NEW MEXICO
HUMAN SERVICES DEPARTMENT

Medicaid Management Information System Replacement (MMISR) Project

PROPOSAL ADDENDUM 9 (Nine)

ADDENDUM TITLE: MMIS Activity Data

Created/Updated: January 31, 2018
Version: 1.2

Revision History

Date	Version # & Reason for Revision	Requester	Editor/Author
05/12/2016	1.1– Formatting consistency across documents	n/a	Sherri Poindexter
1/31/2018	1.2 – Updating description and Numbers, Unify Formatting		Chris Pruett Shaun Meeks

Data Estimates

The data below represent the known counts with a brief description for each of the current processes identified, as of February, 2018, to assist in determining the resource capacity that may be needed for the infrastructure. These are subject to change over the course of the procurement process.

Providers Enrolled:

Providers are enrolled as Fee for Service (FFS) providers or as Managed Care-Only providers. There are currently 66,614 active Providers enrolled in the MMIS. If a Provider is approved to serve FFS Members, that provider is automatically approved as well to serve MCO Members. Managed Care-Only providers don't wish to serve the FFS members and thus are restricted to affiliation with the Managed Care Organizations. The goal of the new MMIS is to have a single enrollment process with no need for providers to affiliate with one or more MCO.

	Currently Active Providers
FFS Enrolled Provider	27,960
MCO Enrolled Provider	38,654
Total Enrolled (FFS + MCO)	66,614

New Provider Applications:

Month	Received
July 2017	759
August 2017	759
September 2017	744
October 2017	725
November 2017	621
December 2017	530

Provider Maintenance:

Once a provider is enrolled there are other activities which may occur. Providers may choose to make changes (updates) to their record at any time.

Provider File Updates

Month	Received
July 2017	4117
August 2017	2450
September 2017	2557
October 2017	3168
November 2017	1942
December 2017	3044

Some providers are required to recertify their enrollment every three years; this process utilizes Turnaround Documents (TADS) which when returned by the provider are used to update the

provider record. Providers who don't return TADs result in termination of the provider's enrollment and usually a considerable amount of effort and claim adjustments.

Turn Around Documents (TADS)

Month	Received
July 2017	709
August 2017	489
September 2017	325
October 2017	230
November 2017	298
December 2017	261

Provider Interface for State Level Registry

New Mexico uses a web-based State Attestation and Tracking System; a State Level Registry (SLR). This system allows New Mexico to interact with the National Level Registry (NLR), providers and other State systems. The State Level Registry (SLR) authenticates and authorizes payments to providers who qualify for the incentive payments. Attestations for the prior year are only allowed during a 3-month period after the end of the year due to constant changes by CMS. Approximately 800-1,000 attestations are received during this period. State Staff check the Provider's attestation to ensure it is properly completed and all information is valid. Once all Verification Items are "passed" and approved by the State in Xerox Dashboard, the attestation is submitted to CMS for a Duplicate Payment Check (D16 interface with CMS). If CMS approves the D16, then the State is permitted to pay the Provider.

EHR Payments

Month	# of Payments
7/1/2017	166
8/1/2017	156
9/1/2017	160
10/1/2017	29
11/1/2017	11
12/1/2017	35

MAD 200 – Medical Credit Adjustment

The Provider Relations team manually enters the MAD 200 Form for the Long-Term Care Medical Care Credit adjustment, which is then processed for payment through the MCOs.

Medical Care Credit (LTC) Adjustment Forms

Month	Received
January 2017	27
February 2017	31
March 2017	28
April 2017	64
May 2017	40
June 2017	6
July 2017	5
August 2017	18
September 2017	12
October 2017	14

Month	Received
November 2017	4
December 2017	6

Claims Processing Counts:

FFS Claims

New Mexico receives FFS claims electronically for all but about 5% of the total FFS claims volume. FFS claims come in via 837 electronic format from providers and clearinghouses, from the COBA contractor, entered into New Mexico's Web Portal, or via the NCPDP point of sale access. In addition, New Mexico system generates adjustments and voids of claims based on audit activity. FFS claims are adjudicated nightly, but go through claims payment weekly.

Type of Claim	Jul'17	Aug'17	Sep'17	Oct'17	Nov'17	Dec'17	Grand Total
Elec Media	115,116	133,881	182,086	167,014	168,287	158,754	925,138
Elec Crossover	102,701	129,829	106,259	67,983	65,829	58,645	531,246
Exam Entry	20,289	23,727	18,657	19,377	18,220	17,233	117,503
PDCS	75,322	88,073	80,479	82,227	81,413	77,053	484,567
System Generated	4,007	2,685	693	2,651	3,658	1,688	15,382
Web Portal	29,193	34,760	33,999	32,494	33,743	30,942	195,131
Grand Total	**346,628**	**412,955**	**422,173**	**371,746**	**371,150**	**344,315**	**2,268,967**

Capitations

New Mexico generates capitation claims based on the monthly enrollment cycle. In addition, capitation claims may be adjusted or voided by the system based on audit activity.

Claim Type	Month	# Cap Claims
CAPS	7/1/2017	700,286
CAPS	8/1/2017	688,952
CAPS	9/1/2017	680,012
CAPS	10/1/2017	676,993
CAPS	11/1/2017	676,192
CAPS	12/1/2017	675,613
TOTAL		**4,098,048**

Encounters

New Mexico receives encounters from its Managed Care Organizations electronically either via 837 format or NCPDP. In addition, New Mexico system generates adjustments and voids to encounters based upon audit activity.

Encounter Type	Jul'17	Aug'17	Sep'17	Oct'17	Nov'17	Dec'17	Grand Total
Non-Pharmacy	1,194,518	1,323,040	1,338,958	1,291,076	982,257	1,070,812	7,200,661
Pharmacy	561,790	646,418	536,708	603,381	804,414	543,818	3,696,529
System Generated	1,930	1,672	172,390	1,792	1,508	2,294	181,586
Grand Total	**1,758,238**	**1,971,130**	**2,048,056**	**1,896,249**	**1,788,179**	**1,616,924**	**11,078,776**

Financial Transactions

In addition to claims, New Mexico makes payments and recovers monies via financial transactions. These may be initiated manually by an Accounting Transaction Request or Numbered Memo or they may occur because of claims activity that creates a negative balance (accounts receivable) or refund for the provider. Manually initiated requests may come from routine, ongoing activities (e.g., cost settlement, supplemental payments for GME, IME, IHS Payments, etc.) or may result from audit activity from Regional Audit Contractor or other external audit entity. All financial transactions are approved by ASD and require a significant amount of staff time and resources to initiate, monitor and handle provider payments.

Month	# Transactions
7/1/2017	6880
8/1/2017	1346
9/1/2017	1193
10/1/2017	5821
11/1/2017	1048
12/1/2017	1141

Prior Authorizations:

Prior Authorizations (PA) for Members not enrolled in an MCO are processed through the MMIS. PA requests for Members enrolled in an MCO are processed by the MCO; volume data isn't currently available. Waiver PAs are received on paper from the Department of Health. Most all other PA requests are entered via electronic interface from either Children's Medical Services (CMS), or the State's TPA contractor, Qualis Health.

PA TYPE & INPUT SOURCE	Jul'17	Aug'17	Sep'17	Oct'17	Nov'17	Dec'17	Grand Total
CMS	**341**	**302**	**312**	**250**	**260**	**211**	**1,676**
CMS INTERFACE	341	302	312	250	260	211	1,676
FFS	**520**	**646**	**651**	**742**	**679**	**557**	**3,795**
PAPER	3	9	14	14	6	6	52
TPA INTERFACE	517	637	637	728	673	551	3,743

PA TYPE & INPUT SOURCE	Jul'17	Aug'17	Sep'17	Oct'17	Nov'17	Dec'17	Grand Total
PDCS	**54**	**28**	**19**	**24**	**22**	**24**	**171**
PDCS INTERFACE	54	28	19	24	22	24	171
WAIVER	**347**	**407**	**345**	**373**	**246**	**213**	**1,931**
PAPER	347	407	345	373	246	213	1,931
Grand Total	**1,262**	**1,383**	**1,327**	**1,389**	**1,207**	**1,005**	**7,573**

Mi Via Waiver Program

The Mi Via Waiver Program is designed to enable Members with disabilities to manage their own services and supports. Mi Via participants can choose to self-direct home and community-based services, supports and goods within an approved plan and budget. With the assistance of a Consultant, participants develop their own Service and Support Plan (SSP) to meet their functional, medical, and social needs. Participants decide what services they need and how to spend their Mi Via budget and may select the person(s) they wish to provide their care. The goal of the waiver program is to enable the Member to stay in the community rather than requiring care in a facility.

Time sheets are submitted to Conduent by hourly employees, such as homemakers. Invoices are submitted by Vendors who provide approved plan services to the clients.

	Mileage	Invoice	Timesheet	Total Processed	Total Received	Unable to Process
July	376	7494	1349	9219	10,230	1011
Aug	485	8995	1433	10,913	9830	0
Sept	410	7393	1393	9196	9854	658
Oct	498	8139	1602	10,239	10,239	0
Nov	360	7274	1652	9286	9286	0
Dec	339	6739	1333	8411	8411	0

Medical Service Questionnaires:

A Medical Service Questionnaire (MSQ) is automatically triggered from the MMIS based upon data submitted on the claim that indicates an accident or trauma was involved. These are used to determine if there is tort coverage. When the client has returned a completed MSQ, an authorized user enters the response information on the Client Detail Medical Service Questionnaire Window. The user may also decide to set up a recovery case to begin the recovery process.

For the period 12/30/2016 thru 12/29/2017, the system generated 15,239 MSQs; 5,312 of which were returned, representing $ 6,645,639.53 in reimbursement amount. The remaining 9,928 MSQ's were not responded to representing $10,028,353.16 in reimbursement amount.

Drug Rebate Invoices (by quarter):

The Drug Rebate Program is a program that includes CMS, State Medicaid Agencies, and participating drug manufacturers that helps to offset the Federal and State costs of most outpatient prescription drugs dispensed to Medicaid patients. Conduent (using DRAMS) processes Drug Rebate invoices and dispute resolution. It also resolves disputes with the MCOs on rebates. The

MMIS stores data and produces reports for billing and analysis. The following table provides the Drug Rebate activity levels for the most recent quarters activity.

Quarter	Invoices Sent	Invoices Disputed	Checks Received
4Q2016	454	48	317
1Q2017	437	55	344
2Q2017	444	61	366
3Q2017	443	14	240
Total	**1,778**	**148**	**1,267**

Members Eligible and Enrolled:
Medicaid eligibility determinations and Managed Care enrollments are processed through ASPEN and then sent to the MMIS. ASPEN data will be sent to the Integration Platform real time. In addition to Medicaid Eligibility, the system receives eligibility for DOH and General Assistance clients and pays claims for services to these clients not eligible for Medicaid.

Eligible Members

Calendar Year	Unique Medicaid Member Counts	Unique Non-Medicaid Member Counts
2014	845,161	1,596
2015	926,120	1,453
2016	974,734	1,298
2017	1,009,713	1,355

For the most recent accounting of members enrolled by category, by program, by MCO and by county, please see the following link, which is updated monthly:

http://www.hsd.state.nm.us/LookingForInformation/medicaid-eligibility.aspx

Managed Care Enrollees

Clients are offered the opportunity to choose an MCO at the time of their Medicaid application. If one is not chosen and the client is mandatory for enrolment, an auto assignment is made.

Calendar Year	Unique Members Enrolled
2014	681,651
2015	743,049
2016	778,925
2017	798,038