MCO with best rating	Molina 58%	Molina 75%	PHP 40%	PHP 15%

[1]UHC did not report 2014 data for these measures, but did report 2015 data. [2]UHC did not report 2014 or 2015 data for these measures.

Access to Care	Behavioral health practitioners	Behavioral health facilities[1]	Total behavioral health providers	MCO with highest ratio of behavioral health providers to members
2016 *(2nd quarter)*	9,761	1,310	11,071	Presbyterian 1:51
2015	9,732	1,042	10,774	Presbyterian 1:50

[1]The increase here is driven by PHP's addition of over 250 BH facilities to its network due to a change in counting methodology; currently being reviewed by HSD.
Source: MCO network adequacy reports.

Consumer Satisfaction	Adults generally happy with the services they received	US Average	Families generally happy with the services provided to their child	US Average
2016	86%	88%	83%	86%
2015	88%	89%	87%	87%

Long Term Services and Supports

	Centennial Care Average Quarterly Enrollment	Total Expenditures (in billions)[1]	Centennial Care Average Quarterly PMPM
	FY16	FY16	FY16
	47,897	$1.41	$1,822
	FY15 46,159	FY15 $1.33	FY15 $1,783

[1]Expenditures include spending for the developmentally disabled, medically fragile and Mi Via waivers, as well as Centennial Care LTSS.
Source: HSD Medicaid projection, 1/11/17.

On a per person basis, the long term services and supports (LTSS) program is the most expensive portion of the Medicaid program, with average annual per person costs exceeding $20 thousand. LTSS expenditures increased faster than enrollment between 2013 and 2014, however that trend has reversed and from 2014 to 2016, enrollment growth outpaced cost: the average quarterly per member per month (PMPM) increased by approximately 6.2 percent from 2014 to 2016, while enrollment increased by 12.6 percent. The biggest cost drivers for long-term services remain personal care services and nursing facilities.

As a result of the 2016 review of performance measures, HSD shifted all three of the LTSS quarterly performance measures to annual reporting for FY17 and discontinued them entirely for FY18. One of the discontinued measures, the number of Medicaid recipients who receive services in the community after transitioning from a nursing facility, will be replaced by a new measure, the percent of recipients with a nursing facility level of care who are being served in the community. The new measure will more accurately reflect one of the key changes of the Centennial Care program, which allows recipients who qualify for community benefits to access them without having to first enter a nursing facility or wait years for a waiver slot to open. Data provided by HSD shows a steady trend of fewer Medicaid recipients in nursing facilities and more utilizing community benefits, evidence of the department's successful efforts to rebalance the LTSS program to serve more recipients in their homes rather than in nursing facilities.

On the other hand, two of the discontinued measures – recipients receiving services within 90 days of eligibility, and identified fall risk patients who receive an appropriate intervention – show poorer performance in FY16 than in FY15. These measures are important indicators of the quality and timeliness of health care received by Medicaid recipients and losing access to this data will make it impossible to determine whether the trend continues. Further, eliminating all existing LTSS measures leaves this important and costly program with a single new measure for which the LFC will have no longitudinal data. LFC staff have encouraged HSD to provide other meaningful LTSS measures and data.

LTSS Quality Measures	Recipients who transition from nursing facilities and are served and maintained with community-based services for six months *(Discontinued)*	Recipients receiving LTSS services within 90 days of eligibility *(Annual only for FY17, then discontinued)*	Identified fall risk patients 65 and older who received intervention *(Annual only for FY17, then discontinued)*
2016 *(2nd quarter)*	n/a	88%	9%
2015	72	93%	17%

Sources: HSD Performance Report FY16 Qtr 3 and Qtr 4; HSD presentation to MAC subcommittee, 12/16.

Access to Care	LTC Practitioners	LTC Facilities	Total	MCO with most LTC providers
2016 *(2nd quarter)*	1,613	318[1]	1,931	Presbyterian = 602
2015	1,591	249	1,840	BCBSNM = 600

[1]The increase here is driven by PHP's addition of over 50 LTC facilities to its network due to a change in counting methodology; currently being reviewed by HSD.
Source: MCO network adequacy reports.

Care Coordination

Care coordination is a key aspect of the Centennial Care program, meant to achieve both better health outcomes and lower costs by assessing and coordinating care for all recipients, particularly those with complex medical needs. When the program began in 2014, MCOs were required to conduct annual health risk assessments (HRAs) on all of their members. Throughout 2014 and 2015 the MCOs struggled to meet this requirement. The LFC's 2015 Centennial Care program evaluation found that at the end of CY14, the MCOs had completed HRAs for only 41 percent of their members. The largest portion of recipients without HRAs were those HSD categorized as unreachable, meaning reasonable efforts to contact them had failed. HSD developed a campaign to reach this population and set quarterly goals for the MCOs.

By the end of CY15, approximately 15.7 percent of Centennial Care recipients still had not been reached for an HRA; MCO reports for the second quarter of CY16 show a reduction to 12 percent. These numbers indicate HSD and the MCOs have made significant progress; however, for three out of four MCOs unreachable members are still the second-largest portion of their total membership.

Care Coordination Levels	Level One (healthy individuals)	Level Two (nursing facility level of care; low to moderate care needs)	Level Three (nursing facility level of care; moderate to high care needs)	Client declined care coordination	Client could not be contacted
2016 *(2nd quarter)*	498,902	51,690	10,628	22,537	81,214
2015	475,232	49,307	9,497	24,774	106,112
2014	433,725	46,709	13,707	22,291	125,134
MCO with highest proportion in CY16	BCBS 82%	UHC 23%	UHC 2.3%	BCBS 4.2%	MHNM 17%

Source: HSD MCO care coordination reports

Centennial Care contract amendments in July, 2016 made significant changes to care coordination requirements. HRAs are now only conducted for new Medicaid enrollees and existing recipients who have a change in health status, as determined by MCO review of utilization and claims data or by self-reporting from the recipient. These changes reflect a reasonable reallocation of resources, reducing MCO administrative burden and costs and allowing greater focus of care coordination efforts on higher need members.

On the other hand, efforts to make contact with the existing unreachable population have stopped; as of June 2016, there were over 81,000 Medicaid recipients in this category. Centennial Care, like all managed care systems with capitated PMPMs, relies on rates that average the costs of people who use a lot of health care services together with those who use some, few, or even no services at all. In the overall system the fact that the MCOs are receiving PMPMs for all of their members, including care coordination costs, without actually providing services to each and every member is not by itself a matter of great concern.

That said, unreachable members have not only not had an HRA completed, they also have not been given meaningful guidance about how to best utilize the managed care system. Possibly as a result, there appears to be a notable correlation between lack of care coordination and non-emergency ER utilization: unreachable Centennial Care members make up a sizable proportion of Medicaid recipients who go to the emergency room with non-emergency conditions. This situation raises concerns about cost inefficiencies and may also be an indicator that many recipients may be unaware of or having difficulty accessing their assigned primary care providers.

Care Coordination Indicators	Number of HRAs required	HRAs completed within 30 days	Total non-emergent ER use by unreachable clients
2016 *(2nd quarter)*	50,748	34%	15%
2015	116,452	34%	15%
2014	185,342	23%	*lacking full data for this year*
MCO with highest proportion in CY16	n/a	MHNM 90%	MHNM 19%

Source: HSD MCO care coordination and utilization reports