CENTENNIAL CARE

Ensuring care for New Mexicans for the next 100 years and beyond…

New Mexico Human Services Department February 21, 2012

Centennial Care: Ensuring Care for New Mexicans for the Next 100 Years and Beyond

Executive Summary

The Vision

As the State moves forward to further refine and implement its modernization plan, New Mexico seeks to try a different approach to slowing the rate of growth in the program while avoiding cuts. Our vision is to build a service delivery system that delivers the right amount of care at the right time in the right setting. Our vision is to educate our recipients to become more savvy health care consumers, promote more integrated care, properly case manage the most at-risk members, involve members in their own wellness and pay providers for outcomes, rather than process. New Mexico believes that the up-front investment in "seeding" medical and health homes and investing in health literacy will return a healthier population and a reduction in the spiraling rate of growth.

The Goals:

- Create a unified, comprehensive service delivery system to assure cost-effective care and to focus on quality over quantity;
- Slow the rate of cost growth (bend the cost curve) in the program over time through better management of care while avoiding cuts; and
- Streamline and modernize the program in preparation for the potential increase in membership of up to 175,000 people beginning January 1, 2014

How Do We Accomplish These Goals?

- In order to avoid cuts in eligibility, services, and payments to providers, we develop a comprehensive system of care that focuses on:
  - » Care Coordination;
  - » Health Literacy by increasing the work of community health workers, the promotoras;
  - » Prevention and patient-centered medical homes;
  - » Payment reforms to reward cost-effective, "best-practices" care;

  - » The use of technology to bring healthcare to the rural and frontier areas of our state; and
  - » Encouraging more engagement in personal health decisions while rewarding those who engage in healthy behaviors. This encouragement will include both a small, sliding co-pay for non-emergency use of an emergency room, as well as rewards for engaging in healthy behaviors, or actively participating in a recipient's care plan.
- Administratively we:
  - » Combine most of our existing waivers into a single, comprehensive waiver to reduce internal bureaucracy and the number of programs over which the federal government has control; and
  - » Build effective management capacity and capability to hold our private sector partners accountable through all levels of the program, while reducing the number of managed care plans.

Why is this Good for New Mexico?

- It modernizes the Medicaid program without cutting back on eligibility or necessary services, or hurting our providers;
- It aligns incentives in the system so that all parties—the state, the plans, the providers and the recipients—are working towards the same goal of better health at less cost;
- It puts New Mexico among the leading states in the design and implementation of a modern, efficient Medicaid program; and
- It introduces "state of the art" techniques arrayed in a single, comprehensive system of care.

CONCEPT PAPER

In June of 2011, New Mexico embarked on an ambitious plan to modernize its Medicaid program to accomplish the following goals:

- To assure that Medicaid enrollees in the program receive the right amount of care at the right time and in the most cost effective or "right" settings;
- To assure that the care being purchased by the program is measured in terms of its quality and not its quantity;
- To bend the cost curve over time; and
- To streamline and modernize the program in preparation for the potential increase in membership of up to 175,000 individuals beginning January 2014.

The State believes now is the time to create a modern, innovative, financially and operationally sustainable program for the future.

Why Modernization and Why Now?

New Mexico is one of the poorest states in the nation and has a faster-than-average growth in its elderly population. These two facts combined place growing demands on the Medicaid program, even before the inclusion of the "newly eligible" under the Affordable Care Act.

Of the approximately 2 million citizens of the State, more than a quarter or 560,000 people currently receive their health care through the Medicaid program. The challenges are many. The program is expensive, consuming about 16% of the current state budget—up from 12% last fiscal year. And, the rate of growth in costs precedes the addition of approximately 175,000 additional people who will be added to the program beginning January 2014 under the Affordable Care Act.

The program is administratively complex, also adding cost. Today, the program operates under 12 separate waivers as well as a fee-for-service program for those either opting out or exempt from managed care. This complicated delivery system is run through 7 different health plans.

Finally, and perhaps most importantly, the State isn't necessarily buying quality; rather rates are determined and payments made based on the quantity of services offered. The State pays for services without regard to whether they represent best practices in medicine and without regard to whether those services help make people healthier or help them manage complex medical/behavioral conditions.

For all of these reasons, the State believes that now is the time to modernize Medicaid to assure that we buy the most effective, efficient health care possible for our most vulnerable and needy citizens and to create a sustainable program for our future.

Current Program Structure

The program is currently operated under a myriad of federal waivers and a fee-for-service component that combined make it administratively inefficient and difficult to manage as well as difficult to navigate for the beneficiaries. Currently the State operates:

- A fee-for-service system for certain short-term eligibility groups and for those Native Americans who "opt out" of managed care;
- A 1915(b) waiver for its Salud program;
- A 1915(b) and a 1915(c) for its Coordination of Long Term Services (CoLTS) program;
- A 1915(b) waiver for its Statewide Behavioral Health Purchasing Collaborative system;
- Two 1915(c) waivers for its two Mi Via (self directed) programs;
- A 1915(c) waiver for the Medically Fragile;
- A 1915(c) waiver for those with AIDS;
- Two 1115 waivers; one for childless adults and one for the parents of CHIP children (the SCI program);
- One 1115 waiver for the CHIP program; and
- A 1915(c) waiver for home and community based services for those with Developmental Disabilities.

See the chart below for more information about the current waivers.

Under these various waivers, the State contracts with seven (7) managed care organizations: 4 for Salud, 1 for behavioral health, 2 for CoLTS. In addition, the State pays its Medicaid Management Information System (MMIS) vendor to process fee-for-service claims, to collect and process encounter data from the MCOs, and to serve as the Financial Management Agency (FMA) for the Mi Via programs. It also contracts with a plan to act as a Third Party Administrator (TPA) to conduct level of care determinations, determine medical necessity for some services in the fee-for-service program, and to review and approve budgets for the Mi Via programs.

The amount of time and expense it takes to manage this patchwork quilt of service delivery systems and vendors robs the State, and ultimately the beneficiaries, of the needed focus on a comprehensive system of care, governed by one waiver and managed to deliver quality health care.

In addition, despite the amount of time and money that flows into the program, New Mexico has no clear indication that it is purchasing quality care. While plans are reporting scores at or near the national average, and in some cases above, on various quality measures, those measures do not include actual health outcomes. It is on the outcomes and paying for quality, that New Mexico wishes to focus its energy and, towards that end, believes it is time to modernize its service delivery system.

Waiver populations and expenditures

Waiver Name	Waiver Type	Expiration Date	Population Covered	SFY 10 Enrollment	SFY 10 Expenditures	Wait List
Salúd!	1915(b)	6/30/13	Traditional Medicaid	390,571	$1,135,112,000	NA
Behavioral Health Services	1915(b)	6/30/13	Traditional Medicaid	430,969*	$238,228,000	NA
CoLTS	1915(b) 1915(c)	1915 (b) - 6/30/12 1915 (c) - 10/31/11	Medicare & Medicaid Duals and Nursing Facility Level of Care	42,934	$800,245,000	NA
MiVia	1915(c)	9/30/14	ICF Level / Self Directed	215	$6,705,000 w/o Admin $7,503,000 w/Admin	NA
MiVia	1915(c)	9/30/14	NF Level / Self Directed	AIDS – 8 D&E – 512 BI – 358	$20,300,000	NA
DD	1915 (c)	Renewed 7/2011	Developmentally Disabled	3,684	$286,092,000 w/o Admin $287,738,000 w/Admin	5400
Medically Fragile	1915 (c)	6/30/15	Individuals with both a Medically Fragile Condition and a Developmental Disability	176 Traditional	$1,712,495 w/o Admin $1,824,000 w/Admin	
AIDS	1915 (c)	6/30/15	Disabled Individuals with AIDS	9	$316,000 w/o Admin $320,000 w/Admin	
CHIP	1115		185-235% of FPL	9,884	$20,919,000	NA
SCI	1115	9/30/14 Child/ Adult 9/30/12 SCI Parents	Below 133% FPL	47,818	$403,332,000	31,858
SCI	1115	9/30/14 Child/ Adult 9/30/12 SCI Parents	Above 133% FPL	3,431		

*Individuals enrolled in CoLTs and Salud receive their BH services through this program as do individuals receiving services in the fee-for-service system.

Modernization: Guiding Principles

As a beginning place for the development of a modernized Medicaid program, the State articulated 4 guiding principles:

- Developing a comprehensive Service Delivery system that provides the full array of benefits and services offered through the State's Medicaid program;
- Encouraging more personal responsibility so that beneficiaries become more active participants in their own health and more efficient users of the health care system;
- Increasing the emphasis on payment reforms that pay for performance rather for the quantity of services delivered; and
- Simplifying administration of the program for the state, for providers and for beneficiaries where possible.

The ideas behind these concepts were fleshed out over a series of public stakeholder meetings, suggestions and comments delivered to the state via the internet, email and "snail mail," cross-stakeholder workgroups and Tribal Consultation. As a result of this widespread consultation, the State's vision has emerged more clearly. (See Attachment A for a summary of stakeholder comments).

Modernization: The Vision

Managed care has been the primary service delivery system for Medicaid in New Mexico for more than a decade. The State began its Salud program in 1997, managed care for behavioral health in 2005 and its CoLTS program in 2008. Like managed care companies everywhere, New Mexico's plans have proven that they know how to manage the dollars they receive in capitation and, by and large, how to establish a network and pay claims in a timely and accurate manner. What New Mexico now challenges its plans to do is manage care and deliver outcomes that can be measured in terms of a healthier population. In order to effectively drive the kind of system change New Mexico seeks, plans will have to think and behave differently and support the movement towards care integration and payment reform.

In order to implement this approach, the State will file a single Section 1115 waiver and then, through procurement and contract, New Mexico will seek managed care organization (MCO) partners who will be challenged to encourage the growth of robust, patient-centered medical homes which will offer primary care, case management and linkages to community supports as well as health literacy and education to their patients. MCOs will be further challenged to support care integration through the proliferation of health homes, targeted first at those with a behavioral health condition plus a chronic physical condition and, over time, towards others with chronic and/or co-morbid conditions. In these health homes, all six services prescribed by federal law will be offered, including intensive care management delivered at the "point of service."

Plans will be expected to manage an aggressive program, using local community resources, to promote health literacy so that beneficiaries have the tools necessary to manage their health care and to become a part of the team for purposes of managing their health conditions.

Further, plans will be challenged to support payment incentives targeted at physicians and hospitals and other health care providers who employ evidence based practices and achieve benchmarked health outcomes.

Over the course of the five years of initial waiver authority, New Mexico will introduce progressive quality goals focused on health outcomes, employ pilot projects based on both geography and specific populations to develop medical and health homes, and challenge its MCO partners to work cooperatively with the provider community and with the State to achieve a health care delivery system that is efficient and effective, controls costs by improving the health of the people the system serves, and reduces health disparities.

The rest of this concept paper introduces some of the specific ways in which New Mexico intends to pursue its vision.

Bending the Cost Curve

Medicaid costs are a function of three things: the numbers of people enrolled in the program; the service package offered; and the rates paid to providers of care. The levers that states have historically used to reduce costs are blunt at best. States have, in the past, reduced eligibility to individuals who are members of optional coverage groups; eliminated optional services and/or put arbitrary limits on mandatory services and/or reduced provider rates and/or increased enrollee cost sharing.

In today's environment, reductions in eligibility are prohibited by federal law until 2014 for adults and 2019 for children; states that violate this prohibition risk Federal Financial Participation (FFP) for their whole program. States have done some "tinkering" around the edges of the service package but elimination of optional benefits rarely yield much savings and arbitrary limitations on the mandatory services is generally less acceptable than asking MCOs to manage services to a standard of medical necessity. Provider rates for Medicaid services are always lower than rates offered either by Medicare or commercial payors and a continuation of rate cuts results in serious access problems.

And yet, costs continue to soar and states struggle under the growing weight as Medicaid consumes increasing percentages of state budgets.

New Mexico seeks a different approach to reduce costs. Its vision is to build a service delivery system that delivers the right amount of care at the right time in the right setting. Its vision is to educate its members to become more savvy health care consumers, promote more integrated care, properly case manage the most at-risk members, involve members in their own wellness and pay providers for outcomes rather than process. New Mexico believes that the up-front investment in "seeding" medical and health homes and investing in health literacy will return a healthier population and a reduction in the spiraling cost curve.

Based on the current program without "counting" the impact of new eligibles under the Affordable Care Act or any legislative changes to the program, the State estimates that the program as described more fully below will reduce the trend rate of the program's growth in costs by somewhere between 2.75-4% over the initial 5-year life of the wavier. That translates into a reduction in expenditures of between $140-$205 million general fund dollars that would otherwise have been spent if the program were to grow as it is currently configured and operated. Accompanying this reduction in the trend rate, the State believes that the system described below will also, and most importantly, have a positive impact on the health of our people.

Principle 1: A Comprehensive Service Delivery System

Key Features:

- A smaller number of plans will deliver the full array of Medicaid services except for home and community based and institutional services to the DD population;
- A comprehensive care coordination system lies at the heart of comprehensive service delivery; members will be stratified by risk and capitation will be adjusted by risk to maximize directing resources to those most in need of health care services;
- Health literacy will become an essential component of comprehensive service delivery;
- The State will encourage integration through the expansion of patient centered medical homes and health homes with intensive care management provided at the point of service to help beneficiaries manage their health and their use of the health care system;
- The State will work with CMS to develop a strategy for streamlining care for those dually eligible for Medicaid and Medicare to ensure seamless care and reduce costs to both programs.
- The State will emphasize the use of technology to bring health care to underserved populations; it will also seek to maximize the use of alternative care settings, like school based clinics, as an alternative to emergency rooms as a primary care setting.

Comprehensive Care

The comprehensive service delivery system has several major components. First, the State plans to reduce the number of managed care plans from 7 to a smaller, more manageable number. All of the plans ultimately selected to participate in the program will be expected to deliver a full range of services, including the service packages now provided under fee-for-service and all existing waivers except for the Developmental Disabilities (DD) waiver for home and community based services and the accompanying Mi Via program for those who meet Institutional Care Facility/Mentally Retarded (ICF/MR) level of care. A list of these services is appended to the back of this concept paper (Attachment B).

In order to maximize the integration of health care services, the state will "carve in" all Medicaid behavioral health services and all home and community based and institutional services now provided under the non-DD waivers. Plans will be expected to manage this full array of services as well as to take primary responsibility for the management of the self-directed services offered under the Mi Via waiver that is available to those who meet nursing facility level of care. The capitation for the MCOs participating in the program will be designed to maximize the incentives to support people in their homes and communities and to begin to address the waiting list for services for the current CoLTS program.

Care Coordination

Fundamental to the kind of comprehensive system of care that New Mexico seeks to provide under the 1115 Waiver is a robust care coordination system. MCOs selected by the State to provide health services to assigned members will be responsible for providing care coordination at a level appropriate to each member's needs and risk stratification.

New Mexico's care coordination system will be based on creating a patient-centered environment in which members are receiving the care they need in the most efficient and appropriate manner. The care coordination approach is continuous and includes:

- Asessing each member's physical, behavioral, functional and psychosocial needs;
- Identifying the medical, behavioral and long-term care services and other social support services and assistance (e.g. housing, transportation or income assistance) necessary to meet identified needs;
- Ensuring timely access and provision, coordination and monitoring of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities and maximize independence; and
- Facilitating access to other social support services and assistance needed in order to promote each member's health, safety and welfare.

The requirements for care coordination currently under consideration are as follows:

Screening and Initiation of Care Coordination

The initial care coordination contact for each member will be performed upon entry into a MCO. The MCO will use all available information and initiate a phone call with each new member to complete the following:

- Introduce the MCO and provide a brief orientation to benefits and to care coordination;
- Obtain additional information about current care needs that were not indicated in encounter and utilization data;
- Identify any immediate or urgent needs;
- Screen for participation in disease management;
- Obtain information about family or other caregivers who may participate in care planning;
- Confirm information about behavioral health or substance abuse care indicated by encounter or utilization data; and
- Make initial risk level assignment.

Based on the member outreach call and, in the case of current enrollees, utilization and encounter data that the plans will have for their members, individuals will be assigned a risk-stratification group. The stratification process will take into consideration many different elements, including but not limited to age, diagnosis, treatment history, and current needs, presence of mental health issues and/or substance abuse and living arrangements. If the member is assigned to a minimum level of need, it is an indication that they appear to be in stable health and have low needs for support and coordination. These members may have the following characteristics:

- No complex or co-morbid health conditions;
- Low ER use;
- Stable housing and social supports; and/or
- No behavioral health or substance abuse treatment needs.

For these low-risk members, no further assessment may be needed unless and until claims, encounters or real-time health information data or a trigger event signals a change in status.

If the member is assigned to a higher level of need they may need more intensive care coordination. An example of criteria for a higher level might include that the member:

- Has co-morbid health conditions;
- Has had frequent ER use in the past 3-month period;

- Has a low-risk mental health or substance use disorder that is stable or presents with minimal functional impairment in home, school/work and community settings; and/or
- Is receiving substance abuse services.
- Some members will require intensive coordination, typically those with the most expensive or high-risk service needs. The following is an example of this profile in which the member:
- Is medically complex or fragile;
- Has had high ER use in the past 3-month period;
- Has a high-risk mental health diagnosis or is an individual who is Seriously and Persistently Mentally Ill(SPMI);
- Is transient and without a natural support network;
- Has co-occurring mental health and substance abuse diagnosis; and/or
- Meets institutional level of care criteria.

The initial assignment of a member to a risk-stratification group will be based on the entry assessment and will dictate how cases are processed (e.g. time-frames, frequency and type of contact). However, the completion of a comprehensive assessment may be necessary to establish a fully informed risk group assignment. The group assignment may change based on results of the comprehensive assessment that provides more information about the members individualized needs, current risk and future risk-factors.

Comprehensive Assessment/Care Planning

Once members are assigned an initial risk group a care coordinator will contact members who appear to have complex needs and a higher level of risk and complete a comprehensive assessment to confirm that the member is in the appropriate risk group and to inform the development of a written plan of care. A comprehensive assessment will typically take more time and require that the care coordinator include input from a care planning team as appropriate, including the member, family or caregivers (with the member's permission), and providers.

Based on the assessment a care plan will be developed that includes the services and supports that the member needs to stabilize or improve the member's health, safety and well-being. The care plan document will include all physical health, behavioral health, social and transportation needs identified for the member. This will allow the member to understand what services are available and create a foundation for discussions about health between the member, the member's care givers, care coordinator and providers.

The MCO may utilize a care coordination team to manage the tasks related to care coordination and assign certain tasks to team members with appropriate education and training. However the process will be designed to require a specific care coordinator to act as the

liaison or "face of the program" for the member. The design goal is to foster trust and communication, reduce confusion for members, their families, and providers and improve care.

Ongoing Care Coordination

Ongoing care coordination will be based on the assigned risk group and will include required elements such as:

- Delivery of initial and on-going comprehensive assessments;
- Required members of the care planning team;
- Frequency and type of contact with members;
- Data monitoring requirements; and/or
- Triggers for reassessment and case review.

As the State finalizes its vision of care coordination, it will seek further stakeholder input; this is one of many places where the input of the community will lead to a stronger program.

New Mexico will rely on certain events and/or data to trigger a review of a member's health status and needs. These triggers will include events such as 1) Abuse/Neglect reports involving the member; 2) New diagnosis with significant health or safety impact; 3) New diagnosis involving behavioral health or substance abuse; 4) Hospitalization; 5) Request by provider or family member; and 6) Any other indication that the member may need to move to a new risk group. In addition, plans will be expected to have software that will enable the care management staff to access patient records in real time and on demand from all providers in the system. When a trigger event occurs for a member, the MCO will assign a care coordinator to complete a comprehensive assessment for low and medium risk members or deploy the assigned care coordinator to update the assessment for a member who is already receiving complex case management.

Care coordination for members who either receive or are in need of behavioral health services and/or substance abuse treatment will include referrals for service, monitoring of wait times for services, and compliance with recommended treatment including medication. It is anticipated that these care plans may require more frequent contact by the care manager and more intensive coordination efforts. For those members with SPMI, the care manager will focus efforts on reducing emergencies and improving overall stability. For members with substance abuse treatment needs, the care manager will focus on prevention of relapse and reduction of physical health issues. In both cases the care manager will develop a care plan that considers and addresses the physical, behavioral and social support needs of these members. The care plan team will include any ancillary care members and/or community services provided to address the complex nature of these cases.

Aligning Care Coordination and Capitation

In order to maximize the alignment of care coordination intensity with the capitation rate structure, the state is working with its actuaries to develop a capitation structure based on risk stratification and it is the state's goal to align the two and focus both dollars and care coordination strategies on those who are most at risk. The state believes that the combination of money and care coordination resources maximize the chances that the plans will manage utilization to achieve maximum health outcomes and maximum efficiency in the system. In addition, the state plans to examine risk stratification methodologies and explore the idea of using maintenance within or movement across stratification levels as a measurable heath outcome that may be tied to capitation rates or payment reforms. Simply stated, the goal is that the dollars will follow the plan of care; more complex cases will receive additional resources.

Care Coordination/Patient-Centered Medical Homes and Health Homes

While the basic care coordination model described above will, at least initially, be the responsibility of the MCOs, the State will, over the next several years, move intensive care coordination to the "point of service" by incentivizing the proliferation of patient centered medical homes and health homes. As individuals choose or are enrolled in either the medical home primary care model and/or the health home for the management of chronic conditions, those entities will assume responsibility for intensive care coordination. The MCOs will be expected to continue to provide overarching care coordination, technical assistance, and to assure the care coordinators in these "point of service" models full access to all of the MCO resources and utilization and encounter data that would be required for a care coordinator to understand the entire spectrum of a beneficiaries needs.

Several other features of the comprehensive system of care include:

Health Literacy

New Mexico has some success stories helping beneficiaries understand their health needs and how to access the health care system. The Federally Qualified Health Centers (FQHCs) in particular rely on community health workers called promotoras. However, the promotoras are not statewide and not all providers are allied with them. The State will require plans to do much more aggressive outreach to their patients and offer information both about how to navigate and most efficiently use the health care system as well as how to manage their health conditions. Much of this work can be most effectively done through the use of a trained, "lay" workforce to work with beneficiaries to engage in their own health. Whether the plans "make or buy" this service, it will be a contractual requirement that community health workers be available as a resource to both the Care Coordination staff and to beneficiaries

who seek to educate themselves about their health. In addition, plans will be expected to develop culturally sensitive, relevant and accessible materials on using the health care system and addressing chronic health care issues.

Patient-Centered Medical Homes

New Mexico has contractually encouraged its Salud MCOs to work towards the development of patient-centered medical homes. Progress has been made but there is more work to be done to "grow" both urban and rural medical homes where primary care is provided and the patient is surrounded by both care coordination and access to other community supports. The new requirement in the Affordable Care Act (ACA) to pay primary care physicians at 100% of the Medicare rate will be helpful in furthering the establishment of primary care medical homes. For the years 2014-2016, the federal government will make up the difference between current payment rates and the new requirement. If the medical homes can demonstrate better health outcomes for their patients, the State may consider continuing a higher payment rate to those providers that demonstrate quality metrics.

Health Homes

The next step in the integration of care is the establishment of health homes. New Mexico is currently working with a Section 2703 planning grant to design its first State Plan Amendment (SPA) to establish health homes throughout the state. The initial concentration for the health home model is for individuals receiving services to treat a behavioral health condition. The State's intent is to initially develop health homes in pilot site Core Service Agencies (CSAs) in Albuquerque and expand to other geographic areas of the State as best practices develop. This model for behavioral health homes is being designed in conjunction with the physical health MCOs and the model will be used for other populations as the health home concept is expanded. Over time, the State intends to establish health homes for other chronic conditions.

The health homes, once established, will assume responsibility for the six services required by federal law:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and

- The use of health information technology to link services, as feasible and appropriate.

The State will work with CMS and its actuaries to assure that services provided by the health homes are not duplicated by the MCOs. The intent is to push comprehensive case management to the point of service with oversight and back-up resources provided by the MCOs' care coordination systems.

Self Direction

The State intends to continue but modify the self-directed programs currently offered under 1915(c) waivers for those with AIDS, those who are medically fragile, those with Traumatic Brain Injury and those who otherwise qualify for Home and Community Based Services because they meet nursing facility level of care. As is the case today, beneficiaries choosing to self-direct must take responsibility both for hiring their care providers and developing their own budgets. The State will contract with an outside vendor to perform the functions of the FMA but the plans will be expected to take responsibility for assisting beneficiaries in the development of budgets and assisting in the selection of staff through their care coordination systems.

Behavioral Health Carve-In

Based on feedback from expert panels and other stakeholders about the most efficient way to achieve full integration of physical and behavioral health, New Mexico has determined that behavioral health services will be "carved in" and provided by the contracted MCOs under the 1115 waiver. It is important to the State to ensure that transparency is maintained in how behavioral health dollars are spent and collect data that informs on which services and systems are effective. Therefore, the State intends to apply the following standards:

- The MCO will not be permitted to subcontract management of behavioral health services to a managed, risk-bearing Behavioral Health Organization (BHO);
- The MCOs will receive a sub-capitation rate for behavioral health services which will protect current service dollars in the system; however, plans will be given more flexibility in the expenditure of behavioral health funds as they demonstrate their ability to meet performance measures, including maximizing integration of physical and behavioral health;
- The MCOs will be required to employ a licensed, clinical behavioral health psychiatrist as a part of its medical management team to take an active role in clinical and policy decisions; and
- The MCOs will be required to contract with either Core Service Agencies (CSAs) and/or qualified core service provider networks to manage much of the delivery of behavioral

health services. Some of the service dollars will be kept by the MCO as money that can be used to incentivize maximum integration of physical and behavioral health.

Currently, New Mexico operates forty-one CSAs located throughout the State for children and adults. These entities provide prevention, early intervention, treatment and recovery services related to behavioral health. These CSAs will be a big part of the delivery system and will:

- Provide behavioral health services to those members who choose the CSA as their provider;
- Deliver all out-of-home assessment and service planning; and
- Provide care coordination to members with a primary diagnosis of SMI or Serious Emotional Disturbance (SED) as well as being part of an interdisciplinary team of care coordination for members with co-morbid diagnoses.

The benefit package for behavioral health services is still undergoing review for possible changes or expansion of key services. Potential expansions of the benefit package include: additional addiction services, respite, peer support, family support and transition services.

The Dually Eligible

The population that is eligible for both Medicaid and Medicare is costly. In 2010, the dual eligibles made up 15% of the total Medicaid population nationwide but they accounted for 39% of total Medicaid costs. To a large extent, those costs are a product of their demographic and morbidity characteristics. The duals are older, sicker, and more likely to be disabled than the population in general.

The high cost of caring for the dual eligible population is also the product of uncoordinated and at times conflicting policies between the two programs. One example of this is the rule on "homebound" care in Medicare. This severely limits the home care options provided to Medicare Beneficiaries, and shifts an undue burden of the care for the dual eligibles onto Medicaid. To the extent that Medicaid accepts that burden and even amplifies the home care provided to the duals through programs like Mi Via, PCO, or one of the 1915 (c) waivers in New Mexico, Medicare stands to save money through a reduction in its own high readmission rates. In 2010, the nationwide re-admission rate in the Medicare program was 16.1%; 13.9% in the Albuquerque area. However, those hospital savings accrue entirely to the Medicare program that is primary payer of hospital services under Part A. The State of New Mexico does not share in those savings, despite the fact that it was the state's home care initiative that was largely responsible for reducing hospital stays and re-admissions.

New Mexico has a long history of exploring avenues to realize savings for dual eligible population. The CoLTS program was a first step in placing the Medicaid benefit for the duals under managed care. But the separate silos of Medicaid and Medicare dollars continue to reduce the economic benefit for the state. In September 2011, New Mexico submitted a Letter of Interest (LOI) to CMS to pursue the capitated integrated care model described in a "Dear State Medicaid Director (SMDL # 11-008)" letter. The letter was issued by the Medicare-Medicaid Coordination Office established under Section 2602 of the Patient Protection and Affordable Care Act of 2010.

The capitated care option provides for a three-way contract between the state, CMS, and the health plans to provide the full range of Medicaid and Medicare benefits. Under this approach, the health plans would receive a single payment for Medicare and Medicaid services. CMS is working on the development of a proposed rate which would incorporate savings for both the federal and state government.

A Word About Access

Every stakeholder with whom the State met mentioned lack of access as a big problem for New Mexico. Not only is the state medically underserved, but the distances between towns and, especially cities large enough to attract a full array of physicians and other professionals, is much greater than in the average state. The State will continue to look at creative ways to both increase the size of the workforce and to employ creative technologies to expand access. Three strategies, in particular, are under discussion and include:

- The University of New Mexico runs an excellent telemedicine program called ECHO that uses traditional physician training practices such as chart rounds and leverages web conferencing to train primary care providers to become "specialists" in treating complex conditions and illnesses such as opioid addiction, hepatitis C, pediatric obesity and high risk pregnancy. The State will seek ways to support the ECHO program and make it more widely used by primary care practices throughout the state;
- The State will look for ways to encourage the use of school based clinics, not only to treat children and adolescents during school hours but to use the facilities as potential places to supply urgent care services outside of school hours to the wider community.
- As the State reviews its payment reform strategies, it will look at potential ways to incentivize other rural and frontier initiatives that will maximize access to primary and preventive care services.

Quality Assurance and Quality Management Strategies

We believe that New Mexico's modernization will result in improved quality of life and satisfaction with services for those who participate and their families. New Mexico will implement a comprehensive quality approach across the entire continuum of services and settings that

promotes quality improvement and that focuses on customer perceptions of quality, with mechanisms to ensure ongoing feedback from persons receiving care and their families in order to immediately identify and resolve issues and to improve the overall quality of services and the system.

The State will develop and implement quality assurance and quality improvement strategies to ensure the quality of services provided under the demonstration. Such strategies may include the use of data collection and reporting, outcome measures to measure the results of implemented services and initiatives, and mechanisms for direct feedback from members and family or other caregivers regarding the quality of services provided.

The Affordable Care Act

New Mexico is exploring the various options for the implementation of the Affordable Care Act. At a minimum, the state anticipates that up to 175,000 individuals will become eligible for the benchmark benefit that will be defined by the federal government and offered through the Medicaid plans. Streamlining the system now should assist the health plans in their ability to more easily absorb this new group of eligibles beginning in January 2014.

Focus on Managed Care

The State believes that with its focus on second generation managed care and a much tighter set of contractual requirements, our Medicaid recipients will receive better care, leading to better outcomes in managed care. In order to minimize any residual fee-for-service program, the State will also seek CMS authority to:

- Waive the requirement that the State pay for prior quarter coverage; under this waiver, the State would not be required to pay for services that recipients received in the quarter prior to their determination of eligibility for Medicaid; and
- The State will require that recipients choose a health plan at the time of their application for Medicaid eligibility or, at a minimum, on the date of their eligibility determination. This will enable individuals to be enrolled more quickly in a health plan and begin receiving coordinated services sooner.

Principle 2: Personal Responsibility

Key Features:

- **Waiver authority to implement the sliding scale co-payment already enacted in State law, 27-2-12.16;**

- **A modest co-pay on brand name drugs when a generic substitute is available; this will not apply to psychotropic drugs;**
- **Incentives to reward individuals for key preventive activities like a yearly health scan and, for the more complex and at-risk population, compliance with a plan of care they contributed to forming; and**
- **Long Term Care Insurance Partnership Plan.**

The State believes that there is merit in engaging individuals more in the process of staying and/or getting healthy and in using the health care system more efficiently. Towards those ends, the State is seeking authority to pursue a properly aligned array of incentives to facilitate that engagement.

Changing Behavior: Co-Payments

In 2009, the New Mexico legislature enacted statute to impose a sliding scale co-payment on Medicaid recipients with incomes above 100% of the federal poverty level. The legislation provides that a co-payment may be assessed when the hospital from which the recipient seeks services:

- Does an appropriate screening to assure that the recipient does not require emergency services;
- Informs the recipient that he/she does not have a condition requiring emergency services;
- Informs the recipient that if he/she still wants the service, he/she will be subject to a co-pay;
- Provides the recipient with the name and address of a non-emergency Medicaid provider; and
- Offers to provide the referral to the non-emergency provider to facilitate the scheduling of the service.

The amount of the co-pay in state statute is:

- For a child whose household income is 100-150% of the federal poverty level, $6.00;
- For an adult whose household income is 100-150% of the federal poverty level, $25.00
- For a child whose household income is above 150% of the federal poverty level, $20.00; and
- For an adult whose household income is above 150% of the federal poverty level, $50.00

The State will include a request for waiver authority to implement this existing state law because, as the legislature believed at passage, this approach is one way to incentivize individuals to seek care in more appropriate settings. This is particularly true when coupled with incentives to both the hospitals and the MCOs to also participate in a statewide effort to make appropriate care settings available. The total amount of money assessed to Medicaid recipients calculated in this co-payment would be deducted from the capitation paid to the plans. The amount of the aggregate deduction would be based on historical data already being analyzed by the State's actuaries. However, the State would preclude the plans from passing the amount of the deduction on to the hospitals (pursuant to the statute) and would contractually require the plans to absorb the deduction but seek ways to incentivize their provider networks to do things to help alleviate the problem such as keeping non-traditional office hours, working more closely with patients to help educate them on when the ER is appropriate and when care can be provided in a more efficient setting and/or setting up nurse triage lines to help people make better decisions about when to access the ER. In this way, the system shares in the push to keep people out of the ER for routine and non-emergent care.

In addition to the co-pay for the non-emergent use of the emergency room, the State will seek to implement a modest co-pay of $3.00 for the demand for a legend drug when there is a generic substitute readily available. This co-pay will not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions.

Changing Behavior: Incentives

The State is also planning to pursue an incentive program that will reward members for certain healthy behaviors. Currently, the recommendations from our stakeholders, including plans, physicians, Federally Qualified Health Centers (FQHCs), and advocates is that we focus on strategies that everyone can participate in. The State is considering several different approaches to focus on helping recipients be active participants in their health care. One idea is to tie a reward (probably in the form of a Gift Card to either a retailer and/or a local Farmer's Market that would be offered through the MCOs) to a "high-risk" beneficiary who participated in the development of a plan of care and complied with that plan for six months or a year. For children, the incentive event might be a wellness visit and follow-up with any issues identified during that visit. For healthy adults, the reward might be tied to quantifiable participation in a regular exercise program or assuring that their children received all appropriate immunizations.

The State is also exploring the potential to implement an Electronic Benefit Transfer (EBT) card with points that a member could earn for certain healthy behaviors either in addition to or in lieu of the individual gift card approach. Points could be used to purchase over-the-counter drugs or other items that Medicaid does not pay for.

Education:

The State is exploring the cost/benefit of sharing, at least with "frequent flyer" members, e.g. those who overuse the ER, those who are drug seeking or using 5 or more prescriptions a month, a quarterly Explanation of Benefits (EOB) that would inform the member of the costs of the care being provided and explore with the member whether those costs are leading to better outcomes and how, working with a care coordinator, that member might begin to use the system more efficiently.

Long Term Care Partnership Plan

As a part of its effort to increase the sense of personal responsibility, the State of New Mexico will submit a State Plan Amendment to CMS in order to become a long term care insurance partnership state. That means that individuals will be able to purchase private long term care insurance at market rates that have the potential to cover much if not all of their eventual long term care needs. This has great potential to avoid middle income people from having to spend down their savings and assets in order to qualify for Medicaid to gain access to long term care. To the extent that individuals eventually do apply for Medicaid, the program can "count" the full value of the policy as an asset which has the effect of delaying entry into the system until the full value of the policy has been spent on services. On the other side, Medicaid agrees not to go after estate recovery at least to the extent of the value of the policy. This is an excellent first step in helping folks plan for taking care of their long term care needs.

Principle 3: Payment Reform (Pay for Performance)

Key Features:

- **MCO focused performance measures that will include both process and outcome measures**
- **Pilot projects for both physicians and hospitals to test payment reforms tied to quality outcomes and best practices**

The medical care system in the United States has been cited repeatedly as the costliest in the world, and yet one where the outcome measures of morbidity and life expectancy trail behind most of the rest of the developed nations. The reasons for this disconnect between medical expenditures and outcomes are complex, but fundamentally they reflect a system where providers are rewarded for the volume of the services that they provide, rather the health outcomes of the patients that they serve.

HEDIS Measures

Over the past three decades much of the commercial and the Medicaid population has been enrolled into some form of managed care with the intention that a managed care organization that bears risk for the health of its members would be incentivized to deliver care proactively to avoid more costly episodes of care in the emergency room and hospital inpatient settings. As a way of holding the MCOs accountable for the delivery of preventive services, the industry developed a series of process measures to assess the effectiveness of the delivery of preventive health measures known as the Health Effectiveness Data and Information Set (HEDIS). The New Mexico Human Services Department has incorporated many of these HEDIS measures as contractual requirements for the Salud managed care plans, including:

- ER Utilization
- Ambulatory care utilization
- Well Child visits in the first 15 months of life
- Childhood immunizations
- Use of appropriate asthma medications
- Breast cancer screening
- Comprehensive diabetes care
- Timeliness of prenatal and postpartum care
- Frequency of ongoing prenatal care

This list of process measures will be evaluated and most kept. However, the State will implement additional measures to focus more specifically on the elderly and disabled and those with behavioral health needs.

Payment Reform

In addition, the State plans to move beyond process measures to begin to align incentives and reward providers directly for achieving measureable health outcomes for their patients such as:

- Successful management using evidence-based, best practices for the treatment of conditions prevalent in New Mexico; and
- Reduced rates of readmission to the hospital for the same condition; and

Payment incentives for the health plans and the providers can take a variety of forms ranging from the non-financial like the reporting of peer to peer comparative data on the use of

evidence based best practices to financial incentives like the development of bundled rates for hospitals targeted towards reducing the number of readmissions for the same diagnosis within 30 days. New Mexico would like to pilot both of these approaches as follows:

- Reporting of Peer to Peer Comparative Data: The State proposes to work with physicians in the State to develop metrics that represent best practices for the treatment of adults with diabetes and of children with asthma. We will turn these metrics into data points that will be collected via the MCOs and reported within the physician community. We will focus on these two disease states to start and examine whether the reporting on best practices begins to change the practice patterns of the physician community. To the extent that this simple, non-financial incentive works, the State will work with the physician community to add other disease states prevalent in New Mexico to our list over time.
- Bundled Rates for Urban Hospitals: The second pilot the State seeks to pursue is to work with our actuaries to develop a bundled rate for an initial hospital stay and the 30 days post-discharge for two disease states: pneumonia and coronary disease. These are two of the disease states for which there is the most frequent readmission of patients to inpatient hospital for the same diagnosis as the original within 30 days. The State wishes to explore whether using a bundled rate will reduce the number of readmissions within 30 days for the same diagnosis and will challenge hospitals, care managers and plans to become more vigilant about post-discharge planning and follow-up with patients.

The State will pursue other quality initiatives over time but believes that beginning with several small pilots will help inform about what kinds of payment reform strategies might lead to better quality outcomes over time.

Principle 4: Administrative Simplification

Key Features:

- **Streamline the Service Delivery System, thereby freeing state staff to better manage contracts and focus on system improvements**
- **Exploration of other simplification techniques, e.g. consolidated credential and re-credentialing processes**

Medicaid was created by an act of Congress in 1965, but it was not the program that we know today. Over the years, succeeding administrations have added a plethora of new coverage groups beyond the initial AFDC entitled population. The range of service options has also been expanded to include long-term care; home and community based care; and managed care.

The product in the states of this growth by accretion is a bewildering array of different Medicaid eligibility coverage groups and service delivery options, each of which must be memorialized in a Medicaid State Plan and/or various waivers before the state can draw down federal matching funds. As noted above in this paper, the New Mexico Medicaid program currently operates a fee-for-service system and three managed care programs, under twelve different waiver programs. Each of these programs has its own series of federal reporting requirements which place an ever increasing administrative burden on Medicaid staff. And yet each of these programs provides at their core the same set of primary care and ambulatory care services to their recipients, basic services such as hospital inpatient and outpatient care, physician services, lab, x-ray, etc.

Under the Global waiver approach, all of these programs (except home and community based and self-directed services for the DD population) would be subsumed under a single CMS Research and Demonstration Waiver authorized by the Secretary of Health and Human Services under section 1115 of the Social Security Act. The benefits to the state of New Mexico would include:

- Reduced administrative burden in terms of federal reporting;
- Reduced activities involved in renewing federal waiver approval;
- Increased accountability for the more limited number of MCOs that will contract for the entire Medicaid population and their service array;
- Greater ease of provider compliance in dealing with the billing, authorization, formulary, and credentialing requirements of a more limited number of MCOs; and
- More focus from the State on the evolution of a service delivery system that focuses on outcomes and quality.

In addition, the State continues to seek ways to make the system less complex and burdensome on both beneficiaries and providers. The State believes that the comprehensive delivery system is an excellent place to make the program less complex to our beneficiaries and reduce the "siloing" of individuals depending upon their eligibility categories.

Single Credentialing Agency

The State is also exploring the concept of procuring the services of a single entity to credential and re-credential providers. While this approach may not save significant dollars, the State believes it will reduce administrative efforts for the medical community. The State would procure the services of a NCQA accredited agency in order to assure that no plan would put its NCQA status at risk. A centralized credentialing entity will assist in assuring that providers' information is accurate and up-to-date to minimize risks that payments will be delayed because a provider isn't properly "registered" in the state system.

Native Americans

New Mexico is home to 22 different tribal nations and pueblos. For over a century, the members of these tribes have looked to the Indian Health Service (IHS) as the federal obligation to provide their access to health care services under the treaties signed in exchange for their lands.

The IHS is often the only accessible health provider in the more remote frontier areas of the state. However, many Native Americans have found that they cannot rely solely on IHS to fulfill that obligation. Medicaid plays an increasingly significant role in funding health services for the Native American population in the state. In 2009, the state share of Medicaid cost of services provided to Native Americans off the reservation ($93 million) exceeded the 100% federal Medicaid share claimed for services provided to Medicaid-eligible Native Americans at either IHS or tribally contracted 638 health care facilities.

Despite the efforts of the Human Services Department and their providers:

- Native Americans continue to experience the greatest negative health disparities of any population in the state in terms of morbidity, mortality, and the consequences of substance abuse
- Over 60,000 Native Americans who are likely to be eligible for Medicaid have never enrolled
- Native Americans are confused as to where to go to seek care (IHS vs. private providers)
- Contract health funds and the service array available at IHS facilities continue to be reduced

Native Americans are confronted by a fragmented health care delivery system that functions one way when they reside on the reservation and another way when they do not. One potential solution to this fragmented service delivery system is the enrollment of the Medicaid–eligible Native American population in managed care.

Recognizing that there is legitimate concern among the Native American communities about being required to enroll in managed care, the state, in addition to the Tribal Consultation held in August, directed the consultants to convene informal workgroups and consultations in order to invite the community to work towards the goal of taking more control over parts of the system. (See Attachment C for a complete list of consultation).

During two days of an informal workgroup including Native American advocates and providers as well as representation from the IHS, the discussion focused on how the State might encourage the tribes to play a greater role in the management of their care through one of

the following options:

- Requiring the MCOs to contract with IHS and or 638 clinics as part of their networks so that Tribes who are able, are paid to provide primary care, care management and/or transportation and other basic health care services;
- Transforming existing clinics or other provider sites to function as Health Homes for Native American's with chronic conditions;
- Providing a subset of Medicaid services as a sub-capitated provider to the MCOs under the Global waiver; and/or
- Forming a Native American MCO that would contract directly with the state.

At this time it is the State's intent to move the Native American population into the comprehensive delivery structure but, at a minimum, require the plans to contract with on-site care managers and to engage a Native American clinical person to assist in developing strategies to reduce the enormous health disparities that continue to cost lives and money, while enhancing cultural appropriateness of care coordination, services and care delivery.

The State will work with the tribes to provide technical support towards converting existing clinics and/or developing provider sites that can function as integrated health homes for the care of those with chronic conditions. This will further enhance the opportunity for Native American Medicaid recipients to receive care and care coordination in their communities as well as potentially provide economic opportunities to the tribes.

In the past, the federal government has engaged in the process of contracting with Tribes for the delivery of health care services financed by the Indian Health Service. These activities were authorized by Congress under Public Law 93-638. The State is interested in extending this "638" self-determination process by exploring the use of "mini block grants" to any tribe or community that seeks to take greater control of Medicaid service delivery for their members. These mini-block grants can benefit the Native American communities by:

- Offering greater control of the service delivery system;
- Locating the focus of care coordination at the local level where individuals can receive culturally appropriate services from tribal members, overcoming the most frequently mentioned barrier to the success of the current CoLTS model in the Native American community;
- Encouraging the development of Native American care delivery systems as potential engines of economic opportunity; and
- Providing more opportunity for the Native American communities to serve their members regardless of whether those members are Medicaid eligible or not.

The option of creating a full-risk Native American MCO may not be feasible in the short-term due to the lack of capital and administrative infrastructure and expertise. However, in the future it should not be ruled out as a way for the tribes to design and manage health care that is accountable to their own people and their values.

These ideas will be explored more fully in both Tribal Consultation and informal workgroup settings.

New Mexico Stakeholder Input
Attachment A: New Mexico Stakeholder Input

During the months of July & August 2011, the State conducted a series of public stakeholder meetings to collect the concerns, opinions and advice of members, advocates, providers and citizens of all regions of New Mexico. Public meetings were heavily publicized and well-attended in the following locations:

Clovis, Civic Center – Wednesday, July 6, 2011
Farmington, San Juan College – Tuesday, July 12, 2011
Roswell, Public Library – Tuesday, July 26, 2011
Las Cruces, New Mexico Farm & Ranch Museum – Wednesday, July 27, 2011
Albuquerque, University of New Mexico – Thursday, July 28, 2011
Santa Fe, Willie Ortiz Building – Tuesday, August 2, 2011
Tribal Council, Indian Pueblo Cultural Center – Wednesday August 3, 2011

The following tables represent individual public comments made by attendees. The comments are categorized according to the four principles of the Medicaid modernization project.

Principle 1: Comprehensive Coordinated Delivery System

Comment/Consideration	Program Area
Single provider coordinating care for cancer patients.	Care Coordination
Outcome Measures focused on screening, care coordination, quality of life.	Quality
PACE model of care is best for Pueblo communities to deliver long-term care.	LTC
Include SSP services to the deaf/blind community as a Medicaid covered service.	Benefits
Need to increase the ability for small businesses and individuals to provide in small areas.	Providers
Support for community health workers. Have preventive care at home or community based or school based health centers	Access
More support for care givers. Programs like Mi Via people can hire their own support.	Benefits
Make it easier for people to keep working and get services at home.	Access
Respite for care givers. People who provide long term services develop their own problems.	Benefits
Not penalizing docs for conditions they can't control. Can't monitor when people eat or going to gym.	Benefits
Ending gross receipts tax for doctors.	Providers
Co-pays hurt patients and providers. Docs see fewer patients and patients seek fewer care.	Benefits
Improve access to services and resources to rural areas and create a competition; Transportation in rural areas.	Access
Comprehensive directory of providers would be helpful to patients; Even just a once a month clinic that came in to release pressure could relieve costs.	Access

Comment/Consideration	Program Area
Better verification of eligibility.	Access
Early intervention and preventative care make a big difference and are working. Would like to see more of that.	Quality
Integrate physical and behavioral health.	Benefits
Individualize teaching and training for a specific client or caregiver or family to take better care at home.	Model
Consumer wants to have more input into their care plan.	LTC
Respite hours based on acute level. Ability to bank that respite if not used one year. Roll over to the next year or get credit back at least.	Care Coordination
Supply coordination. Continuing to get supplies that they don't need. Huge waste. Local recycle deposit for the supplies	Model
More vouchers for assisting people with rent.	Benefits
Services coordinators for MCOs have too large caseloads.	Care Coordination
Better management of Fraud and abuse.	Quality
Don't cut attendant care hours. This leads to other things that cost more – example: hours cut and suffered injury while attendant wasn't there.	Benefits
Reward patient and providers for getting and giving preventative care, rather than charging co-payments for services. Would be a true partnership between patient and provider.	Model
Long-term care – 30 day requirement to get the waiver from a long-term care facility to home. Instead waive these requirements so people can get out when they want to get out. Cost savings will justify.	LTC
Adult Daycare may help people stay in home Occupational Therapy, PT and Speech Therapy Home based services.	Benefits
Criteria of services needs to be addressed.	Benefits
Quicker assessments; Base assessments on what the client is telling them instead of prompting them on what they may need.	Care Coordination
Define the diagnosis of developmental disability.	Benefits
Incentives. Giving people an incentive to go to work to get programs. Example: SSI or SSDI Ticket to Work program.	Model
More education to people about resources, i.e. behavioral health.	Model
Increase income limits, the guideline to obtaining waiver services.	Model
More Preventive services.	Benefits
Expand Tele-health.	Model
Cover vision services.	Benefits
Extend reenrollment; Express eligibility, if a child qualifies for free food, auto-enroll in New MexiKids.	Model
Healthcare for undocumented.	Model
Reduce prior auths required by MCO.	Model
Increase hours for TBI.	Benefits
Keep PCO.	Benefits

Principle 2: Personal Responsibility

Comment/Consideration	Program Area
Include health education; More education on taking medications. Keep them out of hospital; Quality of care givers under PCO. There needs to be better quality care givers. More than 40 hours of training and training should be specialized, especially with those people with Developmental Disabilities. Caregivers may not have the experience or training to support needs; Need outreach workers that go to communities.	Model
Include assistance scheduling preventive care.	Benefits
Offer nutrition classes.	Benefits
Offer access to exercise facilities.	Benefits
Study Native American populations separately when designing programs for health promotion and disease prevention; Reward and incentives need to be client specific.	Model
Internet access is not reliable in rural areas; Phone-based for those without internet	Access
Stop smoking aids	Benefits
Access to healthy foods in rural areas	Access
Don't make documentation by providers too labor intensive	Providers
Support service providers are working well	Benefits
Comprehensive Health Plan where everybody played a part – providers and patients • Skill building activities • Utilizing PCP to set goals • Preventative services as a mandatory benefits for participant of Medicaid • Mandatory training • Education • Economics All in conjunction with BH, agree with Parity.	Model
Providers responsibility • Rewarding patient by acknowledgement • Nurses are big on preventative care and can be an example • Provider incentives when patient gets healthier and stays healthier • Patient should see a benefit too by decreased co-pays. Universal electronic medical records will help with keeping track of medications	Model
Cut off payment after 2nd baby – Pay for 2 babies only; Time limit to program. . . moves to stair-step program to get them off.	Benefits
In ER, to prevent a violation the client has to be seen by a medical providers. . . could that be a nurse practitioner or MD who says this is not an emergency situation go to walk-in clinic.	ER
Need more dental health willing to take Medicaid	Benefits
If you don't have an area where a medical professional is available, do a triage and have a medical hotline that has the professional education to ask the right questions about an ER situation – Make mandatory.	ER

Comment/Consideration	Program Area
Keep Medicaid in schools and funding for School based health centers.	Access
Better transportation and access.	Access
Nurse and medical hotline.	Access
Extended hours for urgent care centers.	Access
Child care assistance.	Benefits
Co-payment for non-emergency ER if urgent care is open.	ER
Ensure more behavioral health and substance abuse providers.	Access
Financial incentives – gas cards and school supplies.	Model
State needs to be better, effective outreach programs.	Model
Develop a stair-step program to get people off Medicaid.	Model
Better regulation on TANF and Food Stamps (can't buy candy or pop or cigarettes).	Model
Could be a sliding scale to co-pays; No co-pays for non-generic drugs. Generic medications react different with some people.	Benefits
Volunteer to help pay for the premiums.	Model
Often times people go to ER because they run out of medications. – Need a better way to get them their medications.	Access
Health home for physical care – What about a pharmacy home? Coordination between pharmacies to help manage the medications.	Model
Funding mobile crisis response in rural areas.	Access
No shows, cost money. Needs to be some kind of consequence that is very sensitive and tailor made.	Model
IHS should be a performance based pay provider using bench marks and quality control measures.	Quality
IHS needs to develop secondary services based on epidemiology data, chronic disease patterns.	Access
Reward PCPs who achieve healthy behaviors of their patient panels.	Model
Limited access to PCP in rural areas • Access to specialists • Follow up services • Preventative services • Telemedicine Crisis units in rural areas	Access
Cost to copy records.	Technology
Access between physicians. Physicians not talking to each other.	Providers
Electronic Medical Systems not universal.	Technology
Service duplication due to records.	Technology
Information not being shared between doctors and hospitals.	Technology
Helping providers hold people accountable – need more doctors that can spend a longer period of time with patients to get to know them and develop a relationship to encourage them to take more responsibility for their own care.	Providers
Relates to recruitment and retention of doctors in rural and frontier areas.	Access

Principle 3: Pay for Performance

Comment/Consideration	Program Area
Should be rewards built in for preventative health care, particularly there seems to be a lack of services for adults on the Medicaid side.	Model
Coordination of care activities for both PH and BH need to have parity with face to face contact or treatment activities to coordinate care.	Care Coordination
ECHO program – Telemedicine/teleheatlh program that is involved with educating providers as well as volunteers, aimed at chronic disease. Now been informed that Molina is paying providers to present cases. In a larger area not a big deal, but in rural area it is. Can it be incorporated at some level in Medicaid Modernization.	Benefits
Expansion of promaturas throughout the state.	Model
Doctors not getting adequate reimbursement.	Providers
Lose middle management.	Model
Have all service fees the same across the board for all providers.	Providers
State needs to focus on the top five arenas of physical and mental health.	Model
Operational definitions need to be identified.	Model
Look at high users and provide incentive goals to lower use.	Model
Let providers develop and incentivize.	Model
On recipient end – have levels of co pays. People who do not take doctor's advice to improve their health will be charged higher co pays after the first year on the program.	Model
Part of Medicaid eligibility requirement is to make a mandatory one year screening package. Saves catastrophic down the road.	Model
Incentives – like car insurance if you don't have accidents you get money back. Under Health Care Reform would be good to have incentives for not over utilizing care.	Model
Keep all 12 waivers as we have them. Global gives opportunity below 1902 baseline. Very risky to manage ourselves.	Model
Home visits generated by providers. If providers generate it will help keep people healthy. Check-ups would reduce visits to hospital.	Benefits
Money incentives to stay healthy.	Model
Make recipients aware of the costs. Send out information on how much their visits cost.	Model
System change, such as student loan forgiveness program for Medicaid providers. Look at percentage of Medicaid clients they take throughout their career.	Model
Needs to be an easier process for prescribing doctors to be able to order medication. MCOs need to be better at helping people get the right medications.	Access
Need to see people more quickly before an ER visit.	ER
Rural areas, such as Hatch and Anthony don't have urgent care and their only option is ER; Urgent care is not available or closes early.	ER
Need to use a hot/warm line staffed by nurses to determine if an ER visit is necessary.	ER
How come Medicaid only covers certain transportation companies and not a wider variety.	Access
Community based health at the schools.	Access
Alternative hours/extended hour.	Access
Penalty fee for no shows and cancellations.	Model
Incentivize clinics for holding patients accountable.	Model

Principle 4: Administrative Simplicity

Comment/Consideration	Program Area
Native Americans should be allowed to opt-out for CoLTS and Salud.	Model
Consider a waiver specifically for Native American "carve-out" and make them totally dependent on federal funding thus relieving the state of FMAP.	Model
Understanding eligibility is problematic in reservation communities.	Model
Design and implement a centralized Managed care; Financial Accounting and Analysis Bureau (MCFAAB) Meet all financial reporting requirements Complete capitation reconciliation Managed care enrollment Desktop Recoupments MCO/state expenditure analysis Related performance measure computations Provide data to actuaries, Legislative committee, etc	Model
Hospitals would like to see a reduction in the number of MCOs to negotiate with.	Providers
Include behavioral health to coordinate physical and behavioral through a single MCO.	Model
Streamline physical and administrative access of Native Americans to the healthcare system.	Model
Slowly decrease non-mandatory services by reducing services to the healthy first and chronically ill last.	Model
Do not introduce additional premiums or co-payments.	Model
Review Scopes of Practice and allow providers to work at the "top of their scope" and to the fullest extent of their education and NM law.	Providers
Consider competitive bidding.	Model
Simplify re-enrollment process, especially with chronic conditions.	Model
Simplify the credentialing process for providers.	Model
Increase provider incentives to work in rural areas.	
Tort reform brought up to increase doctors who want to practice in NM and reduce overutilization of services.	Model
Have to have a one-stop shop for eligibility.	Model

New Mexico Waivers

Attachment B: Waiver Services

	Salúd! 1915(b)	Behavioral Health Services 1915(b)	CoLTS 1915(b) 1915(c)	MiVia 1915(c) (ICF/MR and NF Waivers)	DD 1915 (c)	Medically Fragile 1915 (c)	AIDS 1915 (c)	CHIP 1115 (services for which a co-pay is required)	SCI (services for which a co-pay is required)
Accredited Residential Treatment Center Services		✔							
Adult Day Health			✔						
Ambulatory Surgical Services	✔		✔						
Anesthesia Services	✔		✔						
Assertive Community Treatment Services (ACT)		✔							
Assisted Living			✔	✔					
Assistive Technology					✔				
Audiology Services	✔		✔						
Behavior Support Consultation				✔	✔	✔			
Behavior Management Skills Development Services		✔							
Behavioral Health and Substance Abuse: Outpatient Office Visit and Outpatient Substance Abuse Treatment Inpatient Behavioral Health and Inpatient Detox								✔	✔
Case Management	✔		✔		✔	✔	✔		
Community Direct Support				✔					
Community Integrated Employment Services									
Community Transition Relocation Specialists					✔				
Community Transition Services			✔						

	Salúd! 1915(b)	Behavioral Health Services 1915(b)	CoLTS 1915(b) 1915(c)	MiVia 1915(c) (ICF/MR and NF Waivers)	DD 1915 (c)	Medically Fragile 1915 (c)	AIDS 1915 (c)	CHIP 1115 (services for which a co-pay is required)	SCI (services for which a co-pay is required)
Comprehensive Community Support Services		✔							
Consultant Support Guide				✔					
Crisis Supports					✔				
Customized Community Supports				✔	✔				
Customized In-Home Living Supports				✔	✔				
Day Treatment Services		✔							
Dental Services	✔		✔		✔			✔	✔
Diabetes Treatment									✔
Diagnostic Imaging and Therapeutic Radiology Services	✔		✔						✔
Dialysis Services	✔		✔						✔
Durable Medical Equipment and Medical Supplies	✔		✔						✔
Emergency Response			✔	✔					
Emergency Services (including emergency room visits)	✔		✔					✔	✔
Employment Supports				✔					
Environmental Modifications			✔	✔	✔				
EPSDT	✔		✔						
EPSDT Personal Care	✔		✔						
EPSDT Private Duty Nursing	✔		✔						
Family Planning	✔		✔						
Federally Qualified Health Center Services	✔								
Home Health Aide				✔		✔			

	Salúd! 1915(b)	Behavioral Health Services 1915(b)	CoLTS 1915(b) 1915(c)	MiVia 1915(c) (ICF/MR and NF Waivers)	DD 1915 (c)	Medically Fragile 1915 (c)	AIDS 1915 (c)	CHIP 1115 (services for which a co-pay is required)	SCI (services for which a co-pay is required)
Home Health Services	✔		✔						✔
Homemaker/Direct Support Services				✔					
Homemaker/Personal Care							✔		
Hospice Services	✔		✔						
Hospital Inpatient	✔	✔	✔					✔	✔
Hospital Outpatient	✔	✔	✔					✔	✔
Independent Living Transition Service					✔				
Inpatient Hospitalization in Free Standing Psychiatric Hospitals		✔							
Intense Behavioral Support					✔				
Intense Medical Living Supports					✔				
Laboratory Services	✔		✔						
Licensed Alcohol and Drug Abuse Counselors		✔							
Living Supports					✔				
Multi-Systemic Therapy Services		✔							
Non-Accredited Residential Treatment Centers and Group Homes		✔							
Nursing					✔				
Nursing Facility Services			✔						
Nutritional Counseling				✔	✔	✔			
Nutritional Services	✔		✔						
Occupational Therapy			✔		✔				✔
Oral Surgery									✔
Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospital		✔							

	Salúd! 1915(b)	Behavioral Health Services 1915(b)	CoLTS 1915(b) 1915(c)	MiVia 1915(c) (ICF/MR and NF Waivers)	DD 1915 (c)	Medically Fragile 1915 (c)	AIDS 1915 (c)	CHIP 1115 (services for which a co-pay is required)	SCI (services for which a co-pay is required)
Outpatient Health Care Professional Services		✔							
Personal Care Services			✔						
Personal Plan Facilitation				✔					
Personal Support/Companion					✔				
Personal Support Technology/On-Site Response Site					✔				
Pharmacy Services	✔	✔	✔						
Physical Health Services	✔		✔						
Physical Therapy			✔		✔				✔
Physician Visits		✔			✔			✔	✔
Pregnancy Termination Procedures	✔		✔						✔
Preliminary Risk Screening and Consultation Related to Inappropriate Sexual Behavior					✔				
Prescriptions								✔	✔
Preventive Services	✔		✔						
Private Duty Nursing			✔	✔	✔	✔	✔		
Prosthetics and Orthotics	✔		✔						
Psychosocial Rehabilitation Services		✔							
Reconstructive Surgery									✔
Rehabilitation Services	✔		✔						✔
Related Goods				✔					
Reproductive Health Services	✔		✔						
Respite			✔	✔	✔	✔			
School-Based Services	✔	✔	✔						

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Service Coordination			✔						
Skilled Maintenance Therapy Services (including OT, PT and Speech)			✔						
Skilled Therapy for Adults				✔		✔			
Socialization and Sexuality Education					✔				
Specialized Medical Equipment and Supplies						✔			
Special Rehabilitation			✔						
Specialized Therapies				✔					
Speech and Language Therapy			✔		✔				✔
Telehealth Services	✔								
Tot-to-Teen Health Checks	✔		✔						
Transplant Services	✔		✔						
Transportation (Medical)	✔		✔						
Transportation (Non-medical)				✔	✔				
Treatment Foster Care	✔								
Treatment Foster Care II	✔								
Vision Services	✔		✔						
Women's Health Services									✔

Attachment C: Outreach to Native Americans

Meeting and Attendees	Date
Tribal Consultation, Pueblo Cultural Center, Albuquerque. 79 individuals attended. Secretary Squiers outlined the 4 principles of the Modernization effort and the State's desire to create a comprehensive, integrated system of care for New Mexico. There was mixed feedback from the attendees ranging from an emphasis on the state and the federal governments honoring the treaty obligations to provide health care to Native Americans to concerns about managed care to advocating of managed care as a way of decreasing health disparities.	August 3, 2011
As part of the outreach effort, the Department of Human Services and Alicia Smith & Associates scheduled a 2-day workgroup with invited staff from the Indian Health Service and the tribes. The meetings were held at the HSD offices in Santa Fe, New Mexico. The attendees included: Brent Earnst – Deputy Secretary HSD Theresa Belanger – Native American Liaison HSD Betina McCracken – Secretary's Office HSD Kim Horan – HSD David Antle –Pueblo of Isleta Roxanne Spruce Bly – Bernalillo County off-Reservation Native American Health Commission Robin Clemmons – Pueblo of Acoma Richie Grinnell – IHS Earlene Groseclose – IHS Lisa Maves – Pueblo of Jemez April Wilkinson – Pueblo of Acoma Jennifer Nanez – Pueblo of Acoma Sandra Winfrey – IHS Comments included: Concerns with the managed care experience with the CoLTS program. Some stated that it their members had never seen a care coordinator from the CoLTS plans; Recent experiences with Salud plans have been better; A full-blown Native American MCO is probably not an option at this point, although there was interest in managing discrete portions of the Medicaid benefit; Discussion of the role that IHS and tribal 638 facilities could play in managed care as Patient Centered Medical Homes and/or Health Homes as both a means of economic opportunity and a way to let Native American's play a more active role in providing care; Care coordination and case management must be done locally if it is to be meaningful and successful for tribal members	September 28-29, 2011
As a follow-up to the workgroup meetings, Alicia Smith and David Parrella from Alicia Smith & Associates met with Governor Lujan at the Laguna pueblo to discuss economic opportunities that could be available to the tribes under a managed care model.	October 4, 2011
Alicia Smith met witih Dr. Ron Lujan and his son, Eric as well as with Robin Clemmons from Acoma to discuss their concerns and desire for a more active role in providing care to their own Tribes. They also shared their concerns that the current plans in New Mexico do not contract with and/or reimburse Tribes for care management and transportation services they provide. They would like to see a replication of a PACE-like model.	Week of October 10th, 2011

Meeting and Attendees	Date
David Parrella travelled to Window Rock to meet with Roselyn Begay, the Director of the Navajo Nation Department of Health, and the members of her staff. Also in attendance was Floyd Thompson from the Window Rock Area Office of the Indian Health Service. Comments included: Interest in contracting with the state to manage some portion of the Medicaid budget, but frustration that they could not contract directly with CMS. One stated goal was that ultimately the Navajo Nation would like to be able to manage its own Medicaid program as a carve out from the Four Corners states (New Mexico, Arizona, Utah, Colorado) Any contract with the state to manage Medicaid benefits would need to include risk corridors to protect the tribe from catastrophic costs Eligibility intake at the IHS facilities is an issue since many tribal members lack transportation and have to hitch-hike to the hospital for services. When they are referred to out-stationed eligibility workers for Medicaid intake, they often do not have the necessary documentation with them and are required to make another trip to apply.	November 4, 2011
David Parrella met with Dr. Ron Lujan and his son, Eric, from the Taos Pueblo in Albuquerque. Comments included: Dr. Lujan was opposed to any attempt to force the enrollment of Native Americans in private for-profit managed care companies. He was very clear about his desire for the state to maintain the "opt out" option from managed care for Native Americans. Dr. Lujan is interested in a model where the state would contract to a consortium of Native American service providers for the elderly along the lines of the PACE program.	November 4, 2011
David Parrella to meet with members of the Albuquerque Area Indian Health Board	December 8, 2011
Follow-up Tribal Consultation to review the Final Concept Paper	TBD