HUMAN SERVICES DEPARTMENT

LEGISLATIVE FINANCE COMMITTEE

NICOLE COMEAUX, JD,MPH, NM MEDICAID DIRECTOR

DECEMBER 13, 2022

INVESTING FOR TOMORROW, DELIVERING TODAY.

BEFORE WE START…

On behalf of all colleagues at the Human Services Department, we humbly acknowledge we are on the unceded ancestral lands of the original peoples of the Apache, Diné and Pueblo past, present, and future.

With gratitude we pay our respects to the land, the people and the communities that contribute to what today is known as the State of New Mexico.

Evening drive through Corrales, NM in October 2021.
By HSD Employee, Marisa Vigil

HUMAN SERVICES DEPARTMENT

MISSION

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

GOALS

We help NEW MEXICANS

1. Improve the value and range of services we provide to ensure that every qualified New Mexican receives timely and accurate benefits.

We communicate EFFECTIVELY

2. Create effective, transparent communication to enhance the public trust.

We make access EASIER

3. Successfully implement technology to give customers and staff the best and most convenient access to services and information.

We support EACH OTHER

4. Promote an environment of mutual respect, trust and open communication to grow and reach our professional goals.

STRUCTURE

1. Background
   - Medicaid enrollment, population health care needs, expenditures, utilization, provider network
2. Access to Timely Healthcare
   - Appointment times, provider directories, contract terms for network adequacy
3. MCO Oversight
   - Rewards program, creating network, OSI participation
4. Provider Payment Rates
   - Transparent rate setting, rate increases could improve access, directed payments
5. Provider Recruitment and Retention
   - Provider types, licensure, MCO effort, graduate medical education

EVALUATION RECOMMENDATIONS

- General agreement and alignment
- Statewide provider shortage
- Important interventions that Medicaid can make that will help, such as provider rate increases
- The ”fix” that is needed to improve access to healthcare in New Mexico should be squarely centered in broad public policy and legislative action.

Recommendations	
Concur	13
Concur with Condition	12
Disagree	3
Total Count	**28**

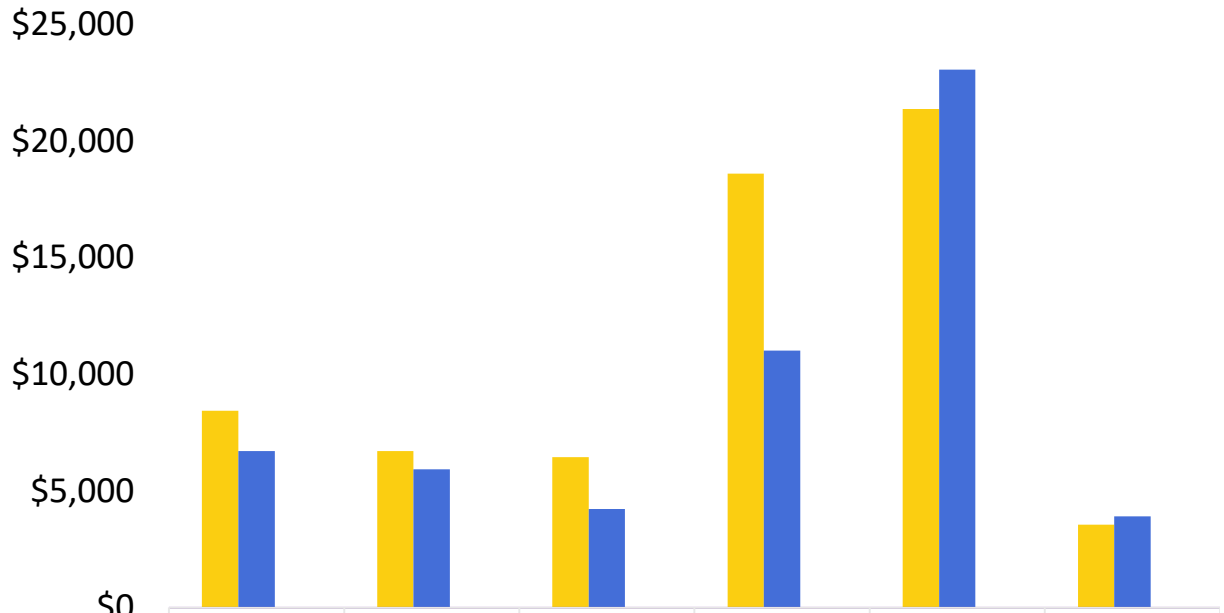
NEW MEXICO MEDICAID: TURQUOISE CARE

- **9/6 New 5-year 1115 Waiver with 16 new program initiatives**
- **9/30 New Medicaid Managed Care Contract and Request for Proposals to be released.**
- **8/5 Completed and published Comprehensive Provider Rate Benchmarking; Strategic Plan - complete 12/30.**
- Drafted complete Medicaid billing manual - complete 12/2022.
- Federal approval for reimbursement for services for all Medicaid children in schools (benefitting 386,023 school-age children).
- Distributed COVID-19 rate adjustments from FY22 $174 M appropriation ($26 M SGF).
- Completed $130 M in economic recovery payments to Home and Community-based Service providers.
- Continued elimination of Developmentally Disabled Waiver Waitlist in partnership with DOH.

ARE WE SPENDING TOO MUCH ON MEDICAID?

New Mexico ranks 48th out of 54 states and territories in total Medicaid expenditures per recipient at $6,712 per year, averaged across all programs.

Annual Per Capita Medicaid Expenditures: NM Relative to US Median and Minimum



	Total	Adult: ACA Medicaid expansion	Adult: non-expansion, non-disabled, under age 65	Aged	People with disabilities	Children
US Median	$8,436	$6,709	$6,451	$18,610	$21,372	$3,556
New Mexico	$6,712	$5,931	$4,227	$11,021	$23,066	$3,921
NM % Above/Below Median	-20.4%	-11.6%	-34.5%	-40.8%	7.9%	10.3%
Per Capita Spending National Ranking	48th	10th	47th	46th	24th	22nd

The content of these slides, specifically references to the end of the Public Health Emergency, 6.2% FMAP, and Maintenance of effort requirements and timelines, is subject to change as a result of evolving federal guidance, experience, new information, changes in process requirements, and the availability of resources.

HOW A MEDICAID DOLLAR IS SPENT: MORE THAN 90% INVESTED DIRECTLY IN PATIENT CARE

Other Svcs: (BH, Dental, Clinic, Med Supplies, FQHC, Lab & Xray, Transp., Other, Subcap svc)

FACTORS CONTRIBUTING TO INCREASED MEDICAID MANAGED CARE SPENDING 2019 TO 2022

Factor	Cost Increase $(000s)	Cost Share	Comment
Legislative changes and special appropriations		63%	$127 estimated PMPM change. Over the period 2019 to 2022
Legislative Provider Network Investment: enhanced rates and reimbursements	**$287,408**	13%	$37.63 estimated PMPM change for HCQS (NF, ICF/IID); permanent hospital (201-205) rate increases (for profit, gov't, not for profit, trauma hospital, Native American), minimum wage increases, E&M to 90% of Medicare, dental, behavioral health and benefit changes, temporary COVID-19 provider rates (hospitals, NFs, NEMT, FQHC)
Legislative member related investment: population health care cost increase (demographic trending)	$344,844	16%	$45.15 estimated PMPM change for demographic trend adjustments.
Legislative directed payments	**$353,661**	16%	9% growth; Includes Directed Payments to providers & hospitals, IHS, other.
Legislative investment: Health Insurance Premium Surtax	$149,241	7%	$19.54 estimated PMPM change, from SB317.
Other non-medical expenses	$188,499	9%	$24.68 estimated PMPM change for all other non-medical expenses.
Membership growth in managed care	$893,841	39%	18% growth; 130,200 new members since 2019.
Total Changes	**$2,217,497**	**100%**	

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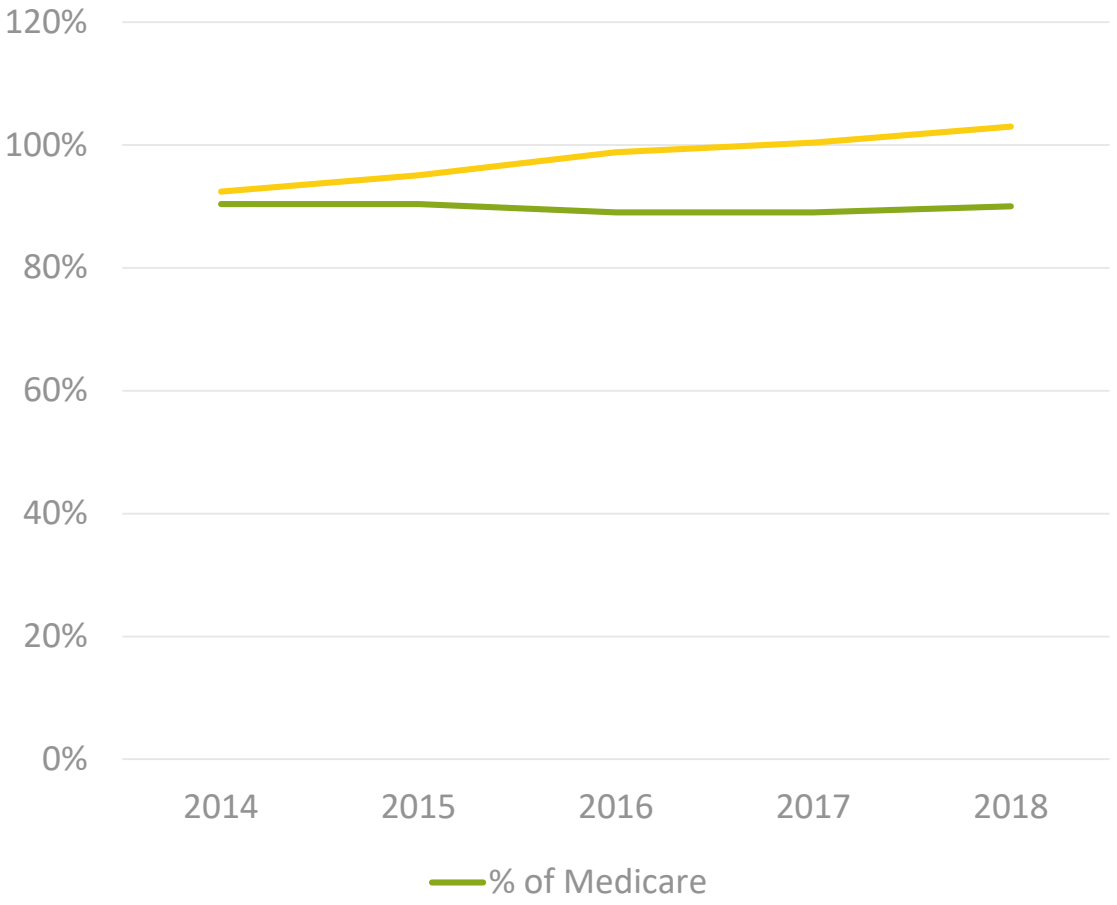
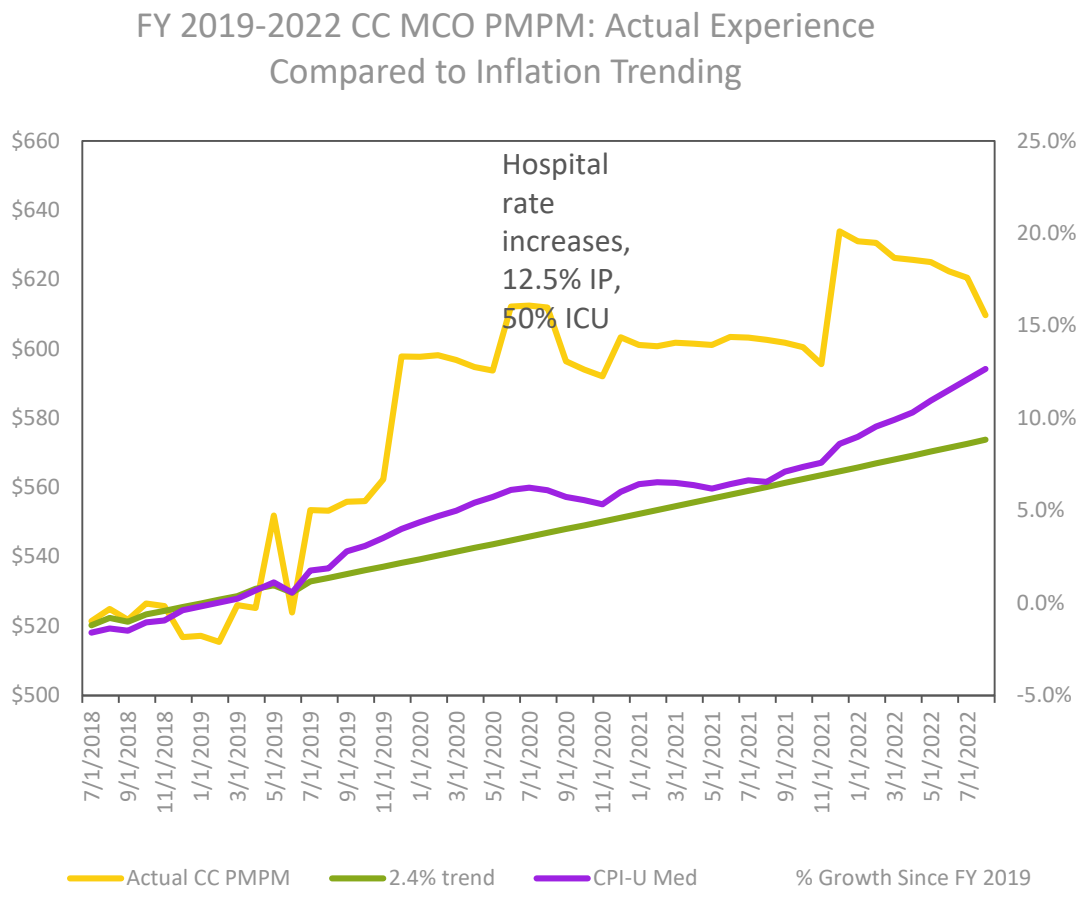
MAINTAINING PROVIDER NETWORK: HISTORIC MEDICAID PROVIDER RATES VS. CPI (MEDICAL) INFLATED RATES

SOURCES: HTTPS://WWW.KFF.ORG/MEDICAID/STATE-INDICATOR/MEDICAID-TO-MEDICARE-FEE-INDEX/?CURRENTTIMEFRAME=0&SORTMODEL=%7B%22COLID%22:%22LOCATION%22,%22SORT%22:%22ASC%22%7D , HTTPS://WWW.BLS.GOV/CHARTS/CONSUMER-PRICE-INDEX/CONSUMER-PRICE-INDEX-BY-CATEGORY-LINE-CHART.HTM



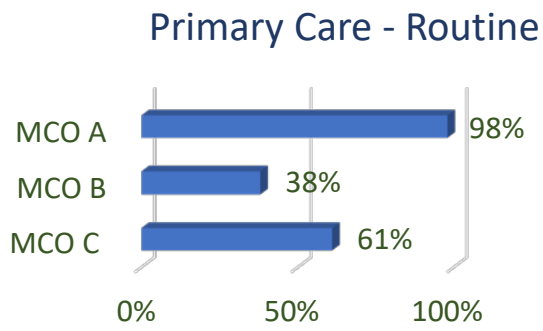


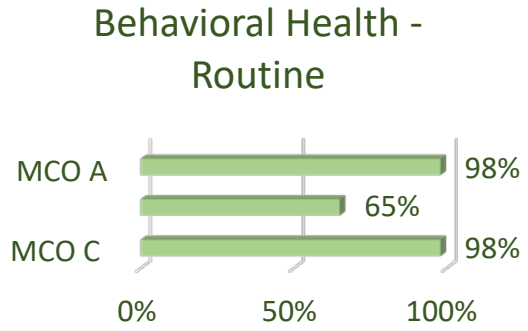
HUMAN SERVICES DEPARTMENT

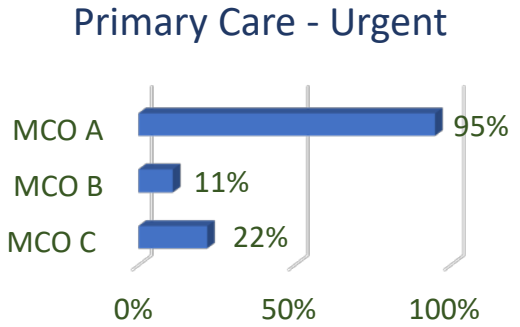
Investing for tomorrow, delivering today.

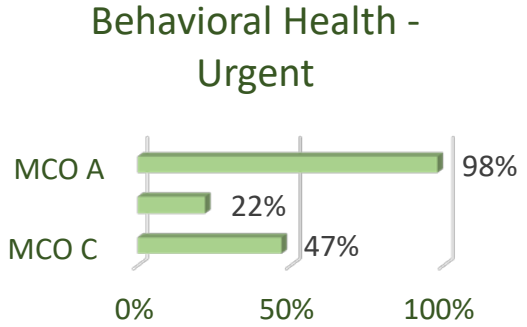
ACCESS: TIMELY HEALTHCARE

- New Turquoise Care Contract
  - 90% Medical Loss Ratio (MLR) aimed at improving quality of care
  - Expanded MCO reporting and monetary penalties for non-compliance
  - Minimum reimbursement rate for contract providers at or above the state plan approved fee schedule
  - More stringent provider network requirements
  - A single centralized vendor to process applications
  - Enhanced MCO staffing requirements, including qualifications, staffing levels, and training
  - Focus on social determinants of health
- Additional state efforts
  - Independent external quarterly secret shopper
  - Medicaid management Information System will have system implementation to create a single provider directory that MCO systems are connected to and batch into nightly



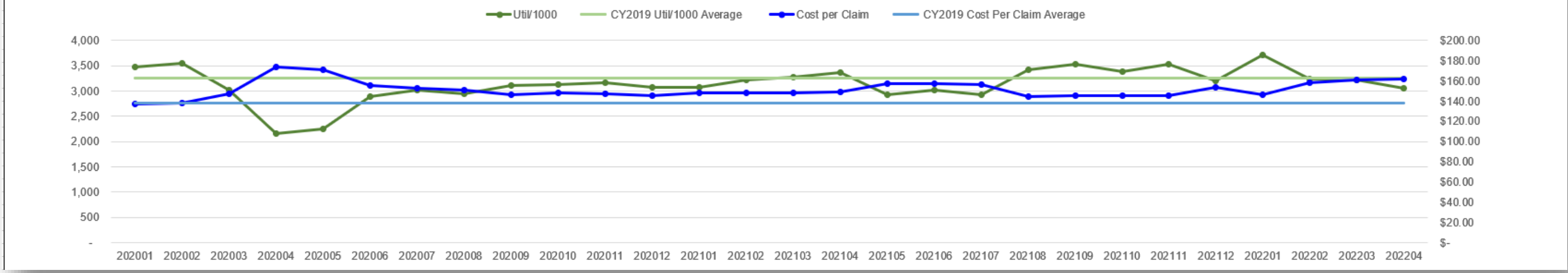






ACCESS: MEDICAID UTILIZATION

Service:	Cost per Claim and Util/1000 (Actuals) Adjusted for Days																												
All Other	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112	202201	202202	202203	202204	CY2019 Avg
Actual MMs	677,782	678,108	679,863	691,731	701,484	708,412	715,889	723,439	729,096	734,765	741,561	748,741	753,187	757,132	761,191	764,982	767,919	771,195	775,274	779,845	783,300	786,918	790,046	792,900	796,504	799,138	800,551	803,299	**668,499**
Cost per Claim	$ 137.19	$ 138.62	$ 147.71	$ 173.48	$ 170.93	$ 155.49	$ 152.97	$ 150.69	$ 146.82	$ 148.31	$ 147.63	$ 145.98	$ 148.13	$ 148.34	$ 148.14	$ 148.89	$ 157.42	$ 157.18	$ 156.34	$ 145.02	$ 145.47	$ 145.36	$ 145.54	$ 153.84	$ 146.04	$ 158.67	$ 161.35	$ 161.62	**$ 138.11**
Util/1000	3,479	3,552	3,017	2,166	2,259	2,884	3,020	2,938	3,119	3,125	3,163	3,076	3,074	3,221	3,279	3,361	2,932	3,028	2,935	3,430	3,537	3,395	3,525	3,209	3,710	3,236	3,219	3,052	**3,254**



- Ensuring access top priority
- Understanding the “right” level of utilization
- Focus on performance measures and member outcomes
  - Waiver – population health waiver to drive changes not through traditional fee for-service utilization but also through investing in new opportunities with Federal partners to reimburse for health related social determinants (e.g. housing, housing supports, food)

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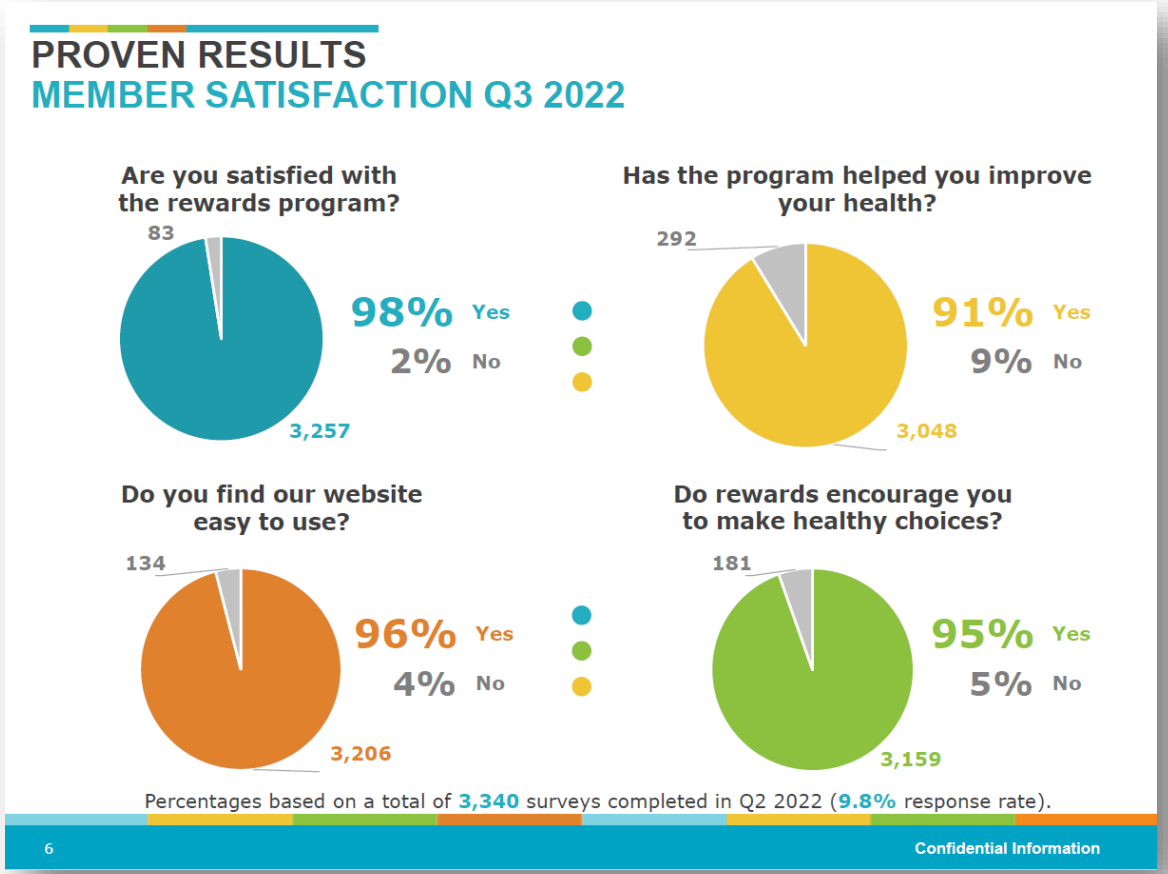
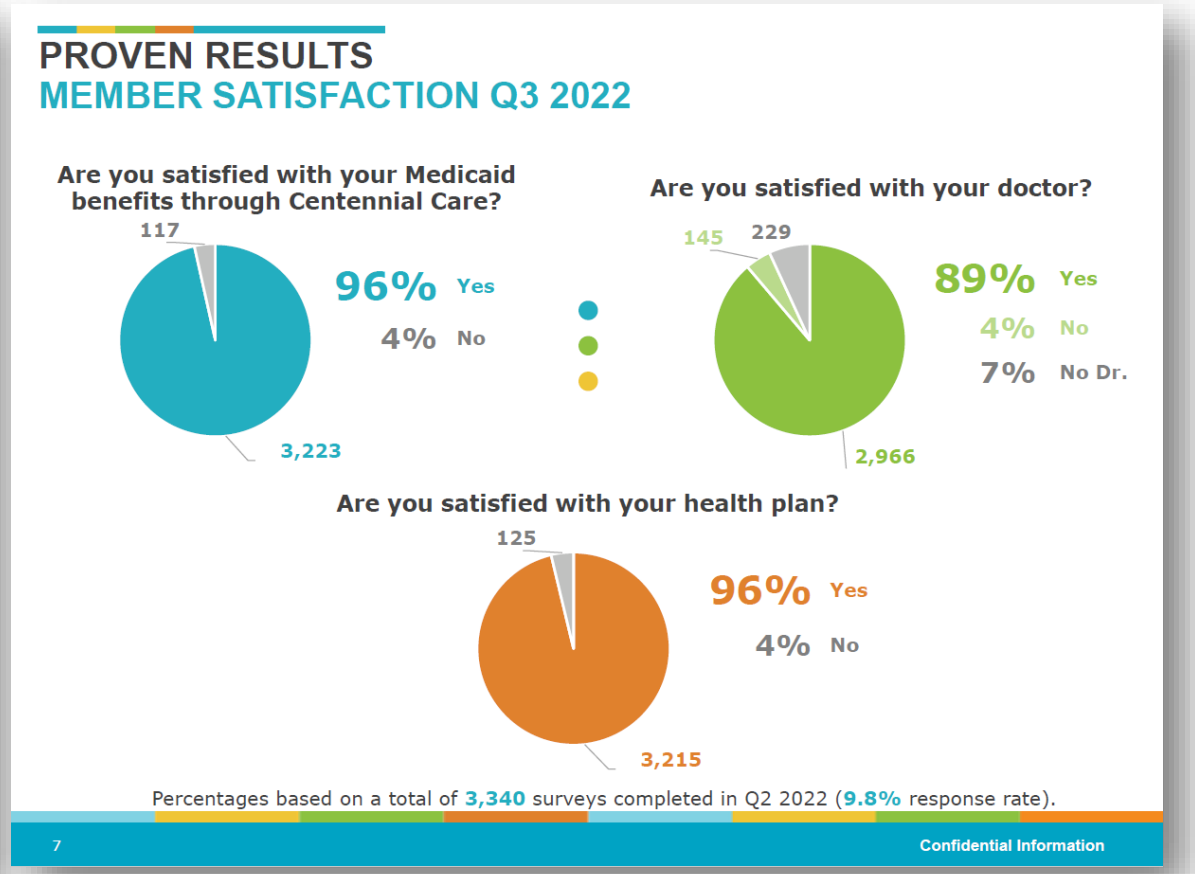
ACCESS: MEDICAID MEMBER SATISFACTION





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MEDICAID MCO ACCOUNTABILITY

- MCOs continually meet contractual network adequacy requirements
- New, more stringent requirements in Turquoise Care
- Cannot hold MCOs accountable for contracting where there simply are not providers

Table 1: CY 2021 Medicaid Network Standards

HSD Access and Distance Standards
Access Requirements
▪ Member caseload, or panel, of any PCP should not exceed 2,000
▪ Members have adequate access to specialty providers
▪ The MCO shall increase the number of unique members with a telemedicine visit by 20% annually, in rural, frontier, and urban areas for physical health specialists and behavioral health specialists[1]
Distance Requirements for PCPs and Pharmacies
▪ 90% of urban members shall travel no farther than 30 miles
▪ 90% of rural members shall travel no farther than 45 miles
▪ 90% of frontier members shall travel no farther than 60 miles
Distance Requirements for Behavioral Health Providers, Specialty Providers, LTC Providers, Hospitals and Transportation Providers
▪ 90% of urban members shall travel no farther than 30 miles
▪ 90% of rural members shall travel no farther than 60 miles[2]
▪ 90% of frontier members shall travel no farther than 60 miles[2]
Timeliness Requirements
▪ No more than 30 calendar days for routine, asymptomatic, member-initiated, outpatient appointments for primary medical care
▪ No more than 60 calendar days for routine, asymptomatic member-initiated dental appointments
▪ No more than 14 calendar days for routine, symptomatic member-initiated, outpatient appointments for nonurgent primary medical care, behavioral health, and dental care
▪ Within 24 hours primary medical, behavioral health, and dental care outpatient appointments for urgent conditions
▪ Consistent with clinical urgency but no more than 21 calendar days for specialty outpatient referral and consultation appointments, excluding behavioral health
▪ Consistent with clinical urgency but no more than 14 calendar days for routine outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments
▪ Consistent with the severity of the clinical need, walk-in rather than an appointment, for outpatient diagnostic laboratory, diagnostic imaging, and other testing
▪ Consistent with clinical urgency, but no longer than 48 hours for urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing
▪ No longer than 40 minutes for the in-person prescription fill time (ready for pickup)
▪ No longer than 90 minutes for the "called in by a practitioner" prescription fill time (ready for pickup)
▪ Consistent with clinical needs for scheduled follow-up outpatient visits with practitioners
▪ Within 2 hours for face-to-face behavioral health crisis services

[1] If the MCO achieves a minimum of 5% of total membership with telemedicine visits, as of November 30th each year, then the MCO must maintain that same 5% percentage at the end of each calendar year to meet this target.

[2] Unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HSD.

HUMAN SERVICES DEPARTMENT

MCO ACCOUNTABILITY: REWARDS PROGRAM

DRIVES TOWARD OUTCOMES RATHER THAN UTILIZATION

ACTIVITY COMPLETION BY QUARTER
Q3 2021 – Q3 2022

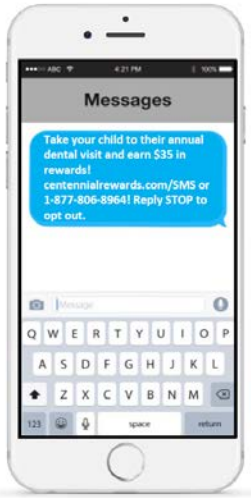
Activity	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022
Adult PCP Visit	17,684	13,087	21,165	17,667	16,848
Antidepressant	N/A	N/A	61,538	64,643	70,753
Child & Adol. PCP Visit	N/A	N/A	8,024	45,689	43,224
COVID-19 Vaccine	9,436	7,621	10,463	7,477	6,340
Dental	41,108	54,501	62,808	64,435	42,472
Diabetes	16,323	11,304	18,607	15,228	9,454
Flu Shot	4,008	12,044	7,193	3,078	2,762
Follow-up for BH	N/A	N/A	674	50	70
Prenatal Care Visit	3,646	3,113	3,576	3,532	3,197
Postpartum Visit	401	753	5,196	8,701	2,584
Schizophrenia	9,704	6,672	10,040	9,727	10,308
Well-Baby Checkups	28,504	24,650	26,937	24,391	27,122

Antidepressant Rx adherence and Well-baby visits increased the most since Q2 2022.

INCENTIVIZES HEALTH BEHAVIOR CHANGES

MULTIMEDIA CAMPAIGNS
RESULTS & ANALYSIS

- ✓ **Well-Baby Campaign**
  - **217K** texts sent Apr. '21-Aug. '22
  - **42K** emails sent Apr. '21-Aug. '22
  - **35.41%** of members engaged completed a visit within 60-days*
- ✓ **Child Dental Campaign**
  - **154K** texts sent in Jul. '21-Jul '22
  - **139K** emails sent in Jul. '21-Jul '22
  - **25.07%** of members engaged completed a visit within 60-days*



*Statistically significant (p value <0.001); Claims through August 2022.

MEMBER SATISFACTION HIGH; UNTAPPED POTENTIAL (TSROC)

CENTENNIAL REWARDS
MEMBER TESTIMONIALS

Help for Low Income Members

"You have been great and very helpful. A lot of these things I wouldn't be able to buy myself. All my life I wanted an electric toothbrush, but I couldn't afford it. It makes me feel so good that I have this program."

Great Rewards

"I appreciate what I get. I have used everything that I've ordered. The biggest win was the exercise bands. I'm so grateful that there is this program."

Friendly Reminder

"This is a very good program. It motivates people, and you get goodies! It helps me remember to do things like doctors visits."

PROVIDER PAYMENT RATES

- Medicaid payments are still 20% below Medicare fee schedule rates

Table 1. Overview of New Mexico Benchmarking Results by Service Area ($ in Millions)

		CY2019			CY2021	
Phase 1 Service Area	**Service Subgroups**	**Total Medicaid Expenditures[2]**	**Count of Members[3]**	**Managed Care Percent of FFSE[4]**	**NM FFS Percent of Medicare**	**NM FFS Percent of State Benchmarks[5]**
ALL	**ALL**	**$2,107.6**	**673,684**	**103%**	**88%**	**91% to 124%**
HCBS	1115 Waiver Community Benefit	$432.6	67,331	124%	88%	90% to 145%
	State Plan Case Management	$13.0	30,756	169%	89%	85% to 158%
	1915(c) Waiver Services[6]	$403.1	5,036	N/A[6]	N/A[3]	N/A[6]
Physician & Other Practitioners	Evaluation & Management	$213.4	476,601	101%	82%	106% to 149%
	Surgery	$80.5	159,582	107%	89%	85% to 149%
	Radiology/Laboratory/Pathology	$69.7	351,403	100%	94%	88% to 120%
	Medicine	$64.0	287,118	100%	86%	79% to 139%
	Anesthesia	$14.0	46,641	30%[5]	86%	57% to 114%
HCPCS Level II	Other HCPCS Level II	$105.5	142,007	97%	82%	73% to 113%
	Non-Emergent Medical Transportation (NEMT)	$49.8	33,685	226%	N/A	46% to 159%
	Emergent Medical Transportation (EMT)	$42.7	39,116	106%	70%	77% to 172%
	Physician Administered Drugs	$41.8	47,533	101%	100%	97% to 103%
	Durable Medical Equipment	$22.8	29,993	117%	96%	72% to 114%
Maternal & Child Health	Maternity-Related	$46.6	25,157	87%	93%	80% to 139%
	Child Health & Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	$37.3	166,497	99%	112%	109% to 154%
	Newborn-Related Care	$18.5	15,741	104%	95%	101% to 140%
	Family Planning	$12.5	33,473	95%	104%	113% to 134%
Behavioral Health	General Behavioral Health	$138.0	100,380	100%	97%	101% to 152%
	Opioid Treatment Program	$25.5	7,628	99%	N/A	105% to 392%
	Applied Behavioral Analysis	$19.6	1,140	98%	N/A	73% to 172%
Dental	Diagnostic/Preventive/Other	$116.3	302,982	96%	N/A	79% to 109%
	Orthodontics	$13.3	11,787	94%	N/A	90% to 166%
FQHC/RHC	Federally Qualified Health Centers	$116.2	136,975	99%	N/A[6]	N/A[6]
	Rural Health Clinics	$11.0	20,286	107%	N/A[6]	N/A[6]

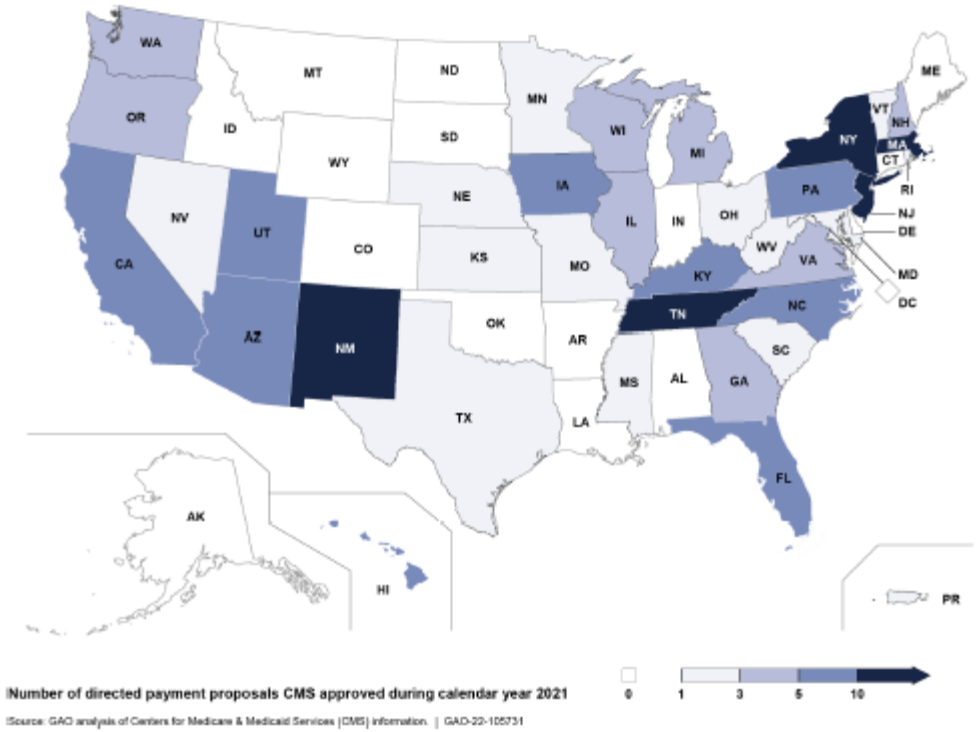
PROVIDER PAYMENT: MCO OVERSIGHT/COST CONTROL

Cost Control Tool	Mechanism	Dollar/percent impact
1. Risk Arrangement	• Single sided risk arrangement with profit capped at 3% (50% share after that)	• $180M cap
2. Medical Loss Ratio (MLR)	• 2019 – set at 86% of dollars expended must go to medical costs; no more than 14% to administrative expenditures • 2021 – amended contract to require 88% must go to medical costs; no more than 12% to admin	• 2019 - $5.16B to medical expense • 2021 - $5.28B to medical expense
3. Performance Measures & Delivery System Improvement Targets	• More capitation dollars at risk (3.5%) than they can gain in profit (3%)	• $210M at risk
4. Rate Adjustments	• "2020 MCO windfall" – required MCOs to cover cost of temporary COVID rate increases without adjusting their rates • 2021/22 – added .5% downward adjustment to rates due to MOE population decreases utilization and acuity • 2022 – exercised 1.5% rate reduction regulatory option considering continued PHE population and utilization trends	• 2020 - $123M MCO payment reduction • 2021/22 – $60M reduction over two years • 2022 - $93M payment reduction
5. Value-Based Purchasing Requirements	• Contract requires MCOs to have progressive number of provider contracts in VBP arrangements with risk structures that drive quality and outcomes, not volume	• All MCOs met target and have 36% of contracts in VBP arrangements
6. Risk Adjustment Methodology	• Changed the risk adjustment methodology (to CDPS+Rx) in 2021 to ensure more accurate payment by member type • Added a high-risk member pool to reduce potential for adverse member selection	• Realigned $23 million between MCOs • Realigned $4 million between MCOs

PROVIDER PAYMENT RATES: DIRECTED PAYMENTS

- CMS required that directed payments:
  - Be tied to utilization and delivery of services under the managed care contract,
  - be distributed equally to specified providers under the managed care contract,
  - advance at least one goal in the state's managed care quality strategy, and
  - not be conditioned on provider participation in intergovernmental transfer (IGT) agreements (42

Figure 3: State Directed Payments Approved in 2021



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-22-105731

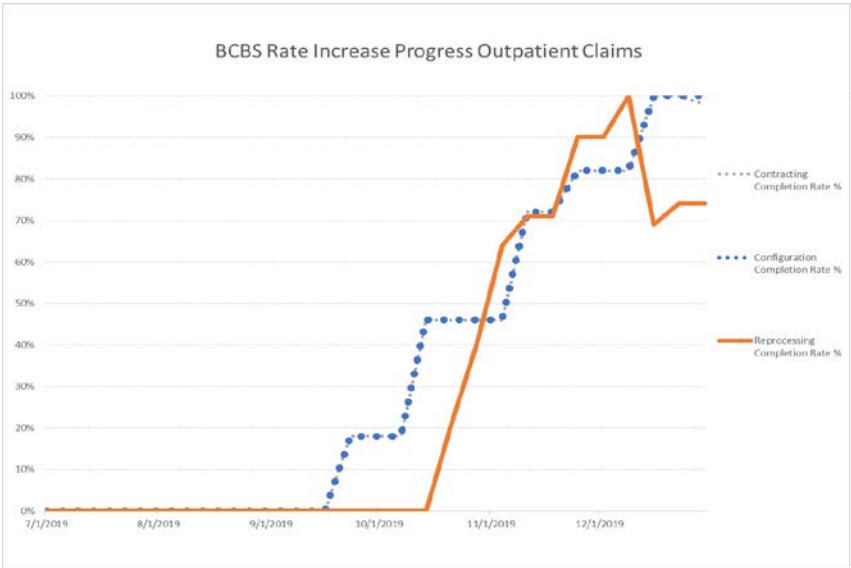
Note: Medicaid managed care contract rating periods differ across states and may not correspond with the year in which the state directed payment proposal was approved.

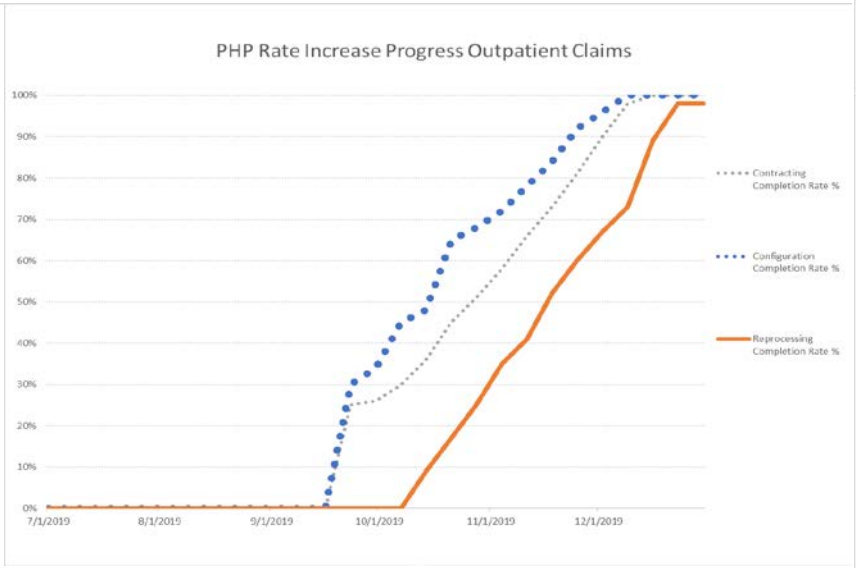
Table 4: Summary of New Mexico State Directed Payment Impacts by Service Area ($ in Millions)[6]

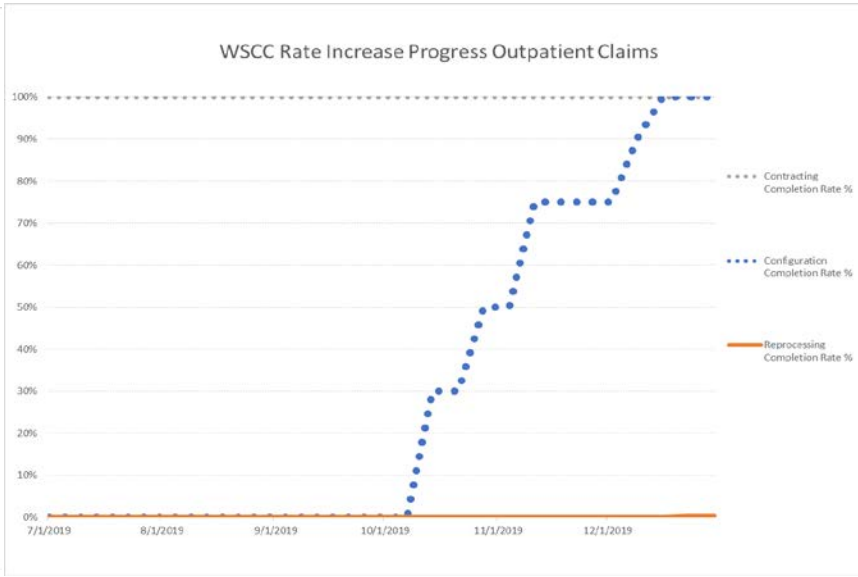
	CY 2019[7]	CY 2022
Service Area	**Estimated Increase to Managed Care Expenditures**	**Estimated Magnitude ($M)**
Inpatient Hospital	14%	$195.7
Outpatient Hospital	22%	$189.5
Nursing Facility and Hospice	46%	$168.9
Residential Treatment Centers	0%	$0
Other Institutional	0%	$0

MEDICAID PROVIDER RATE INCREASES 2019

- Rate increases take 3-6 months to implement depending on complexity of contacts (providers = simple, hospitals = complex)
- All July 1 increases now fully implemented
- MCOs may need to recontract, configure system, then repay claims
- It will take 3-6 months to implement 10/1 and 1/1/2020 increases







HSD GOAL 2 – CREATE EFFECTIVE TRANSPARENT COMMUNICATION TO ENHANCE THE PUBLIC TRUST

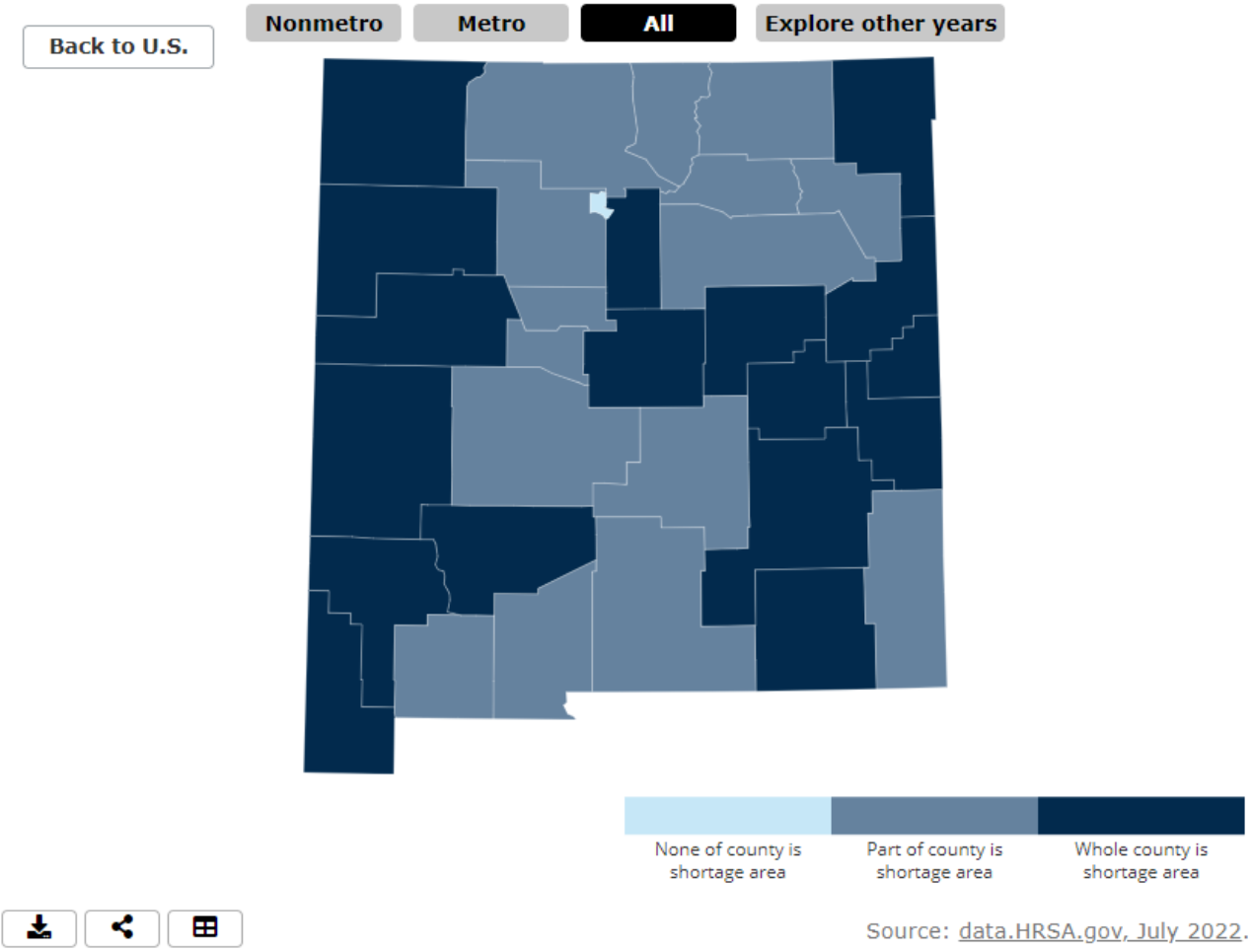
- Quarterly Dashboards of Managed Care fee and benefit changes, current period enrollment and total managed care costs: https://www.hsd.state.nm.us/about_the_department/meetings/
- CMS Quarterly and Annual Monitoring Reports: https://www.hsd.state.nm.us/public-information-and-communications/centennial-care/reports/
- Medicaid Eligibility Reports: https://www.hsd.state.nm.us/medicaid-eligibility-reports/
- MCO Letters of Direction: https://www.hsd.state.nm.us/lookingforinformation/centennial-care-letters-of-direction/
- Consumer Assessment of Health Plans: https://www.hsd.state.nm.us/lookingforinformation/cahps-reports/
- External Quality Review Organization Reports: https://www.hsd.state.nm.us/external-quality-review-organization-eqro-reports/
- Healthcare Effectiveness Data and Information Sets: https://www.hsd.state.nm.us/healthcare-effectiveness-data-and-information-set-hedis-reports/
- MCO MLR Reports https://www.hsd.state.nm.us/lookingforinformation/mco-reviews-audits/

HSD provides the following to LFC:

Quarterly	
MCO Financial Reports (cost and utilization)	MCO Geo Access Reports
MCO Network Adequacy Reports	MCO Program Integrity Reports
MCO Care Coordination Reports	MCO Value Based Purchasing Reports
MCO Pharmaceutical Reports	
Annually	
MCO Financial Reports (administrative costs and revenue and expenditures)	MCO Sanctions, Recoupments and Penalties
MCO Annual MLR Calculations	MCO Provider Satisfaction Surveys
Behavioral Health Satisfaction Surveys	Actuary Rate Certification Reports

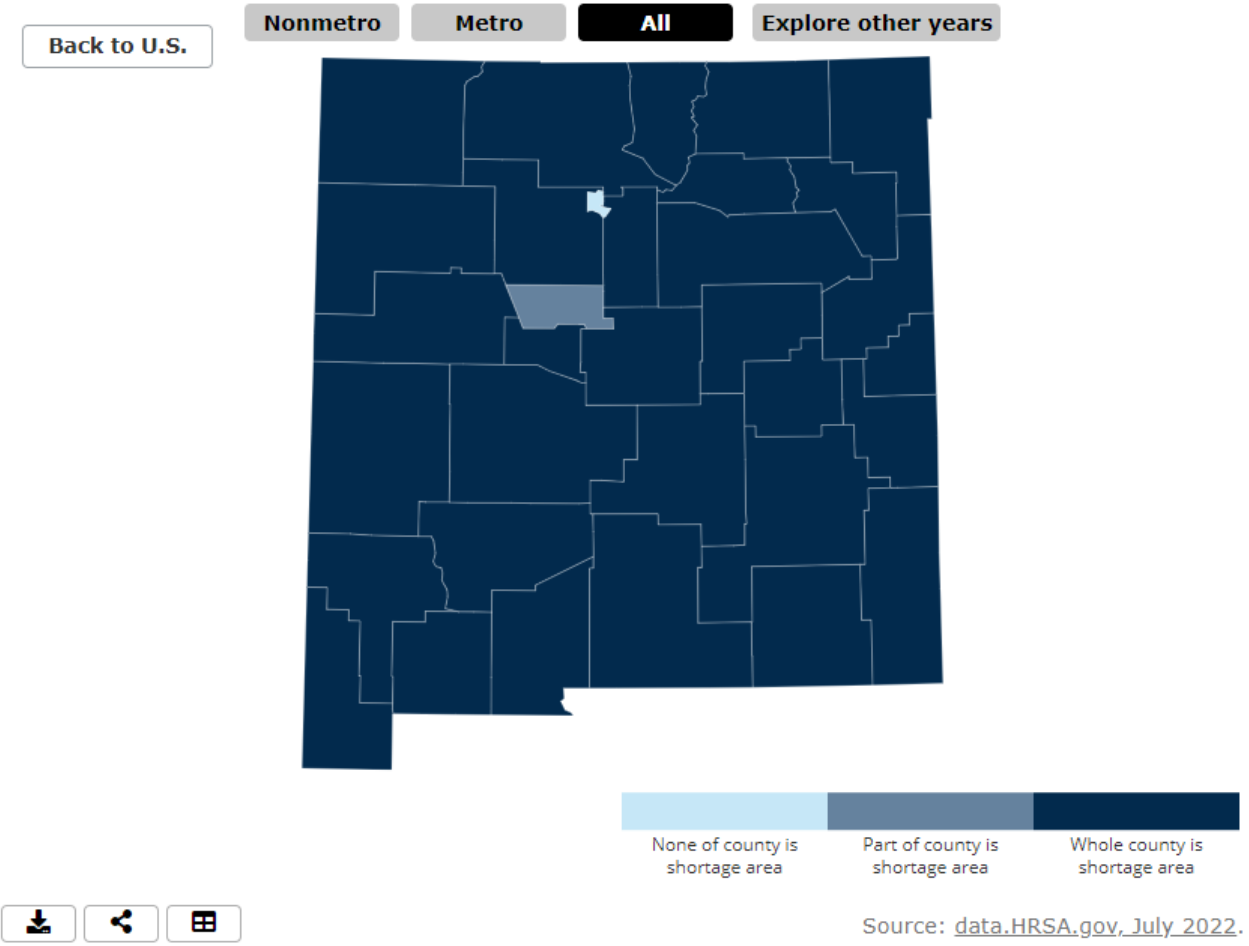
PROVIDER RECRUITMENT AND RETENTION STRATEGIES

Health Professional Shortage Areas: Primary Care, by County, 2022 - New Mexico



Source: data.HRSA.gov, July 2022.

Health Professional Shortage Areas: Mental Health, by County, 2022 - New Mexico



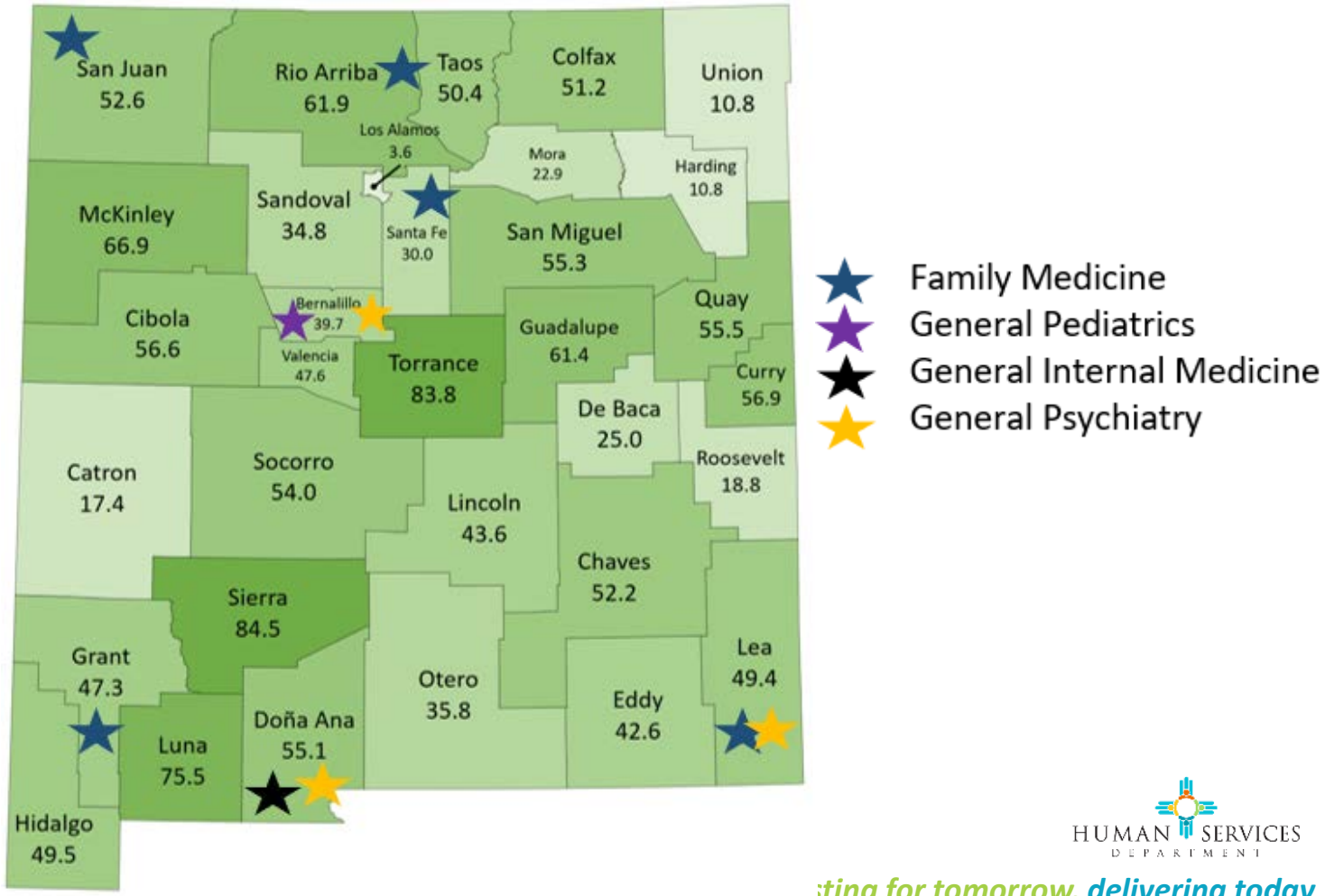
Source: data.HRSA.gov, July 2022.

The content of these slides, specifically references to the end of the Public Health Emergency, 6.2% FMAP, and Maintenance of effort requirements and timelines, is subject to change as a result of evolving federal guidance, experience, new information, changes in process requirements, and the availability of resources.

2023 PRIMARY CARE RESIDENCY EXPANSION UPDATE

- Over a 5-year period, starting in 2019, HSD expects primary care residencies to grow, from 8 to 16 (100% increase).
  - Number of primary care residents in training will increase from 142 to 264 (86% increase) during this 5-year period.
  - Number of graduates each year will grow from 48 to 82, a 71% increase.

PC Residencies Under Development as of 11/2022 & County Residents Enrolled in Medicaid as of 11/2021 (%)



NEW WAIVER WORKFORCE PROPOSALS

Pipeline/ Training	Behavioral Health Workforce Development Program	Preceptorship rate development
	Community-based Training and Recruitment:	Family Medicine and NP Residency Training
		CMHC Behavioral Health Recruitment Fund
	Workforce Development Grant Program:	CHW Supervisors Training Program Grant
		CHW Training Capacity Expansion Grants
		Recovery Coach Supervisor Training Incentive Fund
		Peer Specialist Training Capacity Expansion Grant
Recruitment/ Retention	Student Loan Repayment Program:	Site based: site payment
		Individual based: lender Payment
	Primary Care/Behavioral Health Special Projects Program	
	Rural Obstetric Hub and Spoke Pilot Expansion	

HUMAN SERVICES DEPARTMENT

QUESTIONS?

INVESTING FOR TOMORROW, DELIVERING TODAY.