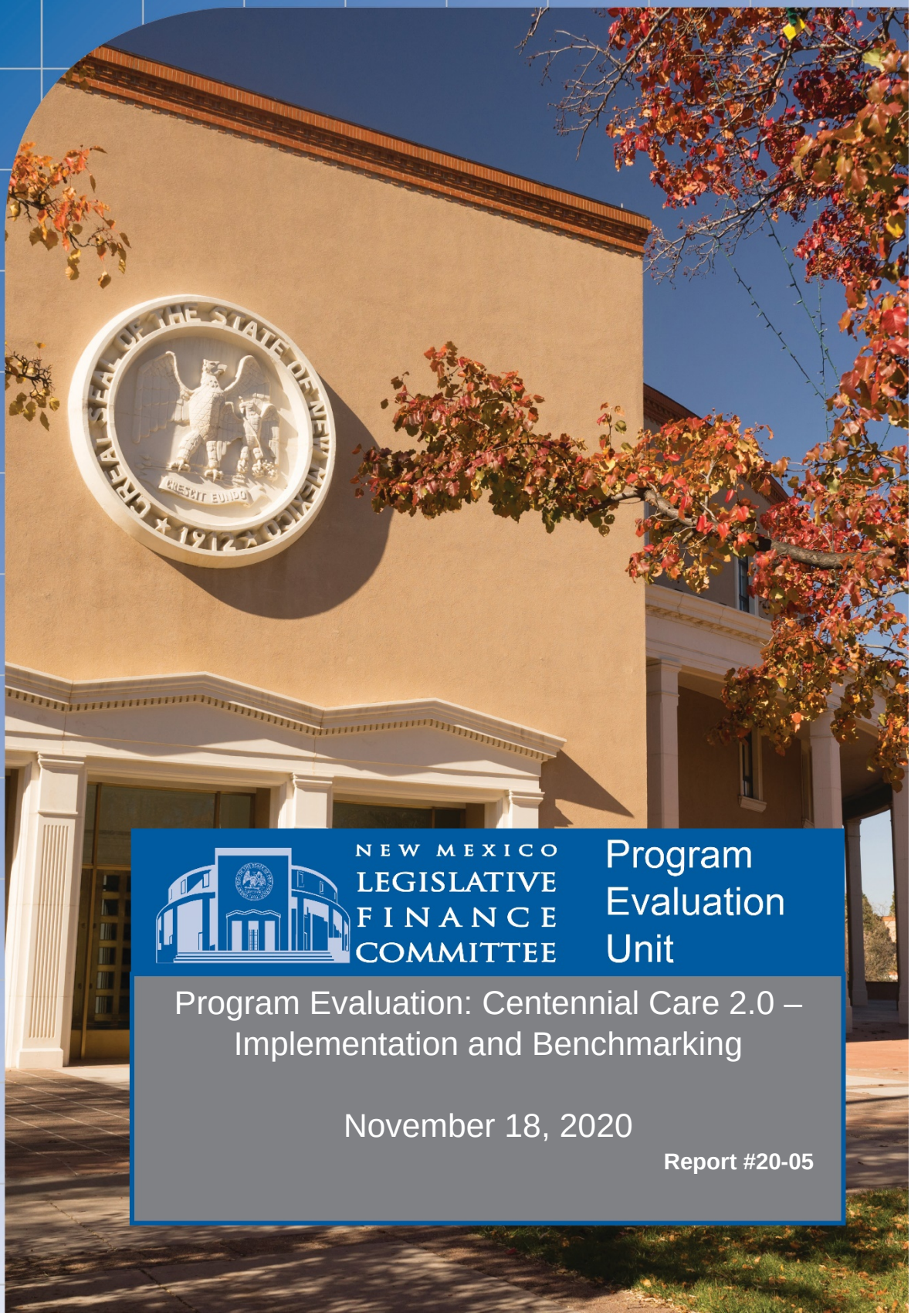

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Program Evaluation Unit

Program Evaluation: Centennial Care 2.0 – Implementation and Benchmarking

November 18, 2020

Report #20-05

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David Abbey
Director

November 18, 2020

Dr. David Scrase, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504

Dear Secretary Scrase:

The Legislative Finance Committee (Committee) is pleased to transmit the evaluation, *Centennial Care 2.0 – Implementation and Benchmarking.* The evaluation examined costs and health outcomes of the state managed care Medicaid program. Exit conferences were conducted with the Human Services Department to review the contents of the report.

The report will be presented to the Committee on November 18, 2020. The Committee would like plans to address the recommendations within this report from the Human Services Department within 30 days from the date of the hearing.

I believe this report addresses issues the Committee asked us to review and hope your department will benefit from our efforts. We very much appreciate the cooperation and assistance we received from your staff.

Sincerely,

David Abbey

David Abbey, Director

Cc: Senator John Arthur Smith, Chair, Legislative Finance Committee
Representative Patricia A. Lundstrom, Vice-Chair, Legislative Finance Committee
Ms. Debbie Romero, Acting Secretary, Department of Finance and Administration

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Centennial Care 2.0 Costs are Increasing and Health Outcomes are Stagnant

While the costs for Centennial Care, the state's Medicaid managed care program, increased from $3.9 billion in 2014 to $5 billion in 2019, and per enrollee spending has simultaneously increased, member utilization of healthcare and their health outcomes have remained fairly constant. At the same time, it remains unclear if key elements of Centennial Care 2.0 intended to reduce costs and improve outcomes, such as care coordination and health homes, are meeting their goals. In particular, care coordination has consistently seen a decrease in the number of care coordination activities performed, leading to a significant increase in the cost per activity.

Centennial Care 2.0, initiated in January 2019 and set to run through December 2023, is the latest iteration of Centennial Care, a revamp of the Medicaid managed care program started in 2014 that consolidated previously separate Medicaid managed care programs into five programs: physical health, behavioral health, long-term supports and services, physical health for the Medicaid expansion population, and behavioral health for the Medicaid population. Three managed care organizations (MCOs), Blue Cross Blue Shield, Presbyterian Health Plan, and Western Sky Community Care, offer healthcare services and coordination to Medicaid members in exchange for a fixed monthly capitation rate per enrollee paid by the state. Overall, Centennial Care 2.0 aims to modernize the Medicaid program by improving efficiency and effectiveness of health delivery to New Mexicans in order to improve health and reduce costs.

In 2020, the Covid-19 pandemic both increased enrollment and decreased utilization. The economic downturn caused by the pandemic drove more people to enroll in Medicaid, as well as a federal requirement prohibiting disenrollment while the state receives enhanced federal funds for Medicaid, but overall use of healthcare services decreased as New Mexicans initially delayed or avoided care. However, despite the decrease in healthcare utilization and subsequent decrease in healthcare spending by MCOs, MCOs are receiving higher capitation rate payments from the state. The state has limited options to reconcile this disparity between MCO payments and MCO spending, but some level of rate adjustments are possible.

Evaluation Objectives:

Review and summarize impact of Centennial Care 2.0 on Medicaid costs and beneficiary health outcomes,

Analyze changes to MCO costs under Centennial Care 2.0, and

Evaluate changes to healthcare access and health outcomes under Centennial Care 2.0.

Key Findings

Program costs for Centennial Care 2.0, expected to reach $5.7 billion by FY22, are generally tied to program enrollment, but the cost increase between FY19 and FY20 was also attributed to a series of rate increases.

Analysis indicates around 90 percent of new enrollees – Centennial Care 2.0 enrollment increased by 11 percent following the onset of the pandemic – are from lower cost Medicaid groups. Although enrollment has grown significantly, utilization and healthcare spending data shows members are not accessing healthcare services at the same rate as in the pre-pandemic period.

The state has spent $736 million, including federal revenues, on care coordination under Centennial Care, yet little is known about its impact on cost savings or health outcomes. Following a policy change in lessening care coordination activities required of MCOs in 2017, cost per coordination activity significantly increased while overall costs remained largely the same.

New Mexico health outcomes, as measured by the Healthcare Effectiveness Data and Information Set (HEDIS), among the Medicaid population have generally remained the same. Comparing New Mexico with other Medicaid populations, 76 percent of adult and child measures are below the national median value. Centennial Care 2.0 is in the early stages of its value-based purchasing (VBP) system, which aims to improve health outcomes among members by financially incentivizing healthcare providers to target and improve health outcomes. However, VBP's impact on health outcomes is not yet fully understood.

Key Recommendations

The Human Services Department should

- Consider decreasing capitation rates by the allowed 1.5 percent in light of decreased healthcare utilization among members during the pandemic;
- Consider recalculating capitation rates more frequently during the duration of the pandemic to more accurately reflect the impact of Covid-19 on the Centennial Care 2.0 program;
- Develop and adopt new care coordination measures to track cost effectiveness of care coordination activites;
- Adopt a set of health outcome measures specifically for the care coordination population and contractually obligate MCOs to collect, analyze, and report this data;
- Continue its efforts in data transparency and include quarterly health outcome data, including within value-based purchasing agreements, on its publicly available online performance scorecard;
- Standardize how MCOs populate value-based purchasing reports; and
- Exercise the contract option to increase overall value-based purchasing spending requirements by 5 percent in 2021 and an additional 5 percent in 2022.

New Mexico Medicaid Managed care Enters its Second Phase with Centennial Care 2.0

Medicaid, created by Title XIX of the Social Security Act in 1965 to provide health insurance for families receiving welfare, is a federal-state funded program for financing health services for low-income groups. Since that time, Congress has expanded the program considerably to include other low-income adults, the elderly, the blind, pregnant women, children, and people with disabilities.

Under the Affordable Care Act (ACA), New Mexico expanded Medicaid in 2014 to include all persons earning less than 138 percent of the federal poverty level (FPL), or $35,535 a year for a family of four in 2020. Under the ACA, the new enrollees, referred to as the Medicaid expansion population, were initially subsidized by the federal government at 100 percent through 2016, followed by a gradual stepping down of the federal match until ultimately stabilizing at 90 percent in 2020.

Not only has Medicaid eligibility changed over the years, but the kinds of services covered by Medicaid have also expanded. For states that approve it, Medicaid can include basic dental care, preventive care, early diagnosis, prescription drug costs, and similar services. States are given authority to set and adjust their own eligibility criteria, scope of services, and rate of payment while following broad federal guidelines. However, to receive federal funding, states must provide base services to certain groups, including those on income-maintenance as well as others.

Major Events in the Medicaid System	
1965	The U.S. Congress passes Medicaid Title XVII and Medicare Title XIX as components of the Social Security Act to provide health insurance for families receiving welfare.
1967	The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) comprehensive health services benefit for all Medicaid children under age 21 are established.
1973	New Mexico implements Medicaid with the passage of the 'Public Assistance Act,' later known as Medicaid.
1977	The Health Care Financing Administration (HCFA) assumes control over federal Medicaid and Medicare programs.
1981	Freedom of choice waivers (1915b) and home- and community-based care waivers (1915c) are mandated. States are required to pay additional payments to hospitals treating a disproportionate share of low-income patients (called disproportionate share hospitals, or DSH).
1988	Medicaid coverage for uninsured pregnant women becomes mandatory,
1990	Medicaid for children ages 6-18 is phased in. Also, the Medicaid prescription drug rebate program is enacted.
1994	The Legislature requires managed care for most Medicaid recipients.
1997	The federal government encourages expansion of managed care by making waivers more easily accessible. Congress authorizes State Children's Health Insurance Program (SCHIP).
1997	New Mexico implements managed care.
2001	HCFA renamed Centers for Medicare and Medicaid Services (CMS).
2005	New Mexico behavioral health services carved out into a separate managed care contract.
2008	Coordinated Long-Term Care Services (CoLTS) managed care program begins.
2012	HSD submits an 1115 Medicaid demonstration waiver application to the Centers for Medicare and Medicaid Services. The New Mexico plan is called Centennial Care.
2013	The federal government approves New Mexico's Medicaid Waiver proposal. Governor Martinez announces New Mexico will expand access to Medicaid for up to 170 thousand eligible New Mexicans under the Patient Protection and Affordable Care Act.
2014	Centennial Care integrates physical and behavioral health and HSD selects four MCOs to manage state general and federal grant funds. This change coincides with Medicaid expansion and the establishment of the New Mexico Health Insurance Exchange.
2015	HSD submits statewide home- and community-based services transition plan amendment
2017	HSD submits an 1115 demonstration waiver renewal application for Centennial Care. The renewal of the program is called Centennial Care 2.0. HSD solicits proposals from managed care organizations.
2018	The federal government approves the renewal application for Centennial Care 2.0. HSD awards contracts to two legacy MCOs (Blue Cross Blue Shield and Presbyterian) and one MCO new to the state (Western Sky Community Care).
2019	HSD seeks federal authority to amend the Section 1115 Centennial Care 2.0 waiver. The amendments include removing co-payments and premiums for certain members.
2020	The federal government approves a series of NM Medicaid waivers and flexibilities in response to the Covid-19 pandemic.

Over 80 Percent of the Nearly 870 Thousand New Mexicans Enrolled in Medicaid are Served Through Centennial Care 2.0

Key Medicaid Terms:

- Capitation payment – a monthly fixed payment by HSD to managed care organizations (MCO) on behalf of each Medicaid beneficiary.
- Centers for Medicare and Medicaid Services (CMS) – the agency in the Department of Health and Human Services (DHHS) with responsibility for administering the Medicaid, Medicare, and State Children's Health Insurance (CHIP) programs at the federal level.
- Managed care organization (MCO) – entities that serve Medicaid beneficiaries through a network of employed or affiliated providers on a risk basis to provide a specified package of benefits to enrollees in exchange for monthly capitation payments.
- Medical loss ratio (MLR) – a provision requiring health insurance issuers to spend a minimum percentage of premium dollars on medical care with limits on the proportion spent on administration, marketing, and profits.
- Per-member, per-month (PMPM) – the average per-member, per-month amount in capitation payments HSD pays to MCOs.
- Supplemental Security Income (SSI) – a federal entitlement program that provides cash to low-income aged, blind, or disabled individuals. Individuals with SSI benefits are eligible for Medicaid coverage.
- Temporary Assistance for Needy Families (TANF) – a block grant program that makes federal matching funds available to states for cash and other assistance to low-income families with children.

Centennial Care 2.0 is the state's federally approved Medicaid managed care program. The program is currently in its second iteration after the original Centennial Care program was approved for an extension by the federal Centers for Medicare and Medicaid Services (CMS) in December 2018, extending the program through December 2023.

The initial iteration of Centennial Care came into existence in 2014 and consolidated previously separate Medicaid managed care programs. The Centennial Care program established five Medicaid programs: physical health, behavioral health, long-term supports and services, physical health for the Medicaid expansion population, and behavioral health for the Medicaid population.

Physical Health (PH) - This program consists of 12 cohorts of enrollees, including Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) recipients, pregnant women (up to 250 percent of FPL), breast and cervical cancer patients, children under 19 years of age, and children in foster care who meet the income eligibility up to 133 percent of federal poverty level.

Long-Term Services and Supports (LTSS) - This program area primarily consists of nine cohorts, including enrollees dually eligible for Medicare and Medicaid, seniors ineligible for Medicare, and Mi Via and other self-directed home- and community-based service recipients who earn up to 133 percent of the federal poverty level, or $16,612 a year for an individual in 2020.

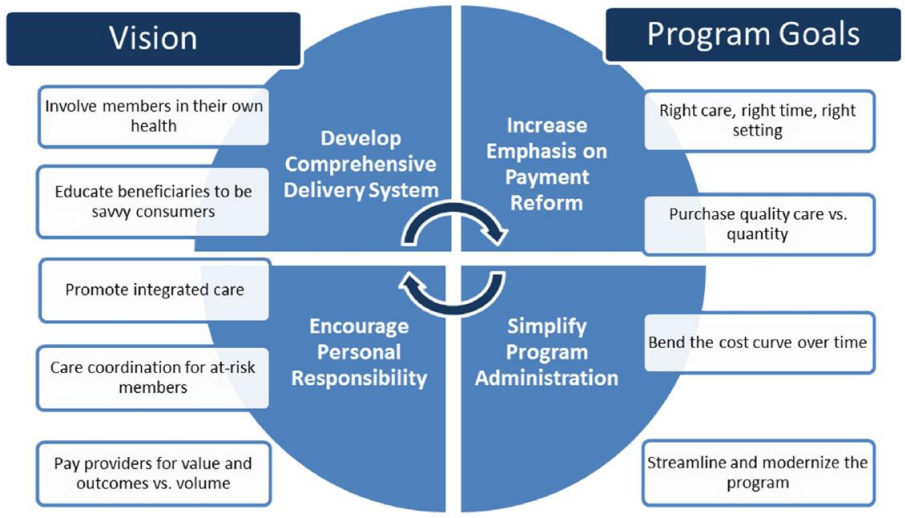
Behavioral Health (BH) - All physical and long-term service and support Medicaid enrollees are automatically eligible for behavioral health services through Centennial Care. There are seven cohorts for behavioral health services.

Medicaid Expansion Physical Health - This group includes enrollees not otherwise eligible for Medicaid, as well as Medicaid recipients from other programs, such as the majority of former State Coverage Initiative (SCI) enrollees and Family Planning clients meeting the income eligibility requirements. Under the ACA, New Mexico opted to expand Medicaid eligibility to 138 percent of federal poverty level. People eligible under these expanded guidelines are assigned to one of 12 Medicaid expansion cohorts.

Medicaid Expansion Behavioral Health - All Medicaid expansion physical health enrollees are also eligible for behavioral health services and are assigned to one behavioral health cohort.

Centennial Care 2.0 was designed to build off the original program's successes while also pursuing new, additional goals. These include refining care coordination, increasing the use of preventive services, promoting administrative simplification, and encouraging members' involvement in their own care.

Figure 1. Centennial Care 2.0 Guiding Principles, Visions, and Goals



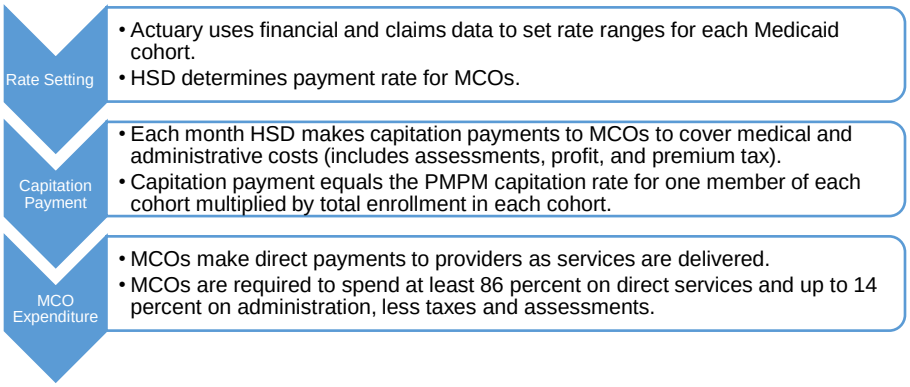
Source: HSD Centennial Care 2.0 Concept Paper

Managed care organizations (MCOs) offer healthcare services under Centennial Care 2.0, as well as retain responsibility for coordinating a member's full array of services, including acute health, pharmacy, behavioral health, institutional, and home- and community-based services. The MCOs issue contracts with healthcare providers and facilities to establish a healthcare network that provides care to Medicaid managed care members. MCOs are paid a fixed monthly capitation rate by HSD per enrollee and assume the cost for providing covered services.

The rates paid by HSD are developed by a contracted actuary that establishes rate ranges for groups of Medicaid enrollees or cohorts. The monthly capitation payments to MCOs for every Medicaid recipient cover all medical and administrative costs associated with providing Medicaid benefits. MCOs must, per contractual agreement, dedicate at least 86 percent of expenditures to direct services and a maximum of 14 percent of expenditures to administrative overhead. This proportion is referred to as medical loss ratio or MLR.

A common metric within both capitation payments and MCO expenditures is the amount spent per-member, per-month or PMPM. PMPM can represent either a capitation amount or MCO expenditure divided by the enrollment for that month.

Figure 2. Centennial Care 2.0 Rate Setting Overview



As discussed in detail in LFC's *Health Notes: Centennial Care 2.0 Medicaid MCO Procurement* from 2018, Centennial Care 1.0 MCOs Molina Healthcare and UnitedHealthcare were not selected as MCOs for Centennial Care 2.0. Consequently, Molina and UnitedHealthcare Centennial Care members were redistributed among the Centennial Care 2.0 MCOs.

New Mexico contracts with three MCOs: Blue Cross and Blue Shield of New Mexico; Presbyterian Health Plan, Inc.; and Western Sky Community Care, Inc. Blue Cross Blue Shield and Presbyterian Health Plan were contracted MCOs during the original Centennial Care program, while Western Sky Community Care is a new addition.

The Human Services Department Made Significant Changes to Centennial Care 2.0 six Months After Federal Approval

HSD requested a significant amendment to the federally approved Cenntenial Care 2.0 program (its "waiver") in June 2019. Most significantly, the prior administration sought to change member behaviors to encourage lower-cost healthcare services by requiring premiums and co-payments from its Centennial Care 2.0 members, features that were not part of the first iteration of Centennial Care. Specifically, co-payments were to be required for nonemergency use of hospital emergency departments and nonpreferred prescription drugs (where a generic is available). Additionally, Medicaid expansion adults with an income over 100 percent of the federal poverty level would have been subject to monthly premiums. However, the current administration chose not to enact the premiums and co-payments and formally sought their removal via a demonstration waiver amendment in June 2019 (CMS approval letter dated February 2020).

In addition, the Centennial Care 2.0 amendment also removed limitations on retroactive Medicaid eligibility, increased the number of Community Benefit slots by 1,500, and expanded the Centennial Home Visiting pilot program by removing restrictions on the number of counties and potential members that may participate in the pilot program.

The Covid-19 Pandemic has Created new Policies and Guidelines for Medicaid

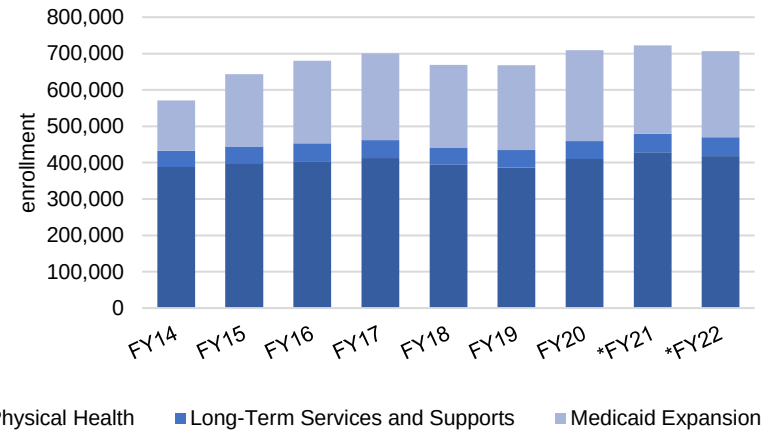
As a result of the Covid-19 pandemic, HSD has pursued and received CMS approval for seven federal waivers and seven disaster state plan amendments, which have resulted in a significant number of flexibilities related to federal requirements of the program. Some significant changes included requiring MCOs to provide the same reimbursement level for out-of-network care, suspending prior authorization requirements for specific services, and increasing telehealth and phone visit option. Also of significance, HSD instituted a series of rate increases for provider support, with an estimated total cost related to Covid-19 of $240.5 million, which includes Centennial Care 2.0 and fee-for-service Medicaid, with an estimated $43.8 million coming from the general fund. (see Appendix B).

Enrollment Growth and Capitation Rate Increases Are Driving Centennial Care 2.0 Spending to All-Time Highs

Centennial Care spending is predominantly driven by program enrollment. In June 2014, shortly after Centennial Care's inception, enrollment was 570 thousand; it increased to 700 thousand by June 2017. Much of the growth between 2014 and 2017 can be attributed to the enrollment of additional members resulting from expansion of eligibility under the ACA. Under Centennial Care 2.0, from January 2019 onwards, program enrollment stabilized around 665 thousand, a trend that was continuing prior to the Covid-19 pandemic.

Centennial Care 2.0 costs to the general fund are expected to surpass $1 billion. At the onset of Centennial Care, the program cost a total of $3.9 billion in 2014, with around $900 million coming from the general fund. In FY20, total program costs are estimated at $5.2 billion, with $950 million supported by the general fund, plus an additional $330 million in other state funds. In FY21, program costs are anticipated to increase to $5.7 billion, with the cost to the state surpassing $1 billion. It is important to note that while program costs have increased, the federal revenues have grown simultaneously.

Chart 1. Total Centennial Care Enrollment

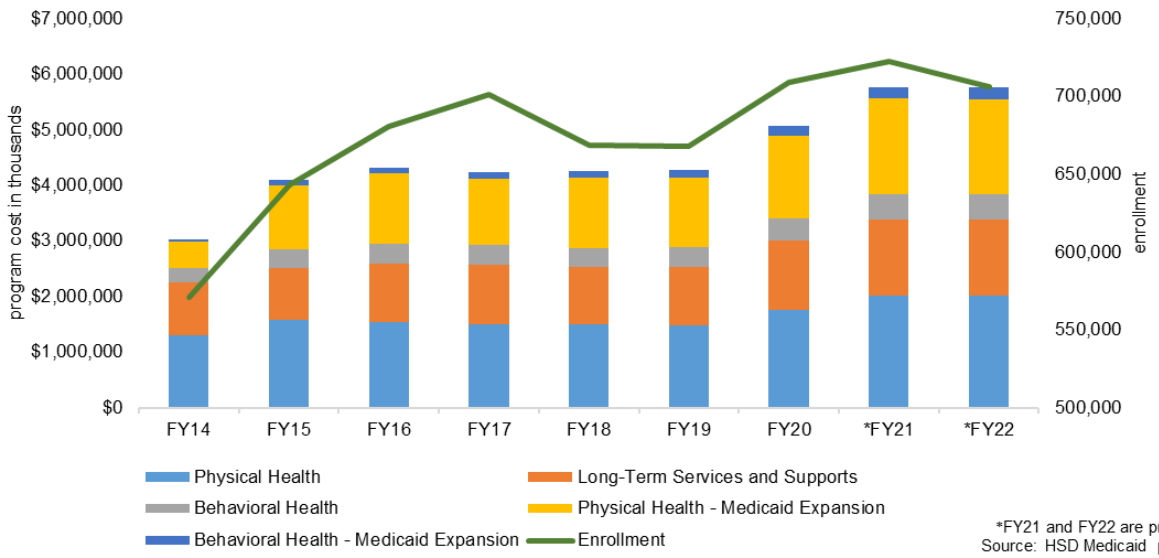


Source: HSD Medicaid projections

Federal Medical Assistance Percentage - The portion the federal government pays to a state for Medicaid expenses – the FMAP – is based on a statutory fomula that takes into account each state's per capita income with some adjustments. Different FMAPs exist for different Medicaid groups such as traditional physical health and long-term services and supports, Medicaid expansion, and Children's Health Insurance Program (CHIP). For federal fiscal year (FFY) 2020, the federal government paid New Mexico a blended FMAP of 78.75 percent before the pandemic and 80.60 percent following a higher FMAP federally enacted due to the pandemic.

Physical health, both base and expansion populations, comprise the greatest costs within the managed care program. Physical health costs for the base population totaled over $2 billion in FY21, with an additional $1.7 billion in physical health costs for the Medicaid expansion population, bringing physical health's share of total costs to 65 percent. Long-term services and supports accounted for $1.4 billion, or 24 percent, while behavioral health comprised the remaining 11 percent of Centennial Care 2.0 costs in FY21.

Chart 2. Centennial Care Spending by Program and Centennial Care Enrollment
(in thousands)



*FY21 and FY22 are projections
Source: HSD Medicaid projection

Capitation rate increases for 2020 led to an estimated $70 million in additional general fund spending

Updated healthcare trends and rate increases to providers and hospitals drove the capitation rate increases. Based on an analysis performed for HSD by their actuary, Mercer, the best estimate for total capitation rate spending increased by $365 million (with $70.6 million coming from the general fund) across all Centennial Care 2.0 programs from the fourth quarter rates of 2019. Over a quarter of the change was attributed to updated healthcare trends over the past 12 months. Twenty percent was attributed to provider and hospital rate increases. Other cost drivers include minimum wage adjustments, health insurance exchange fees, and other nonmedical changes to the Centennial Care 2.0 program.

Per-member, per-month capitation rates significantly increased across all programs between FY19 and FY20. Global capitation payments translate into PMPM rates, and therefore, as a result of the capitation rate increase, the PMPM rate increased in FY20 through FY21. It is worth noting the relative stability of rates between FY14 and FY19, especially as the rate increases

between FY19 and FY20 were the largest since Centennial Care's inception.[1] The rates associated with members in behavioral health increased the most at 16 percent, followed by physical health (12 percent), the Medicaid expansion population (11 percent), and long-term care (7 percent). It is worth noting that when comparing FY20 to FY16, before cost containment measures were introduced, the percentage increases are substantially lower.

Table. 1 Per-Member, Per-Month Centennial Care Costs

Group	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21 (Q2)
Physical Health	$298	$322	$317	$301	$304	$307	$343	$350
Long-Term Services and Supports	$1,745	$1,784	$1,812	$1,776	$1,767	$1,789	$1,913	$2,055
Medicaid Expansion Population	$548	$552	$533	$468	$453	$447	$494	$517
Behavioral Health	$56	$55	$55	$54	$54	$58	$67	$71

Source: HSD Medicaid projection data.

Utilization patterns and service costs across programs are stable

Healthcare utilization data is regularly tracked and reported by HSD. Standard utilization metrics are reported on a use per 1,000 member basis. Additionally, typical healthcare use events (admissions, days of stay, visits, etc.) are referred to as units. For example, an admission event is an inpatient stay without regard to the number of days stayed at the facility by the member, whereas the days unit would include each day stayed.

While capitation rates increased, members used healthcare services at relatively similar rates as in the past, with some fluctuations in costs. In the physical health program, inpatient admissions in 2019 were slightly lower than in 2017 at 92 admissions per 1,000 members. The average cost per inpatient admission during this time also decreased by $500 to $8,446. Emergency department visits remained virtually unchanged, with a utilization rate of 553 ED visits per 1,000 members and cost slightly increased by about 10 percent to $379. However, a noticeable decrease occurred with practitioner and physician services; use decreased from 8,343 services per 1,000 members to 7,692 services per 1,000 members, which can also be thought of as 8.4 services per member reduced to 7.7 services per member.

Table 2. Physical Health Utilization

Physical Health Utilization (Units per 1,000 Members)				Cost per Unit		
Service Grouping	2017	2018	2019	2017	2018	2019
Inpatient (Admissions)	92.8	98.6	91.5	$ 9,143	$ 9,390	$ 8,446
Inpatient (Days)	405.3	430.3	397.4	$ 2,094	$ 2,151	$ 1,943
Practitioner / Physician (Services)	8,342.5	8,649.7	7,692.4	$ 67	$ 70	$ 76
Emergency Department (Visits)	553.9	590.0	553.3	$ 348	$ 367	$ 379
Outpatient (Visits)	1,437.8	1,589.8	1,565.3	$ 274	$ 281	$ 274
Pharmacy (Scripts)	4,842.9	4,887.4	4,767.7	$ 65	$ 63	$ 61

Note: 2019 utilization data is not considered final and subject ot change as data may lag by one year.

Source: Centennial Care Annual Reports.

[1] While relative stability was observed in overall spend, PMPM decreased in FY17 due to cost containment that occurred in July 2016 and January 2017.

Within behavioral health, inpatient admissions fell between 2017 and 2019, from 40 admissions per 1,000 members to 37 admissions per 1,000 members. However, both behavioral health practitioner services and behavioral health outpatient and clinic services increased, although their relative cost of services is fairly low.

Table 3. Behavioral Health Utilization

Behavioral Health Utilization (Units per 1,000 Members)				Cost per Unit		
Service Grouping	2017	2018	2019	2017	2018	2019
Inpatient (Admissions)	40.2	44.6	36.6	$ 1,095	$ 460	$ 527
Inpatient (Days)	116.7	95.2	78.2	$ 377	$ 216	$ 246
BH Practitioner (Services)	217.1	208.4	250.7	$ 120	$ 134	$ 129
Core Service Agency (Services)	223.4	240.3	219.3	$ 109	$ 134	$ 157
BH outpatient / clinic (Services)	2,926.5	3,604.5	3,483.0	$ 60	$ 56	$ 56
Pharmacy (Scripts)	1,822.4	1,783.8	1,748.7	$ 56	$ 59	$ 53

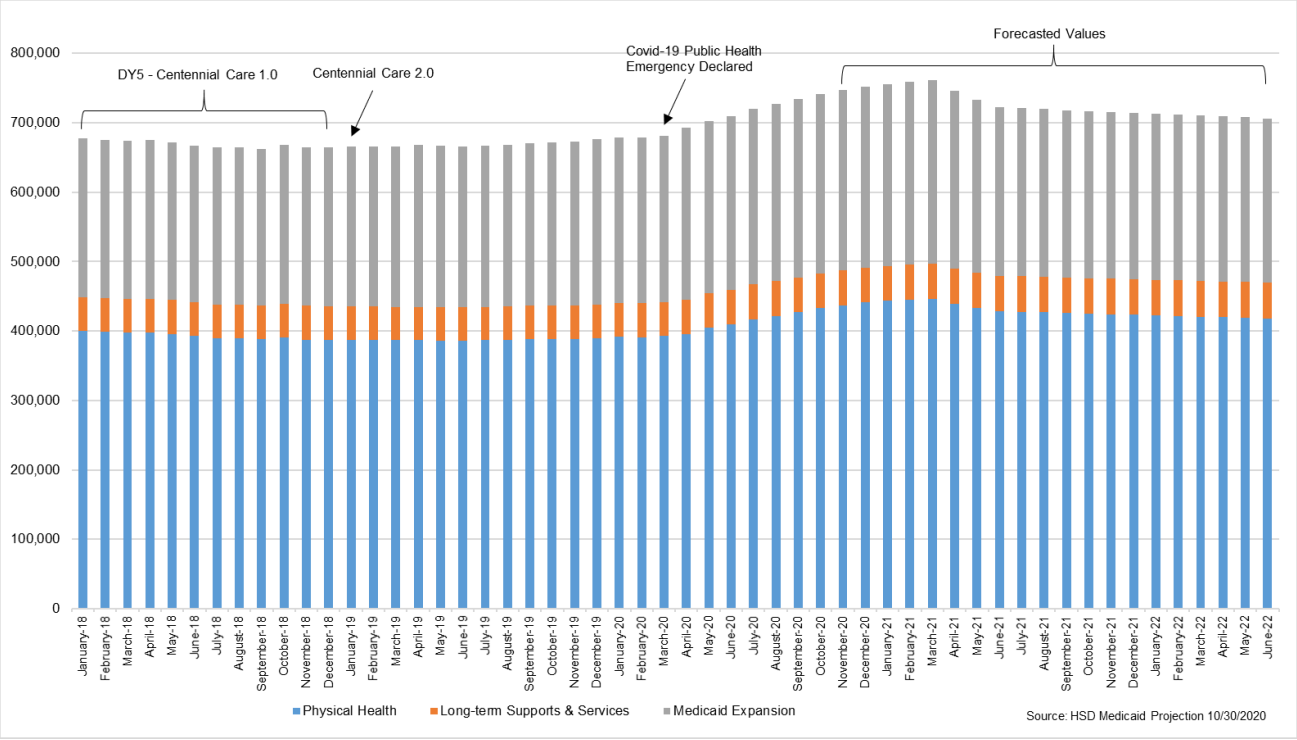
Note: 2019 utilization data is not considered final and subject ot change as data may lag by one year.

Source: Centennial Care Annual Reports.

The Pandemic has led to Increased Enrollment and Payment to MCOs, but MCOs Have Lower Utilization and Spending

The effect of Covid-19 on Medicaid managed care is a complex and evolving situation with many factors at play: increased enrollment, demographic shifts in the enrolled population, temporary rate changes, shifts in healthcare utilization, and declining spending by MCOs.

Chart 3. Centennial Care Monthly Enrollment January 2019 – June 2022



The economic downturn created by Covid-19 corresponded with increases in enrollment. Between January 2018 and March 2020, Centennial Care 2.0 membership ranged from a minimum of 662.2 thousand to a maximum of 680.5 thousand, and the month-to-month percentage difference never exceeded 1 percent (plus or minus). In March 2020, all of that changed. As New Mexico's unemployment rate increased to 11.4 percent, Centennial Care 2.0 enrollment increased by over 12 thousand members to 692.7 thousand, representing a 1.8 percent increase in membership in March 2020. Since March 2020, at least 6,500 new Centennial Care 2.0 members per month have been enrolled, whereas the prior new member enrollment high, dating back to January 2018, was 6,300. As of October 2020, 740.7 thousand New Mexicans are enrolled in the Centennial Care 2.0 program.

Table 4. Medicaid Group Enrollment Changes March - September 2020

Group	Change: March 2020 to Sept 2020	% of Total Change
Breast and Cervical Cancer	3	0.0%
Children, including CHIP and not in another category	16,893	32.0%
CYFD Children	150	0.3%
Developmentally Disabled	95	0.2%
Home & Community Based Waiver	576	1.1%
Institutional Care	(332)	-0.6%
Other Adult Group/Expansion	16,386	31.1%
Parents and Caretakers (Non Expansion Adults)	18,431	34.9%
Pregnant Women	1,058	2.0%
Supplemental Security Income Related	350	0.7%
Transitional Medicaid	(1,119)	-2.1%
Working Disabled	271	0.5%
Total	52,762	100.0%

Note: Medicaid Enrollment Report values may not perfectly align with HSD Medicaid projection values.

Source: Medicaid Enrollment Report, March and September 2020

Pandemic enrollment increases have been driven by three lower-cost sub-groups: children, parents and caretakers, and Medicaid expansion adults. A closer look at recent enrollment trends reveals that, of the newly enrolled members since March 2020, 35 percent are parents and caretakers (non-Medicaid expansion adults), 32 percent are children, and 31 percent are Medicaid expansion adults. Children and parents and caretakers average a per-member, per-month (PMPM) rate of around $300, and expansion adults average a PMPM rate of around $500 (neither group PMPM includes behavioral health costs). When compared with the average Supplemental Security Income beneficiaries (average PMPM around $1,200) or long-term care members (average PMPM around $1,800), these new enrollees are less costly in terms of capitation payments.[2]

National studies suggest delayed or avoided medical care impacts healthcare sectors differently. Analysts nationwide are racing to describe how the use of medical care has changed since Covid-19. Based on preliminary studies, it appears delayed or avoided care varies by type of care and the progression of the virus over time. The Petersen Center on Healthcare, in partnership with Kaiser Family Foundation, reported significant declines in personal consumption expenditures for dental services and hospitals from June 2019 to June 2020. Other studies have found outpatient visits have returned to prepandemic levels.[3] As the virus recedes and surges locally, people become more or less willing or able to interact with the healthcare system.

The pandemic does not appear to be limiting patient ability to schedule a timely appointment. LFC conducted a survey of New Mexico primary care providers (PCPs) serving Medicaid members to determine scheduling delays or impacts caused by earlier pandemic-related closures or public health orders. It is important to note that the survey was conducted in mid-August, and members use of the healthcare system is likely influenced by caseload trends and perception of safety. A 2016 LFC survey of Medicaid PCPs in rural, frontier, and urban communities across seven counties was used as a baseline against which to gauge 2020 findings.

Current time to get a primary care appointment is half the time it was four years ago. Notably, the average time to the next available appointment dropped from 5.3 weeks to 2.6 weeks from 2016 to 2020. While data on telehealth was not collected for the 2016 survey, a Centennial Care annual report from that same year noted most telehealth visits were for behavioral health. In 2020, that appears to have changed, with 97 percent of surveyed PCPs offering telehealth for primary care visits. Additionally, 97 percent of surveyed providers in 2020 have not extended their hours as a result of the pandemic.

[2] Cohort PMPM rates differ based on age and other characteristics. The federal vs. state payment share will also differ among the sub-groups.

3 National studies on the pandemic's impact on healthcare utilization primarily rely on commercial insurance data. HSD does note that New Mexico managed care data did show a significant decrease between April and May 2020, but appeared to begin recovering in June 2020. Further analysis in the coming months will allow better understanding of this trend.

Table 5. LFC Primary Care Provider Phone Survey Average Time To Next Appointment
(in weeks)

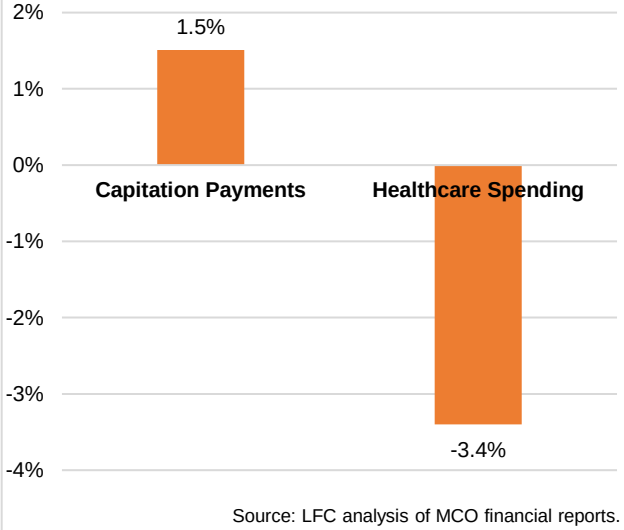
	Urban			Rural			Frontier	
	Bernalillo	Dona Ana	Santa Fe	Chaves	McKinley	San Juan	Mora	Statewide Average
2016	6.3	3.6	4.6	3	3.2	7.4	3	5.3
2020	3.7	0.7	2.3	1	3.2	4.3	1.8	2.6

Note: Survey conducted August 2020. Survey sample size = 187, confidence level = 90%, margin of error = 5.5%
Source: LFC data

As MCO enrollment and capitation payments increased between the first quarter and second quarter of 2020, overall healthcare spending by MCOs decreased. Overall, capitation payments to MCOs totaled $1.22 billion in the first quarter of 2020 and increased by over $18.3 million in the second quarter of 2020. Over this same period, healthcare spending by MCOs decreased by $36.6 million, despite the increased Centennial Care 2.0 enrollment.

The largest increase in capitation payments from HSD to MCOs between the first and second quarter of 2020 came from the Medicaid expansion physical health program, yet actual healthcare expenditures decreased in this program. The number of members in the Medicaid expansion physical health program increased by 2.6 percent, and total capitation payments from HSD to the MCOs directed to this program increased by 3.4 percent, or $12.5 million. Over the same period, however, healthcare spending in the program decreased by 2 percent, or $6.4 million. The observed decrease in healthcare spending was driven by an $8.8 million quarterly decrease in outpatient expenditure, a $4.1 million quarterly decrease in other physical health services, a $4 million quarterly decrease in dental, and a $3.5 million quarterly decrease in physician visits. Overall decreases offset noticeable quarterly increases, such as inpatient hospital ($10.6 million) and federally qualified health centers ($4.6 million).

Chart 4. Centennial Care 2.0 Percentage Change Q1 to Q2, 2020



Source: LFC analysis of MCO financial reports.

Utilization of services among the physical health Medicaid expansion population was significantly lower in the second quarter of 2020 than in the second quarter of 2019. Among all major service categories, utilization was noticeably down in 2020 through the second quarter. Inpatient admissions were 35 percent lower, outpatient surgeries were down 57 percent, and emergency department visits were nearly 20 percent lower.

Table 6. Physical Health Medicaid Expansion Utilization 2019 vs. 2020 (Q1 and Q2)

Category	Unit Description	2019 (Thru Q2)	2020 (Thru Q2)	2019 to 2020 % Change
Inpatient Hospital - Acute	Days	56,807	34,421	-39.4%
Inpatient Hospital - Acute	Admits	11,482	7,461	-35.0%
Inpatient - Specialty Hospital	Days	23,251	4,177	-82.0%
Inpatient - Specialty Hospital	Admits	726	287	-60.5%
Non-Acute LTC/SNF/Respite	Days	31,956	19,699	-38.4%
Non-Acute LTC/SNF/Respite	Admits	1,772	1,027	-42.0%
Ambulatory Surgery Centers - Outpatient Surgeries	Visits	3,299	1,418	-57.0%
Outpatient Hospital - Emergency Room	Visits	82,403	66,149	-19.7%
Outpatient Hospital - Urgent Care	Visits	4,968	4,272	-14.0%

Source: LFC analysis of MCO financial reports.

Few options are available to recoup MCO payments or better align capitation rates with current healthcare utilization

Federal guidance requires states to adhere to a maintenance of effort to receive federal assistance during the pandemic. At the start of the pandemic, the federal government boosted its support to state Medicaid programs by increasing the FMAP by 6.2 percent, but to maintain it, states must comply with statutory requirements, and any violation will result in having to pay back the additional funds. The primary stipulations are no new eligibility and enrollment requirements, no cost-sharing for testing, no addition of premiums, and no disenrollment of Medicaid members. Worth noting, before the pandemic, New Mexico averaged 7,000 disenrollments per month, meaning these individuals who would ordinarily be disenrolled continue to be enrolled, receiving Medicaid benefits, and adding to the number of individuals covered by the state.

Medical loss ratio (MLR) – a provision requiring health insurance issuers to spend a minimum percentage of premium dollars on medical care with limits on the proportion spent on administration, marketing, and profits.

Standard recoupment options include profit limits and medical loss ratio (MLR) requirements, but timely action lags due to data reconciliation. The Centennial Care 2.0 contracts specify the maximum profit (underwriting gain) an MCO is allowed to make is 3 percent annually, with any profit in excess shared with the state at 50 percent. The MLR requires MCOs to spend 86 percent of capitation payments on medical care with 14 percent allowable for administration, marketing, and profits. While pandemic-related decreases to healthcare spending could possibly increase underwriting gains above 3 percent or lower the MLR below the required 86 percent, these metrics for 2020 are unlikely to be certified and finalized until mid-year 2022. Current preliminary 2018 and draft 2019 values show no MCO exceeded the 3 percent underwriting gain, and in fact two of the three in 2019 are reporting losses.

HSD asked MCOs to absorb pandemic related relief payments. With the traditional recoupment methods taking years to materialize, and uncertainty surrounding the amounts, if any, to be recouped, HSD asked MCOs to absorb Covid-19 related relief payments. MCOs voluntarily agreed to absorb an estimated $46 million in pandemic relief according to HSD.

Beyond MCOs' absorption of relief payments, CMS allows states to adjust capitation rates, making it possible for the state to better align rates with utilization. MCO rates are allowed to be increased or decreased by up to 1.5 percent per rate cell (specific Medicaid member cohort groups) without requiring new CMS certification.[4] Additionally, MCOs may implement rate changes voluntarily. Lastly, rather than following typical rate-setting timelines, rate-setting analysis could be performed more frequently during the pandemic. Because the rate-setting process uses recent encounter data and the latest trend analyses, the decreases in healthcare utilization, among other trends, would be incorporated into the newest rates.

Recommendations

The Human Services Department should

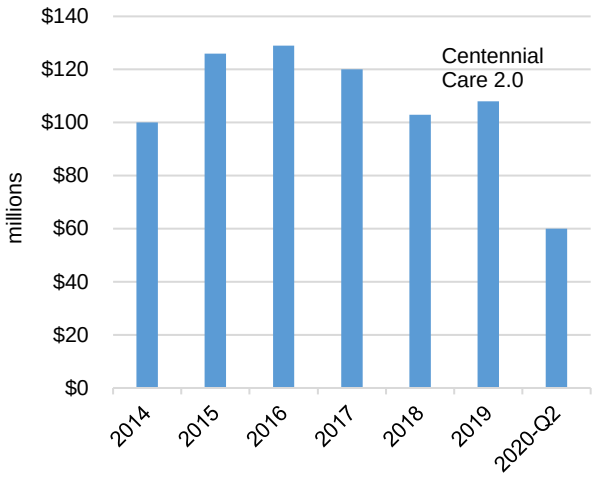
- Consider decreasing capitation rates by the CMS-allowed 1.5 percent in light of decreased healthcare utilization among members during the pandemic; and
- Consider recalculating capitation rates more frequently during the duration of the pandemic to more accurately reflect the impact of Covid-19 and consequent shutdowns on the Centennial Care 2.0 program.

[4] A rate adjustment of 1.5% or lower would still require a contract amendment, and approval of that amendment by CMS.

Under Centennial Care 2.0, Over $100 million is Spent Annually on Care Coordination with Little Tracking of Savings or Outcomes.

Since Centennial Care was first introduced in 2014, care coordination has been a centerpiece of the state's plan

Chart 5. Total Cost of Care Coordination
(in millions)



Source: LFC analysis of MCO reports

Care coordination is a key strategy to reduce costs while improving health by increasing preventive care. Specifically, the approach entails contacting patients to profile their health needs and risks and then facilitating the coordination of their care across settings and providers. However, ***who*** is providing the coordinated care, ***what*** activities are included in this care, ***how*** it is paid for, and ***to whom*** it is directed varies greatly. In New Mexico, both MCOs and healthcare providers engage in various care coordination activities that are both medical and administrative in nature and are reimbursed at different rates. More intensive care coordination is directed to Medicaid members with complex and chronic healthcare needs.

Care coordination can help improve the health of New Mexicans; however, significant resources have been dedicated to these efforts without tracking associated health outcomes,

How Care Coordination Works

Step One: Health Risk Assessment (HRA) Every new Medicaid member and those with a change in health status receives an HRA, which obtains basic health and geographic information. It determines the need for a CNA and whether a nursing facility level of care assessment is needed. It is completed within 30 days from member enrollment date.

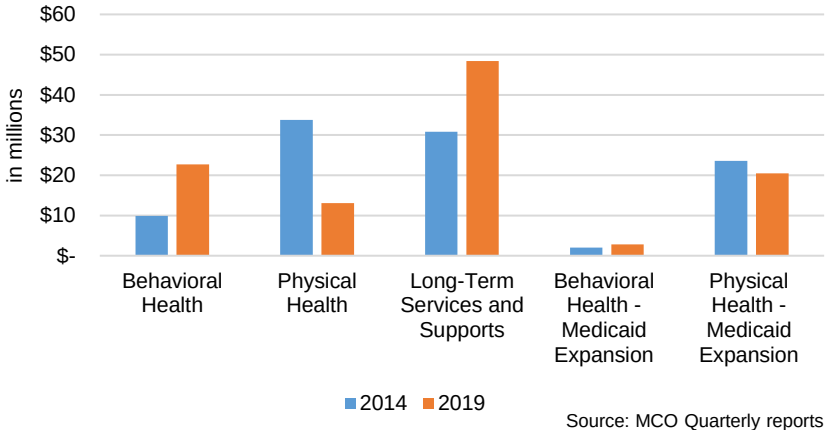
Step Two: Comprehensive Needs Assessment (CNA) Members are assessed for care coordination level two or three including assessment of physical, behavioral, and long-term care needs. It must be completed within 30 days of HRA completion date and repeated at least annually.

Step Three: Comprehensive Care Plan (CCP) Based on the CNA, a CCP is charted for the member in consultation with providers and specialists as needed.

Since 2014, care coordination costs increased with no demonstrated savings

The annual cost of care coordination grew 8 percent from 2014 to 2019 from $100 million to $108 million, driven by enrollment and rate increases. Funding for care coordination supports staff at MCOs to conduct health risk assessments (HRAs), comprehensive needs assessments (CNAs), comprehensive care plans (CCPs), and other activities. Funding is divided between medical and administrative expenses associated with coordinating care for members in each of the five Medicaid programs. From 2014 to 2019, enrollment increased 17 percent. In 2019, long-term services supports and behavioral health accounted for 66 percent of care coordination costs or $71.1 million out of a total $108 million.

Chart 6. Cost of Care Coordination by Program Area 2014 vs 2019



Source: MCO Quarterly reports

Mercer, HSD's actuary, establishes the best estimates for per-member, per-month (PMPM) reimbursement for care coordination in each of the five Centennial Care 2.0 programs. These PMPM estimates are captured within the global MCO capitation rate. Recent trends show the care coordination PMPM reimbursement increased by an average of 14 percent between 2019 and 2020 across all programs.[5]

Table 7. Per-Member, Per-Month Cost of Care Coordination

Centennial Care 2.0 Program	2019 PMPM	2020 PMPM	2019-2020 % Change
Physical Health	$3.35	$4.03	20.30%
Behavioral Health	$1.46	$1.69	15.80%
Long-Term Services and Supports	$67.68	$72.73	7.50%
Physical Health - Medicaid Expansion	$6.63	$7.76	17.00%
Behavioral Health - Medicaid Expansion	$0.74	$0.95	28.40%

Source: Centennial Care rate certification documentation.

To put these numbers in context, a 2018 study from the University of Minnesota quantified the cost of care coordination to help advise the state of Minnesota on future payment policy. The study calculated a PMPM cost of care coordination and looked at staff hours, staff type, and care coordination activity. The cost of care coordination varied across the five study sites from $1 to $12 per patient per year, compared with $1.69 to $7.76 in New Mexico in 2020 for the population not in long-term services and supports (which is a more equal comparison with the population in the Minnesota study). The

[5] According to HSD, a new methodology was used to calculate the PMPM rate settings to account for changes in MCO staffing from 2019 to 2020. The data available in Table 8 was collected from rate setting documentation for Centennial Care that did not include this revised methodology. According to HSD's new methodology, the 2019 care coordination PMPM was $10.37 and the 2020 care coordination PMPM was $11.82. A draft rate for 2021 was $9.96

Minnesota variation was driven by whether patients had a mental health diagnosis, multiple diagnoses or multiple chronic diagnoses, and the patient's social determinants of health and socioeconomic status. Hours devoted to care coordination tasks, and the wages and credentials of staff also contributed to the variation in cost. A notable difference with the Minnesota study was that care coordination was performed by a team within clinical provider sites within a Patient Centered Medical Home model rather than care coordinators hired by MCOs.

Savings attributed to care coordination were projected during the first Centennial Care waiver but for Centennial Care 2.0 have not been projected or tracked. For the first iteration of Centennial Care, HSD reported in its waiver to CMS that an estimated 80 percent of overall projected savings would come from care coordination activities: $31 million from care coordination and $37 million from health homes (a more focused form of care coordination delegated to providers and directed at specific member populations).[6] In the state's 2017 waiver application to CMS that described Centennial Care 2.0, the department did not attribute any savings to care coordination.

MCOs report on various care coordination assessments and tasks. While care coordination involves completing three main assessments (HRAs, CNAs and CCPs), there are also other related tasks, such as in-person visits with members with greater need (designated as level two and level three) as well as telephone visits and other touch points. Table 9 outlines the numbers of completed tasks associated with some of these key activities for 2019 and through the first two quarters of 2020.

Table 8. Care Coordination Tasks

Reported Care Coordination Task	2019	2020 -Q2
HRAs completed for new members and those with a change in health status	30,536	29,644
Care Coordination Assignments Completed	9137	4613
CCPs completed for level two & level three members	34,291	18,715
CNAs completed for level two & level three members	28,285	18,033
In-person visits for level two & level three members	17,149	9,993
Telephone Contacts	42,883	27,803

Source: LFC analysis of MCO reports

[6] CMS Final Budget Neutrality Caveats for Centennial Care Waiver

MCOs shifted focus from quantity towards quality of care coordination, but outcomes and cost-savings were not tracked. Beginning in 2016**,** MCOs were no longer required by HSD to complete HRAs for all enrollees but rather only for new Medicaid enrollees and existing recipients with a change in health status. From 2014 to 2019, 75 percent fewer HRAs were required and completion rates increased from 40 percent in 2016 to 67 percent in 2019.

Table 9. Care Coordination Indicators

Year	# of HRAs required	% HRAs completed within 30 days	Level 3 members who received quarterly in-person visits
2014	185,342	23%	60%
2015	116,452	34%	59%
2016	84,566	40%	52%
2017	63,409	57%	69%
2018	57,009	42%	42%
2019	45,541	67%	60%

Source: LFC Medicaid Accountability reports & MCO quarterly reports

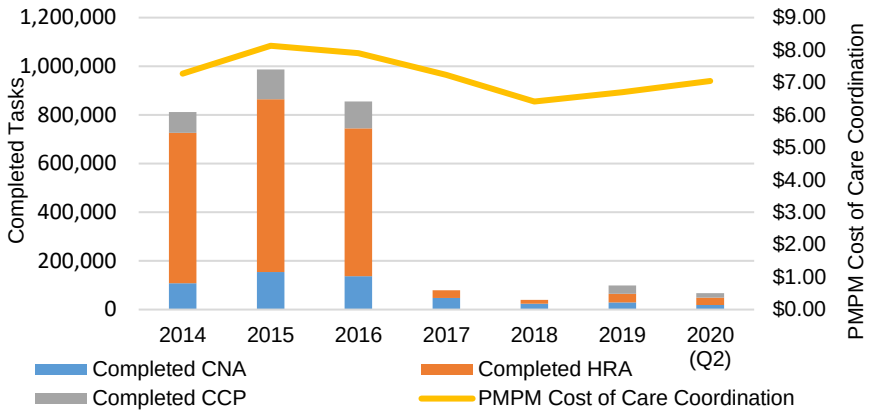
The change in HRA requirements, at least in theory, allowed MCOs to focus on care coordination for higher needs members (level two and level three members), and the percent of in-person visits for these members should increase. However, with this scaling down in HRAs, there was not also a scaling up in the percent of in-person visits for higher needs members in care coordination. Additionally, whether, and at what cost, these in-person visits led to better health outcomes that reduce costly health interventions remains unknown.

MCOs completed significantly fewer care coordination assessments but were paid only slightly less. From 2014 to 2019, the number of completed HRAs, CNAs and CCPs declined by 88 percent, attributed mostly to the above-mentioned change in HRA requirements. While HRAs, CNAs and CCPs are the primary assessment tools, there are also additional routine touchpoints (including phone calls and in-person visits) that MCOS are required to complete according to deadlines as mentioned above. Centennial Care 2.0 contracts with MCOs include requirements for when these touchpoints need to be completed. From 2014 to 2019, the per-member cost of care coordination dropped only 8 percent (from $7.27 to $6.70 PMPM), indicating MCOs are paid more for doing fewer of these assessments, with more regular touchpoints, but without measures to examine improved health outcomes.

Care Coordination in Oregon

In 2012, Oregon replaced its MCOs with Coordinated Care Organizations (CCOs), offering integrated care across physical, behavioral and dental benefits, much like New Mexico did under the first Centennial Care waiver. There are 16 CCOs across Oregon that are locally governed, accountable for health outcomes, receive a global budget and also have some flexibility to pay for social needs of members. They are required to focus on care coordination and can receive bonus payments for improving outcomes. A 2018 evaluation of Oregon's CCOs found that two thirds of all measures tied to bonus payments improved. The CCOs report publicly on these measures, including benchmarks and improvement targets.

Chart 7. Per-Member Per-Month Cost of Care Coordination and Completed Care Coordination Tasks



Source: LFC analysis of MCO reports

Outcomes that should result from effective care coordination conducted by MCOs are not tracked. Because care coordination currently seeks to reduce both costs and improve health outcomes, effective measurement should address both issues.

Cost measures can assess the relative resource use for particular patient populations that are engaged in care coordination or the costs associated with the actual care coordination tasks themselves, such as health risk assessments and comprehensive needs assessments, among other activities.

Health measures track the reductions in certain rates of disease, use of medications, and hospital admissions. In 2020, HSD contractually requires MCOs to track 10 performance measures connected with health outcomes, four of which could be tracked for the population of Medicaid members receiving care coordination. In prior years, the contractual requirement was for 19 performance measures (in 2018) and 13 performance measures (in 2018). The *Healthcare Effectiveness Data and Information Set* (HEDIS) could be used to identify measures applicable to the care coordination population. Encounter data from MCOs could then be used to analyze these outcomes for members in care coordination.

The CMS recommends five metrics that measure improved health outcomes that can result from effective communication and coordination of care among beneficiaries, their families, and their providers. While these measures are not specifically connected to the population of Medicaid members enrolled in care coordination, they are a helpful way to rank New Mexico's health outcomes and could be tracked for the population enrolled in care coordination. Compared with other states reporting on the CMS metrics, New Mexico has significant room for improvement: For four out of these five measures, New Mexico ranks near the bottom three-quarters of states reporting (see Appendix C: New Mexico's Ranking in CMS' Health Outcomes Resulting from Effective Communication and Coordination of Care). Table 11 outlines these potential cost and health outcome measures for care coordination.

While these measures represent a limited selection of potential options, there are additional and significant resources with larger sets of measures. The Agency for Healthcare Research and Quality published an atlas of 96 measures, and the National Quality Forum maintains an online repository of endorsed measures of care coordination.

Table 10. Measures of Care Coordination

Cost-Effectiveness	
Category	**Measure**
Resource Use Measures (endorsed by the National Quality Forum)	Relative Resource Use for People with Diabetes
	Relative Resource Use for People with Cardiovascular Conditions
	Total Resource Use Population-based PMPM Index
	Total Cost of Care Population-based PMPM Index
Measures of Cost of Care Coordination Tasks	Cost of Health Risk Assessments
	Costs of Comprehensive Needs Assessments
Health Outcomes	
Performance Measures Outlined in MCO Contracts and Tracked for Care Coordination Population	Antidepressant Medication Management (AMM): Continuous Phase
	Follow-Up After Hospitalization for Mental Illness
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30 Day
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
Potential HEDIS Measures Relevant to Care Coordination Population	Controlling High Blood Pressure
	Comprehensive Diabetes Care
	Medication Management for People With Asthma and Asthma Medication Ratio
	Cholesterol Management for Patients with Cardiovascular Conditions
Centers for Medicare and Medicaid Services: Health Measures Resulting from Effective Communication and Coordination of Care	Use of Multiple Concurrent Antipsychotics in Children & Adolescents
	Follow-Up After Hospitalizations for Mental Illness: Ages 6-20
	Follow-Up After Hospitalizations for Mental Illness: Ages 21 & Older
	PQI 01: Diabetes Short-Term Complications Admissions Rate
	Number of Hospitalizations per 1,000 Long-Stay Nursing Home Resident Days

Source: CMS, HEDIS, Agency for Healthcare Research and Quality, National Quality Forum

Health homes enroll fewer members than expected with some positive outcomes. Health homes are a model of healthcare coordination where individuals with more complex and chronic health conditions receive integrated care and are connected to services from either individual providers or teams of providers. In exchange for this level of targeted coordination, states receive a higher level of federal reimbursement or a 90 percent FMAP for two years. The expectation is that costly hospitalizations, and presumably, complex health conditions will be reduced.

Current health home enrollment falls 60 percent short of 2018 projected enrollment. In 2016, New Mexico first applied to CMS to initiate the health home model in two rural counties and chose to focus on Medicaid-eligible adults with severe mental illness (SMI) and children and adolescents with severe emotional disturbances (SED). HSD proposed a phased-in roll-out of health homes, with a projected enrollment of 9,475 eligible Medicaid members by the end of phase two. Projected state costs were $3.8 million over two years. As of June 2020, seven providers delivered coordinated care in 12 counties to 3,289 members. Two health homes provide high fidelity wraparound services to 150 children and adolescents. Current enrollment stands at 40 percent of 2018 projections. HSD received CMS approval in July 2020 to include

substance use disorder (SUD) to the eligible set of conditions for health homes. CareLink NM is the umbrella program that coordinates the health homes.

Members enrolled in health homes had better health outcomes for some but not all of the reported measures compared with others not enrolled. Health outcomes are tracked for members enrolled in health homes and compared with members enrolled in MCOs as well as with regional targets. Health home enrollees showed better health results than both MCOs and regional targets on ten of the 17 tracked HEDIS measures. For five of the 17 measures, health home enrollees showed worse results. For one measure, health homes outperformed MCOs but regional data was not available and, for another, health homes outperformed MCOs but not the regional target. (See Appendix H for full list of HEDIS measures and results for health home members and comparison groups.)

Costs savings for the 3,289 members enrolled in health homes in New Mexico are unknown. Studies find health homes yield mixed results when it comes to both improved member health and cost savings. A 2017 report from the Urban Institute for the Department of Health and Human Services evaluated the first 13 health home programs approved in 11 states.[7] While these health homes were first attempts at the model and there is significant variation among states, the report notes program effectiveness is variable and largely depends on the type of health home provider and length of enrollment for members. The study found no significant savings nor significant spending for Medicaid enrollees in primary care health homes, pointing to net partial savings. For Medicaid members enrolled at health homes located at Community Mental Health Centers (CMHC), however, there were significant cost savings for those enrollees with greater exposure to the program, highlighting the importance of maintaining enrollee engagement.

A study of a health home program in Missouri found both health improvements as well as cost savings. The 2019 analysis of Missouri's CMHC health home program found cost savings of $98 PMPM and a return-on-investment of 2:1 over the first year of the program. Over a four-year period, the study found hospitalizations among health home enrollees decreased by 14 percent, and emergency department visits decreased by 34 percent. Additionally, there were overall Medicaid savings of $2 million. The study attributes these service reductions largely to the health homes use of "advanced, customizable data analytics," which enabled them to identify gaps in patient treatment and patient adherence to treatment.

[7] Spillman, Brenda C., Allen, Eva H. *Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Evaluation of Outcomes of Selected Health Home Program, Annual Report – Year Five, May 2017,* Prepared for the U.S. Department of Health and Human Services

Recommendations

The Human Services Department should:

- Develop and adopt new care coordination measures to track cost effectiveness of care coordination activites;
- Establish benchmarks to increase oversight of care coordination at the MCO level;
- Adopt a set of health outcome measures specifically for the care coordination population and contractually obligate MCOs to collect, analyze, and report this data; and
- Track, report, and publicly share health outcomes and cost savings associated with health homes.

Despite Increased Spending, New Mexico Health Outcomes are Stagnant and Underperform National Comparisons

Out of 26 Healthcare Effectiveness Data and Information Set (HEDIS) measures regularly tracked by LFC, fewer than half noticeably improved between 2016 and 2019. The percentage of adult members with access to preventive and ambulatory care, used as a proxy for annual well-visits, remained the same between 2016 and 2019 at 76 percent. Among children ages 1 to 6, access to primary care also remained flat over the four-year period at around 85 percent. Noticeable declines occurred within the behavioral health realm, with the percentage of members receiving follow-up behavioral health services within seven days after discharge for a behavioral health admission decreasing from 42 percent in 2016 to 25 percent in 2019. Even with an expanded timeframe of 30 days, the number receiving follow up decreased from 62 percent to 40 percent when expanding the follow-up timeframe to 30 days. Performance improved for measures on infants who had six or more well-child visits during the first-year and newborns whose mothers had a prenatal visit in the first trimester, both increasing by 10 percentage points between 2016 and 2019.

Table 11. HEDIS Measures, 2016 - 2019

HEDIS Domain	HEDIS Measure - Medicaid Population	2016	2017	2018	2019	2016 to 2019 Trend
Behavioral Health	Adults with major depression who received continuous treatment with antidepressant medication	32.0%	34.0%	34.0%	38.4%	Better
	Individuals discharged from inpatient facilities who received follow-up services at seven days	42.0%	38.0%	29.0%	25.1%	Worse
	Individuals discharged from inpatient facilities who received follow-up services at thirty days	62.0%	62.0%	47.0%	40.3%	Worse
	Individuals receiving opioids from four or more providers for 15 or more days	N/A	N/A	19.0%	19.3%	Stable
	Members with alcohol abuse or dependence who had two or more additional visits with 30 days	N/A	12.0%	13.0%	12.9%	Stable
	Members with alcohol abuse or dependence who initiated treatment within 14 days of diagnosis	N/A	38.0%	38.0%	38.6%	Stable
	Members with opioid abuse or dependence who had two or more additional visits within 30 days	N/A	26.0%	30.0%	26.6%	Stable
	Members with opioid abuse or dependence who initiated treatment within 14 days of diagnosis	N/A	48.0%	57.0%	58.1%	Better
Care Coordination and Chronic Disease Management	Adults with diabetes who had a HbA1c test during the year	84.0%	77.0%	85.0%	85.3%	Better
	Patients with persistent asthma prescribed and maintained on appropriate medication	54.0%	57.0%	56.0%	58.9%	Better
Healthy Children	Children ages 2 to 20 who had at least one dental visit during the year	68.0%	70.0%	72.0%	68.4%	Stable
	Children ages 3 to 6 who had one or more well-child visits during the year	85.0%	84.0%	57.0%	58.5%	*
	Infants who had 6 or more well-child visits during first 15 months	56.0%	59.0%	60.0%	66.4%	Better
	Newborns whose mothers had prenatal visit during first trimester (or within 42 days of enrollment)	77.0%	73.0%	77.0%	87.0%	Better
Physical Health - Access to Care	Adults with access to preventive & ambulatory care	76.0%	80.0%	77.0%	76.2%	Stable
	Children ages 1 - 6 years with access to primary care	84.0%	86.0%	86.0%	84.8%	Stable
	Children screened for lead poisoning by their second birthday		39.0%	42.0%	39.6%	Stable
	Women receiving timely postpartum care	58.0%	57.0%	62.0%	70.2%	Better
Physical Health - Disease Management	Cardiovascular patients with controlled high blood pressure	54.0%	50.0%	50.0%	51.5%	Worse
	Patients 75% compliant with asthma medication	29.0%	31.0%	36.0%	39.9%	Better
	Patients with COPD managed with corticosterioid medication	43.0%	52.0%	50.0%	46.6%	Better
	Patients with poor diabetes control (lower is better)	48.0%	46.0%	48.0%	48.3%	Stable
Physical Health - Effectiveness of Care	Adult patients receiving body mass index assessment	79.0%	80.0%	77.0%	84.6%	Better
	Child/adolescent patients receiving body mass assessment	61.0%	61.0%	57.0%	64.3%	Better
	Children receiving appropriate treatment for upper respiratory infections	88.0%	89.0%	90.0%	87.9%	Stable
	Patients with lower back pain who did not have an imaging study for diagnosis	70.0%	71.0%	70.0%	74.0%	Better

Note: * HEDIS metric calculation changed

Source: HEDIS data and LFC Medicaid Accountability Reports.

Of the 58 adult and child core measures voluntarily submitted to CMS for 2019, 76 percent are below the national median value.[8] While only 10 of 32 adult outcome measures were better than the national Medicaid median value, the number of child measures at or above the national median value was worse, with only four of 26 measures above the median (see Appendix E for individual metric detail). Primary care access and preventive care measures for both the adult and child sets are areas for targeted improvement in New Mexico. This includes measures such as the percentage of children with six or more well-child visits during the first 15 months of life and the percentage with a primary care visit in the last two years.

Table 12. Adult and Child Health Outcome Core Set - Number Above National Median

Health Outcome Domain	Adult	Child
Behavioral Healthcare	7 of 18	1 of 6
Care of Acute and Chronic Conditions	2 of 9	1 of 4
Dental and Oral Health Services	N/A	1 of 1
Maternal and Perinatal Health	1 of 1	0 of 2
Primary Care Access and Preventive Care	0 of 4	1 of 13
Total	10 of 32	4 of 26

Source: CMS Adult and Child Core Measures.

New Mexico's reported perinatal healthcare measure in 2019 was below the national median value. The percentage of live births weighing less than 2,500 grams (5.51 lbs.) among the Medicaid population in New Mexico in 2019 was 9.7 percent. This is near the national median value of 9.5 percent but more than a full percentage point worse than the best performing states.

Table 13. Perinatal Healthcare Measures, FFY19

Measure Name	State Rate	Median	Bottom Quartile	Top Quartile
Live Births Weighing Less Than 2,500 Grams	9.7%	9.5%	10.7%	8.5%

Source: CMS Adult and Child Core Measures.

The Centennial Care 2.0 contracts require MCOs to meet specific performance measures or face financial sanctions. The 10 performance measures included in the contracts are based on HEDIS technical specifications. Yearly targets are the incremental increases needed for each MCO to reach the 2018 regional averages plus 1 percentage point by 2023 (see Appendix F for list of performance measures and yearly targets). Failure to meet a performance measure in a calendar year results in a financial penalty of up to 2 percent of total annual capitation payments paid to the MCO divided by the number of performance measures. In 2019, the largest financial penalty possible would have been around $85 million, with the largest MCO-specific penalty potentially totaling nearly $50 million.

Eight of the 10 performance measures have a 2020 to 2023 targeted increase of less than 5 percentage points for their respective member groups. The most ambitious performance measure improvement is for assessment and

[8] HSD uses regional averages to compare MCO performance in the contracts. LFC did not have access to regional metrics and presents national comparisons.

counseling for nutrition and physical activity for children, which requires a14 percentage point increase between 2020 and 2023 to meet the contractual target.

While the performance measures specified in the contracts are well-intentioned, the relatively modest improvements in specific health outcomes may be better achieved through other vehicles, such as value-based purchasing. Additionally, rethinking the performance measure penalty aspects with MCOs, and potentially removing the risk to those funds, could enable HSD to negotiate lower capitation payments on the front-end.

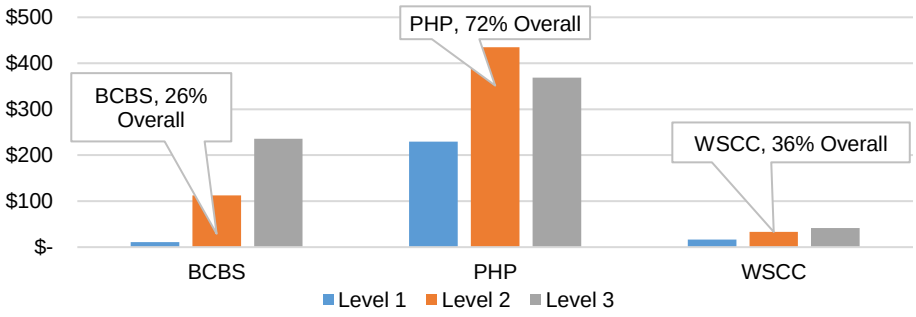
$1.5 billion in value-based purchasing agreements between MCOs and providers seek to improve health outcomes

Covid-19 has thrown into question how health-outcome-related performance measures will be handled for 2020.

Value-based purchasing initiatives seek to improve health outcomes by realigning financial incentives to reward providers for coordinating care. Broadly defined, VBP is any activity undertaken by the MCOs to hold providers accountable for the costs and quality of the care they provide. Centennial Care 2.0 contracts established three VBP levels, with specific requirements for the MCOs to meet annually. Level one is a bonus and incentive fee schedule payable to providers when the outcome or quality scores meet agreed-on targets. Level two is upside-only shared savings with providers when the outcome or quality scores are met; the provider is not at-risk of financial loss. Level three is provider risk-sharing (at least 5 percent upside and downside risk) or capitated payments to providers with full risk, much the same way HSD pays MCOs on a capitation basis (see Appendix G for VBP contractual requirements).

All MCOs exceeded the required VBP spend target of 24 percent in 2019, totaling $1.5 billion in expenditures. Presbyterian led all MCOs with 72 percent of its healthcare expenditure in 2019 categorized as VBP, with the VBP amount totaling $1.03 billion. Blue Cross Blue Shield had $359 million in VBP in 2019 (26 percent of total healthcare expenditure), and Western Sky had $92 million in VBP (36 percent of total healthcare expenditure).

Chart 8. 2019 Value-Based Purchasing by Level and MCO
(in millions)



Source: MCO value-based purchasing reports

Additional VBP analysis and reporting on health outcomes would provide useful insight around member health outcomes. Current value-based purchasing reports provided to HSD by the MCOs provide detailed information regarding provider performance and payment specifics, but understanding how VBP is impacting Centennial Care 2.0 members' health across all providers, and all MCOs, is difficult to interpret. Standardizing how MCOs name and report health outcome variables in the VBP reports would streamline health outcome analysis and enable benchmarking of health outcomes.[9] Currently, it is also unclear if health outcomes differ among level one, level two, and level three VBP arrangements.

Some challenges exist for MCOs to reach future VBP targets. Between 2019 and 2022, overall VBP spending by MCOs is required to increase from a minimum of 24 percent to a minimum of 36 percent, as defined in the MCO contracts. Additionally, HSD has the contractual right to increase the VBP percentage requirements by 5 percent in both 2021 and 2022. During structured MCO interviews, some MCOs stated future contractual requirements surrounding a greater share of healthcare spend occurring in level two and level three could prove challenging. The challenges of entering into shared savings or full capitation agreements were due to a lack of provider network knowledge of value-based purchasing agreements and a disconnect between MCO and provider perceived goals within the Centennial Care 2.0 framework. Also some behavioral health and long-term services and supports providers lack the scale and financial stability to support level two and level three agreements.

Recommendations

The Human Services Department should

- Continue its efforts in data transparency and include quarterly health outcome data, including within value-based purchasing agreements, on its publically available online performance scorecard;
- Standardize how MCOs populate value-based purchasing reports; and
- Excersice the contract option to increase overall value-based purchasing spending requirements by 5 percent in 2021 and an additional 5 percent in 2022.

[9] MCOs are allowed to develop their own measures with providers as part of the VBP agreements.

HUMAN SERVICES DEPARTMENT

Michelle Lujan Grisham, Governor

David R. Scrase, M.D., Secretary

Angela Medrano, Deputy Secretary
Kari Armijo, Deputy Secretary
Nicole Comeaux, J.D., M.P.H., Medicaid Director

November 16, 2020

Mr. Jon Courtney
Deputy Director for Program Evaluation
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87501

Dear Mr. Courtney:

The New Mexico Human Services Department (HSD) appreciates the opportunity to review and respond to the Legislative Finance Committee's (LFC) evaluation report of the Centennial Care 2.0 program and costs.

The Centennial Care 2.0 program began operation in January of 2019. With the arrival of a new administration and a legislature committed to the health of New Mexicans the program underwent significant changes in the first twelve months of operation. Some of these efforts included waiver changes to roll back previous administration policies that served as barriers to access to care which the report highlights as an area for targeted effort, and changes to expand home visiting and increase community benefit slots. Additionally, in recognition of cost containment in 2016 and stagnant rates, the legislature endorsed a multi-phase strategy to address the low Medicaid reimbursement rates for those who deliver care and services to the most vulnerable New Mexicans to help rebuild and protect New Mexico's health care delivery network.

Three months into its second year, the coronavirus pandemic jolted the program into a public health crisis and an economic crisis. In the state with the highest poverty rate in the country prior to the pandemic, this meant extraordinary growth in the Medicaid program and a significant responsibility for the agency and the Managed Care Organizations (MCOs) to respond rapidly to address immediate needs for remote work, waivers for telehealth flexibility, payment in alternative care settings, etc. These circumstances quickly demonstrated the countercyclical nature of the program – during economic downturns, more people enroll in Medicaid, increasing program spending at the same time state revenue falls requiring difficult decisions to be made about how to prioritize programmatic efforts and balance budgets

While we agree generally to consider or adopt the recommendations in the report, we feel the report is singularly focused on increased costs and not on substantially increased revenues, may give only a

partial picture of program spending and experience, and passes over many of the accomplishments the program has achieved in less than two years' time amid unparalleled challenges.

In light of key recommendations made by the LFC within its report, HSD provides the following responses:

Cost Management

1. ***LFC Recommendation – HSD should consider decreasing capitation rates by the allowed 1.5 percent in light of decreased healthcare utilization among members during the pandemic.***

HSD has been considering changes to capitation rates since the inception of the program, will continue to do so, and therefore agrees with the spirit of the recommendation. However, we do not agree with the specific percent reduction in recommendation. In particular, we have been conducting ongoing analysis of the impact of the Public Health Emergency (PHE) on utilization and cost and will continue to consider options to address decreased utilization. However, reducing capitation rates by 1.5 percent would result in actuarially unsound rates which our actuary cannot certify, and which CMS will not approve. We presented this data to the LFC this fall. Additionally, as was noted in the report, HSD has limited options to make rapid changes to adjust for the changes in utilization using standard underwriting gain limits and medical loss ratios (MLR) due to requirements that data collection occur over a longer period of time to ensure validity of the experience.

There are many ways to achieve the spirit of the recommendation. HSD has already implemented some of these. For example, in recognition of the potential for MCOs to have unused capitation payments due to the unprecedented growth in the Medicaid program as a result of worsening economic conditions, the federal Maintenance of Effort (MOE) requirement, and necessary public health measures to reduce the spread of COVID-19 that reduced utilization in March and April, HSD made program changes to require the MCOs to absorb the cost of emergency COVID-19 relief payments for the quarter from April through June of calendar year 2020, without providing a corresponding increase to their rates. Providers from all service areas were expressing need for support for both increased costs (e.g. personal protective equipment needs), and decreased revenue (e.g. suspension of elective procedures), and HSD's approach helped to provide an estimated $240.5 million in emergency relief to providers while immediately addressing concern about the decreased utilization for MCOs.

2. ***LFC Recommendation – HSD should consider recalculating capitation rates more frequently during the duration of the pandemic to more accurately reflect the impact of Covid-19 on the Centennial Care 2.0 program.***

HSD is closely monitoring utilization changes during the pandemic to determine the actuarial soundness of the capitation rates and will consider adjusting rates more frequently to accurately account for the impact of COVID-19. However, the Centers for Medicare and Medicaid Services (CMS) require that rate certifications be done on a 12-month rating period [Per 42 CFR §438.2, "rating period" means a period of 12 months selected by the state for which the actuarially sound capitation rates are developed and documented in the rate certification.]. CMS will consider a time period other than 12 months to address unusual circumstances. For example, CMS would approve a time period other than 12 months for the following reasons: (a) when the state is trying to align program rating periods, which may require a rating period longer than one year (but less than two years); or (b) when the state needs to make an amendment to the contract and the rates for an already approved rating period need to be adjusted accordingly. Therefore, while we are able to make smaller changes to rates for services more than once a year, our actuary could not recertify our overall capitation rates without meeting one of these exceptions from CMS and then would not be able to continually update overall rates. HSD is currently making projections to ensure that we accurately reflect the impact of COVID-19 on the program but with the virus surging again in New Mexico the volatility and uncertainty require that HSD take measured steps to ensure the stability of the program.

3. ***LFC Recommendation – HSD should develop and adopt new care coordination measures to track cost effectiveness of care coordination activities.***

HSD agrees with this recommendation and will begin these efforts in SFY2022. HSD will collaborate with LFC to design measures to track cost effectiveness of care coordination activities. One of the key initiatives outlined in the Centennial Care 2.0 1115 waiver is to refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care. HSD appreciates this recommendation and will work to develop measures to ensure we are meeting these program goals in addition to tracking cost effectiveness. There are inherent challenges in *proving* cost effectiveness: to what group should the intervention group be compared, the lack of any comparative national data; the need to develop data system enhancements to track cost effectiveness.

Program Management

4. ***LFC Recommendation – HSD should establish benchmarks to increase oversight of care coordination at the MCO level.***

HSD agrees with this recommendation and will begin these efforts in SFY2022. HSD will develop and establish benchmarks to increase care coordination oversight at the MCO level. Currently, HSD performs over 200 monthly chart reviews monitoring care coordination activities and will begin work to develop care coordination key healthcare metrics that drive improvements for member health outcomes.

5. ***LFC Recommendation – HSD should standardize how MCOs populate value-based purchasing reports.***

HSD has been working on modifications to how we define, measure, and track value based purchasing. With the onset of the pandemic, we put further development of these considerations on hold and turned our focus to submitting many waivers to better support our members and providers during this crisis. We plan to reopen our deliberations after the pandemic and consider this recommendation in SFY2022. HSD will continue to work with the MCOs on a robust and transparent value-based purchasing program.

One of the key initiatives outlined in the Centennial Care 2.0 1115 waiver is to expand payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes. While there are challenges to establishing these arrangements as outlined in the report for providers resulting in varied arrangements, we agree that standardized reporting would enable better measurement of outcomes.

Tracking Health Outcomes

6. ***LFC Recommendation – HSD should adopt a set of health outcome measures specifically for the care coordination population and contractually obligate MCOs to collect, analyze, and report this data.***

HSD agrees with this recommendation and will begin these efforts in SFY2022. HSD will adopt health outcome measures specifically for the care coordination population to assess progress. HSD will collaborate with the MCOs to establish the performance measurement data to improve data collection of care coordination member health outcomes. HSD is also exploring ways to use information technology to better identify members, identify needs, and track outcomes.

7. ***LFC Recommendation – HSD should continue its efforts in data transparency and include quarterly health outcome data, including within value-based purchasing agreements, on its publicly available online performance scorecard.***

HSD is dedicated to transparency of performance data, as evidenced by our new public website. Once we have clarified a more robust approach to value based purchasing (than the one we inherited), we plan to develop appropriate metrics. HSD will work to incorporate health outcome data related to VBP arrangements, but this recommendation may significantly underestimate the complexity of such performance measurement as evidenced by the paucity of such data nationally. HSD places a high priority on using data to identify key priorities, track progress, and prove effectiveness of public

investments. The online HSD Performance Scorecard aligns with the HSD Strategic Plan, promotes transparency and oversight, and tells HSD's story more accurately and from customers' perspective. The Scorecard is a visual representation of the work we do every day and how it connects to the HSD mission and vision. The current 31 measures cover areas related to finance, growth, quality, employees, and consumer/beneficiary satisfaction.

8. ***LFC Recommendation – HSD should exercise the contract option to increase overall value-based purchasing spending requirements by 5 percent in 2021 and an additional 5 percent in 2022***

HSD agrees with this recommendation and will revisit this option in SFY2022. as we have more information on how the public health emergency impacts value-based purchasing. For 2021, MCOs have already completed their contracting cycle. Additionally, this may be unobtainable given current pandemic circumstances for the provider community. However, value-based purchasing is central to the overall Centennial Care 2.0 program and we will consider this option for 2022.

9. ***LFC Recommendation – HSD should track, report, and publicly share health outcomes and cost savings associated with health homes.***

HSD will consider this recommendation SFY2022. HSD currently tracks HEDIS measures for health home outcomes and will consider how best to report and share more of the data. Cost savings are more difficult to track due to the lack of an appropriate "control group" and the fact that people with medical issues are more likely to affiliate with a medical home than those who do not regularly seek care. HSD is committed to working to develop a methodology, but we want to be clear that such effectiveness measures will likely focus on smaller subsets of membership, such as those with diabetes or congestive heart failure, and on a small number of metrics for each subgroup.

In addition to our responses to the specific recommendations above, we believe that there are many positive aspects of the program that were not touched upon in the review. Further, the increase in Federal matching revenue that has occurred in Centennial Care 2.0 has been the source of better access for members, better reimbursement for providers, and the maintenance of many critical services, such as behavioral health, during the pandemic. While we understand that the purpose of such evaluations may be to focus on "what is not going well," the fact is that value can only be appraised by understanding the positive revenue, network, and health outcomes being achieved in the first two years of Centennial Care 2.0.

HUMAN SERVICES
DEPARTMENT

Sincerely,

David R. Scrase, M.D.
Secretary
cc: Kari Armijo, Deputy Secretary, HSD
Angela Medrano, Deputy Secretary, HSD
Nicole Comeaux, Medicaid Director, Medical Assistance Division
Neal Bowen, Director, Behavioral Health Services Division

Appendix A. Evaluation Scope and Methodology

Evaluation Objectives.

- Review and summarize impact of Centennial Care on Medicaid costs and beneficiary health outcomes;
- Analyze changes to MCO costs under Centennial Care 2.0; and
- Evaluate changes to healthcare access and health outcomes under Centennial Care 2.0.

Scope and Methodology.

- Reviewed:
  - Applicable statute and administrative code.
  - LFC file documents.
  - Agency policies and procedures, and data.
  - Managed care Organization (MCO) data.
  - National and local best practices.
  - Relevant performance measures, administrative data, and related documents.
- Interviewed appropriate staff and stakeholders.
- Researched evaluation reports from other states and national groups as well as academic literature.

Evaluation Team.
Jacob Rowberry, Lead Program Evaluator
Catherine Dry, Program Evaluator
Mitch Latimer, Program Evaluator

Authority for Evaluation. LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

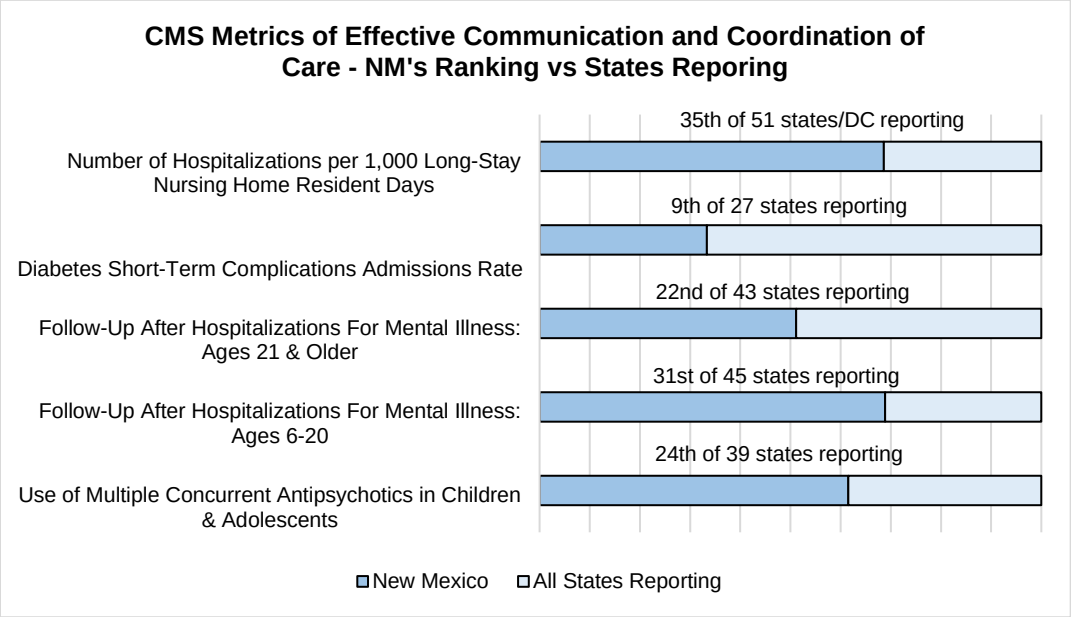
Exit Conferences. The contents of this report were discussed with the Human Services Department Secretary, Medicaid Director, and staff on November 13, 2020.

Report Distribution. This report is intended for the information of the Office of the Governor, Department of Finance and Administration, Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

Jon Courtney, Ph.D.
Deputy Director for Program Evaluation

Waiver Type	Policy Change	Estimated Total Cost (millions)	Estimated GF Cost (millions)
Appendix K for HCBS	Retainer Payments for PCS services (1 quarter)	$0.00	$0.00
Appendix K for Mi Via, Med Frag & DD Waiver	Increase assistive technology budget from $250.00 to $500.00 (1 quarter)	$0.03	$0.01
	Support waiver participants (personal care) in an acute care hospital or short-term institutional stay (DD waiver, Med Frag waiver, and Mi Via Waiver) (1 quarter)		
	Increase rates for supported living, intensive medical living, family living (DD waiver) (1 quarter)	$9.10	$1.90
Disaster SPA	Delayed reconciliation of SBHC cost reports for FFY18	$0.00	$0.00
	EMSA –to cover COVID-19 testing	$1.90	$0.50
	COVID-19 testing uninsured group for uninsured beginning 3/18	$1.30	$0.00
	Targeted Access Payments (Disaster SPA)	$16.80	$3.50
	Hospital Access Payments	$57.60	$12.10
	Advance payment of DSH for first 2 quarters of 2020	$16.40	$3.50
	DRG ICU 50% rate increase (1 quarter) for 201 Acute Care Hospitals	$50.60	$7.10
	DRG inpatient stays 12.4% rate increase (1 quarter) for 201 Acute Care Hospitals	$16.20	$2.30
	12.4% rate increase (1 quarter) for providers 202-205	$3.50	$0.60
	30% rate increase to short term skilled & custodial nursing facility services for COVID-19 + patients (1Q)	$6.70	$1.40
	30% rate increase for Assisted Living Facilities (ALFs) for COVID-19 positive patients (1 quarter)	$0.06	$0.01
	$1 rate increase to pharmacies for curbside pickup (1 quarter)	$1.90	$0.30
	Other Provider Rate Increases(1 quarter)	$13.10	$2.40
Managed Care	Increase non-emergency ground transportation (NEMT) rates (1 quarter)	$1.60	$0.40
	E&M/Non-E&M/Medicaid only rate increase (1 quarter)	$36.60	$6.30
	Targeted Access Payments (Regular SPA)	$7.20	$1.50
	TOTAL Medicaid Costs	$240.50	$43.80

Appendix C: CMS Metrics Care Coordination



Appendix D: Care Coordination Cost by Program Area

Care Coordination Expenses by Program Area					
Program Area	**CY14**	**CY19**	**% Change**		**CY20/Q2**
Behavioral health	$9.9	$22.6	128%		$12.6
Physical Health	$33.8	$13.0	-62%		$14.7
Long Term Services & Supports	$30.8	$48.4	57%		$20.7
Behavioral Health - Expansion	$2.0	$2.7	35%		$1.6
Physical Health - Expansion	$23.6	$20.5	-13%		$8.9
Total	$100.1	$107.4	7%		$58.5

Source: LFC analysis of MCO reports

Appendix E: CMS Adult and Child Core Measure Sets

Metric	Median Rate	NM Rate
Percentage Diagnosed with Major Depression who were Treated with and Remained on Antidepressant Medication for 12 Weeks: Ages 18 to 64	51.3	50.9
Percentage Diagnosed with Major Depression who were Treated with and Remained on Antidepressant Medication for 6 Months: Ages 18 to 64	34.4	33.9
Percentage of Emergency Department (ED) Visits for Alcohol and Other Drug Abuse or Dependence with a Follow-Up Visit Within 30 Days of the ED Visit: Ages 18 to 64	21.7	17
Percentage of Emergency Department (ED) Visits for Alcohol and Other Drug Abuse or Dependence with a Follow-Up Visit Within 7 Days of the ED Visit: Ages 18 to 64	13.9	9.7
Percentage of Emergency Department (ED) Visits for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days of the ED Visit: Ages 18 to 64	52.1	50.1
Percentage of Emergency Department (ED) Visits for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days of the ED Visit: Ages 18 to 64	38.4	37
Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days after Discharge: Ages 18 to 64	54.8	41.7
Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days after Discharge: Ages 18 to 64	32.3	25.6
Percentage of Sexually Active Women Screened for Chlamydia: Ages 21 to 24	60.2	56.6
Percentage of Women Delivering a Live Birth who had a Postpartum Care Visit on or Between 21 and 56 Days after Delivery	61.2	62
Percentage of Women Screened for Cervical Cancer: Ages 21 to 64	55.1	54.4
Percentage of Women who had a Mammogram to Screen for Breast Cancer: Ages 50 to 64	53.4	49.4
Percentage who had a Diagnosis of Hypertension and Whose Blood Pressure was Adequately Controlled During the Measurement Year: Ages 18 to 64	60	50.4
Percentage who had an Outpatient Visit with a BMI Documented in the Medical Record: Ages 18 to 64	83.5	77.3
Percentage who Received at Least 180 Treatment Days of Ambulatory Medication Therapy and Annual Monitoring: Ages 18 to 64	87.4	84.3
Percentage with a New Episode of Alcohol Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64	39.9	38.3
Percentage with a New Episode of Alcohol Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64	11.2	12.9
Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64	42	41.8
Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64	15.7	15.8
Percentage with a New Episode of Opioid Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64	54	56.6
Percentage with a New Episode of Opioid Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64	27.7	29.7
Percentage with a New Episode of Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64	39.9	40.1
Percentage with a New Episode of Other Drug Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64	10.8	11.1
Percentage with Diabetes (Type 1 or Type 2) who had a Hemoglobin A1c (HbA1c) Test: Ages 18 to 64	86.1	84.9
Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 19 to 50	53.8	45
Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 19 to 64	54.6	46.7
Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 51 to 64	57	51.5
Percentage with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on Antipsychotic Medication for at Least 80 Percent of their Treatment Period: Ages 19 to 64	59.1	54.4
Percentage with Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder who were Dispensed an Antipsychotic Medication and had a Diabetes Screening Test: Ages 18 to 64	79.8	79.9
Inpatient Hospital Admissions for Diabetes Short-Term Complications per 100,000 Beneficiary Months: Ages 18 to 64	19.1	12.4
Percentage with Diabetes (Type 1 or Type 2) who had Hemoglobin A1c in Poor Control (>9.0%): Ages 18 to 64	38.8	48.3
Ratio of Observed All-Cause Readmissions to Expected Readmissions: Ages 18 to 64	0.8283	0.5526

Appendix E: CMS Adult and Child Core Measure Sets

Metric	Median Rate	NM Rate
Percentage Completing the Human Papillomavirus (HPV) Vaccine Series by Their 13th Birthday	34.4	35
Percentage Enrolled in Medicaid or Medicaid Expansion CHIP Programs for at least 90 Continuous Days with at Least 1 Preventive Dental Service: Ages 1 to 20	49.1	54.7
Percentage Newly Prescribed ADHD Medication with 1 Follow-Up Visit During the 30-Day Initiation Phase: Ages 6 to 12	48.6	45.2
Percentage Newly Prescribed ADHD Medication with at Least 2 Follow-Up Visits in the 9 Months Following the Initiation Phase: Ages 6 to 12	58.6	56.8
Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days after Discharge: Ages 6 to 17	66.3	61.7
Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days after Discharge: Ages 6 to 17	41.9	38.9
Percentage of Sexually Active Women Screened for Chlamydia: Ages 16 to 20	49.9	47.8
Percentage of Women Delivering a Live Birth with a Prenatal Care Visit in the First Trimester or within 42 Days of Enrollment in Medicaid or CHIP	80.7	76.6
Percentage Receiving Meningococcal Conjugate and Tdap Vaccines (Combination 1) by Their 13th Birthday	78.6	72.2
Percentage Up-to-Date on Immunizations (Combination 3) by their Second Birthday	68.8	66.8
Percentage who had 1 or More Well-Child Visits with a Primary Care Practitioner: Ages 3 to 6	69	56.8
Percentage who had 6 or More Well-Child Visits with a Primary Care Practitioner during the First 15 Months of Life	64	60.1
Percentage who had a Measles, Mumps, and Rubella (MMR) Vaccination by their Second Birthday	87.6	87.1
Percentage who had a New Prescription for an Antipsychotic Medication and had Documentation of Psychosocial Care as First-Line Treatment: Ages 1 to 17	62.8	61
Percentage who had an Outpatient Visit with a Primary Care Practitioner or Obstetrician/Gynecologist who had Body Mass Index Percentile Documented in the Medical Record: Ages 3 to 17	69.7	57.2
Percentage with a PCP Visit in the Past Two Years: Ages 12 to 19 Years	90.3	84.8
Percentage with a PCP Visit in the Past Two Years: Ages 7 to 11 Years	91.1	86.9
Percentage with a PCP Visit in the Past Year: Ages 12 to 24 Months	95.5	94.1
Percentage with a PCP Visit in the Past Year: Ages 25 Months to 6 Years	87.7	84.7
Percentage with at Least 1 Well-Care Visit with a Primary Care Practitioner or Obstetrician/Gynecologist: Ages 12 to 21	50.6	39.9
Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 12 to 18	64.6	58
Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 5 to 11	72.8	71.4
Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 5 to 18	69.4	64.9
Emergency Department Visits per 1,000 Beneficiary Months: Ages 0 to 19	43.6	37.2
Percentage of Live Births that Weighed Less Than 2,500 Grams	9.5	9.7
Percentage on Two or More Concurrent Antipsychotic Medications: Ages 1 to 17	2.6	2.3

Appendix F: 2019 HEDIS and Performance Measures

		CY19 HEDIS			Performance Measures			
Performance Measure	**Group/Detail**	**BCBS**	**PHP**	**WSCC**	**CY20**	**CY21**	**CY22**	**CY23**
1 - Well Child Visits in the First fifteen (15) Months of Life	% members first 15 months	65.94%	66.67%	N/A	62.62%	63.72%	64.82%	65.91%
2 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	% members 3-17 years of age	45.50%	49.15%	50.40%	48.52%	53.33%	58.14%	62.93%
3 - Prenatal and Postpartum Care	% of member deliveries of live births that received a prenatal care visit in the first trimester or within 42 calendar days of enrollment.	84.43%	90.51%	70.80%	78.67%	80.70%	82.73%	84.75%
4 - Prenatal and Postpartum Care	% of member deliveries that had a postpartum visit on or between 7 and 84 calendar days after delivery.	64.48%	75.43%	59.10%	63.35%	64.65%	65.95%	67.26%
5 - Childhood Immunizations Status: Combination 3	% of member children 2 years of age	70.80%	69.83%	58.30%	68.01%	69.27%	70.53%	71.78%
6 - Antidepressant Medication Management: Continuous Phase	% members 18+ diagnosed with new major depression and received at least 180 days continuous treatment with antidepressant medication	37.35%	39.31%	32.80%	34.33%	34.76%	35.19%	35.61%
7 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation	% of adolescent and adult members with new episode of alcohol or other drug (AOD) dependence who received initiation of AOD treatment.	41.05%	42.79%	42.70%	43.34%	44.74%	46.14%	47.54%
8 - Follow-up After Hospitalization for Mental Illness: 30 Day	% of discharges for members 6+ who were hospitalized for mental illness	41.62%	40.22%	35.10%	48.42%	50.22%	52.02%	53.80%
9 - Folluw-up After Emergency Department Visit for Mental Illness: 30 Day	% of emergency department for members 6+ who had principal diagnosis of mental illness	56.27%	61.01%	45.60%	43.52%	45.01%	46.50%	48.00%
10 - Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	% of members 18-64 with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed antipyschotic medication and had a diabetes screening test	79.02%	79.51%	70.80%	80.63%	81.35%	82.07%	82.78%

Appendix G: Value-Based Purchasing Contractual Requirements

Aggregate VBP Targets			
Contract Year 1 (Jan 1 – Dec 31, 2019)	**Contract Year 2** (Jan 1 – Dec 31, 2020)	**Contract Year 3** (Jan 1 – Dec 31, 2021)	**Contract Year 4** (Jan 1 – Dec 31, 2022)
• Level 1: 8% • Level 2: 11% • Level 3: 5% • **Total: 24%**	• Level 1: 10% • Level 2: 13% • Level 3: 7% • **Total: 30%**	• Level 1: 11% • Level 2: 14% • Level 3: 8% • **Total: 33%** ***HSD reserves the right to modify the percentage in Year 3 increasing 5% from Contract Period 2.***	• Level 1: 12% • Level 2: 15% • Level 3: 9% • **Total: 36%** ***HSD reserves the right to modify the percentage in Year 4 increasing 5% from Contract Period 3.***
Modifications will be conveyed to the CONTRACTOR at least 60 days prior to the beginning of contract period three.			

VBP Level 1 – Minimum Requirements			
Level 1: Fee schedule based with bonus or incentives and/or withhold payable only when outcome/quality scores meet agreed-upon targets.			
Contract Year 1	**Contract Year 2**	**Contract Year 3**	**Contract Year 4**
8%	**10%**	**11%**	**12%**
• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities.	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed percentage achieved in prior year.***	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed percentage achieved in prior year.***	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long -Term Care Providers including nursing facilities. ***All included provider requirements must exceed percentage achieved in prior year.***

Appendix G: Value-Based Purchasing Contractual Requirements

VBP Level 2 – Minimum Requirements			
Level 2: Fee schedule based, upside-only shared savings-- available when outcome/quality scores meet agreed-upon targets (may include downside risk).			
Contract Year 1	**Contract Year 2**	**Contract Year 3**	**Contract Year 4**
11%	**13%**	**14%**	**15%**
• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Actively build readiness for Long-Term Care Providers including nursing facilities.	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Actively build readiness for Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional PH Providers with at least 2 small Providers • BH Providers (whose primary services are BH) • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH) • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***

VBP Level 3 – Minimum Requirements			
Level 3: Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or global or capitated payments with full risk.			
Contract Year 1	**Contract Year 2**	**Contract Year 3**	**Contract Year 4**
5%	**7%**	**8%**	**9%**
• Traditional PH Providers. • Implement a CONTRACTOR led BH provider level workgroup that works with BH Providers to design full risk model (see definitions).	• Traditional PH Providers. • Develop BH full-risk contracting model • Implement a CONTRACTOR led Long-Term Care Providers including nursing facilities provider level workgroup to design full-risk model (see definitions). ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional PH Providers. • BH Providers (whose primary services are BH). • Actively build Long-Term Care Providers including nursing facilities full-risk contracting model (see definitions). ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• 8% with traditional PH Provider. • 1% with Providers who are primarily BH. • Long-Term Care Providers including nursing facilities over prior year. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***

Appendix H: Health Outcomes for Health Home Enrollees: CLNM Health Outcomes

HEDIS TECHNICAL SPECIFICATIONS SUMMARY TABLE

CLNM MEMBER DATA AGGREGATED ACROSS MCOs FOR APRIL 1, 2017 TO MARCH 31, 2018
ALL MCO MEMBER DATA AGGREGATED ACROSS MCOs FOR CALENDAR YEAR 2017

MEASKEY	Measure Name	Sub Measure Name	Total Numerator (CLNM Members served)	Total Denominator (CLNM Members in Measure)	Total Numerator (All MCO Members Served)	Total Denominator (All MCO Members in Measure)	CLNM Rate	MCO CY17 Rate	NCQA/ Quality Compass Regional Averages
ADV18	Annual Dental	Total	130	173	179322	255194	75.14	70.27	69.57
AMM18	Antidepress Meds	Acute Phase	63	142	5983	12307	44.37	48.61	51.29
AMM18	Antidepress Meds	Continuation Phase	39	142	4083	12307	27.46	33.18	35.71
BCS18	Breast Cancer	--	75	115	12727	23006	65.22	55.32	52.11
CBP18	Control High BP **	Total	NA**	199	15286	30856	NA**	49.54	44.85
CCS18	Cervical Cancer	--	255	431	66201	125908	59.16	52.58	55.43
CDC18	Comp Diabetes	A1c Test	131	151	23282	27193	86.75	85.62	84.51
CDC18	Comp Diabetes	A1c>9 – lower is better	113	161	13186	27193	70.19	48.49	52.77
CDC18	Comp Diabetes	Eye Exam	80	161	14924	27193	49.69	54.88	52.09
FUH18	Follow-Up Hosp MH	30 Days	68	98	3684	5981	69.39	61.60	55.18
FUH18	Follow-Up Hosp MH	7 Days	56	98	2275	5981	57.14	38.04	31.00
IET18	Init Engage AOD	Egmt Total	200	347	10545	26523	57.64	39.76	12.81
IET18	Init Engage AOD	Init Total	139	347	3956	26523	40.06	14.92	42.84
MMA18	Med Mgmt Asthma	Total 5 to 64 50% Covered	14	23	3685	6579	60.87	56.01	N/A
MMA18	Med Mgmt Asthma	Total 5 to 64 75% Covered	10	23	2043	6579	43.48	31.05	29.10
SAA18	Adh Med Schizo	80% Coverage	51	80	1581	2912	63.75	54.29	53.22
SSD18	Diab Screen Schiz	Diab Screen	155	180	4898	6369	86.11	76.90	80.55
W3418	Well Child 3-6 Yr	--	10	17	35598	58437	58.82	60.92	71.94

** NA – requires medical record review

Source: HSD