

**Medicaid 1115 Waiver Renewal Subcommittee Meeting**  
**Meeting Minutes**  
**November 18, 2016 — 8:30am – 11:30am**  
**Presbyterian Cooper Center 9521 San Mateo Blvd. NE, Albuquerque, New Mexico**

**Subcommittee Members:**

Myles Copeland, Aging & Long-Term Services Department David Roddy, New Mexico Primary Care Association Dawn Hunter, Department of Health Jeff Dye, New Mexico Hospital Association  Christine Boerner, Legislative Finance Committee Joie Glenn, New Mexico Association for Home & Hospice Care Kristin Jones, CYFD (proxy for Sec. Jacobsen) Carol Luna-Anderson, The Life Link  Mary Kay Pera, New Mexico Alliance for School-Based Health Care	Jim Jackson, Disability Rights New Mexico Linda Sechovec, New Mexico Health Care Association Sandra Winfrey, Indian Health Service Naomi Sandweiss, Parents Reaching Out (proxy for Lisa Rossignol) Dave Panana, Kewa Pueblo Health Corp. Mary Eden, Presbyterian Health Plan Fritz Hardy (proxy for Doris Husted), The Arc of New Mexico Rick Madden, New Mexico Medical Society Carolyn Montoya, University of New Mexico, School of Nursing Lauren Reichert (proxy for Steve Kopelman), New Mexico Association of Counties
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**Absent Members:**

Steve Kopelman, New Mexico Association of Counties Kris Hendricks, Dentistry for Kids Monique Jacobsen, Children Youth and Families Department	Patricia Montoya, New Mexico Coalition for Healthcare Value Lisa Rossignol, Parents Reaching Out Doris Husted, The Arc of NM
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**Staff and Visitors Attending:**

Nancy Smith-Leslie, HSD/MAD Angela Medrano, HSD/MAD Wayne Lindstrom, HSD/BHSD Karen Meador, HSD/BHSD Michael Nelson, HSD Kari Armijo, HSD/MAD Dan Clavio, HSD/MAD Kim Carter, HSD/MAD	Robyn Nardone, HSD/MAD Tina Sanchez, HSD/MAD Laine Snow, HSD/BHSD Cynthia Melugin, HSD/BHSD Jared Nason, Mercer Jessica Osborne, Mercer Cindy Ward, Mercer Amilya Ellis, UHC
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<p>Tallie Tolen, HSD/MAD Theresa Belanger, HSD/MAD Curt Schatz, UHC Liz Lacouture, PHP Jessica Bloom, Consumer advocate Pauline Lucero, Isleta Elder Center Lisa Maury, New Mexico Coalition to End Homelessness Maggie McCowen, New Mexico Behavioral Health Providers Assoc. Elly Rael, UHC Jeanene Kerestes, BCBSNM Shawna Romero, BCBSNM Mary Kate Nash, HCS/Molina</p>	<p>Patricia Lucero, Isleta Elder Program Teresa Turietta, New Mexico Assoc. Home &amp; Hospice Care Margaret White, HealthInsight New Mexico Debi Peterman, HealthInsight New Mexico Jennifer Crosbie, Senior Link Deanna Talley, Molina Kyra Ochoa, Santa Fe County Rachel Wexler, DOH Sarah Howse, PMS Beth Landon, NMHA</p>
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Agenda Item	Details	Discussion
I. Introductions	<ul style="list-style-type: none"> <li>• Jared Nason from Mercer and Angela Medrano delivered opening comments.</li> <li>• Reviewed options for providing comments and recommendations in addition to the meeting.</li> <li>• Presented agenda overview.</li> </ul>	<ul style="list-style-type: none"> <li>• Medical Assistance Division (MAD) would like everyone to have the opportunity to contribute ideas and recommendations for the waiver renewal</li> <li>• All are encouraged to use the website to submit additional comments that were not mentioned during the meetings.</li> <li>• All recommendations regarding care coordination (CC) and population health should be submitted by November 30, 2016.</li> </ul>
II. Care Coordination – Transitions of Care	<ul style="list-style-type: none"> <li>• Identify funding to focus on facilities improving discharge planning.</li> <li>• Enhanced care coordination as part of transitions (short-term):               <ul style="list-style-type: none"> <li>– Jail release, inpatient stay, nursing facility to community, children in residential facilities.</li> </ul> </li> <li>• Incentives for outcomes of a successful discharge:               <ul style="list-style-type: none"> <li>– Attend follow up PCP visit, no unnecessary ED visit post discharge for 30 days, no preventable readmission post discharge for 30 days, filling medications, completing medication reconciliation (provider).</li> </ul> </li> <li>• Incentives for member adherence to recommended follow-up.</li> <li>• Member rewards.</li> </ul>	<ul style="list-style-type: none"> <li>• Carolyn commented that many members do not have a primary care physician (PCP) and cannot get one assigned quickly enough.</li> <li>• Wayne commented that Behavioral Health Services Division (BHSD) will have an emergency department (ED) information exchange tool next year that will help promote real time interventions.</li> <li>• Children, Youth, and Families Department (CYFD) recommended focus on out-of-home placement transitions in addition to residential.</li> <li>• Mary noted that Presbyterian is working on the Emergency Department Information Exchange (EDIE) system Wayne referred to, phase 1 rolls out November. Most hospitals are in final contract phase and will sign and link-in by the end of 2016.</li> <li>• MAD should focus on elements of the system that are least likely to be “thrown-out” under the new Federal administration.</li> <li>• Measure discharge outcomes at 30 and 60 days for released inmates as this is a critical time particularly for those with substance abuse issues.</li> <li>• Managed care organizations (MCOs) need information at discharge as quickly as possible.</li> </ul>

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		<ul style="list-style-type: none"> <li>• Dave noted that most Native American Members are in fee-for-service (FFS). There is a practice in place to assign care manager who sees member prior to discharge and provides assistance with PCP follow-up, durable medical equipment and prescription. This is a challenge because the practice is only open Monday through Friday. This could be replicated in other practices.             <ul style="list-style-type: none"> <li>— Many tribes have community health representatives performing care management tasks but are not reimbursed for it.</li> </ul> </li> <li>• Jeff Dye commented that hospitals are challenged by unnecessarily long “Awaiting Placement” status during the approval process. Auto authorizations or a supplement payment to hospital would “grease the skids for approval.”             <ul style="list-style-type: none"> <li>— Expand readmission measure to look at what caused the readmission.</li> </ul> </li> <li>• Linda commented to look at Illinois model for Medicaid billing during discharge planning for incarcerated individuals.             <ul style="list-style-type: none"> <li>— Look at medication reconciliation practices between hospital and receiving facility to identify discharge issues.</li> </ul> </li> <li>• Carol noted that transition is complicated by homelessness and is a cost driver.</li> <li>• Joie commented that skilled nursing visits after discharge is underutilized and should be incented.</li> <li>• David requested additional data on the transition issues. Notes that it appears that each MCO would be challenged to cover all hospitals. Recommends considering a consolidated approach and not require four MCOs to</li> </ul>

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		build care management programs. – Review Colorado’s regional approach to care coordination.
III. Care Coordination – Higher Needs Populations	<ul style="list-style-type: none"> <li>• Improved engagement of family and other community supports:               <ul style="list-style-type: none"> <li>– Family/caregiver role, increase use of community health workers / Certified Peer Support Workers (CPSWs).</li> </ul> </li> <li>• Promote creative approaches by MCOs to support unique high needs populations.</li> <li>• Focused education and interventions that are condition or location specific:               <ul style="list-style-type: none"> <li>– Areas with fewer providers, transportation issues and/or specific cultural aspects, areas with high risk pregnancies, with high prevalence of diabetes, chronic obstructive pulmonary disease and other chronic diseases.</li> </ul> </li> <li>• Use of Community Health Workers for more intensive "touch" for these members.</li> <li>• Expand health homes.</li> <li>• Use of population health information to develop targeted education and interventions.</li> </ul>	<ul style="list-style-type: none"> <li>• Carolyn noted concern about increasing the family/caregiver role and stated that we rely heavily on parents who best understand a child’s complex needs however “we are turning parents into nurses and if we are doing that there needs to be more in terms of respite for these families.”</li> <li>• Lauren recommended looking at personal care services (PCS)-like payment for home care for a few hours a week if the family is doing the work anyway.               <ul style="list-style-type: none"> <li>– Consider use of incentives, gift and gas cards when Members achieve certain goals. Expand comprehensive community support (CCS) billing to others outside core services agencies and allow intensive case management (ICM) to bill as well. Allow transportation workers to have the opportunity to engage members and expand their role from "bus driver" to support staff.</li> </ul> </li> <li>• CYFD is investing in a wraparound model: child and family teams that has large care coordination components; they have identified support of the family and family child team.               <ul style="list-style-type: none"> <li>– Consider children who are being reunited with their family as a higher need population. Without appropriate services that are timely, the reunification is at-risk.</li> <li>– The intensity of care coordination is higher than people receive in the current model. Caseloads are too high for this population.</li> <li>– Focus on health literacy and developing providers that</li> </ul> </li> </ul>

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		<p>will communicate to members about available resources. Look at strategies that support participation in needed services and activities.</p> <ul style="list-style-type: none"> <li>• Carol notes that caseloads are too high. 1:200 case load is not a relationship; the relationship is what brings change and builds engagement; and is why peer support workers work- they have a relationship with members.             <ul style="list-style-type: none"> <li>— Mercer asked for Carol to add information on how to prioritize care coordination considering a limited number of available care coordinators and limited funding: where should the State focus for this recommendation.</li> </ul> </li> <li>• Mary Kay Pera: School-based health centers should be leveraged better. They are identifying kids at risk for emotional and physical needs including prenatal care. The kids trust the support staff there, and they know these children; mostly school clinicians and other support staff at schools. They are ideal for care coordination of adolescents.</li> <li>• MCOs should collaborate with local community resources and provide compensation to the local resources that provide CC to members; these community service providers are doing CC (MCO and FFS members and not getting reimbursed for this).</li> <li>• Consider concept of Para-Medicine: Emergency medical services contact high users/hard to engage and form relationship in a way that no other health worker really has and results are promising.</li> <li>• Naomi, proxy for Lisa Rossignol: "Members are saying they do not even know about CC" or "my CC keeps changing" and "if I speak Spanish, phone contacts are more challenging, and we would prefer face-to-face</li> </ul>

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		<p>contacts".</p> <ul style="list-style-type: none"> <li>• Monique commented about transition for youth aging out of foster care and juvenile justice system; high risk for homelessness and incarceration.             <ul style="list-style-type: none"> <li>– Explore Youth Peer Support Workers.</li> </ul> </li> <li>• Fritz noted that guardians get left out of transition and discharge conversations.             <ul style="list-style-type: none"> <li>– There are too many CCs; parents of kids on Waivers have too many CCs to share their story; provide more services to the parent- do not need all of these CCs (adult children in parent's home).</li> <li>– CCs are not completing tasks requested of them.</li> </ul> </li> <li>• Dave commented that MCOs are not held accountable; assessments for Tribal members are not occurring; so shift the money or put stronger requirements on the MCOs; majority of tribes are complaining about the MCO conducting assessment as they (the Tribal members) already know the member and do not see value in the duplication of effort to assess by MCO.</li> <li>• Lauren commented that counties are using cash accounting versus accrual practices; could we get help to switch to accrual to work more effectively with Medicaid.</li> </ul>
<p>IV. Care Coordination – Provider Role</p>	<ul style="list-style-type: none"> <li>• Consider pilot opportunities for MCOs to incorporate local supports (regional systems, homeless, family members) into care coordination.</li> <li>• MCOs could share dollars with local programs for direct linkages to members.</li> <li>• MCO and Provider Incentives for outcomes.</li> <li>• Value-based payment approaches mean more responsibility for providers to provide</li> </ul>	<ul style="list-style-type: none"> <li>• General comment and discussion:             <ul style="list-style-type: none"> <li>– Focus on a higher level of physical health-behavioral health (PH-BH) integration.</li> <li>– Competencies within CC and with providers are in siloes. Example - anxiety disorders showing up as chest pain; and those with chronic or acute PH conditions show up as having emotional issues; Look for ways to do a better job integrating and educating providers. Note – This is the topic for the December meeting.</li> </ul> </li> </ul>

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	<p>care coordination to meet value based payment goals.</p> <ul style="list-style-type: none"> <li>• Value-based payment approaches will involve / delegate care coordination to providers.</li> </ul>	<ul style="list-style-type: none"> <li>– Patient-centered medical homes (PCMHs) are doing this: if they are meeting the requirements of the PCMH; it is more than training it is frame of mind to be open to assisting BH comorbidities.</li> <li>– Community Asset Mapping and Hospital Community level data should be built into the CC model.</li> <li>– In Long Term Care (LTC): facilities need a better understanding of where the MCO CC and the hospital CC roles lie and how they work toward the same goals.</li> <li>– Providers need clarification on what information can be shared especially those that provide confidential services.</li> <li>– We are not hearing from everyone who is touching or caring for a member and it builds a holistic view of the member and their needs.</li> <li>– MCOs are getting paid for CC while the community CC is still occurring. They are not getting the financial support and the "addition" of MCO CC is not only a waste of dollars, it further fragments CC for the member.</li> <li>– If we are thinking about moving CC and "flexing" where CC occurs the MCO requirements need to be aligned and accountable for things they can control and report.</li> <li>• Mary Kay -School-based clinics are doing PH-BH integration.             <ul style="list-style-type: none"> <li>– Need flexibility for where CC exists: community needs likely vary and it could vary by individual where the 'best' place for CC may be for that member.</li> </ul> </li> <li>• Fritzi mentioned that provider turn-over means that the</li> </ul>



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V. Population Health	<ul style="list-style-type: none"> <li>• Consider pilot opportunities for MCOs to incorporate local supports (regional systems, homeless, family members) into care coordination.</li> <li>• MCOs could share dollars with local programs for direct linkages to members.</li> <li>• MCO and Provider Incentives for outcomes.</li> <li>• Value-based payment approaches mean more responsibility for providers to provide care coordination to meet value based payment goals.</li> <li>• Value-based payment approaches will involve / delegate care coordination to providers.</li> </ul>	<p>term Medical Home really isn't a home.</p> <ul style="list-style-type: none"> <li>• Department Health has robust collection of health data; use existing data that looks at highest disease burden.</li> <li>• Consider the following populations for focus:               <ul style="list-style-type: none"> <li>– Tobacco use</li> <li>– Obesity</li> <li>– All high cost drivers</li> <li>– High teen birth rates</li> <li>– Geography: looking at neighborhoods</li> <li>– Food deserts</li> <li>– High pollution</li> <li>– Seniors age 60 and beyond</li> <li>– High-risk populations coming out of jail.</li> </ul> </li> <li>• Secretary Copeland - Support family care givers who support this population through Alzheimer's Association and Savvy Care Giver program to relieve care giver burden.</li> <li>• General comment and discussion:               <ul style="list-style-type: none"> <li>– Consider partnering with Senior Centers and providers to help keep people in their homes.</li> <li>– Support Senate Bill-42 to improve justice reform and divert Medicaid members prior to being incarcerated through diversion programs.</li> <li>– Provide police training for people with identified mental health (MH) issues versus criminal issues.</li> </ul> </li> <li>• Naomi commented that adverse childhood experiences and link to health outcomes and incarceration and substance abuse (SA).</li> <li>• CYFD commented to focus on parents who have children at risk for out of home placement.</li> </ul>

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		<ul style="list-style-type: none"> <li>— Employment of CYFD youth; need jobs and life skills.</li> <li>• Carol Luna-Anderson: MH and trauma population have shorter life-expectancy and disparities in outcomes. Many are tobacco users and have poorer self-care and the chronicity of disease tends to be high cost toward end of disease.</li> <li>• Fritzi notes that she has heard for years that we need a resource book and if it is created, it is out of date almost immediately or focuses on specific populations such as individuals with developmental disabilities.</li> <li>• Wayne commented that the BH collaborative has an automated portal and contains a resource directory for LTC and Veterans Services. Providers can enter detailed information on the service and within 24 hours, a provider is contacted to verify the information. Information is uploaded to the system after validation occurs.             <ul style="list-style-type: none"> <li>— A service directory will only be good if providers update their information.</li> <li>— The MCOs could require that their providers supply information.</li> <li>— There is a site called New Mexico Network of Care: 3 Different Portals.</li> <li>— CYFD has a site for community resources.</li> <li>— Affordable Housing is a real need: support and supported housing services are desired and can impact outcomes.</li> </ul> </li> <li>• MCO: The new Medicaid Management Information System will be a great tool to look at health issues and disparities.</li> <li>• Support services really are keys to improving population health outcomes.</li> </ul>

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		<ul style="list-style-type: none"> <li>• Karen commented that some states have added services to support pre-tenancy and staying in housing.               <ul style="list-style-type: none"> <li>– Supports that help keep them in housing and linking to service and health supports.</li> </ul> </li> <li>• Department of Health commented that there is a lack of education for providers to identify SA issues and social determinants of health needs.               <ul style="list-style-type: none"> <li>– Not everything that is needed can be solved by Medicaid; and not everything can be "outcomes" based and aging is an example. Outcome measures can drive restriction to care. For example, reducing readmissions rates can be achieved by not admitting them to avoid the penalty.</li> </ul> </li> <li>• General comment and discussion:               <ul style="list-style-type: none"> <li>– Language we use in waiver should appeal to new administration and focus on needs of rural areas.</li> <li>– Rural transportation is major New Mexico issue, particularly with seniors.</li> </ul> </li> <li>• David-Tribal technical advisory committee for the Centers for Medicare and Medicaid Services and wants HSD to vet decisions with all tribes and not just those who attend meetings; thinks it should be on the agenda to really get input and share 1115 ideas with Tribes.</li> </ul>
VI. Public Comments	<ul style="list-style-type: none"> <li>• Care coordination service is needed at the community level</li> <li>• Keep a broad view of population health statewide and note many contributing factors</li> <li>• Importance of cultural competency</li> </ul>	<ul style="list-style-type: none"> <li>• Need hands-on care coordination services at the community level:               <ul style="list-style-type: none"> <li>– Santa Fe County has identified top give needs: three BH issues, food access, and homelessness.</li> <li>– We need better provider alignment throughout the system and communities.</li> <li>– Santa Fe County would like to partner with HSD/MAD to pilot better care coordination and develop a</li> </ul> </li> </ul>

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		<p>regional health support system.</p> <ul style="list-style-type: none"> <li>• Utilizing regional and community health councils may be beneficial and progress made with the State Innovation Models grant project should be noted.</li> <li>• Cultural competency and effective use of resources are important.</li> <li>• Requested not using acronyms.</li> </ul>
VII. Meeting Close	<ul style="list-style-type: none"> <li>• Follow-up materials</li> <li>• HSD contact protocol</li> <li>• Next meeting date</li> </ul>	<ul style="list-style-type: none"> <li>• Instructions for how the subcommittee should submit comments.</li> <li>• Request all care coordination and population health recommendations are submitted by November 30, 2016.</li> <li>• Next meeting is on December 16, 2016 in Santa Fe at the Administrative Services Building on Rodeo Road.</li> </ul>

**Acronym Guide for MAD / HSD 1115 Waiver Renewal Process**

ABCB – Agency-Based Community Benefit  
ACO – Accountable Care Organization  
ADL – Activity of Daily Living  
ALTSD – NM Aging and Long Term Services Department  
BCBSNM – Blue Cross Blue Shield of NM  
BH – Behavioral Health  
BHSD – Behavioral Health Services Division of the HSD  
CB – Community Benefit  
CBSQ - Community Benefit Services Questionnaire  
CCBHCs - Certified Community Behavioral Health Clinic  
CC – Care Coordination  
CCP – Comprehensive Care Plan  
CCS – Comprehensive Community Support  
CHIP – Children’s Health Insurance Program  
CHR – Community Health Resources  
CMS – Centers for Medicaid and Medicaid Services, division of the HHS  
CNA – Comprehensive Needs Assessment  
CPSW – Certified Peer Support Worker  
CSA – Core Service Agency  
CYFD – NM Children, Families and Youth Department  
DD – Developmental Disability and Developmentally Disabled  
D&E – Disabled and Elderly  
DOH – NM Department of Health  
ED – Emergency Department  
EDIE – Emergency Department Information Exchange  
EPSDT – Early and Periodic Screening, Diagnostic, and Treatment  
EVV – Electronic Visit Verification  
FAQ – Frequently Asked Questions  
FF – Face to Face  
FFS – Fee for Service  
FQHC – Federally Qualified Health Center  
HCBS – Home and Community-Based Services  
HH – Health Home  
HHS – US Health and Human Service Department  
HRA – Health Risk Assessment  
HSD – NM Human Services Department  
IHS – Indian Health Service  
IP – In-patient  
LOC – Level of Care  
LTC – Long Term Care  
LTSS – Long-Term Services and Supports  
MAD – Medical Assistance Division of the HSD  
MC – Managed Care  
MCO – Managed Care Organization  
MH – Mental Health  
MMIS – Medicaid Management Information System  
MMISR – Medicaid Management Information System Replacement  
NF – Nursing Facility  
NF LOC – Nursing Facility Level of Care

NMICSS – NM Independent Consumer Support System  
PCMH – Patient-Centered Medical Home  
PCP – Primary Care Physician  
PCS – Personal Care Services  
PH – Physical Health  
PH-BH – Physical Health – Behavioral Health  
PHP – Presbyterian Health Plan  
PMS – Presbyterian Medical Services (FQHC)  
SA – Substance Abuse  
SBHC – School-Based Health Center  
SDCB – Self-Directed Community Benefit  
SED – Severe Emotional Disturbance  
SMI – Serious Mental Illness  
SOC – Setting of Care  
SUD – Substance Use Disorder  
UHC – United Health Care  
VBP – Value-Based Purchasing