Stakeholder Engagement Process Leading to Development of Concept Paper

1. MAC 1115 Waiver Renewal Subcommittee, October 14, 2016

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

AGENDA

MAC 1115 Waiver Renewal Subcommittee Meeting

1474 Rodeo Road, Santa Fe, NM
October 14, 2016
8:30 – 11:30 AM

Topic	Time
Introductions Role of subcommittee Renewal waiver timeline Overview of current waiver	8:30 – 9:15 am
Areas of focus for waiver renewal	9:15 – 10:10 am
Break	10:10 – 10:20 am
Care coordination	10:20 – 11:25 am
Meeting close – next steps	11:25 – 11:30 am

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CENTENNIAL CARE: NEXT PHASE

Kickoff Meeting of the 1115 Waiver Renewal Subcommittee
October 14, 2016

Agenda

- Introductions
- Role of subcommittee
- Subcommittee guidance
- Renewal waiver timeline
- Overview of current waiver
- Key areas for consideration
- Renewal waiver
- Care coordination
- Meeting close/next steps

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Role of Subcommittee

- Provide feedback on key issues for renewal
- Obtain comprehensive and diverse stakeholder input
- Provide input early in the process
- Help to guide development of the concept paper
- Focus on issues relevant for waiver

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Guidance for Discussion

What is waiver vs. non-waiver topics

Waiver

- System Transformation: Items that require waiver authority to implement
- Eligibility changes or expansions
- Benefit packages
- Financing

Non-Waiver

- Policy or implementation issues
- New contract terms, process, or tools
- Modification of provider qualifications
- Implementation of quality strategy and monitoring approaches

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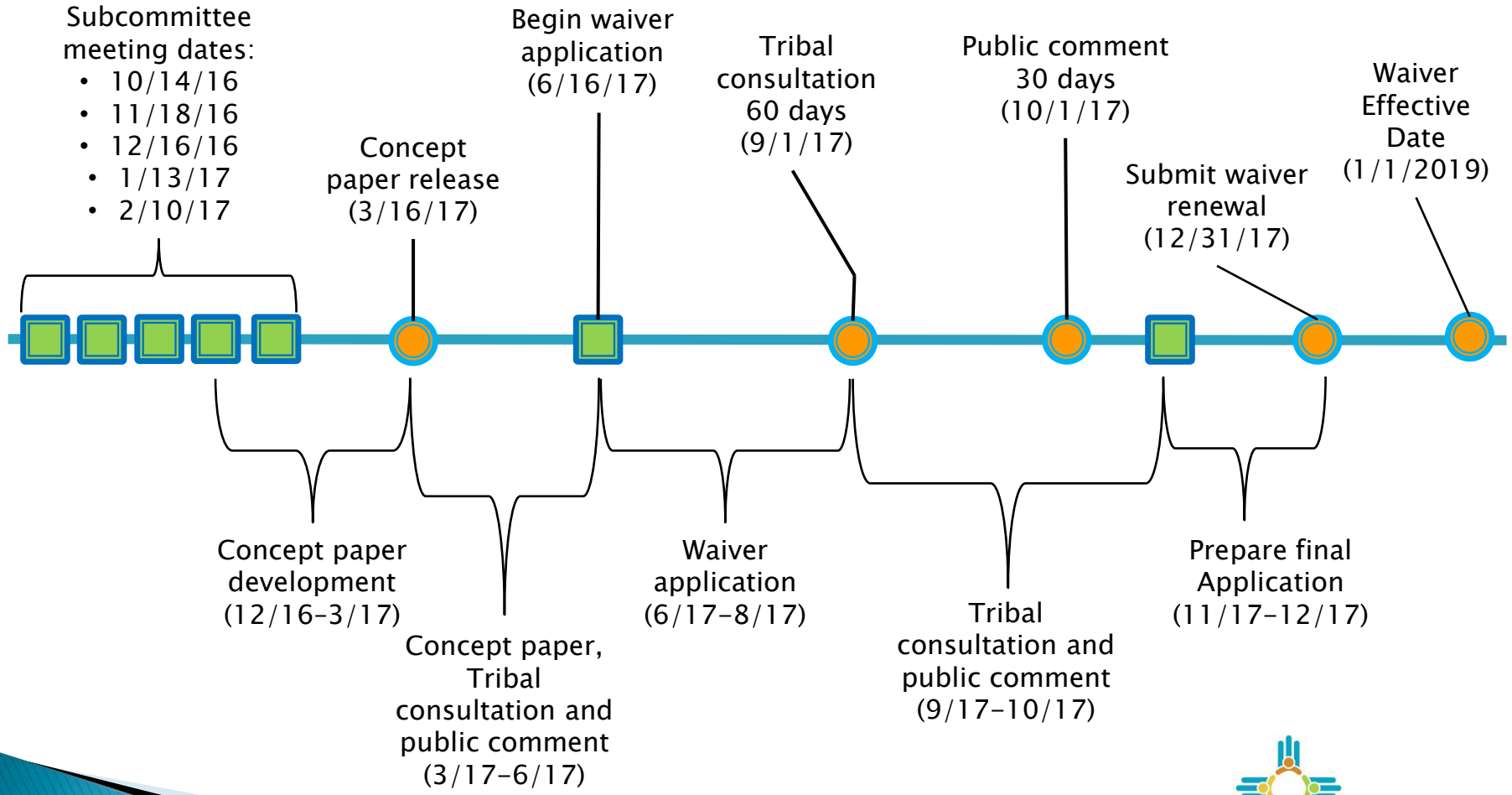
1115 Waiver Renewal

Timeframe



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Overview of Current Waiver

Program Goals

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

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 by members for their own health
- Increasing the emphasis on payment reforms that pay for quality rather than for quantity of services delivered
- Simplifying administration of the program for the state, for providers and for members where possible

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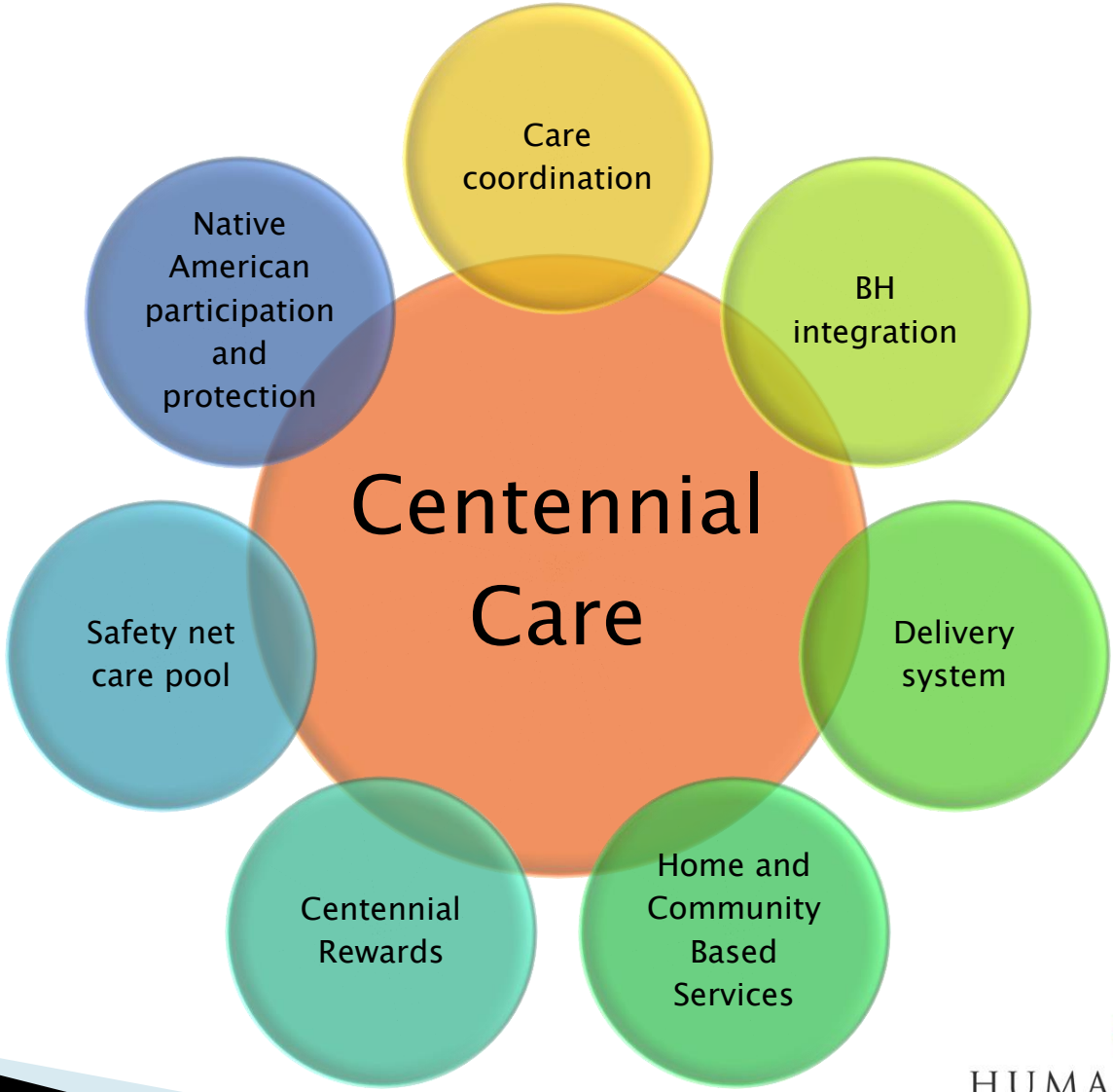
Overview of Centennial Care



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Current Program Successes

Principle 1

Creating a comprehensive delivery system

Build a care coordination infrastructure for members with more complex needs that coordinates the full array of services in an integrated, person-centered model of care

- Care coordination
  - 950 care coordinators
  - 60,000 in care coordination L2 and L3
  - Focus on high cost/high need members
- Health risk assessment
  - Standardized HRA across MCOs
  - 610,000 HRAs
- Increased use of community health workers
  - 100+ employed by MCOs
- Increase in members served by PCMH
  - 200k to 250k between 2014 and 2015
- Telemedicine – 45% increase over 2014
- Health Home – Implemented Clovis and San Juan (SMI/SED)
- Expanding HCBS – 85.5% in community and increasing community benefit services
- Electronic visit verification
- Reduction in the use of ED for non-emergent conditions

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Current Program Successes

Principle 2

Encouraging Personal Responsibility

Offer a member rewards program to incentivize members to engage in healthy behaviors

- Centennial Rewards
  - health risk assessments
  - dental visits
  - bone density screenings
  - refilling asthma inhalers
  - diabetic screenings
  - refilling medications for bipolar disorder and schizophrenia

- 70% participation in rewards program
- Majority participate via mobile devices
- Estimated cost savings in 2015: $23 million
  - Reduced IP admissions
  - 43% higher asthma controller refill adherence
  - 40% higher HbA1c test compliance
  - 76% higher medication adherence for individuals with schizophrenia
- 70k members participating in step-up challenge

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Current Program Successes

Principle 3

Increasing Emphasis on Payment Reforms

Create an incentive payment program that rewards providers for performance on quality and outcome measures that improve members health

- July 2015, 10 pilot projects approved
  - ACO-like models
  - Bundled payments
  - Shared savings

- Developed quarterly reporting templates and agreed-upon set of metrics that included process measures and efficiency metrics

- Subcapitated payment for defined population
- Three-tiered reimbursement for PCMHs
- Bundled payments for episodes of care
- PCMH Shared Savings
- Obstetrics gain sharing

- Implemented minimum payment reform thresholds for provider payments in CY2017 in MCO contracts

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Current Program Successes

Principle 4

Simplify Administration

Create a coordinated delivery system that focuses on integrated care and improved health outcomes; increases accountability for more limited number of MCOs and reduces administrative burden for both providers and members

- Consolidation of 11 different federal waivers that siloed care by category of eligibility; reduce number of MCOs and require each MCO to deliver the full array of benefits; streamline application and enrollment processes for members; and develop strategies with MCOs to reduce provider administrative burden
- One application for Medicaid and subsidized coverage through the Marketplace
- Streamlined enrollment and re-certifications
- MCO provider billing training around the State for all BH providers and Nursing Facilities
- Standardized the BH prior authorization form for managed care and FFS
- Standardized the BH level of care guidelines
- Standardized the facility/organization credentialing application
- Standardized the single ownership and controlling interest disclosure form for credentialing.
- Created FAQs for credentialing and BH provider billing

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Future Outlook and Opportunities

Outlook

- As Medicaid approaches covering almost half of New Mexico's two million population, immense opportunity to drive value and health outcomes for our State
- Continued Medicaid enrollment growth/spending growth combined with reduced oil and gas revenue and an aging population continue to drive—
  - Innovations for LTSS program and better management of dually-eligible population
  - Advancement of value-based purchasing arrangements
  - Strategies to improve care for high utilizers—5 percent of members who account for 50% of spend

Opportunities

- Continue to build upon existing waiver goals and principles
- Improve engagement for unreachable members
- Appropriate level of care coordination for high need populations
- Performance incentives for MCOs and providers

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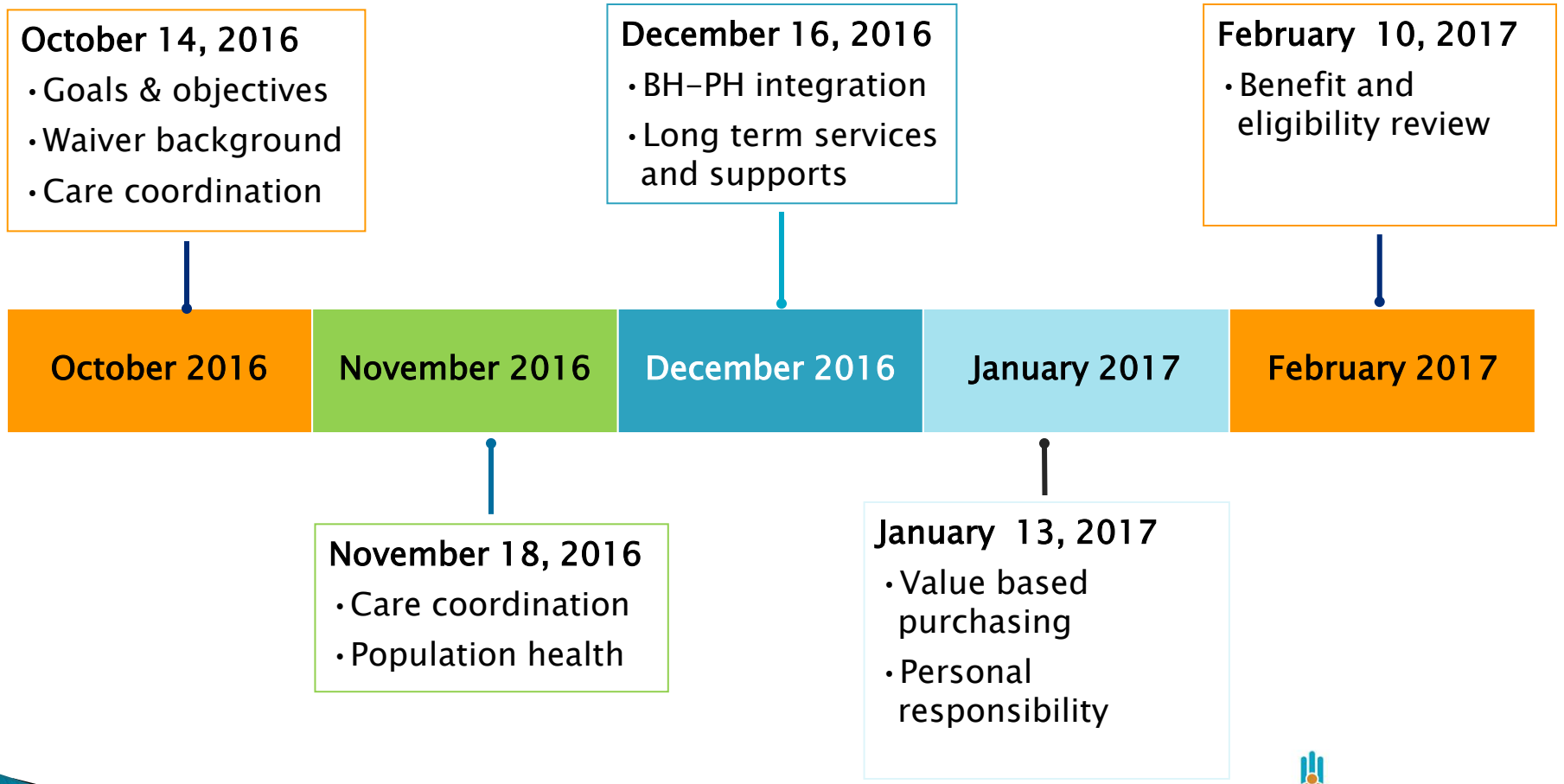
Subcommittee Meetings

Timeframe for Discussion



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Renewal Waiver

- Areas of Focus

Renewal Waiver

Areas of Focus

- Refine care coordination
- Expand value based purchasing
- Continue efforts for BH & PH integration
- Address population health
- Opportunities to enhance long term services and supports
- Provider adequacy
- Benefit alignment and member responsibility

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Care Coordination

Opportunities/Goals

- Improve transitions of care
- Focus on higher need populations
- Provider's role in care coordination

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Care Coordination

Improve Transitions of Care

1. Improve Transitions of Care

- Follow-up after 7 days
- Readmission rates
- Care Coordination chart audits demonstrating opportunities to improve transitions of care
- There is also evidence in Care Coordination audits that suggest a higher-level of care coordination is needed during these critical transitions

Benefit	Challenges	Questions/Feedback
➢ Reduce readmissions ➢ Improve member confidence in their healthcare and providers ➢ Ensure care delivered in the right place	➢ Communication with hospitals/facilities ➢ Engagement of family and other community supports ➢ Member adherence to recommended follow-up	1. What is the value of this initiative to the program overall? 2. What are strategies to improve communication between MCOs and Providers? 3. What are strategies to better engage families? 4. What is the capacity to increase planning and follow-up by care coordinators?

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Care Coordination

Focus on higher need populations

2. Focus on high utilizers, children with special health care needs, difficult to engage members and incarcerated populations

- Use of the Emergency Department (ED) to meet primary care needs
- The largest percentage of high utilizers has a behavioral health diagnosis including mental health and substance abuse.
- Children with special health care needs require unique care coordination interventions due to extent of health needs.
- Incarcerated population requires early interventions prior to release to increase community tenure and recidivism rates.

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Care Coordination

Focus on higher need populations

Benefit	Challenges	Questions / Feedback
➢ Reduced ED use ➢ Reduced hospitalization and re-admission rates ➢ Increase comprehensive holistic care through primary care and specialists ➢ Reduced recidivism ➢ Improved continuity of care	➢ Accessible primary care particularly after-hours ➢ Member understanding/acceptance of appropriate use of the ED ➢ Follow-up care after ED visits ➢ Engaging hard to reach members in care coordination ➢ These populations have high social, economic and resource needs	1. What is the value of this initiative to the program overall? 2. What are other strategies beyond care coordination that may be effective? 3. How can we incentivize participation in care coordination through co-payments (i.e., waive some co-pays for those engaged in care coordination or charge co-payment for non-emergent use of ED)? 4. How can we use Community Health Workers or others as resources for a more intensive touch for these members? 5. What are some interventions to engage hard to reach members?

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Care Coordination

Provider's role in care coordination

3. Increase Access to Care Coordination at Provider Level

- National best practice evidence suggests that provider-based care coordination has the most impact on members who are difficult to engage
- Providers have the most interaction with members and impact on their health
- There are providers in the community who are interested in delivering care coordination and have the capacity and experience to do so
- Additionally providers are increasingly invested in the outcomes for their members as they take on more financial risk through participation in value based purchasing initiatives

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Care Coordination

Provider's role in care coordination

Benefit	Challenges	Questions / Feedback
➢ Efficiency in locating and interacting with members, accessing records and health history ➢ Improve member confidence and trust in their healthcare and providers ➢ Strengthen relationships between members and primary care ➢ Improve preventative care rates ➢ Reduce unnecessary ED utilization	➢ MCO role in quality and provider oversight ➢ Avoiding duplication of efforts ➢ Data sharing and tracking ➢ Reducing confusion for members in transitions ➢ Payment structures ➢ Readiness to deliver all elements of care coordination in the provider community	1. What is the value of this initiative to the program overall? 2. What are challenges we have not already identified? 3. How do we build capacity and readiness in the provider community? 4. Who should be delegated and how does the State encourage delegation (i.e., incentives to MCOs for reaching a percentage of delegation)? 5. Without delegation, what other strategies can we implement to be more inclusive of providers in responsibility for outcomes? 6. What are the minimum staff qualifications to provide care coordination at the provider level?

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Next Steps

- Next subcommittee meeting November 18th
- Subcommittee documents
- Email for follow-up questions/clarifications
  - Email Address: **HSD-PublicComment2016@state.nm.us**
  - Include "Waiver Renewal" in email subject line:
  - Include a background, proposed solution and impact in your correspondence

- **Information Links**
  - Centennial Care (CC) 1115 Waiver Submission Documents:
  - http://www.hsd.state.nm.us/Centennial_Care_Waiver_Documents.aspx

  - Centennial Care 1115 Waiver Approval Documents:
  - http://www.hsd.state.nm.us/approvals.aspx

  - Centennial Care Reports:
  - http://www.hsd.state.nm.us/reports.aspx

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Centennial Care 1115 Waiver Renewal Subcommittee
Care Coordination Brief
October 14, 2016

Background

Launched on January 1, 2014, Centennial Care provides a comprehensive delivery system for Medicaid members that integrates physical, behavioral and long-term care services; ensures cost-effective care; and focuses on quality over quantity.

Fundamental to the program is a robust care coordination system that requires coordination at a level appropriate to each member's needs and risk stratification. The care coordination program creates a person-centered environment in which members receive the care they need in the most efficient and appropriate manner. Care coordination activities include:

- Assessing 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, such as housing and transportation;
- Ensuring timely access, 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 while maximizing independence; and
- Facilitating access to other social support services and resource assistance needed in order to promote each member's health, safety and welfare.

All Medicaid members receive a health risk assessment (HRA) and are placed in an appropriate level of care coordination 2 or 3. Those in higher levels of care coordination (level 2 or 3) receive a comprehensive needs assessment (CNA) to assess physical, behavioral and long-term care (LTC) needs and receive a person-centered care plan. Members in care coordination level 2 receive semi-annual in-person visits, quarterly telephone contact, and an annual CNA to determine if the level of coordination and care plan are appropriate. Members in care coordination level 3 receive monthly telephone contact, quarterly in-person visits and a semi-annual CNA to determine if the level of coordination and care plan are appropriate.
The following outlines the requirements for care coordination level 2 and 3:

Based on the CNA, care coordination **level 2** will be assigned to a member with **one** of the following:

- Co-morbid health conditions;
- High emergency room used, defined as 3 or more emergency room visits in 30 days;
- A mental health or substance abuse condition causing moderate functional impairment;
- Requiring assistance with 2 or more Activities of Daily Living (ADL) or Instrumental Activities of Daily Living(IADL) living in the community at low risk;
- Mild cognitive deficits requiring prompting or cues; and/or
- Poly-pharmaceutical use, defined as simultaneous use of 6 or more medications from different drug classes and/or simultaneous use of 3 or more medications from the same drug class.

Based on the CNA, care coordination **level 3** will be assigned to a member with **one** of the following:

- Who are medically complex or fragile;
- Excessive emergency room use as defined as 4 or more emergency room visits in a 12 month period;
- A mental health or substance abuse condition causing high functional impairment;
- Untreated substance dependency based on the current DSM or other functional scale determined by the State;
- Requiring assistance with 2 or more ADLs or IADLs living in the community at medium to high risk;
- Significant cognitive deficits; and/or
- Contraindicated pharmaceutical use.

The following outlines the caseload to care coordination ratios:

Care coordination level 2: • Members not residing in a nursing facility 1:75, and • Members residing in a nursing facility 1:125; and • Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit 1:100;
Care coordination level 3: • Members not residing in a nursing facility 1:50; and • Members residing in a nursing facility 1:125; and • Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit in care coordination 1:75; and
Care coordination for Members who participate in the Self-Directed Community Benefit: • Members under age of twenty-one (21) 1:40

Care Coordination Monitoring

The State conducts a variety of activities to monitor the MCOs' care coordination activities. In 2014 and 2015, the State conducted 1 onsite audit and 2 desk audits of MCO Care Coordination member records. The desk audits have shown:

- Improvement in MCO compliance with Care Coordination contractual requirements
- A need for further development of the MCO care coordinators, including improving member engagement rates and
- A need for improved documentation of member needs.

As a result, the MCOs developed internal action plans to address concerns or deficits found in the audits. Action plans include more information about the MCOs' self-auditing, trend identification, and details related to following-up on expected outcomes. The State conducts ongoing monitoring of the MCOs' internal action plans, provides ongoing technical assistance, and conducts trainings for MCO Care Coordinators on general Care Coordination activities and Care Coordination documentation requirements.

Each year, Medicaid Centennial Care members participate in the Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey. In relation to Care Coordination, the survey reported an average of 78% member satisfaction for the 2014 survey. The 2015 survey is due in October 2016. In

addition, the MCOs are required to submit quarterly reports to the State regarding care coordination activities including the number of HRAs, CNAs and Comprehensive Care Plans (CCPs) completed.

Accomplishments Related to Care Coordination

The Centennial Care MCOs have hired approximately 950 care coordinators. The MCOs have conducted 610,000 health risk assessments and have assigned 70,000 members to higher levels of care coordination (levels 2 and 3). These assessments have resulted in more than 250,000 members receiving care in patient-centered medical homes and more than 24,000 members receiving home and community based services. The MCOs have collaborated with the University of New Mexico's ECHO Care program to provide access to an intensivist team for 500 high need/high cost members that included primary care physicians, behavioral health counselors, specialists as needed, and community health workers.

During the period of September 2014 through June 2016, the MCOs launched a campaign to reach those members who were unreachable. Successful strategies included but were not limited to:

- Call campaigns were implemented;
- Contracts with several organization were established to complete HRAs;
- Member advocates were deployed to residential addresses to make in-person visits;
- Specialized care coordination teams were developed to locate members; and
- Offices were set-up specifically for walk-in members who need assistance.

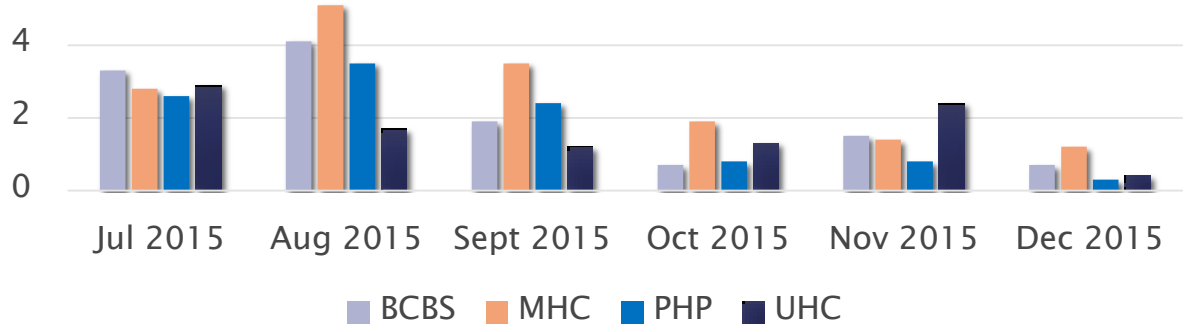
As a result, 248,513 previously unreachable members were successfully reached by the MCOs during this campaign. The percent of unreachable members, as compared to enrollment, decreased to 11.62% and 164,267 HRAs were completed during this period.

In order to develop a solid Care Coordination infrastructure, the State and the MCOs recognized the importance of Community Health Workers (CHWs) in assisting with the engagement of members in their healthcare. CHWs also provide health education, health literacy, and community support linkage. The State included a Delivery System Performance Improvement Target within the MCOs' contracts to increase the utilization of CHWs. To date, the MCOs have:

- Employed more than 100 CHWs directly or through a contractual relationship;
- Utilized CHWs to work with members who are high Emergency Department (ED) utilizers and redirect them to PCPs; and
- Partnered with UNM to expand the role of CHWs

In addition to the use of CHWs in working with members who have high ED utilization, the State implemented the Super Utilizer Project with MCOs to track members with ED use. The goal of the project is to review MCO care coordinator activities with the selected members in an effort to reduce this utilization, as well as share successful activities resulting in reduced utilization with all MCOs. The MCOs have identified that intensive engagement with some members and addressing their medical deficits (i.e., inability to fill medications) their ED utilization decreases. It is important to note

that some members take longer to accept the engagement and some will ultimately refuse. The following graph illustrates progress in ED reduction for the top 10 utilizers with each MCO.



The State provided the MCOs with access to the Predictive Risk Intelligence System (PRISM) to assist with monitoring member utilization. PRISM provides the MCOs with historical member service utilization. The MCOs have collaborated to begin utilization of the Emergency Department Information Exchange (EDIE), to enhance Care Coordination Activity at Emergency Departments. EDIE will provide the MCOs with real time data regarding member utilization of the ED. HSD had defined varying levels of ED utilization (excessive, frequent, and high) for the MCOs to better define the need for care coordination for members.

In 2015, in an effort to streamline care coordination processes, the State and the MCOs collaborated to streamline the Health Risk Assessment (HRA) across all four MCOs. Streamlining of the HRA provided uniformity for MCOs in identifying Medicaid members who need a CNA and potentially a higher level of care coordination.

In 2016, the State and MCOs implemented the Health Home project for members with Severe Mental Illness (SMI) or Severe Emotional Disturbance (SED) in 2 counties (Curry and San Juan) to enhance the integration and coordination of primary, acute, behavioral health and long-term care services. This phase I implementation allows for the delegation of care coordination to the selected provider agencies and allows HSD to monitor impact for potential expansion statewide.

Additional MCO care coordination initiatives include:

- Molina Healthcare working with the Metropolitan Detention Center (MDC) to begin Care Coordination prior to an incarcerated member's release.
- MCOs partnering with community agencies, such as Albuquerque Ambulance and Kitchen Angels, to conduct home visits for super ED utilizers.

Care Coordination Challenges

As Centennial Care continues to grow, there continues to be room for improvement and opportunities to enhance the program through furthering best practices identified. Engaging certain members in the care coordination process continues to be a challenge, particularly those who are classified as "high

utilizers". Communication between care coordinators and various partners (hospitals, nursing homes) needs to be strengthened and incentivized. Thoughtful role definition and collaboration between MCO care coordinators and Department of Health case managers for the Developmentally Disabled and Medically Fragile populations requires continuous review. Finally, HSD continues to work towards further enhancing the seamless integration of physical and behavioral health services.

New Ideas for Care Coordination

HSD has reviewed information from a variety of data sources including claims and utilization trends, HEDIS outcomes, MCO reports, Special Project reports and Care Coordination reviews and file audits. In addition, HSD continually looks to other states for models with positive outcomes. Great strides have been made in the implementation of a comprehensive care coordination model, the training and capacity building of MCO staff and initial outcomes from the investment in care coordinators.

HSD has identified a few areas where an enhancement or shift in the approach to Care Coordination promises to continue to improve health outcomes, lower cost and increase member participation in managing their own care.

While these are not the only ideas HSD is considering, the following are Care Coordination priorities for discussion with this sub-committee as we continue the process of refining our vision:

- Focus on Transitions of Care through targeted care coordination.
- Increase care coordination and competency to manage the unique challenges of special populations such as high utilizers, inmate populations, and members who are difficult to engage in care coordination.
- Increase access to care coordination functions at the provider level when appropriate
- Implement a Coordination First Model - allows for multiple care coordination contacts to complete assessments
- Expansion of the Health Home pilot to allow selected providers to conduct care coordination activities

Stakeholder Engagement Process Leading to Development of Concept Paper

2. MAC 1115 Waiver Renewal Subcommittee, November 18, 2016

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

AGENDA

1115 Waiver Renewal
MAC Subcommittee Meeting

Presbyterian Learning Center Room 13110
Presbyterian Cooper Center
9521 San Mateo Blvd. NE
Albuquerque, NM 87113

November 18, 2016
8:30 – 11:45 AM

Topic	Time
Introductions	8:30 – 8:40 am
Feedback from October meeting	8:40 – 8:45 am
Care coordination discussion	8:45 – 10:00 am
Break	10:00 – 10:10 am
Population health discussion	10:10 – 11:20 am
Public comment	11:20 – 11:35 am
Meeting close	11:35 – 11:45 am

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

Absent Members:

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

Staff and Visitors Attending:

Nancy Smith-Leslie, HSD/MAD	Robyn Nardone, HSD/MAD
Angela Medrano, HSD/MAD	Tina Sanchez, HSD/MAD
Wayne Lindstrom, HSD/BHSD	Laine Snow, HSD/BHSD
Karen Meador, HSD/BHSD	Cynthia Melugin, HSD/BHSD
Michael Nelson, HSD	Jared Nason, Mercer
Kari Armijo, HSD/MAD	Jessica Osborne, Mercer
Dan Clavio, HSD/MAD	Cindy Ward, Mercer
Kim Carter, HSD/MAD	Amilya Ellis, UHC

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 Shawnna Romero, BCBSNM Mary Kate Nash, HCS/Molina	Patricia Lucero, Isleta Elder Program Teresa Turietta, New Mexico Assoc. Home & 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

Agenda Item	Details	Discussion
I. Introductions	• Jared Nason from Mercer and Angela Medrano delivered opening comments. • Reviewed options for providing comments and recommendations in addition to the meeting. • Presented agenda overview.	• Medical Assistance Division (MAD) would like everyone to have the opportunity to contribute ideas and recommendations for the waiver renewal • All are encouraged to use the website to submit additional comments that were not mentioned during the meetings. • All recommendations regarding care coordination (CC) and population health should be submitted by November 30, 2016.
II. Care Coordination – Transitions of Care	• Identify funding to focus on facilities improving discharge planning. • Enhanced care coordination as part of transitions (short-term): – Jail release, inpatient stay, nursing facility to community, children in residential facilities. • Incentives for outcomes of a successful discharge: – 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). • Incentives for member adherence to recommended follow-up. • Member rewards.	• Carolyn commented that many members do not have a primary care physician (PCP) and cannot get one assigned quickly enough. • 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. • Children, Youth, and Families Department (CYFD) recommended focus on out-of-home placement transitions in addition to residential. • 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. • MAD should focus on elements of the system that are least likely to be “thrown-out” under the new Federal administration. • Measure discharge outcomes at 30 and 60 days for released inmates as this is a critical time particularly for those with substance abuse issues. • Managed care organizations (MCOs) need information at discharge as quickly as possible.

Agenda Item	Details	Discussion
		• 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. — Many tribes have community health representatives performing care management tasks but are not reimbursed for it. • 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." — Expand readmission measure to look at what caused the readmission. • Linda commented to look at Illinois model for Medicaid billing during discharge planning for incarcerated individuals. — Look at medication reconciliation practices between hospital and receiving facility to identify discharge issues. • Carol noted that transition is complicated by homelessness and is a cost driver. • Joie commented that skilled nursing visits after discharge is underutilized and should be incented. • 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

Agenda Item	Details	Discussion
		build care management programs. – Review Colorado's regional approach to care coordination.
III. Care Coordination – Higher Needs Populations	• Improved engagement of family and other community supports: – Family/caregiver role, increase use of community health workers / Certified Peer Support Workers (CPSWs). • Promote creative approaches by MCOs to support unique high needs populations. • Focused education and interventions that are condition or location specific: – 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. • Use of Community Health Workers for more intensive "touch" for these members. • Expand health homes. • Use of population health information to develop targeted education and interventions.	• 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." • 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. – 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. • 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. – 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. – The intensity of care coordination is higher than people receive in the current model. Caseloads are too high for this population. – Focus on health literacy and developing providers that

Agenda Item	Details	Discussion
		will communicate to members about available resources. Look at strategies that support participation in needed services and activities. • 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. – 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. • 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. • 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). • 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. • 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

Agenda Item	Details	Discussion
		contacts". • Monique commented about transition for youth aging out of foster care and juvenile justice system; high risk for homelessness and incarceration. – Explore Youth Peer Support Workers. • Fritzi noted that guardians get left out of transition and discharge conversations. – 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). – CCs are not completing tasks requested of them. • 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. • 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.
IV. Care Coordination – Provider Role	• Consider pilot opportunities for MCOs to incorporate local supports (regional systems, homeless, family members) into care coordination. • MCOs could share dollars with local programs for direct linkages to members. • MCO and Provider Incentives for outcomes. • Value-based payment approaches mean more responsibility for providers to provide	• General comment and discussion: – Focus on a higher level of physical health-behavioral health (PH-BH) integration. – 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.

Agenda Item	Details	Discussion
	care coordination to meet value based payment goals. • Value-based payment approaches will involve / delegate care coordination to providers.	– 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. – Community Asset Mapping and Hospital Community level data should be built into the CC model. – 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. – Providers need clarification on what information can be shared especially those that provide confidential services. – 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. – 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. – 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. • Mary Kay -School-based clinics are doing PH-BH integration. – 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. • Fritzi mentioned that provider turn-over means that the

Agenda Item	Details	Discussion
		term Medical Home really isn't a home.
V. Population Health	• Consider pilot opportunities for MCOs to incorporate local supports (regional systems, homeless, family members) into care coordination. • MCOs could share dollars with local programs for direct linkages to members. • MCO and Provider Incentives for outcomes. • Value-based payment approaches mean more responsibility for providers to provide care coordination to meet value based payment goals. • Value-based payment approaches will involve / delegate care coordination to providers.	• Department Health has robust collection of health data; use existing data that looks at highest disease burden. • Consider the following populations for focus: – Tobacco use – Obesity – All high cost drivers – High teen birth rates – Geography: looking at neighborhoods – Food deserts – High pollution – Seniors age 60 and beyond – High-risk populations coming out of jail. • Secretary Copeland - Support family care givers who support this population through Alzheimer's Association and Savvy Care Giver program to relieve care giver burden. • General comment and discussion: – Consider partnering with Senior Centers and providers to help keep people in their homes. – Support Senate Bill-42 to improve justice reform and divert Medicaid members prior to being incarcerated through diversion programs. – Provide police training for people with identified mental health (MH) issues versus criminal issues. • Naomi commented that adverse childhood experiences and link to health outcomes and incarceration and substance abuse (SA). • CYFD commented to focus on parents who have children at risk for out of home placement.

Agenda Item	Details	Discussion
		– Employment of CYFD youth; need jobs and life skills. • 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. • 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. • 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. – A service directory will only be good if providers update their information. – The MCOs could require that their providers supply information. – There is a site called New Mexico Network of Care: 3 Different Portals. – CYFD has a site for community resources. – Affordable Housing is a real need: support and supported housing services are desired and can impact outcomes. • MCO: The new Medicaid Management Information System will be a great tool to look at health issues and disparities. • Support services really are keys to improving population health outcomes.

Agenda Item	Details	Discussion
		• Karen commented that some states have added services to support pre-tenancy and staying in housing. – Supports that help keep them in housing and linking to service and health supports. • Department of Health commented that there is a lack of education for providers to identify SA issues and social determinants of health needs. – 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. • General comment and discussion: – Language we use in waiver should appeal to new administration and focus on needs of rural areas. – Rural transportation is major New Mexico issue, particularly with seniors. • 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.
VI. Public Comments	• Care coordination service is needed at the community level • Keep a broad view of population health statewide and note many contributing factors • Importance of cultural competency	• Need hands-on care coordination services at the community level: – Santa Fe County has identified top give needs: three BH issues, food access, and homelessness. – We need better provider alignment throughout the system and communities. – Santa Fe County would like to partner with HSD/MAD to pilot better care coordination and develop a

Agenda Item	Details	Discussion
		regional health support system. • Utilizing regional and community health councils may be beneficial and progress made with the State Innovation Models grant project should be noted. • Cultural competency and effective use of resources are important. • Requested not using acronyms.
VII. Meeting Close	• Follow-up materials • HSD contact protocol • Next meeting date	• Instructions for how the subcommittee should submit comments. • Request all care coordination and population health recommendations are submitted by November 30, 2016. • Next meeting is on December 16, 2016 in Santa Fe at the Administrative Services Building on Rodeo Road.

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

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CENTENNIAL CARE NEXT PHASE

1115 Waiver Renewal Subcommittee
November 18, 2016

Agenda

Introductions	8:30 – 8:40
Feedback from October meeting	8:40 – 8:45
Care coordination continued	8:45 – 10:00
Break	10:00 – 10:10
Population health	10:10 – 11:20
Public comment	11:20 – 11:35
Wrap up	11:35 – 11:45

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Renewal Waiver
Areas of Focus

- Refine care coordination
- Expand value based purchasing
- Continue efforts for BH & PH integration
- Address social determinants of health
- Opportunities to enhance long term services and supports
- Provider adequacy
- Benefit alignment and member responsibility

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Care Coordination

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Care Coordination

Opportunities/Goals

- Improve transitions of care: *The movement of a member from one setting of care (examples: inpatient facilities, rehabilitation settings, skilled settings and after incarceration) to another setting or home*[1]
- Focus on higher need populations
- Provider's role in care coordination

[1] Adapted from CMS' definition of terms, Eligible Professional Meaningful Use Menu Set of Measures; Measure 7 of 9; Stage 1 (2014 Definition) updated: May 2014. retrieved: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downl

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Improve Transitions of Care

Feedback	Concepts	Further Discussion

➢ Communication across health providers and managed care is a challenge
➢ Real time information is critical to transitions
➢ Care Coordinator's access in hospitals is challenging
	➢ Identify funding to focus on facilities improving discharge planning
	➢ Enhanced care coordination as part of transitions (short-term):
	  ➢ Jail release
	  ➢ Inpatient stay
	  ➢ Nursing facility to community
	  ➢ Children in residential facilities
	➢ Incentives for outcomes of a successful discharge:
	  ➢ 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)
	➢ Incentives for member adherence to recommended follow-up:
	  ➢ member rewards
		1. Are there ideas here that will have more impact than others?
		2. What are good measures for defining a successful discharge?
		3. Carrot or stick for adherence to discharge plan?
		4. Any other at-risk populations we should address?

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Focus on Higher Needs Populations

Feedback	Concepts	Further Discussion

➢ Improve education to members about use of public health services
➢ Increase member education and use of community supports such as public health services:
  ➢ Community Health Workers / Certified Peer Support Worker (CPSW)
  ➢ School-based health centers
  ➢ Expand Health homes
	➢ Improved engagement of family and other community supports:
	  ➢ Family/caregiver role
	  ➢ Increase use of community health workers / CPSWs
	➢ Promote creative approaches by MCOs to support unique high needs populations.
	➢ Focused education and interventions that are condition or location specific:
	  ➢ Areas with fewer providers, transportation issues and/or specific cultural aspects
	  ➢ Areas with high risk pregnancies, with high prevalence of diabetes, COPD and other chronic diseases
	➢ Use of Community Health Workers for more intensive "touch" for these members
	➢ Expand health homes
	➢ Use of population health information to develop targeted education and interventions
		1. How can we incentivize member participation in care coordination? In their healthcare? In preventative care?
		2. How can we use Community Health Workers and others as resources for a more intensive role for these members?
		3. What are some interventions to engage hard to reach members?
		4. Who are higher need populations we should consider?

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Provider's Role in Care Coordination

Feedback	Concepts	Further Discussion
➢ Information sharing with local providers is key. ➢ Need for further definition of care coordination roles based on where a member is receiving care (FQHC, Senior Center, Jail, ER) ➢ Need to increase consistent use of terms (case management, care coordination, care management) ➢ Increase use of local/community supports to support MCO care coordination. More use of CPSW, peer navigator: ➢ Teen parents, cancer center	➢ Consider pilot opportunities for MCOs to incorporate local supports (regional systems, homeless, family members) into care coordination ➢ MCOs could share dollars with local programs for direct linkages to members ➢ MCO and Provider Incentives for outcomes ➢ Value-based payment approaches mean more responsibility for providers to provide care coordination to meet value based payment goals ➢ Value-based payment approaches will involve / delegate care coordination to providers	1. How do we build capacity and readiness in the provider community? 2. Where should care coordination be provided (physical location)? 3. How do you avoid duplication of efforts between MCO care coordination and provider level? 4. How do you promote communication and coordination between the MCO and provider level care coordination?

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Population Health

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Population Health
Key Terms

- Population Health

"A population-based approach to health care and preventative services improves health outcomes for all populations and helps individuals achieve their highest health-related quality of life" [2]

- Social Determinants of Health

Factors that enhance quality of life and can have a significant influence on population health outcomes. Examples include safe and affordable housing, access to education, a safe environment, availability of healthy foods, local emergency and health services, and environments free of life-threatening toxins [3]

[2] Centers for Medicaid and Medicare, CMS Strategy: The Road Forward (2013-2017); retrieved: https://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf

[3] Adapted from :Office of Disease Prevention and Health Promotion, Health People 2020; 2020 Topics and Objectives: Social Determinants of Health. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

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Population Health

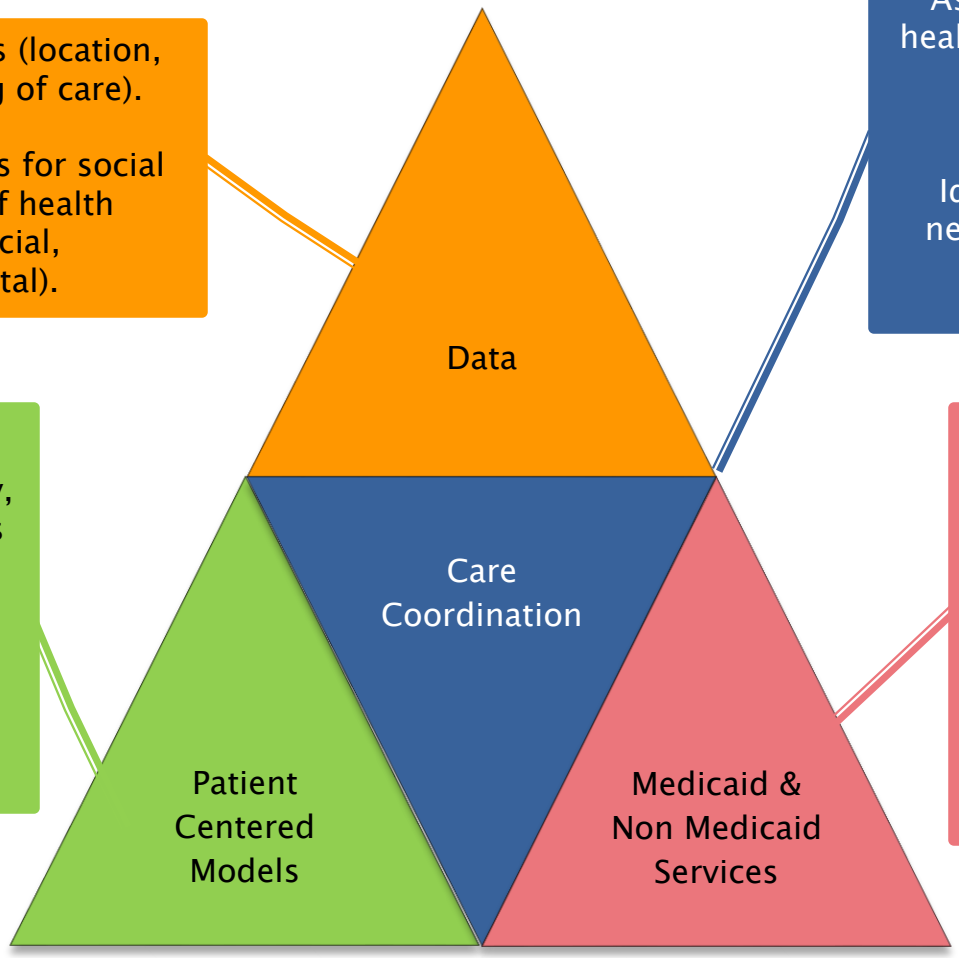
Overview

Define populations (location, condition, setting of care).

Identify data points for social determinants of health (cultural, social, environmental).

Assess physical, mental health conditions and other factors that impact outcomes.

Identify inequities that negatively impact health and address them.



Focus on specific populations by geography, condition or other factors and target interventions.

Consider: high-risk pregnancy, homeless, incarcerated, high/low utilizers.

Address environmental, transportation or other needs needs through services in benefits package.

Improve access to non-Medicaid services such as food banks, rent assistance, supported employment.

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Population Health
Starting the Discussion

Needs	Concepts	Further Discussion
➢ Food ➢ Housing ➢ Transportation (work, school, social needs) ➢ Employment	➢ Chronic disease monitoring and education ➢ Health assessments and data collection ➢ Medication compliance ➢ Condition or region specific initiatives funding and outcomes goals ➢ Housing ➢ Job coaching and support. ➢ Food pharmacies ➢ Linkages to community resources and supports beyond health services	1. What population(s) should we target? Why? 2. Which factors/determinants impact outcomes for this population? How could Medicaid address those factors? 3. How do we move the organization to population-based analysis? Do we have necessary data or analytical capability? 4. How do we create a nimble system that can respond to factors that impact population health?

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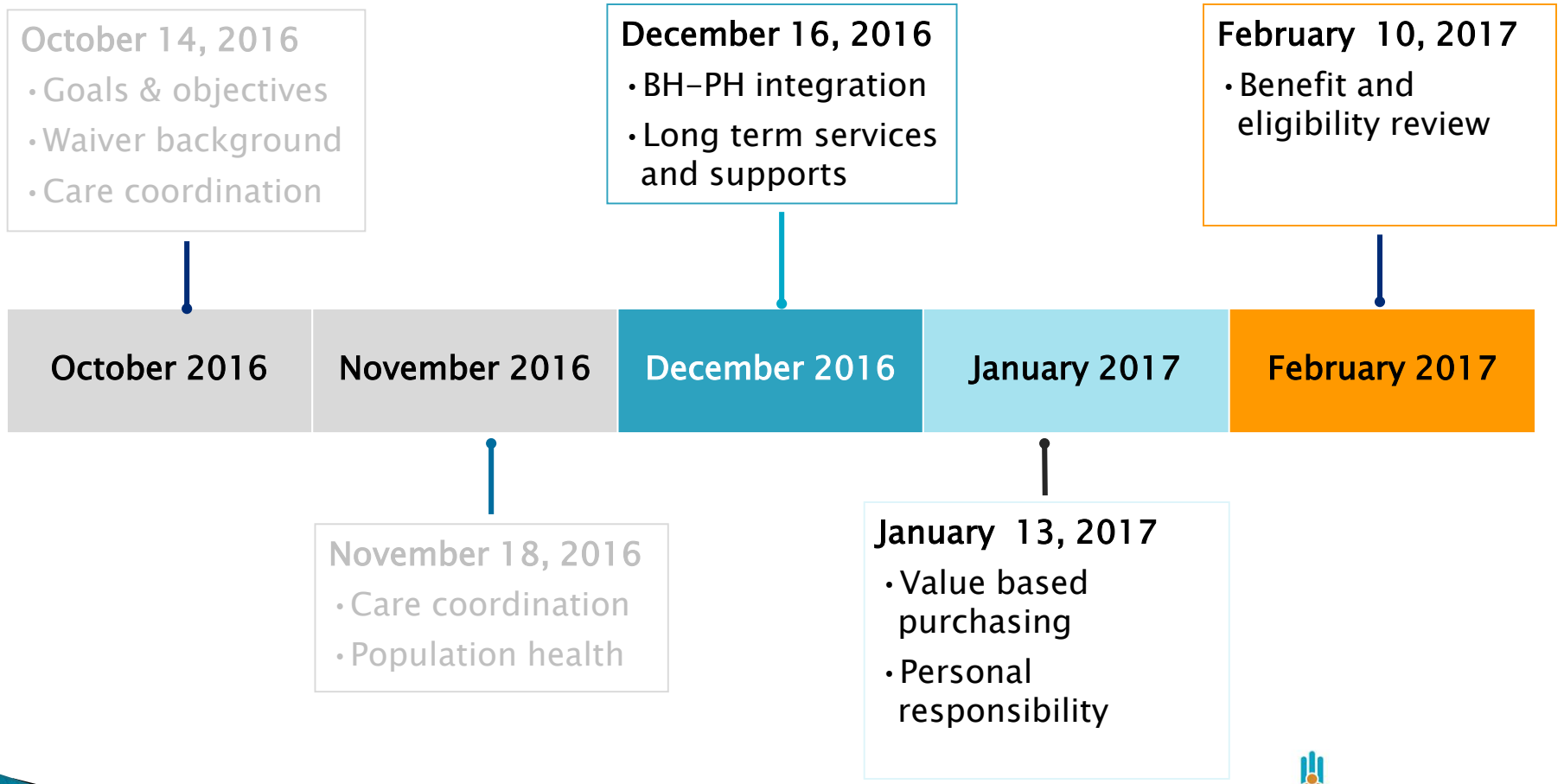
Subcommittee Meetings

Timeframe for Discussion



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Permanent Supportive Housing Information Sheet

What is Permanent Supportive Housing (PSH)?

PSH is an evidence-based practice, centered on the philosophy that people with disabilities can live and thrive in their own housing, regardless of their support needs.

Core elements of PSH include:

- Rights of tenancy – Individuals sign a lease and enjoy the same rights and obligations of tenancy as the general population.
- Choice of housing – Choice includes preferences such as convenience to transportation, physical and behavioral health services, family, shopping, and other essentials.
- Decent, safe, and affordable housing – Tenants pay no more than 30 percent of their income toward rent plus basic utilities. Rental assistance through HUD, state-funded Linkages, and other housing programs subsidizes rent.
- Housing integration – Scattered-site housing is preferable to congregate settings.
- Functional separation of housing and services – Property management functions (reviewing rental applications, collecting rent, eviction/renewal decisions) operate independently of support services (pre-tenancy and tenancy sustaining activities).
- Access to housing – Housing is not based on accepting supportive services.
- Flexible, voluntary, and recovery focused services – Tenants choose which supportive services will help them succeed in their desired housing. Services are tailored toward recovery, improved functioning, and life satisfaction.

What difference does PSH make?

- Better population health outcomes – Providing housing and flexible supports lead to significant improvements in physical and behavioral health. Draft data from a five-year study of a peer-delivered PSH model in Santa Fe shows:[1]
  -PSH associated with good to excellent overall health at 6 and 12 month reassessments
  -Overall health of individuals receiving PSH was higher than the comparison group that received no housing
  -Lower psychological distress at 6 month reassessment
  -Less bothersome symptoms at 6 month reassessment
  -Housing satisfaction significantly correlated with positive outcomes
- Cost efficiency – A 2013 UNM study of Albuquerque supportive housing showed cost savings of $12,831.68 per person through reduced use of shelters, emergency rooms, crisis services, and detention facilities.[2]

[1] Crisanti, Annette, Daniele Duran,R. Neil Greene, Jessica Reno, Carol Luna-Anderson, Deborah Altschul, *A Longitudinal Analysis of Peer-Delivered Permanent Supportive Housing: Impact of Housing on Mental and Overall Health in a Rural, Ethnically Diverse Population.*

- Housing stability – On average, 88% of individuals in the state Linkages PSH program remain housed after one year.
- Federal compliance – PSH complies with the U.S. Supreme Court's decision in Olmstead v. L.C. that individuals with disabilities must be accorded the ability to live in the most integrated setting possible.

What PSH programs does the state of New Mexico currently fund?

- Linkages rental assistance and support services – 165 units
- Transitions rental assistance and support services – 20 units
- Local Lead Agency support for Low Income Housing Tax Credit, Special Needs Units – 509 units

Who does PSH currently assist in New Mexico?

- Homeless (including precariously housed)
- Behavioral health and/or other disabilities
- Extremely Low income
- Youths aged 18-21 transitioning out of CYFD Juvenile Justice or Protective Services (Transitions)

Why include PSH incentives in the 1115 Demonstration Waiver revision?

- We can tailor it to the behavioral health population we believe would be best served by PSH.
- We could choose to allow MCOs to target individuals with both developmental disability and behavioral health conditions.
- We can include all pre-tenancy/transition services, tenancy sustaining services, and state-level housing-related collaborative activities recommended in CMS Information Bulletin dated June 26, 2015.
- We can use the opportunity to evaluate the potential health improvements and cost savings of PSH based on defined outcomes.

What are the challenges to inclusion of PSH incentives in the 1115 Demonstration Waiver revision?

- Shortages of affordable housing in many communities
- Selecting mechanisms for financing housing and services
- Identification of MCO target population of members
- Obtaining CMS approval
- Establishing outcomes for measuring success of the PSH incentives

[2] Guerin, Paul and Alexandra Tonigan, *Report in Brief: City of Albuquerque Heading Home Cost Study*, University of New Mexico Institute for Social Research, September 2013.

Non-Traditional Medicaid and Non-Medicaid Supports
November 17, 2016

Non-Medicaid Covered Services	Service Description
Employment supports	Job training assessments, vocational care coordination services, supported employment, referral to support, skill building and training
Educational supports	Client Based - Educational care coordination services, referral to support, consumer skill building Community & Agency Based - Alcohol, tobacco and other drug related harm reduction, alcohol and tobacco advertising practices, technical assistance on monitoring enforcement of availability and distribution, media campaigns
Child Care	Childcare coordination services, referral to support
Transportation	Transportation coordination services
Supportive Housing	Client Based - Emergency shelter, eviction prevention, housing placement, housing support group, referral to support, transitional living services, Oxford Houses Community & Agency Based - Developing and inventory of supportive housing
Self-advocacy	Education on client rights, arranging legal representation meetings, resiliency goal support, informational support group
Respite	Arrangement of respite services, referral to support
Family Supports	Education of family members, referral to support
Peer Support	Client Based - Peer operated Wellness Centers Community & Agency Based - Warmline
Health Support	Smoking cessation classes, nutritional guidance, physical activity, acupuncture, acu-detox, yoga, traditional healing, referral to support, health and wellness education
Related goods	Veteran's Food Boxes, Naloxone purchase & distribution, referral to clothing/food
Community training	Multi-agency coordination and collaboration, community team-building, neighborhood action training
Education	Parenting and family management, mentors, preschool prevention, youth education groups, learning communities
Research	Outcomes collection and analysis, establishment and replication of best practice.

Centennial Care Covered Benefit	Services	Service Description
General Medicaid Benefits	Nutritional counseling	Nutritional services and interventions consistent with the members physical medical condition.
	Community Interveners	Develop critical connections to a member and their environment. Opens channels of communication between members and others, facilitates the development of independent living. For blind-deaf members age 5+
Community Benefit - Agency Based*	Community transition services	Non-recurring set-up expenses for a member who is transitioning from an institution or other provider operated living arrangement to residence in a private residence.
	Employment supports	job development; job seeking; and job coaching assistance
Community Benefit - Self-Direction*	Customized Community Supports	Activities that assist with acquisition, retention or improvement in self-help, socialization and adaptive skills.
	Employment supports	job development; job seeking; and job coaching assistance
	Transportation (non-medical)	Access to services and activities in the community as specified in the care plan.
	Nutritional counseling services	Assessment, development of nutritional plan, counseling and intervention and observation and technical assistance related to implementation of nutritional plan.
	Related goods	Equipment, supplies, fees not otherwise provided through MCO general benefits.

*Only available to members with a Nursing Facility Level of Care

Stakeholder Engagement Process Leading to Development of Concept Paper

3. MAC 1115 Waiver Renewal Subcommittee, December 16, 2016

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

AGENDA

MAC 1115 Waiver Renewal Subcommittee Meeting

1474 Rodeo Road, Santa Fe, NM

December 16, 2016

8:30 – 11:45 AM

Topic	Time
Introductions	8:30 – 8:40 am
Review Minutes, Feedback from November Meeting	8:40 – 8:45 am
Long Term Services and Supports (LTSS)	8:45 – 10:15 am
Break	10:15 – 10:20 am
Physical Health – Behavioral Health (PH-BH) Integration	10:20 – 11:20 am
Public comment & Wrap up	11:20 – 11:45 am

Medicaid 1115 Wavier Renewal Subcommittee Meeting

Meeting Minutes

December 16 — 8:30am – 11:45am

Administrative Services Division / Human Services Department, 1474 Rodeo Road, Santa Fe, New Mexico

Subcommittee Members:

Myles Copeland, Aging & Long-Term Services Department	Joie Glenn, New Mexico Association for Home & Hospice Care
Doris Husted, The Arc of New Mexico	Lauren Reichert (proxy for Steve Kopelman), New Mexico Association of Counties
Bryce Pittenger, Children, Youth and Families Department	Patricia Montoya, New Mexico Coalition for Healthcare Value
Dawn Hunter, Department of Health	Linda Sechovec, New Mexico Health Care Association
Jim Jackson, Disability Rights New Mexico	Rick Madden, New Mexico Medical Society
Sandra Winfrey, Indian Health Service	David Roddy, New Mexico Primary Care Association
Christine Boerner, Legislative Finance Committee	Lisa Rossignol, Parents Reaching Out
Carol Luna-Anderson, The Life Link	Liz Lacouture (proxy for Mary Eden), Presbyterian Health Plan
Mary Kay Pera, New Mexico Alliance for School-Based Health Care	

Absent Members:

Kris Hendricks, Dentistry for Kids	Carolyn Montoya, University of New Mexico, School of Nursing
Jeff Dye, New Mexico Hospital Association	Dave Panana, Kewa Pueblo Health Corp.

Staff and Visitors Attending:

Kristin Jones, CYFD	Jeanene Kerestes, Blue Cross Blue Shield of New Mexico
Rachel Wexler, DOH	Shawna Romero, Blue Cross Blue Shield of New Mexico
Shannon Cupka, HSD/ALTSD	Ellen Pinnes, The Disability Coalition
Gail Trotter, HSD/ALTSD	Leonard Thomas, Indian Health Services
Lisa Howley, HSD/BHSD	Debi Peterman, Health Insight New Mexico
Wayne Lindstrom, HSD/BHSD	Andrew Conticelli, Molina Healthcare of New Mexico
Karen Meador, HSD/BHSD	Steve DeSaulniers, Molina Healthcare of New Mexico
Theresa Belanger, HSD/MAD	Mary Kate Nash, Molina Healthcare of New Mexico
Michael Nelson, HSD	Deanna Talley, Molina Healthcare of New Mexico
Kari Armijo, HSD/MAD	Theresa Turietta, New Mexico Association for Home & Hospice Care
Kim Carter, HSD/MAD	

Dan Clavio, HSD/MAD	Michael Ruble, New Mexico Behavioral Health Planning Council
Crystal Hodges, HSD/MAD	Tom Starke, Santa Fe Behavioral Health Alliance
Angela Medrano, HSD/MAD	Sarah Howse, Presbyterian Medical Services
Megan Pfeffer, HSD/MAD	Kira Ochoa, Santa Fe County Community Services Department
Nancy Smith-Leslie, HSD/MAD	Sylvia Barela, Santa Fe Recovery Center
Tallie Tolen, HSD/MAD	Jean Crosbie, Senior Link
Robyn Nardone, HSD/NMICSS	Mark Abeyta, United Healthcare
Jared Nason, Mercer	Amilia Ellis, United Healthcare
Jessica Osborne, Mercer	Raymond Mensack, United Healthcare
Son Yong Pak, Mercer	Curt Schatz, United Healthcare
Cindy Ward, Mercer	Elly Rael, United Healthcare
	Ruth Williams, Youth Development, Inc.

Agenda Item	Details	Discussion
I. Introductions	• Angela Medrano delivered opening comments. • Review minutes. • Feedback from the November 18th meeting. • Presented agenda overview.	• Medical Assistance Division (MAD) would like everyone to have the opportunity to contribute ideas and recommendations for the waiver renewal, and all are encouraged to use the website to submit comments. • October 14th meeting focused on care coordination, November 18th meeting focused on population health and today's meeting is focused on long-term services and supports (LTSS) and behavioral health/physical health (BH/PH) integration. • Summary of recommendations for care coordination and population health are in the packet. • MAD has not received any comments to the October 14th meeting minutes. Therefore, the draft meeting minutes is finalized. • Draft meeting minutes from the November 18th meeting is included and comments are requested by the next meeting, January 13, 2017.
II. Long-Term Services and Supports (LTSS)	• Automatic renewal of nursing facility (NF) level of care (LOC) for certain members. • Align benefits for the Agency-Based Community Benefits (ABCB) and the Self-Directed Community Benefits (SDCB). • Establish levels for ABCB and SDCB budget ranges based on need that may include provisions for one time transition costs. • Implement new MCO reimbursement methodology for members who use fewer PCS hours. • Diversification of services provided by nursing homes. • Explore provider fees / taxes:	• In regards to the Consumer Directed Model under personal care services (PCS), Lauren commented that there are additonal complexities with billing the administrative fees related to required administrative activities of the agency. HSD and the MCOs will provide technical assistance to Rio Arriba Senior Services as needed to ensure that they are informed of how to bill correctly. • Joie commented that the provider reimbursements for ABCB and SDCB do not take into consideration the cost for performing supevision and that supervisory requirements should be factored into the reimbursement. • Doris echoed that it makes sense to align benefits for ABCB and SDCB as the current benefits are very confusing.

Agenda Item	Details	Discussion
	– Legislative process. – The Centers for Medicare and Medicaid Services approval.	• Lisa commented that individuals over eighteen years of age receive homemaker services. For those under eighteen years of age, she wants the possibility of access to similar support under Centennial Care rather than wait for a waiver slot. • In regards to assessing a child's ADLs, Lisa commented that assessors need to ask questions related to the child's development level to accurately obtain the child's ADL needs and set aside their own personal biases. • Jessica commented that as part of the assessment process, MCOs are assessing the whole situation including the member's natural supports, the caregiver's stress and they need to be cognizant about what is working and not working for the family. • Lauren commented that the DOH licensure requirements for adult day care is challenging to work with as DOH staff do not explain the requirements and refer proivders to the statute. Also, the adult day care reimbursement rate does not take into consideration no-shows and transportation costs, which could endanger the program. She recommends that the reimbursement rate should take these costs into consideration for the agency's financial viability and increase the billing unit from 2 hours to half day and per diem. • Joie commented that adult day care regulations are outdated and has asked DOH to re-visit the regulations. Also, she stated that MCOs would like to have adult day care as an option of care model. • Jim cautioned the Department about moving towards limiting access such as increasing the number of ADLs to access services. He commented that the Department could look at different payment levels based on the

Agenda Item	Details	Discussion
		outcome of the assessment. • Jim also asked why hours are decreasing for those individuals with no health status changes durding the annual renewal process. In order to maintain their hours, these individuals are forced to go through the fair hearing process. Instead, Jim stated that we need a process for renewing services when there is no change in status as this would be easier for the recipient and the State. • Jim commented that although he appreciates that the Department is doing more waiver allocations for LTC services, he is discouraged that not more people are eligible. • Tallie commented that the Department makes a concerted effort to conduct outreach to allocated individuals by sending multiple packets and tracking them through the eligiblity process. Some do not respond and others are found ineligible. The Department is currently gathering data on attrition of members with waiver slots. • In regards to the NF census, Linda suggested that we need to look at more real time data rather than claims data due to claims lag times. Linda also stated that underfunding of NF must be addressed as mentioned in the Legislative Finance Committee report. Finally, in regards to the NF diversification, she said that NFs can provide adult day care services and provide follow-up services in the community. • Myles commented that NFs can specialize in serving individuals with dementia as part of the diversification strategy. • Dawn commented that increasing the number of ADLs will have an impact on the DOH facilities. She will submit more details in writing.

Agenda Item	Details	Discussion
		• Wayne commented that we should address how to incentivize NFs to work with members with complex behavoral health needs in the waiver renewal application as this is a critical need. • In regards to the NF access issues, Linda commented that we need to better understand the root cause in order to address this issue. For example, a 5 pm admission on a Friday and lack of beds would require different approaches. • In regards to value-based purchasing (VBP) for NFs, Dawn commented that the DOH/DHI lincensing bureau is identifying quality measures that could be helpful to the Department. • Linda thanked Molina Healthcare for its VBP proposal that focuses on incentives rather than using sanctions to achieve better quality. • Jim encouraged the Department to work with providers groups and explore reimbursement rates since revenue is required for doing the work.
III. Physical Health – Behavioral Health (PH-BH) Integration	• Provider education on PH-BH integration models and best practices. • 3 practice structures and 6 levels of collaboration. • Improve identification of behavioral health and substance use issues and linkage to treatment. • Substance abuse treatment availability. • Improve physical health conditions and reduce in morbidity and mortality. • Direct care management: early assessment; treatment engagement; active follow-up; structured patient	• Linda asked if the Department is interested in PH-BH integration for the LTSS program in addition to collaboration with PH providers, and the response was yes to all. • Carol commented that due to long term drug use, BH providers are seeing physical health issues related to brain atrophy which become long-term service needs. In addition, this impacts staff to client ratio when members can no longer take care of themselves in the community. • In regards to telehealth such as Project ECHO, Lisa asked the Department to speak more about how this is being used. – Karen responded that Project ECHO connects

Agenda Item	Details	Discussion
	education; standardized psychotherapy. • Linkage to community resources and population health supports beyond health services	specialists, including psychiatrists, to those who need care especially in rural communities. – IHS representative commented that from an Indian Health Services perspective, they began using telehealth to address the shortage of practitioners and having access to practitioners via telehealth has been very successful. – Lisa commented that she is supportive of telehealth and that we should be mindful that some populations such a monolingual population may not like using telehealth. • Rick commented that substance abuse prevention should be a high priority given the epidemic of opioid and prescription drug abuse and dependence. – Wayne commented that both DOH and BHSD have a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to address this issue. – Last week, the federal government signed the 21st Century Cures Act which allows the State to apply for more funding to address the opioid epidemic. We have until Febrary 17, 2017 to apply. – We are putting together a project team and will meet next week to strategize on how to garner stakeholders feedback. – Total amount being requested is $4.8M for the next two years. • In regards to information sharing with in-home service providers, Joie stated that MCOs are not sharing behavioral health information with caregivers and are citing confidentiality issues. Consequently, caregivers are

Agenda Item	Details	Discussion
		ill prepared and refuse to return if they have encountered unsafe situations. She stated that the caregivers have the right to know about the member's conditions in order to perform their job. – Bryce commented that in the children's world, this is called a run-around and asked the Subcommittee to consider implementing a high-fidelity wrap around with a single care plan. – Wayne echoed that the Subcommittee should investigate how Medicaid can support this model. • Lauren commented that in Rio Arriba County, the county health department conducts a joint case staffing with contracted providers and jails and that this model has been successful. The county's goal is to sustain this program by billing Medicaid. She will submit the details in writing. • David commented that having access to a shared medical record helps with care coordination. • Mary Kay stated that school-based health centers represent a great PH-BH integration model since both PH and BH providers work together and coordinate services and perform shared-decision making. • Dawn echoed Mary Kay's comment by stating that we can support building the SBHC network. Also, she thanked HSD for sharing the Milbank report as it contains good ideas on next steps. • Wayne commented that integration is a heavy lift and encouraged the Subcommittee to consider a broader framework as we work on this issue and reminded the group that integration is not limited to the practice level. – He commented that State departments and MCOs should pay more attention to integration challenges in

Agenda Item	Details	Discussion
		their respective spheres. – Payment structure is a barrier. We need to move away from fee-for-service which rewards quantity and focus on quality and outcomes by treating individuals more holistically. – Finally, we need to look at the whole lifespan from babies being born with opioid addiction to aging and long-term care. • Rick echoed Wayne's comments and commented that having providers co-located makes a huge difference to achieving integration as it allows practitioners to communicate more readily. Both Rick and Wayne stated that not all co-located practices provide integrated care and emphasized the importance of timely communication among practitioners and a holistic approach to treatment. • Lauren commented that in her county, they co-located all of the departments which forced staff to speak more frequently to one another. She felt that it is not necessarily important to have a co-location, but that the value is in building relationships. • Pat suggested leveraging resources from the Medicare/Medicaid ACOs. • Doris and Bryce commented that we need workforce development to focus on working with individuals with intellectual and developmental disabilities as many BH providers do not know how to treat this population. • Carol suggested that using flexible funding to assist members could be helpful. • IHS representative commented that Screening, Brief Intervention and Referral to Treatment (SBIRT) is a good model for looking at outcomes. – Dawn commented that many states are looking at

Agenda Item	Details	Discussion
		SBIRT and that Medicaid (in New Mexico) does not pay for it.
IV. Public Comments	• Focus on quality and not cutting services arbitrarily. • In regards to care coordination, utilize youth support workers. • DOH and HSD consider administrative reorganization to co-create and support regionally in rural areas to advance health care. • Care coordination central hub. • The Subcommittee shouldn't be limited to making recommendations. Instead, require MCOs and providers to provide certain services such as medication-assisted therapy and Screening, Brief Intervention and Referral to Treatment.	• Commenter applauded the Committee for its focus on improving outcomes for Medicaid recipients and reducing costs through focusing on quality and not reducing services arbitrarily. However, the discussion on increasing NF LOC from 2 ADLs to 3 ADLs seems arbitrary. • New Mexico is a recipient of the SAMHSA's Healthy Transitions Grant[1], which is aimed to improve support services for adolescents and young adults with, or at risk of, serious mental health conditions. • Peer support workers should be expanded to include youth since youth relates better to young people who share his/her experience(s). • Through the Healthy Transitions Grant, New Mexico is developing a strategic plan that includes developing outreach and engagement activities for targeted adolescents and young adults. • For those rural areas that will not have health homes or patient-centered medical homes, DOH and HSD should consider administrative reorganization to co-create and support the community in how to pay for services (value). In lieu of health homes, health home look alike models could benefit rural communities. • Establishing a regionally appropriate care coordination hub, that is either independent of MCOs or with assistance from MCOs, may be a viable option.
V. Meeting Close	• Follow-up materials • HSD contact protocol	• Comments on population health, LTSS and PH-BH integration comments are due from committee members

[1] For more information on the SAMHSA's Healthy Transitions Grant, visit https://www.samhsa.gov/nitt-ta/healthy-transitions-grant-information .

Agenda Item	Details	Discussion
	• Next meeting date	by January 6, 2017. • Comments should include recommendations, outcome measures, as well as measurement methods. • Next meeting is on January 13, 2017 in Albuquerque at the Department of Transportation District Three Auditorium.

Acronym Guide for MAD / HSD 1115 Waiver Renewal Process

ABCB – Agency-Based Community Benefit
ACEs – Adverse Childhood Experiences
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
DHI – Division of Health Improvement
D-SNP – Dual Eligible Special Need Plan
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
FIT – Family Infant Toddler Program
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
I/DD – Intellectual and Developmental Disabilities
IHS – Indian Health Service
IP – In-patient
LEAD – Law Enforcement Assisted Diversion
LFC – Legislative Finance Committee
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
NATAC – Native American Technical Advisory Committee
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
SAMHSA – Substance Abuse and Mental Health Services Administration, an agency within the US Department of Health and Human Services
SBHC – School-Based Health Center
SBIRT – Screening, Brief Intervention and Referral to Treatment
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

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CENTENNIAL CARE NEXT PHASE

1115 Waiver Renewal Subcommittee
December 16, 2016

Agenda

Introductions	8:30 – 8:40
Feedback from November meeting	8:40 – 8:45
LTSS	8:45 – 10:15
Break	10:15 – 10:20
PH-BH Integration	10:20 – 11:20
Public comment	11:20 – 11:40
Wrap up	11:40 – 11:45

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Renewal Waiver
Areas of Focus

- Refine care coordination
- Address social determinants of health
- Opportunities to enhance long-term services and supports
- Continue efforts for BH and PH integration
- Expand value-based purchasing
- Provider adequacy
- Benefit alignment and member responsibility

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Long-Term Services and Supports (LTSS)

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LTSS
Overview

Under Centennial Care all members who meet the NF LOC have access to the community benefit

- Increase in the number of unique members who have access to the community benefit:
  - 24,013 users in CY2014
  - 27,836 users in CY2015
  - 27,593 users in 9 months of CY16
  - Community benefit is included in the expansion benefit package
- Average monthly cost of a nursing home is approximately 2.8 times as expensive as the average community benefit
- Recent analysis conducted by the LFC indicated that the overall occupancy rate at nursing facilities has been declining since 2011
- NM ranked in the 2nd best quartile overall in the 2014 national State Long Term Care Scorecard [1]

LTSS Population
Setting of Care Enrollment Mix
(Long Term Nursing Facility vs. Community)

Setting	Nursing Facility	Community Benefit
2011	18.7%	81.3%
2012	18.9%	81.1%
2013	17.3%	82.7%
2014	15.9%	84.1%
2015	14.3%	85.7%

[1] http://www.longtermscorecard.org/

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Community-Based Models for Care

Agency Based Community Benefit (ABCB)

- Community-based alternative to institutional care that maintains members in the home or community
- Member chooses consumer delegated or directed model for personal care services (PCS)

Self Directed Community Benefit (SDCB)

- Community-based alternative to institutional care that facilitates greater member choice, direction and control over covered services
- Member receives annual budget based on need.
- Member directs how to spend the annual budget on services.
- Member (or representative) is common-law employer of providers

Benefits and services vary based on model

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LTSS
Beginning the Discussion

Needs	Concepts	Further Discussion

➢ Streamline NF LOC renewals and improve assistance to individuals
➢ Improve comparability of service offerings between community benefit options and improve transition into SDCB
➢ Continue successes of rebalancing effort between institutionalization and community care
➢ Fiscal sustainability of nursing homes
	➢ Automatic NF LOC renewal for certain members
	➢ Align benefits for ABCB and SDCB
	➢ Establish levels for ABCB and SDCB budget ranges based on need that may include provisions for one time transition costs
	➢ Implement new cohort for members who use fewer PCS hours
	➢ Diversification of services provided by nursing homes
	➢ Explore provider fees / taxes:
	  ➢ Legislative process
	  ➢ CMS approval
	➢ NF LOC ADL change from 2 ADLs to 3 ADLs
	➢ Value-based purchasing arrangements with LTSS providers
		1. What other areas are important to streamline for members?
		2. What other enhancements should be considered for members to remain in the community?
		3. Nursing facility diversification

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Physical Health-Behavioral Health Integration

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BH/PH Integration
Key Terms

Intent of Integration

- "Integration of services through the expansion of patient centered medical homes and health homes with intensive care management provided at the point of service to help recipients manage their health and their use of the health care system."
- "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."

-from current 1115 Waiver

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BH/PH Integration
Models

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice

http://www.milbank.org/publications/evolving-models-of-behavioral-health-integration-evidence-update-2010-2015/

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PH-BH Integration

Opportunities/Goals

- More than mental illness and addiction
- Early onset; early death (>8 million each year)
- Medicaid = largest payer
- Provider and Plan Challenges:
  - Workforce
  - EHR capacity
  - Continuity of care gaps

Increase provider competency to serve members with co-morbid PH-BH conditions

Improve screening for BH conditions, including substance-use disorders

Leverage the emergency department information exchange to identify members who require linkage to mental health and substance abuse treatment

Improve information sharing challenges due to varied interpretations of privacy rules

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PH-BH Integration

Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Increase provider's competency and capacity to manage both physical and behavioral conditions ➢ Increase behavioral health screening across the continuum of care ➢ Remove barriers to sharing information between providers ➢ Value-based payment strategies for integrated care	➢ Provider education on PH-BH integration models and best practices ➢ 3 practice structures and 6 levels of collaboration ➢ Improve identification of behavioral health and substance use issues and linkage to treatment ➢ Substance abuse treatment availability ➢ Improve physical health conditions and reduce in morbidity and mortality ➢ Direct Care management: early assessment; treatment engagement; active follow-up; structured patient education; standardized psychotherapy ➢ Linkages to community resources and population health supports beyond health services	1. Are all three practice models present in New Mexico? What is working well? 2. How can we support provider's capacity to manage co-morbid conditions? 3. How can MCOs encourage patient engagement? Provider engagement? 4. Can MCOs work with local and regional leaders to create stronger forms of integrated care that affect health outcomes? 5. Should HSD identify screening tools that they recommend providers use? 6. What ways can HSD support better information sharing? 7. Can value-based payment models address provider and plan challenges? What models are better suited for integrated providers?

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PH-BH Integration

Ideas

- Increase the number of health homes to additional counties
- Submit an additional health home SPA or amendment to add substance use disorders as primary diagnoses
- Build capacity through additional tele-behavioral health clinical supervision and tele-psychiatry development
- Increase implementation of value-based purchasing or prospective payment methodologies
- Others?

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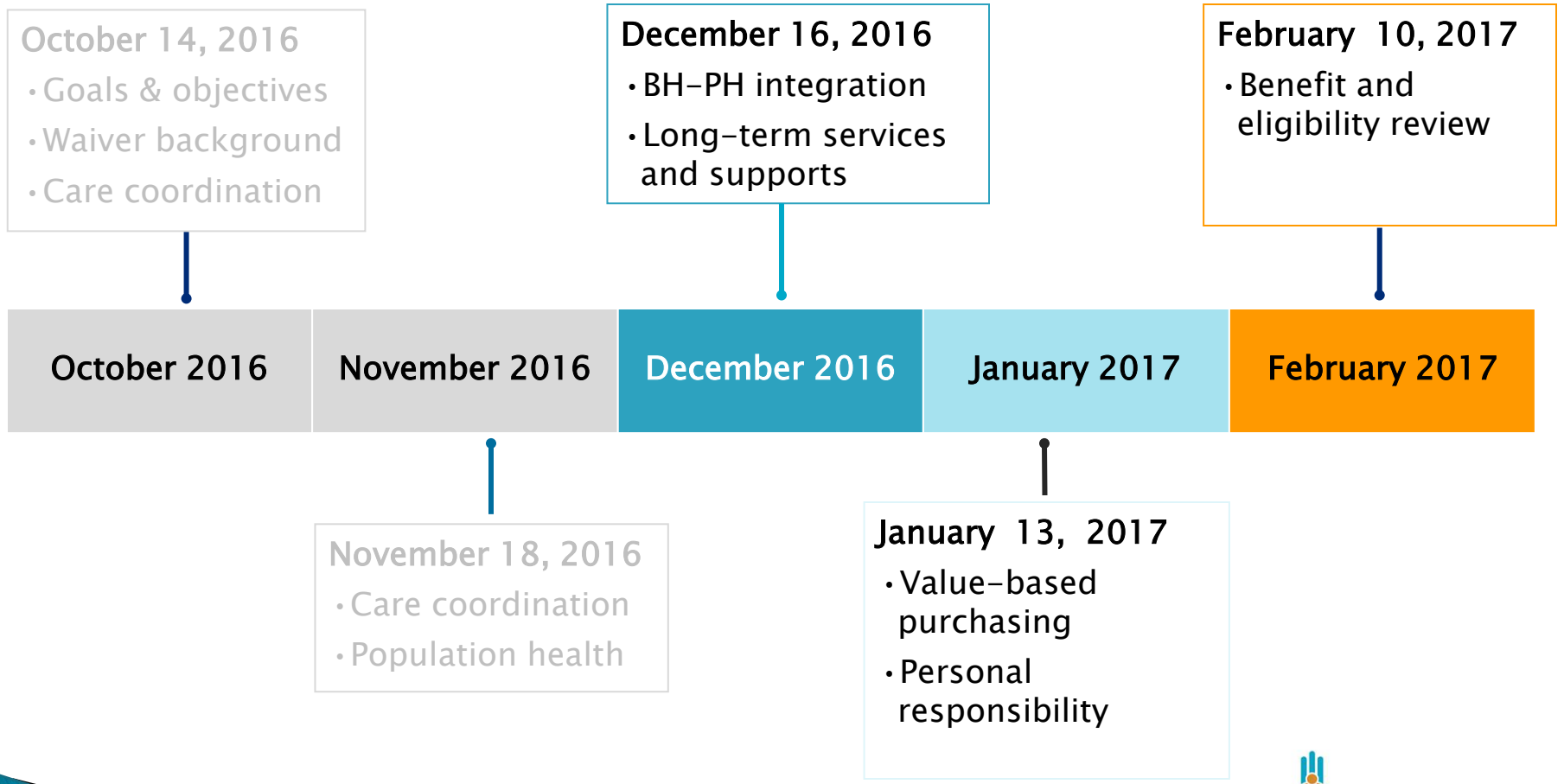
Subcommittee Meetings

Timeframe for Discussion



HUMAN SERVICES DEPARTMENT

Centennial Care 1115 Waiver Renewal Subcommittee
Long-Term Care Brief

Background

Launched on January 1, 2014, Centennial Care provides a comprehensive delivery system for Medicaid members that integrates physical health, behavioral health and long-term services and supports; ensures cost-effective care; and focuses on quality of health care over quantity of services delivered.

Essential to the program is the Community Benefit (CB) home and community-based services (HCBS) program for members who require long-term services and supports (LTSS) to remain in the family residence, in their own home or in community residences. The CB is an alternative to placement in a Nursing Facility (NF) and is available to members who meet Nursing Facility Level of Care (NF LOC). CB services supplement a member's natural supports but do not provide 24-hour care.

With the implementation of Centennial Care, eligibility for HCBS does not require a waiver allocation ("slot") to access HCBS services if the member is eligible for full Medicaid. Also, personal care service (PCS) benefits were changed from being a state plan service to a component of the CB service package. Under the former Coordination of Long-Term Services (CoLTS) program, individuals who were Medicaid eligible could receive PCS under the state plan, and were required to wait for a waiver allocation in order to have access to the full array of CoLTS HCBS. Under Centennial Care, members have access to all CB services that they are assessed to need, without an allocation, upon meeting the NF LOC criteria. Individuals who do not meet full Medicaid financial eligibility requirements require an allocation or waiver "slot". HSD increased its annual waiver enrollment limit (slots) from 3,989 to 4,289 during the 1115 Waiver period (CY 2014-2018).

The member's managed care organization (MCO) provides the CB services as determined appropriate based on the Comprehensive Needs Assessment (CNA). Members eligible for CB services have the option of selecting the Agency-Based Community Benefit (ABCB) or the Self-Directed Community Benefit (SDCB).

Number of LTC Users

	December 2013	CY2014	CY2015	9 months of CY2016
ABCB and SDCB[1]	21,300 (Includes PCO, Mi Via and CoLTS Waiver)	24,013	27,836	27,593
Nursing Facility (long term)	3,529	3,711	3,591	3,530

1 – Includes members who are enrolled as LTSS and Medicaid Expansion.

According to a recent report by the Legislative Finance Committee (LFC) released in October 2016, *Cost, Quality and Financial Performance of Nursing Homes in New Mexico*, the number of individuals living in New Mexico nursing homes declined by 12 percent over the last five years as options for home and community-based care have expanded under Centennial Care. "As such, nursing homes are caring for residents who are gradually becoming more dependent on others for activities of daily living, leading to higher costs of care. This has considerable implications in New Mexico, where 64 percent of nursing home residents rely on Medicaid to pay for their care."

The report recommended that the Department consider pursuing a reimbursement system for nursing homes that takes into account additional categories of patient acuity, as well as provider quality and performance. The Department began exploration of transitioning to a case mix reimbursement structure with the New Mexico Health Care Association and its consultant. It also engaged its audit contractor to conduct an initial analysis of the impact to implement such a transition. The Association's consultant estimated it would require significant additional funds to move to a case mix reimbursement. Considering current budgetary constraints, the Department has been unable to continue to move forward with such an implementation.

The trend of more members choosing to stay in the community rather than residing in nursing homes supports the person-centric goals of Centennial Care and improves their overall quality of life. However, it also results in reduced occupancy rates for nursing facilities and higher average costs to care for those who are residing in nursing facilities. Another recommendation in the LFC report is to pursue payment reform initiatives for nursing facilities, including value-based purchasing (VBP) arrangements that reward quality of care rather than quantity of care. This recommendation aligns with efforts in Centennial Care to advance VBP arrangements. Molina Healthcare recently informed the Department that it is implementing a Nursing Facility Quality Program that will financially reward facilities for achieving quality measures.

The program will begin on January 1, 2017. While these efforts will take time to implement and assess, they represent a movement in the right direction in terms of achieving better healthcare outcomes for members in institutional care settings.

In overall performance of its LTSS program, New Mexico ranks in the second best quartile in the 2014 National State Long-Term Care (LTC) Scorecard published by the AARP and the Commonwealth Fund. Our LTC system is especially strong in terms of:

- Affordability and access (top quartile)
- Choice of setting and provider (top quartile)
- Effective transitions across settings of care (second quartile)

Long-Term Care (LTC) Monitoring

LTC Committee

In late 2015, several LTC related issues were reported to the Human Services Department (HSD) from members and disability rights advocates. HSD created a LTC Committee that included state staff and key representation from each MCO. Meetings began in December 2015 and continue to occur at least monthly.

The LTC Committee's agenda has included:

- MCO care coordination procedures, including the comprehensive needs assessment (CNA);
- How to educate the member on the full array of CB services that may be available to him or her;
- Solutions to improve and document care coordinator discussions with members about CB services and any risks involved when a member declines certain benefits; and
- Compliance with the Federal HCBS Settings Rule by 2019.

The committee created and piloted a supplemental Community Benefit Services Questionnaire (CBSQ) with a risk agreement that is to be used along with the CNA. The risk agreement ensures that a member or his/her representative is aware of risks that may occur when he/she refuses to accept assessed services. The committee also created a CB services brochure to be given to the member during the in-home CNA that explains the services that are covered under the ABCB and the SDCB models.

Based on the results of the pilot and surveys conducted with members and care coordinators, the CBSQ was finalized in September 2016. The MCOs were directed to fully implement the CBSQ beginning in November 2016. HSD is monitoring the implementation through "ride-alongs" with care coordinators. HSD staff will attend random in-home assessments to observe the administration of the CNA and CBSQ and provide feedback to the MCOs regarding improvements as necessary.

MCO Reporting

Since the beginning of Centennial Care, HSD staff review and analyze monthly, quarterly, semi-annual and annual reports related to LTC to monitor over and under-utilization of services, gaps in care and timeliness for nursing facility level-of-care (NF LOC) determinations. Any findings are addressed with the MCOs.

Accomplishments Related to Long-Term Care

MCO Training

In 2016, HSD provided detailed direction and training to the MCOs related to NF LOC and Setting of Care (SOC) reporting timelines for NF LOC determinations, denials and closures. In March of 2016, HSD conducted training for all care coordinators on CB services to ensure that they correctly inform members about available services.

Medicare Alignment

With Centennial Care, the MCOs are required to offer Dual Eligible Special Need Plans (D-SNPs), which allow them to coordinate the full array of a member's Medicaid and Medicare benefits under a single plan and offer enhanced benefits for this population. The goal is to more effectively manage the members' benefits and improve customer service by having a single provider directory and member handbook, one drug plan and no copayments. In October 2016, HSD worked with the MCOs to send a letter to members who are dually eligible for Medicaid and Medicare. The letter and Frequently Asked Questions (FAQ) sheet offered information about the benefits of selecting one MCO for both Medicaid and Medicare coverage. The goal of this mailing was to align enrollment for dual eligible members to ensure better health outcomes and coordination of Medicaid and Medicare benefits. HSD will analyze data to determine the success of the mailing in January 2017 and plan for future outreach to dual-eligibles.

Allocations and Central Registry

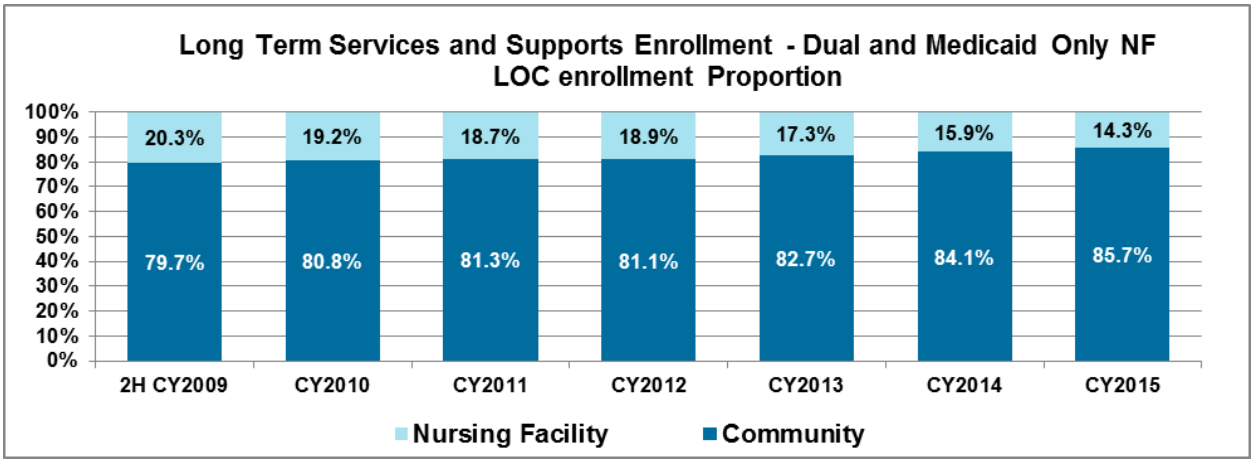
HSD has increased allocation activity throughout Centennial Care as illustrated in the chart below. As of October 2016, there are 15,288 active registrations on the central registry, and regular registrations from 2007 are currently being allocated. Community reintegration and expedited allocations are also being processed. Unfortunately, overall response rates are very low. This may be due to outdated address information in the allocation system and the complexities inherent to Medicaid enrollment.

Number of Allocations

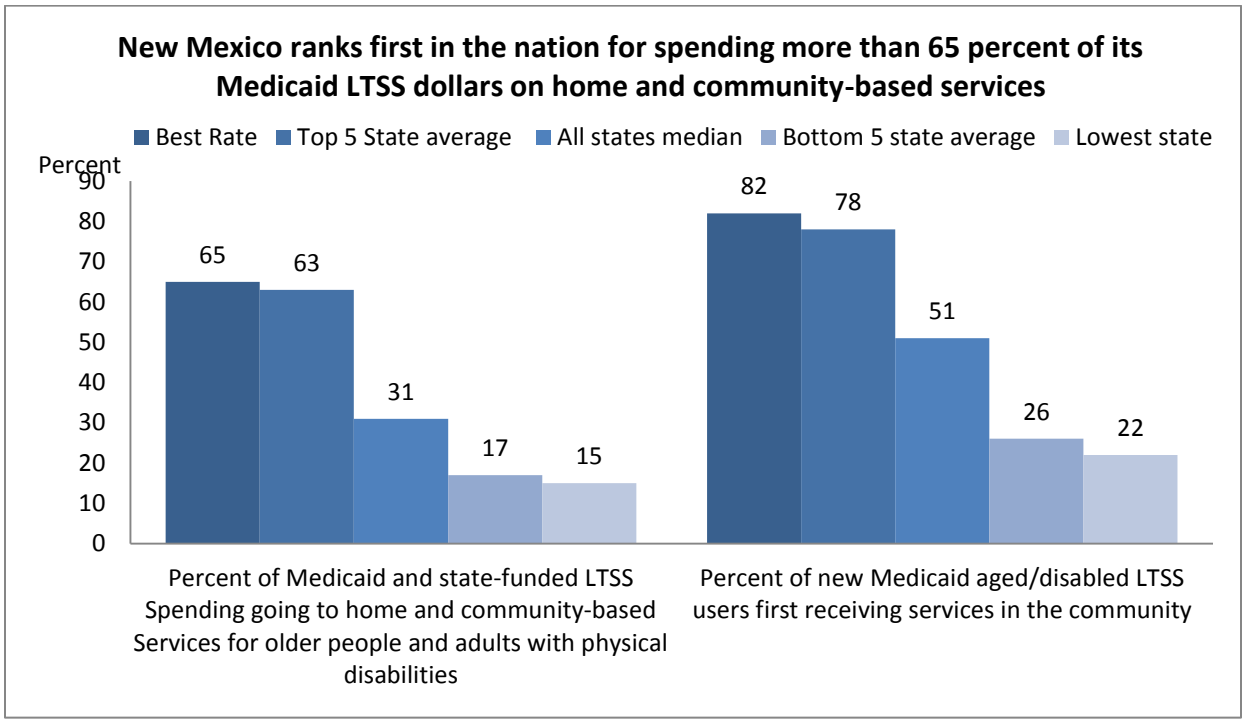
	Allocations Mailed	**Responses Received**	**Response Rates**	**Eligible for Waiver**
2014	1103	630	57%	168
2015	1725	786	46%	106
2016	3347	1476	44%	304

Community Reintegration/Rebalancing

Under Centennial Care, NM has continued to reintegrate members from nursing facilities into the community, with 85.7% of members in the long-term care program being served in the community in 2015.



In the AARP's annual report for 2014, *State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*, New Mexico ranks first in the nation for spending more than 65 percent of its long-term care dollars on home and community-based services.



Top 5 states:

1 New Mexico	**1 Alaska**
2 Minnesota	**2 Minnesota**
3 Washington	**3 New Mexico**
4 Alaska	**4 District of Columbia**
5 Oregon	**5 Idaho**

Data: LTSS Spending - AARP Public Policy Institute analysis of Truven Health Analytics, Medicaid Expenditures for Long Term Services and Supports in 2011 (Revised October 2013); AARP Public Policy Institute Survey (2012); New Medicaid Users - Mathematica Policy Research analysis of 2008/2009 Medicaid Analytical Extract (MAX).

Source: State Long-Term Services and Supports Scorecard, 2014.

Personal Care Services

Personal Care Services (PCS) is the most utilized CB service. Total PCS expenditures have increased from $263 Million with 19,500 users in 2013 to $345.8 Million with 27,836 users in 2015. The state fully implemented an Electronic Verification System (EVV) in November 2016 to ensure members are receiving the approved level of PCS. Many PCS caregivers use MCO supplied tablets with location service to monitor work activities.

NM Independent Consumer Support System (NMICSS)

HSD created an independent system that links together resources throughout the state to assist Medicaid Centennial Care enrollees receiving LTSS. The NMICSS provides Centennial Care beneficiaries, their advocates and counselors with information and referral resources in the following areas:

- Centennial Care health plan choice counseling
- Grievance, appeals rights and fair hearings
- Understanding care coordination and levels of care

The NMICSS provides informational brochures to inform beneficiaries and advocates on how to access the NMICSS and which participating organizations can help with specific topics. HSD developed an NMICSS website www.nmicss.com which provides the following information:

- Central location for resources, links and important phone numbers
- Listing of NMICSS partnering entities and description of available services
- Printable fact sheets regarding LTSS, step-by-step grievance, appeals and fair hearings flow charts, care coordination, the ABCB and the SDCB, and NFs

HSD partners with members of the NMICSS advisory team in planning and hosting semi-annual regional roundtable discussion groups with a focus on long-term services and supports (LTSS) in Centennial Care. The purpose of these meetings is to offer an environment conducive to open discussion regarding LTSS for Centennial Care members, provider advocates, executive leadership from the four MCOs, the Director of the Medical Assistance Division (MAD) and MAD LTSS Bureau. The regional discussions are held at the San Juan Center for Independence in Farmington, the UNM Center for Development and Disability (CDD) Information Network in Albuquerque and The Ability Center in Las Cruces. These discussions have led to increased MCO trainings for care coordination; process improvements between the MCOs, HSD and LTSS providers; and trust building at the community level with MCOs, members and provider advocates. Participating advocacy and provider organizations acknowledge improved relationships with the MCOs and support on-going regional discussions.

Policy Manual Updates

HSD updates the Centennial Care MCO Policy Manual twice a year to include policy clarification for the MCOs and providers. HSD solicits public comment as part of this process. As a result of feedback from advocacy groups and stakeholders, including the NMICSS roundtable discussions, changes have included:

- Removed MCO environmental modification documentation requirement that all other viable resources must be contacted and refuse to provide the service.
- Allowed PCS agencies to create a flexible individualized schedule for members as appropriate.
- Clarified PCS agency transfer process with timeframes.
- Added the purchase of cell phone data in self-directed related goods. There is a $100 per month limit for cell phone services.
- Increased limit from 50 miles to 75 mile radius in self-directed non-medical transportation.
- Clarified that non-medical transportation under self-direction for the purpose of picking up pharmacy prescriptions is allowed.

The CB sections of the Policy Manual will be updated again in March 2017.

LTC Challenges

CB Service Package Alignment

A major issue within the CB is the difference in the CMS approved available benefits in the self-directed and agency-based models. Several services are only available in the self-directed model such as related goods and specialized therapies. Members who struggle with the added employer related requirements of self-direction do not want to switch to ABCB because they will lose access to certain services not included in the ABCB package. HSD may more closely align the available benefits in the 1115 renewal, however, current budget constraints do not allow for an expansion of the program.

Children and Youth Appropriate Services in Centennial Care

The Community Benefit package was designed to meet the needs of the disabled and elderly population. There are many youth (under age 21) on the central registry or receiving CB services while they wait for an allocation to the Developmental Disabilities Waiver that may more appropriately meet their needs. The majority of CB services are not available to children, as they access services through the EPSDT benefit. In most instances, in the agency-based model, they are only eligible for CB respite or BH support consultation services. If a youth

switches to the self-directed model after 120 days in agency-based, he/she may be eligible for other services such as related goods or specialized therapies.

New Ideas for LTC

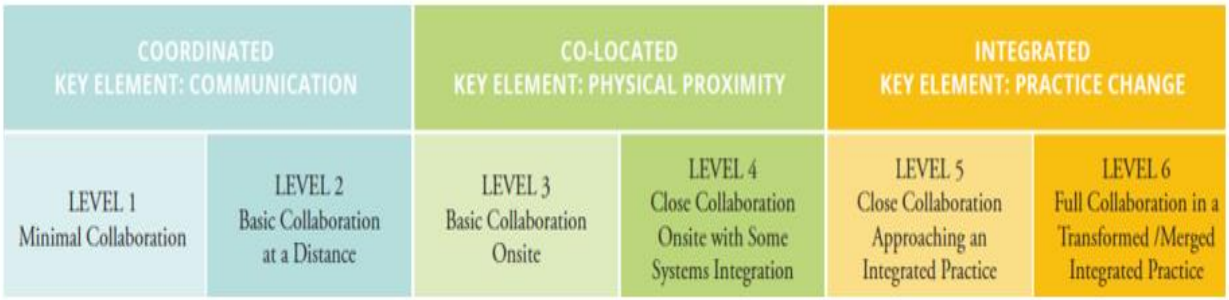
HSD has identified a few areas where improvement for LTC can be made in the waiver renewal if budget availability allows for such changes. These include:

- Aligning the benefits for both ABCB and SDCB models to allow for equity and smoother transitions between models.
- Explore service alternatives under both CB models that may better address members' needs.
- Implement an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change. For example, this could pertain to members with certain conditions such as: renal failure, Alzheimer's, Parkinson's, quadriplegia etc. This would reduce the burden of annual assessments for the member, increase administrative simplicity and possibly bring cost savings. MCOs would still be required to complete an annual CNA and develop an annual care plan.
- Currently, members must need assistance with two activities of daily living (ADLs) to meet NF LOC. The requirement could be changed so that members would need to meet the requirement of assistance with three ADLs to qualify for NF LOC.
- Implement a new cohort/benefit category that would include members with few PCS hours (lower ADL needs).
- Establish CB budget level ranges based on assessed need. There could be three levels: high, middle and low with corresponding dollar amount ranges that would be available to members regardless of chosen CB model.

Behavioral Health-Physical Health Integration Considerations

The Context

- Mental illness and substance use disorders are common, affect people of all ages, and result in substantial disability and cost. Approximately 8 million deaths each year are attributable to behavioral health conditions but come from untreated comorbid health conditions, infections or suicide. Untreated mental illness (including substance use disorders) is not only a source of individual deaths and co-morbidity but also a largely preventable drain on health care system funds.
- New Mexico held a series of Expert Panel meetings in 2010/2011 to review the national and state experience with efforts to integrate mental health (including addiction) and general medical care. The Expert Panel recommendations contributed to the design of the 1115 Waiver with its emphasis on care coordination and its encouragement of a variety of patient-centered clinical practice models.
- Since then collaborative care management research has increased substantially, the strongest evidence of improved health outcomes coming from reviews of depression and diabetes treatment with a growing research base for other mental health conditions as well as interventions incorporating team-based direct care approaches.
- Since then also the deluge of prescription opioid use, dependency and death challenges behavioral health and general medical systems alike, driving up costs as well as creating new urgency for effective prevention and early intervention as well as treatment options.
- Mental disorders are largely chronic illnesses that, while very treatable, are characterized by relapses and recurrences.
- Mental health and substance use treatment is one of the 'essential benefits' in the Centennial Care program. Three-quarters of all serious mental disorders in adults – like major depression, schizophrenia and anxiety disorders – are present by age 25.
- The policy questions New Mexico and other states face is no longer *whether* to promote integration but *how* to provide the infrastructure and financial incentives needed to implement, ensure fidelity, foster innovation and sustain the model.



Successes in Centennial Care

- Integrated financing of BH and PH through capitation payments to MCOs
- Initiation of health homes for Centennial Care members with serious mental illnesses
- Development of the behavioral health provider networks through additional FQHCs delivering specialty behavioral health services
- Submission of application for CCBHC demonstration project
- Movement of care coordination to increasing number of provider/direct service locations
- Integrated Quality Service Review training and New Mexico's Treat First model
- Demystification of medical detox through
    - Partnership between UNM, PHP and the Hospital Association to increase substance use screening in emergency departments
    - Medical detox (withdrawal management) trainings in Gallup, Las Cruces and Albuquerque for hospital and other medical staff

Ideas for next steps

- Increase the number of health homes to additional counties
- Submit an additional health home SPA or amendment to add substance use disorders as primary diagnoses
- Build capacity through additional tele-behavioral health clinical supervision and tele-psychiatry development
- Increase implementation of value-based purchasing or prospective payment methodologies
-

Additional materials:

An updated version of the first behavioral health "Evolving Models of Behavioral Health Integration in Primary Care" that was considered by New Mexico's 'expert panel' describes the proliferation of research since 2010 on the integration of BH and PH through collaborative care models.

http://www.milbank.org/publications/evolving-models-of-behavioral-health-integration-evidence-update-2010-2015/

An executive summary of the full report can be found at: http://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI-Exec-Sum.pdf

Stakeholder Engagement Process Leading to Development of Concept Paper

4. MAC 1115 Waiver Renewal Subcommittee, January 13, 2017

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

AGENDA

MAC 1115 Waiver Renewal Subcommittee Meeting

NM Dept. of Transportation District Three Auditorium
7500 Pan American Freeway NE , Albuquerque, NM 87109

January 13, 2017

8:30 – 11:30AM

Topic	
Introductions	8:30 – 8:40 am
Review Minutes, Feedback from November Meeting	8:40 – 8:45 am
Value-Based Purchasing (VBP)	8:45 – 10:00 am
Break	10:00 – 10:10 am
Member Engagement / Personal Responsibility	10:10 – 11:10 am
Public comment & Wrap up	11:10 – 11:30 am

Medicaid 1115 Wavier Renewal Subcommittee Meeting

Meeting Minutes

January 13, 2017 — 8:30am – 11:30am

District Three Auditorium / Department of Transportation / 7500 Pan American Freeway NE, Albuquerque, New Mexico

Subcommittee Members:

Myles Copeland, Aging & Long-Term Services Department Doris Husted, The Arc of New Mexico Bryce Pittenger, Children, Youth and Families Department Dawn Hunter, Department of Health Ellen Pinnes (proxy for Jim Jackson), Disability Rights New Mexico Sandra Winfrey, Indian Health Service Carol Luna-Anderson, The Life Link Dave Panana, Tribal Representative, Kewa Pueblo Health Corp. Nancy Rodriguez (proxy for Mary Kay Pera), New Mexico Alliance for School-Based Health Care Lauren Reichert, New Mexico Association of Counties	Teresa Turietta, New Mexico Association for Home & Hospice Care Patricia Montoya, New Mexico Coalition for Healthcare Value Linda Sechovec, New Mexico Health Care Association Jeff Dye, New Mexico Hospital Association Rick Madden, New Mexico Medical Society David Roddy, New Mexico Primary Care Association Carolyn Montoya, University of New Mexico, School of Nursing Lisa Rossignol, Parents Reaching Out Liz Lacouture (proxy for Mary Eden), MCO Representative, Presbyterian Health Plan

Absent Members:

Christine Boerner, Legislative Finance Committee	Kris Hendricks, Dentistry for Kids

Staff and Visitors Attending:

Rachel Wexler, DOH Wayne Lindstrom, HSD/BHSD Mark Barnand, HSD/BHSD Theresa Belanger, HSD/MAD Michael Nelson, HSD Kari Armijo, HSD/MAD Dan Clavio, HSD/MAD Angela Medrano, HSD/MAD Megan Pfeffer, HSD/MAD Nancy Smith-Leslie, HSD/MAD	Joie Glenn, Advocacy for Home and Hospice Care Erik Lujan, APCG Health Committee Shawna Romero, Blue Cross Blue Shield of New Mexico Debi Peterman, Health Insight New Mexico Beverly Nomberg, New Mexico Behavioral Health Association and La Familia Gayle Geis-O'Dowd, Molina Healthcare of New Mexico Patty Kehoe, Molina Healthcare of New Mexico Susan Dezavelle, Molina Healthcare of New Mexico Beth Landon, New Mexico Hospital Association

Tallie Tolen, HSD/MAD Robyn Nardone, HSD/NMICSS Jared Nason, Mercer Jessica Osborne, Mercer Son Yong Pak, Mercer Cindy Ward, Mercer	Kathleen Derby, Peer / Certified Peer Support Worker Anthony Yepa, Pueblo de Cochiti Rick Henley, Senior Link Carla V. Martinez, United Healthcare Amilia Ellis, United Healthcare Raymond Mensack, United Healthcare Curt Schatz, United Healthcare Josh Ahrens, United Healthcare Sunah Hoeferkamp, United Healthcare Veronica Esparza, United Healthcare Rodney McNease, University of New Mexico Hospitals

Agenda Item	Details	Discussion
I. Introductions	• Angela Medrano delivered opening comments. • Review minutes. • Feedback from the December 16th meeting. • Presented agenda overview.	• Medical Assistance Division (MAD) would like everyone to have the opportunity to contribute ideas and recommendations for the waiver renewal, and all are encouraged to use the website to submit comments. • This is the 4th Subcommittee Meeting: – October 14th meeting focused on care coordination. – November 18th meeting focused on population health. – December 16th meeting focused on long-term services and supports (LTSS) and behavioral health/physical health (BH/PH) integration. – Today's meeting is focused on value-based purchasing and member engagement and personal responsibility. • MAD has not received any comments to the November 18th meeting minutes. Therefore, the draft meeting minutes are finalized. • Draft meeting minutes from the December 16th meeting is included and comments are requested by January 31, 2017. – Rick commented that on page 9, the meeting minutes need to emphasis the need for a shared electronic medical record to drive integration within a practice. The minutes were amended to reflect the comment.
II. Value-Based Purchasing (VBP)	• Providers have varied levels of readiness for VBP payment strategies and concerns about bearing more risk. • Providers need reliable data, particularly related to costs of services they do not deliver, and technical assistance to utilize data sources. • BH and LTSS providers can be particularly	• Pat commented that New Mexico started aligning quality and focusing on health plans moving towards VBP models under Aligning Forces for Quality (AF4Q). Currently, one of the challenges in implementing VBP is information technology (IT) systems that can manage VBP models at the managed care organization (MCO) and provider levels. She stated that nationally based MCOs tend to lead this charge and asked what they are

Agenda Item	Details	Discussion
	challenged by risk based VBP strategies and often require unique models. • Quality outcome measures can more resource intensive to collect (hybrid measures). • Alignment with other payers is challenging due to population differences and quality measure differences. • Population-based models require providers to think more broadly about unmet non-medical needs (social determinants of health) and how best to keep patients healthy. • No single entity to convene and coordinate a common vision across payers.	doing to build on the infrastructure in New Mexico. • Nancy SL.commented that Molina Healthcare of New Mexico (Molina) and Presbyterian Medical Services (PMS) have made a lot of progress with their IT system to support various VBP models. • Susan from Molina commented that it has a software program that shows providers their total cost of care, and it is able to manipulate data by providers to include the total cost of care, gaps in care and quality measures. Molina makes the data available through an online provider portal and is currently working with providers on how to use the data to improve care. • Liz from Presbyterian Health Plan commented that it provides a hard copy report to providers on a monthly basis and holds regular meetings with providers to review reports. Presbyterian Health Plan is currently building an online interface. • Carol, in respons to Molina and Presbyterian Health Plan comments asked if physical health and behavioral health were intergrated. • David R. commented that Federally Qualified Healthcare Centers are participating in VBP and stated that higher number of members are required to participate in risk-based models. In addition, he commented that having access to data is great; however, it is challenging to access data from multiple sources. • Pat commented that there are some barriers to sharing data from the federal and state regulations perspective and stated that we need to address the State statutes during the current legislative session. She also commented that we need to identify the funding streams to build a better infrastructure to support data sharing.

Agenda Item	Details	Discussion
		• Pat asked if HSD has performed a crosswalk on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) quality measures when building the core Medicaid measures. – Nancy SL. replied that New Mexico has requested the Centers for Medicare and Medicaid Services collaborate with the states on the development of quality measures but has received limited traction since the Medicare leadership's focus differs significantly from Medicaid. • Rick commented that it is important to support providers who are in early stages of readiness such as organizing the data, evaluating reports and data. He further commented that some of the MACRA incentives can help providers who want to participate in VBP but said that incentives are currently limited. • Lauren commented that counties are creating Behavioral Health Investment Zones (BHIZ), which is an accountable care organization (ACO)-like model where providers partner together. She stated that smaller providers and counties get limited attention from MCOs and have limited knowledge about payment structures. She commented that smaller providers and counties would benefits from education and support to get ready for VBP models. • Jeff commented that smaller providers face statistical challenges given the limited volume of members they serve and suggested a phase-in approach for small providers based on established member volume threshold. • Carol commented that small providers would like to participate in VBP and recommended that smaller providers be given an opportunity to participate.

Agenda Item	Details	Discussion
		• Dave commented that Indian Health Services (IHS) and 638 tribal facilities are not engaged in VBP as they are providing services in a fee-for-service environment and asked for a per member per month (PMPM) payment from HSD so that they can provide more robust care management. – Jessica commented that establishing Health Homes could be a mechanism to draw down a PMPM for coordinating care for IHS and 638 facilities. • Linda commented that the LTSS program has unique challenges and the Medicaid payment model does not support the staffing mix. She recommended a case-mix model which expands staff to accommodate night and weekend admissions in nursing facilities. She further commented that she would be introducing legislation during the legislative session. • Nancy R. commented that the younger generation seeks services from different providers such as minute clinic, urgent care, primary care, so limiting access to a specific provider is challenging. The younger generation wants to take their medical record with them. She recommends building technology where all providers can access information. • Rick commented that this issue is not unique to the younger generation and thinks that this is how most members access care regardless of their age. • Nancy R noted that transportation benefit was important for people when determining where to seek care. • Lauren noted that urgent care is often the last choice because of provider shortages. • Pat commented that the Bailit Health has issued a briefing document for the National Association of

Agenda Item	Details	Discussion
		Medicaid Directors that contains information on the prospective payment system[1]. She praised the State for establishing VBP targets for MCOs and commented that the Interagency Benefits Advisory Committee is establishing targets in their contracts on the commercial side with the MCOs. In regards to patient engagement, Pat commented that there are existing campaigns such as Choosing Wisely[2], an initiative of the American Board of Internal Medicine Foundation, that focus on advancing conversations between providers and members to help facilitate making wise decisions about the most appropriate care. • Sandra commented that incentives and penalties should be weighed carefully. For example, the Physician Quality Reporting System (PQRS) quality incentive reporting was so onerous and costly that some smaller providers took the penalty instead. • Ellen commented that ability of providers to meet the members' needs varies. Some people are able get a same day appointment while others cannot, and those that cannot get a same day appointment seek care in urgent care or emergency department. She also commented that MCO provider network changes are a factor in fragmentation of care and should be considered as a contributing factor. • Myles commented that VBP for geriatric population should be incentivized differently since their care needs are unique and members require longer examination time to address multiple chronic conditions.

[1] For further information, see http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf
[2] For further information, see http://www.choosingwisely.org/

Agenda Item	Details	Discussion
		• Carolyn commented that nurse practitioners have full practice authority in the State. She also commented that long wait time and short visits are an access issue. As a result, complex needs may not get addressed. • Doris commented that individuals with disabilities need longer appointments as they have unique challenges such as communication issues and the quality measures for this population may not align with members who are healthy. • Ellen commented that specialty providers are scarce for even those insured by private coverage. There is not enough supply. • Rick commented that New Mexico has a large population of individuals with developmental disabilities and elderly and commented that having advocates that can accompany the member results in better care. • Linda commented that New Mexico has a shortage of workforce, and this requires a critical examination. • Bryce commented that about 65% of New Mexico's children are on Medicaid and many people have adverse childhood experiences that create chronic care conditions. In regards to VBP, providers and MCOs should take on more risk for this population. • Myles commented that we need to look for opportunities to incent partnership with members, families and advocates. • Dawn commented that community health worker could function as advocates. • Lisa commented that pediatricians' workload for children with special needs is high, and pediatricians perform many activities that are not reimbursed by MCOs. She further commented that Colorado families can become

Agenda Item	Details	Discussion
		certified nursing assistants and receive compensation from insurance companies for performing care coordination activities. • Lauren commented that trained volunteers could become advocates for members with special needs. • Nancy R. commented that pediatric population's needs may not align with Medicare quality measures. • Carolyn commented that larger pediatrics practices have social workers or nutritionists on staff and in the office available for members to see; however, this is not financially feasible for small providers especially in rural areas. • Wayne commented that telehealth and Project ECHO can fill some gap in access to care. Also, he commented that we need to equalize the playing field by taking into consideration of member's severity levels when designing VBP models.
III. Member Engagement and Personal Responsibility	• Add new areas of focus, conditions, or behaviors for Centennial Rewards. • Changes to Reward values or expanded Rewards for major or sustained improvements. • Allow Rewards for potential cost-sharing requirements. • Improve engagement and participation in Rewards program through data mining, risk assessment, or technology. • Reduce no-show appointments. • Implement copayments for certain member's use of services. • Implement premiums for higher income members.	• Liz commented that when the copayment determination is left at the provider's discretion, it becomes even more challenging to collect copay. • Ellen commented that cost / benefit should be evaluated prior to implementing copayments. She believes these practices actually result in increased cost for the system. • Lauren commented that general public is passive / not typically active participants in health care. Advocacy should be incentivized and independence encouraged. • Nancy R. commented that a member must be 18 years of age to access the Centennial Rewards Program. Therefore, the program limits participation from teen parents and recommends modifying the minimum age to 14 years of age. In addition, recommended the Centennial Rewards Program should be more user

Agenda Item	Details	Discussion
		friendly such as having mobile access. If the State chooses to apply cost sharing, then the Centennial Rewards Program could cover copayments as an incentive. • Lisa commented that she likes the idea of having a mobile option related to the Centennial Rewards Program as many young individuals are technically savvy; however, she noted that many New Mexicans are not technically savvy and do not have access to the Internet. • Dawn recommended including tobacco cessation and partnering with the Public Health Division on this effort. She also commented that we need to assess member experience in Centennial Rewards Program and incorporate their feedback on the program. • Sandra commented that Native Americans do not get the opportunity to participate in the Centennial Rewards Program and recommended that HSD should explore opportunities to grow Native Americans' participation. • Jeff commented about passive enrollment versus active participation in the rewards program and recommended that the program should be designed to encourage active participation for earning rewards point and not count participants who use services in the normal course as participation. • Nancy SL. commented that the reward redemptions rate is increasing as people learn more about the program. • Lisa commented that copays can be very challenging financially for members and members may need to make a choice between paying for their healthcare or other needs such as food, utility. She further commented that providers will end up absorbing the costs, and cost sharing is barrier to care.

Agenda Item	Details	Discussion
		• Ellen commented that there are many reasons that drive what is viewed as not responsible behavior, and we talk about personal responsibility in terms of finance. She further noted that health system is complicated, and Centennial Care members have added pressures and circumstances. Therefore, she recommended that we need to better understand the drivers for missed appointments rather than consider this population as irresponsible and penalize them. • Dawn recommended that we use data to inform decision making such as evaluating the population who miss appointments and use emergency departments, exploring alternatives to penalties, improving health literacy, teaching members how to use services and accessing right level of care. • Nancy R. recommended that members enrolled in the Children's Health Insurance Program should be excluded from copays. She also commented that clinics already absorb copay costs for children who are accessing "private care", so they cannot afford to absorb more costs. She also commented about poor public transportation in Albuquerque and the long length traveling time. • David commented that he does not support assessing copays and recommends educating on the most cost efficient service such as using generic drugs. • Linda commented that we need to find a way that members could earn enough in rewards to cover copays or other penalties if HSD implement cost share. • Nancy S. reminded the group that HB2 requires the Department to implement cost sharing measures for the Medicaid program.

Agenda Item	Details	Discussion
IV. Public Comments	• Increase Medicaid spending on certified peer support workers	• Commenter discussed the benefits of using CPSW particularly in BH for below reasons: – It is cost effective. – It is an antidote for mental illness stigma. – It promotes wellness and recovery through shared experience and acceptance of illness.
V. Meeting Close	• Follow-up materials • Next meeting date	• Comments on VBP and member engagement and personal responsibility are due from committee members by January 31, 2017. • Comments should include recommendations, outcome measures, as well as measurement methods. • Next meeting is on February 10, 2017, at the Administrative Services Division/Human Services Department.

Acronym Guide for MAD / HSD 1115 Waiver Renewal Process

ABCB – Agency-Based Community Benefit
ACEs – Adverse Childhood Experiences
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
DHI – Division of Health Improvement
D-SNP – Dual Eligible Special Need Plan
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
FIT – Family Infant Toddler Program
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
IBAC – Interagency Benefits Advisory Committee
I/DD – Intellectual and Developmental Disabilities
IHS – Indian Health Service
IP – In-patient
LEAD – Law Enforcement Assisted Diversion
LFC – Legislative Finance Committee
LOC – Level of Care
LTC – Long Term Care
LTSS – Long-Term Services and Supports

MACRA – Medicare Access and CHIP Reauthorization Act of 2015
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
NATAC – Native American Technical Advisory Committee
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
PMPM – per member per month
PMS – Presbyterian Medical Services (FQHC)
PQRS – Physician Quality Reporting System
SA – Substance Abuse
SAMHSA – Substance Abuse and Mental Health Services Administration, an agency within the US Department of Health and Human Services
SBHC – School-Based Health Center
SBIRT – Screening, Brief Intervention and Referral to Treatment
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

HUMAN SERVICES
DEPARTMENT

CENTENNIAL CARE NEXT PHASE

1115 Waiver Renewal Subcommittee
January 13, 2017

Agenda

Introductions	8:30 – 8:40
Feedback from December meeting	8:40 – 8:45
Value-Based Purchasing	8:45 – 10:00
Break	10:00 – 10:10
Member engagement and personal responsibility	10:10 – 11:10
Public comment	11:10 – 11:25
Wrap up	11:25 – 11:30

HUMAN SERVICES DEPARTMENT

Renewal Waiver
Areas of Focus

- Refine care coordination
- Address social determinants of health
- Opportunities to enhance long-term services and supports
- Continue efforts for BH and PH integration
- Expand value-based purchasing
- Member engagement and personal responsibility
- Benefit alignment & Provider adequacy

HUMAN SERVICES DEPARTMENT

Value Based Purchasing (VBP)

HUMAN SERVICES DEPARTMENT

VBP

Opportunities/Goals

- Pay for value, not volume
- Improve quality of care and member outcomes
- Reward care that keeps members healthy or reduces disease burden
- Providers partnering with payers to achieve better outcomes and share in savings
- Bend the cost curve of Medicaid expenditures
- Align VBP strategies with program goals to increase care coordination, improve transitions of care, increase physical and behavioral health integration, reduce health disparities through population health strategies and improve member engagement.

HUMAN SERVICES DEPARTMENT

VBP Guiding Principles

- High value care—best health outcomes at lowest cost.
- Phasing-in of increasingly advanced VBP models.
- Allowing for MCO flexibility of models—considering predominance of certain populations, i.e., percentage of long-term care members, as well as prevalence of chronic and/or high-cost conditions in the population.
- Allowing for provider flexibility—different points of readiness and ability to participate.
- Development of uniform quality goals that align with Centennial Care goals.
- Commitment to training, data sharing and technical assistance to support providers.

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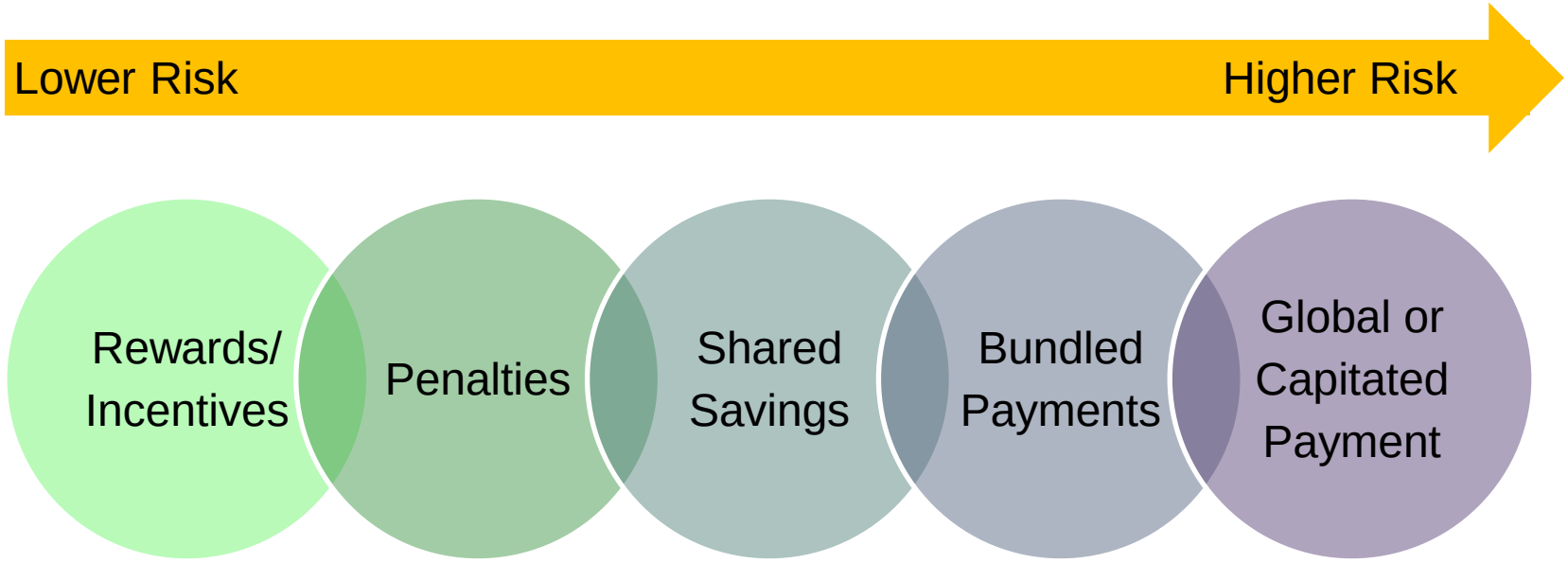
VBP Models



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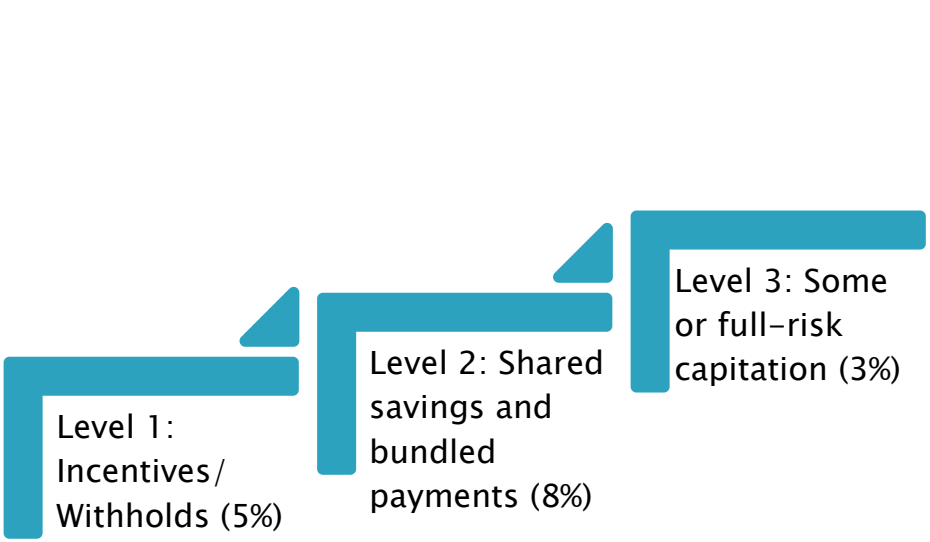
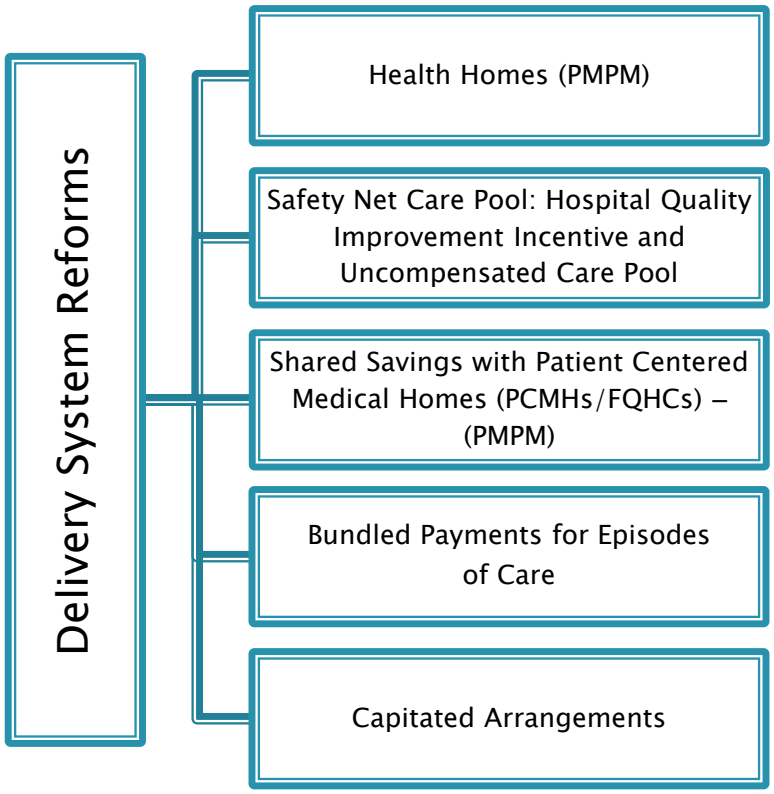
Current VBP Landscape

- In CY17, MCOs are required to spend a minimum of 16% of provider payments in VBP arrangements





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VBP
Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Improving provider readiness for VBP and willingness to bear more risk. ➢ Providers desire flexibility within VBP options. ➢ Minimum threshold of attributed lives to participate in some models. ➢ Actionable and reliable data and reporting. ➢ Standardization of quality measures across payers. ➢ Methods to ensure consistent quality measure reporting and validation.	➢ Providers have varied levels of readiness for VBP payment strategies and concerns about bearing more risk. ➢ Providers need reliable data, particularly related to costs of services they do not deliver, and technical assistance to utilize data sources. ➢ BH and LTSS providers can be particularly challenged by risk based VBP strategies and often require unique models. ➢ Quality outcome measures can more resource intensive to collect (Hybrid Measures).	1. How can we continue to develop our VBP strategy with flexibility for MCOs and providers, but move to more advanced models to achieve greater value and alignment with better healthcare outcomes? 2. How can we support providers who are in early stages of readiness? 3. What modifications are needed in payment structure to facilitate provider transitions to bear more risk over time?

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VBP

Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Eliminating barriers to data sharing/transparency of costs. ➢ Member engagement in improving health outcomes. ➢ State staff skill set and resources to monitor/evaluate VBP. ➢ Continuing to define "value" for Centennial Care Program.	➢ Alignment with other payers is challenging due to population differences and quality measure differences. ➢ Population-based models require providers to think more broadly about unmet non-medical needs (social determinants of health) and how best to keep patients healthy. ➢ No single entity to convene and coordinate a common vision across payers.	4. How can models and payments be designed to support care for patients with high non-medical challenges? 5. What outcomes have the most "value" within the Centennial Care program? 6. What VBP strategies are more effective for BH and LTSS providers?

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Member Engagement & Personal Responsibly

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Member Engagement
Centennial Rewards

Incentive program for members to engage and complete healthy activities and behaviors

Reward opportunities in the form of a credit for redemption in catalog:

- Healthy Smiles $25 annual dental visit
- Step-up Challenge $50
- Annual asthma controller Rx maintenance $60
- Healthy pregnancy $100
- Diabetes management $60
- Schizophrenia Rx maintenance $60
- Bipolar disorder Rx maintenance $60
- Bone density testing $35

Members participating in the program vs non-participants:

- Reduction in inpatient admissions
- Higher HEDIS and quality outcomes
- Higher risk members tend to participate in program
- Increase in Rx refills and medication adherence
- Increase in HbA1c testing compliance

Challenges:

- Participation and redemption rates are increasing each year but are only reaching 206k members

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Member Engagement
Disease Management

The right care – at the right place – at the right time

- Diabetes Self-Management Programs
- Wellness Programs
- Disease Specific Education Classes
- Communication Coaching
- Telephonic outreach
- Wellness benefits offering up to $50 per year in health/wellness purchases
- Care coordination targeting specific chronic diseases
- Targeted Education and self-help materials

Members participating in the program :

- Learn ways to manage their Diabetes independently
- Incorporate healthier eating opportunities and exercise
- Improved understanding of condition
- Improve confidence when speaking to providers about their condition
- Support smoking cessation needs of members
- Improve health outcomes and quality of life

Additional Member Engagement:

- Member Advisory Committee
- Ombudsman Program to assist Members with MCO processes
- Care coordinators developing alternative methods to engage members who are over utilizing the Emergency Department

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Member Engagement
Community Heath Workers

Community health workers role in engaging the member

The right care – at the right place – at the right time

- Improve health and health care literacy
- Make linkages to community supports
- Support care coordination
- CHW's function where the member lives

- Molina community connector
  - Vital member of care coordination team (eyes and ears)
  - Community based (member's home, providers office, statewide agencies)
  - Face-to-face, hands on with the member

- Presbyterian
  - Tribal-based public health announcements that target priority health conditions and promote health literacy
  - Agreements to have community heath representatives assist with completing HRAs
  - Help navigate healthcare systems, educate, and translate

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Member Engagement & Personal Responsibility Cost Sharing

Copayments	Require copayments for certain services and populations
	➢ Expansion, Working disabled, CHIP
	  ➢ Inpatient stays
	  ➢ Outpatient surgeries
	  ➢ Office visits
	  ➢ Non-ER transportation (urban only)
	➢ Most populations
	  ➢ Non-emergency use of emergency room
	  ➢ Use of non-preferred drugs

Premium contribution	➢ Income based
Appointment no-shows	➢ Reduce missed appointments ➢ Expand treat first model

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Member Engagement & Personal Responsibility Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Continue to encourage greater personal responsibility for members engagement in their own health.	➢ Add new areas of focus, conditions, or behaviors for Centennial Rewards. ➢ Changes to Reward values or expanded Rewards for major or sustained improvements. ➢ Allow Rewards for potential cost-sharing requirements. ➢ Improve engagement and participation in Rewards program through data mining, risk assessment, or technology.	1. How to further improve member engagement in the Rewards program? 2. Other ideas for increasing member engagement?

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Member Engagement & Personal Responsibility Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Implement policies that will encourage greater personal responsibility and financial accountability for higher income members. ➢ Financial disincentives for accessing health care in the least efficient manner.	➢ Reduce no-show appointments. ➢ Implement copayments for certain members use of services. ➢ Implement premiums for higher income members.	1. How to structure to incentivize healthy behaviors and use of services? 2. Premium hardship waiver circumstances. 3. Other initiatives beyond financial penalties to reduce appointment no-shows 4. Other ideas to align member engagement and value based purchasing?

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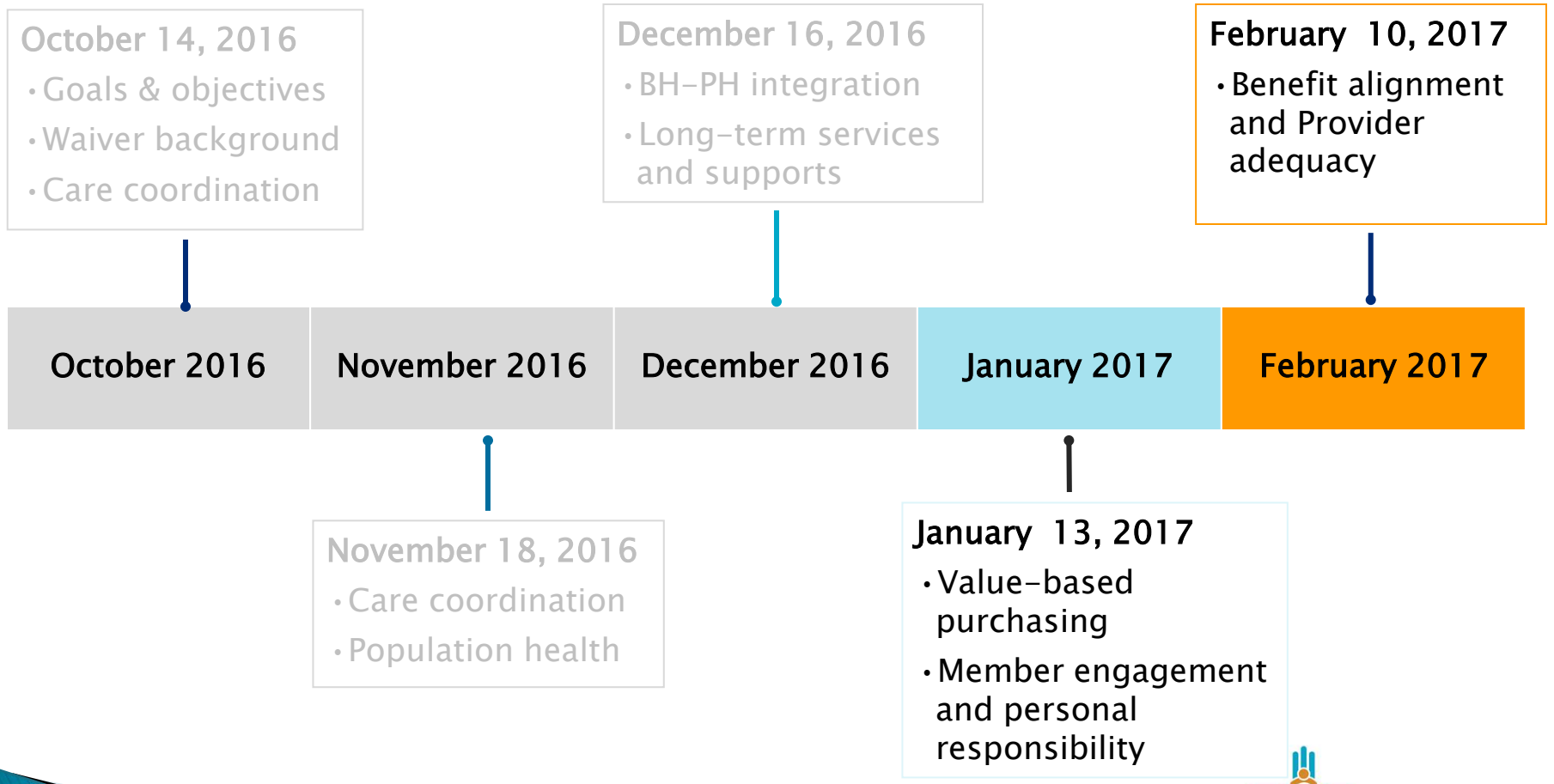
Subcommittee Meetings
Timeframe for Discussion



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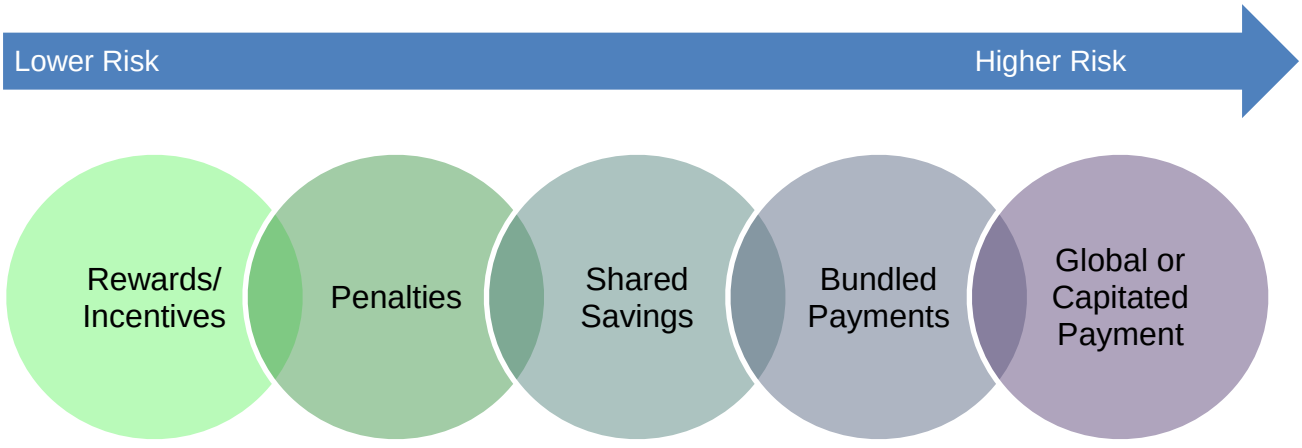
Centennial Care Value-Based Purchasing Brief

Background

The need to improve quality and efficiency in state Medicaid programs has led to implementation of a variety of payment reform efforts across the nation. As states face increasing pressures to maximize the value of their Medicaid spending while enrollment continues to increase, many are seeking strategies that will move the delivery system away from payments on a fee for service basis to paying for improved healthcare outcomes for recipients. The most costly Medicaid members with complex medical needs are served, for the most part, by a system that is not incentivized to improve care coordination or healthcare outcomes.

In its 1115 waiver that authorizes Centennial Care, New Mexico included payment reform as a key goal for its Medicaid managed care program. The Centennial Care contractual agreements required the Managed Care Organizations (MCOs) to pilot payment reform projects that focused on paying for value rather than volume of services. In 2015, the MCOs launched 10 pilot projects with an aim to begin to move the delivery system toward payment for improved quality. The New Mexico Human Services Department (HSD) collaborated with the MCOs to develop key performance measures for the projects in an effort to achieve better alignment for the providers, primarily utilizing a set of HEDIS measures in combination with several efficiency metrics, such as decreasing inpatient readmission rates.

In their value-based payment arrangements, the Centennial Care MCOs are expected to expand pay for value strategies within their provider networks using a variety of value-based purchasing models. Models are generally defined based on the level of up-side or down-side risk incurred within the arrangements.



Value-based purchasing models at the lower risk of the spectrum include incentives or pay for performance where providers are rewarded for hitting defined quality of care goals. Shared savings

models reward providers for meeting quality of care outcomes that save money for the program. Providers generally share in a portion of the savings realized. Risk models include capitated payments for providers who incur full or partial risk in caring for their population or panel of members. Bundled or global payment options reimburse providers an agreed upon rate that includes all services provided to address a specific condition. Examples of bundled payments are maternity care and joint replacement surgeries).

In their recent publication summarizing state approaches to value-based payment models in Medicaid, the Center for Health Care Strategies outlined five approaches states are using within their Managed Care Contracts[1]:

1. Requiring MCOs to adopt standardized value-based purchasing models
2. Requiring MCOs to make a specific percentage of provider payments through approved VBP arrangements *(a current initiative with Centennial Care MCO contracts)*
3. Require MCOs to move toward more sophisticated (more risk based) VBP arrangements over the life of the contract *(a current initiative with Centennial Care MCO contracts)*
4. Require MCOs to actively participate in a multi-payer VBP alignment initiative
5. Require MCOs to launch VBP pilot projects subject to state approval *(a current initiative with Centennial Care MCO contracts)*

Delivery system reforms within Centennial Care include shared savings and bonus payment arrangements with Patient Centered Medical Home practices and Federally-Qualified Health , Centers, which reward providers for achieving agreed-upon quality measures and improved member experience with the practice; provider-delivered, comprehensive care coordination through Health Homes targeted to members with Serious Mental Illness and Severe Emotional Disturbance; bundled payment arrangements for episodes of care, such as maternity and orthopedic services; subcapitated arrangements for providers willing to assume greater risk; and the Safety Net Care Pool that includes the Hospital Quality Improvement Incentive and Uncompensated Care Pool.

VBP Project	Type of Payment Reform			Project Description
	Bundled Payment	**P4P-Shared Savings**	**Some Risk**	
Accountable Care-Link Model		**X**		ACO-like model with shared savings for improving quality and reducing total cost of care.
Bundled Payment for Episodes	**X**			Bundles for bariatric surgery and maternity.
Subcapitated Payment for Defined Population			**X**	For primary care and multi-specialty groups that have care management infrastructure; subcapitation allows both upside/downside risks for defined population.

[1] Leddy, T. McGinnis, T. Howe, G.; Center for Health Care Strategies Inc. “Value-Based Payments in Medicaid Managed Care: An Overview of State Approaches”; Brief, February 2016. http://www.chcs.org/resource/value-based-payments-in-medicaid-managed-care-an-overview-of-state-approaches/

Three-tiered Reimbursement for PCMHs		X		PMPM increases for base care coordination; date transfer to HIE; telehealth; use of EHRs; and performing HRAs. A total performance incentive per member payment is possible if the targets for every measure are met.
Bundled Payments for Targeted Admission Episodes	X			Working to bundle payments for pneumonia and colonoscopies.
PCMH Shared Savings		X		Builds upon current PCMH pay-for-performance model that rewards quality by adding shared savings targets after total medical costs are below a budget threshold.
Obstetrics Gain Sharing		X		Reducing unnecessary primary C-section by developing savings targets that reward appropriate use of C-sections. Obstetricians can earn enhanced payment for meeting metrics related to reducing unwarranted C-sections.

To continue to advance value-based purchasing initiatives, HSD has included new contractual requirements in its 2017 MCO agreements, see Appendix A. In CY17, MCOs are required to spend a minimum of 16% of provider payments in VBP arrangements. Within the 16% HSD identified minimums across the spectrum of three VBP levels in order to ensure flexibility for providers that may not have the level of sophistication or resources needed to bear risk while providing opportunities for those providers that do.

After completing a series of site visits with providers participating in the VBP arrangements, it was evident to HSD that providers wanted flexibility within the VBP options and, in order to bear greater risk, needed comprehensive data and agreed-upon calculations of total cost of care. The MCOs are addressing those needs by regularly meeting with providers and sharing data, including score cards, claims data and, in some cases, providing a software program that enables providers to view utilization and expenditure data for attributed patients.

Defining Value

In order to effectively pay for value, the Centennial Care program is working to refine what “value” means for the program and how that value will be measured to ensure quality of care. This means identifying the appropriate metrics and measures, data sources and reporting strategies that are necessary to monitor VBP arrangements with an eye to our overarching goal of driving administrative simplicity and alignment where possible. Areas that Centennial Care is targeting as value areas are those topics being vetting through the subcommittee process and include:

- Care Coordination
- Physical and behavioral health integration
- Long-term services and supports
- Improving transitions of care
- Population Health

Key Considerations

Advancing value-based purchasing models is a change for the Medicaid program and participating providers. Key consideration areas include:

- **Health Care Providers and MCOs**
  - Engaging and supporting providers in migration to risk
  - Data analytics
  - Data sharing
  - Attribution of members and
  - Member engagement in improving health
  - Flexibility—not all providers are able to take on risk
  - Multi-Payer alignment on payment and measurement of quality
  - Lack of single convener across payers/delivery System
- **Improving Provider Readiness**
  - Capital Investments (including software / technology)
  - Technical Assistance
  - Clear and Consistent Path forward with reasonable milestones
  - Provider feedback / engagement in process
- Data Reporting Quality and Consistency
  - MCO ability to share information with providers
  - Providers' ability and capacity to utilize data and reporting
- **State policy development and monitoring**
  - No clear pathway to engage with CMS to work on alignment of federal and state VBP strategies and quality metrics
  - Resources and expertise at state to monitor VBP
  - How best to evaluate VBP models
- **Identifying ideal VBP strategies for behavioral health and LTSS providers**

Additional Challenges and Barriers

- Continued Use of FFS Payment in Reform Models
- Simply adding P4P bonuses to FFS structure
- Data for Setting Payment Amounts—need transparency around costs
- Provider accountability for costs not within their control
- Patient Engagement—providers must know their patients to be successful
- Member churn within provider practices
- Current Reforms Favor Larger Providers and require minimum number of members
- Transitional Payment Systems
- Staffing / Resource Challenges—State / Provider

Appendis A

VBP in Delivery System Improvement Targets – Centennial Care MCO Contract Language

Value-Based Purchasing

The CONTRACTOR must implement value-based purchasing as outlined in the table below. In order to meet the target, the CONTRACTOR must have met the percentages established below in all three levels; however, CONTRACTORs with more advanced VBP strategies may substitute higher percentages in Level 2 and/or Level 3 for lower percentages in Level 1 as long as the overall target of 16% of payments in VBP arrangements is met for the calendar year.

VBP LEVEL 1	VBP LEVEL 2	VBP LEVEL 3
A minimum of 5% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:	A minimum of 8% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:	A minimum of 3% of all CONTRACTOR provider payments for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:
• Fee schedule based with bonus or incentives and/or withhold (at least 5% of provider payment)—available when outcome / quality scores meet agreed-upon targets.	• Fee schedule based, upside-only shared savings— available when outcome / quality scores meet agreed-upon targets (may include downside risk), and • Two or more bundled payments for episodes of care.	• Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or • Global or capitated payments with full risk.

Additional requirements for VBP in CY17

- At least 3% of the overall 16% in VBP contracting must be with high volume hospitals and require readmission reduction targets of at least 5% of the hospital's baseline.
- CONTRACTOR must include behavioral health community providers in its VBP arrangements.
- CONTRACTOR must include payments to behavioral health community providers in calculating the percentage of overall spend in its VBP arrangements.

MCOs may exclude provider payments for dually-eligible members from the calculation.

Centennial Care 1115 Waiver Renewal Subcommittee
Issue Brief: Member Engagement & Personal Responsibility
January 2017

Overview

One of the core principles of the New Mexico Centennial Care program is to encourage greater personal responsibility of members to facilitate their active participation and engagement in their own health so they can become more efficient users of the health care system. As the Human Services Department (HSD) seeks to renew the Centennial Care waiver, the Department is looking to build on and incorporate policies that seek to enhance beneficiaries' ability to make informed decisions about their health and health care, and to become more active, responsible and involved participants in the health care system.

Member Engagement – Centennial Rewards

The Centennial Rewards program was developed with the launch of Centennial Care in 2014 as a way of providing incentives to members for engaging in and completing healthy activities and behaviors, including:

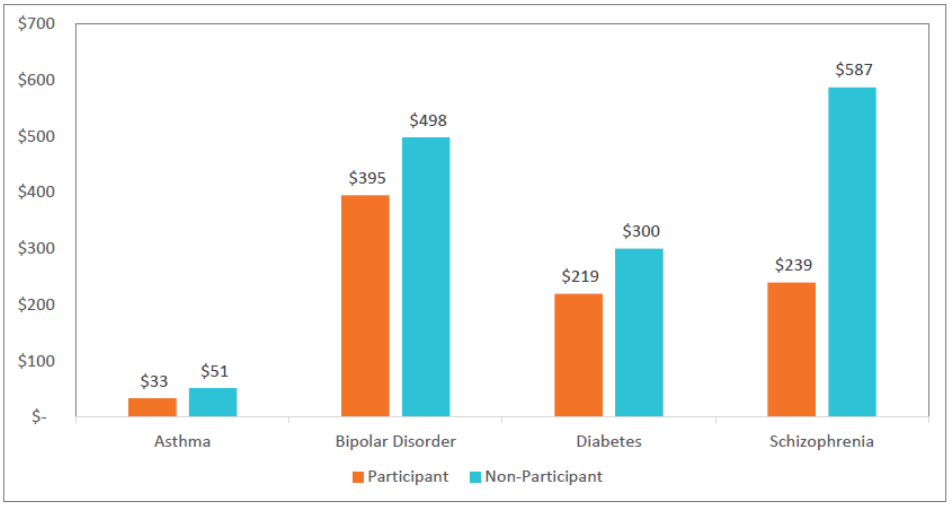
- **Healthy Smiles** to reward annual dental visits for adults and children;
- **Step-Up Challenge** to reward completion of a 3-week or 9-week walking challenge;
- **Asthma Management** to reward refills of asthma controller medications for children;
- **Healthy Pregnancy** to reward members who join their MCO's prenatal program;
- **Diabetes Management** to reward members who complete tests and exams to better manage their diabetes;
- **Schizophrenia and/or Bipolar Disorder Management** to reward members who refill their medications; and
- **Bone Density Testing** to reward women age 65 or older who complete a bone density test during the year.

Members who complete these activities can earn credits, which can then be redeemed for items in a Centennial Rewards catalog.

Centennial Rewards Accomplishments

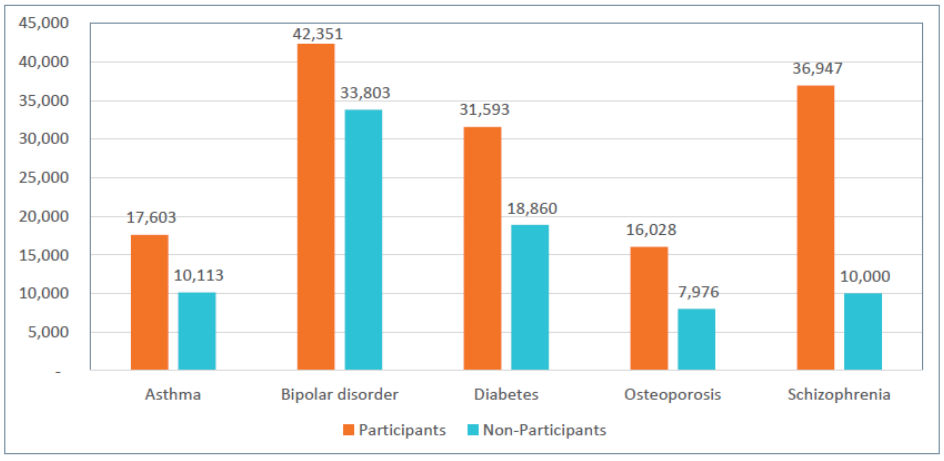
- Inpatient admissions have decreased among participants in the program, resulting in a cost-savings of approximately $23 million in calendar year (CY) 2015.
- The average redemption rate of earned rewards is 24 percent, with the notable exception of the Step-Up Challenge, which has a redemption rate of 85 percent. This suggests that the proactive enrollment required for the Step-Up Challenge has had a substantial positive impact on member use of their rewards.
- Overall cost-savings attributed to the Centennial Rewards program increased by one-third from 2014 to 2015. Reduced inpatient admissions and costs per admission have been the dominant driver behind cost-savings across conditions. See Table 1, below.

Table 1: Reduced Costs Across Conditions



- Participants across all conditions had higher compliance with HEDIS measures and other quality outcomes than non-participants.
- A comparison of risk scores indicates that higher risk members tend to participate in the Centennial Rewards program.
- With a full year of data for the Step-Up Challenge, HSD continues to see positive results regarding cost-savings, utilization and quality measures.
- Prescription drug refills are higher for participants compared to non-participants. Medication adherence for schizophrenia and bipolar disorder have both increased substantially year-over-year and were above 90 percent for participants in 2015. See Table 2, below.

Table 2: Prescription Drug Refill Rates



- HbA1c test compliance for participants increased substantially – nearly 20 percent from 2014 to 2015 – while the year-over-year increase for nonparticipants was only one percent.

Centennial Rewards Challenges

- Despite the decrease in inpatient admissions, emergency room visits were higher among participants in the program than among non-participants. This is true for all conditions in the Centennial Rewards program, except for schizophrenia.
- While the number of participants and redemption rate of rewards continues to increase, HSD seeks to continue growing the number of participants and improve member engagement and motivation. Approximately 206,000 Centennial Care members are currently enrolled in the Rewards program.
- HSD has made some changes to the program to reduce administrative costs and better align rewards with the acuity of the Centennial Care population.

Waiver Renewal Discussion Points

HSD might consider restructuring rewards to either focus on new conditions or to promote more proactive engagement, similar to the active enrollment process for the Step-Up Challenge. Ideas for discussion include:

- **Should Centennial Rewards remain tied to HEDIS or should HSD identify new focus conditions and behaviors?** Examples might include lowering blood pressure, meeting weight loss goals, or smoking cessation, and these conditions might be accompanied by a more proactive opt-in enrollment and tracking process, similar to the Step-Up Challenge.
- **Should the reward values change?** Examples might include items that encourage a healthier lifestyle, such as vouchers for a gym membership or weight loss program, or healthy nutrition assistance through gift cards or the WIC program. Higher-value rewards might also be offered for members that achieve major and sustained improvements in their health (i.e., reversal of diabetes or obesity). Rewards might also include exemptions from cost-sharing requirements, such as co-pays or premiums; or they might be restructured to allow members to accumulate rewards as a type of health savings account that could be used toward payment of cost-sharing responsibilities.
- **How can we improve member engagement through the Rewards program?** Examples might include mining data and risk assessments, using text and email to reach and inform members, and other means to allow members to more easily track their rewards (i.e., through mobile technology).

Member Engagement – Disease Management & Care Coordination

In addition to Centennial Rewards, the Centennial Care program has engaged members through multiple initiatives aimed at helping members better manage their chronic conditions. The Centennial Care MCOs have developed strategies that include member engagement through:

- Diabetes self-management programs and other disease-specific education classes
- Wellness programs
- Communication coaching
- Telephonic outreach
- Wellness benefits offering up to $50 per year in health/wellness purchases
- Care coordination targeting specific chronic conditions

- Targeted education and self-help materials
- Use of community health workers to engage members in meeting their care needs and addressing social determinants of health

The MCOs have also incorporated member engagement through their member advisory committees, ombudsman programs to assist members with understanding MCO processes, and by using care coordinators to develop alternative ways of engaging members who frequently use the emergency department. In addition, members in need of long-term services and supports are able to review Community Benefit services together with their care coordinator to determine which services they are interested in receiving through the Community Benefit Services Questionnaire (CBSQ). Self-Directed Community Benefit members are also actively engaged in developing their plan of care, hiring their own providers and determining rates of pay within the state's approved range of rates. These members are responsible for completing employer-related tasks, such as approving and submitting employee timesheets to the fiscal management agency for payment.

Personal Responsibility – Cost-Sharing

The Patient Protection and Affordable Care Act (ACA) expanded Medicaid eligibility to all nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL). In 2012, the U.S. Supreme Court issued a ruling that effectively made Medicaid expansion optional for states. As of January 1, 2017, a total of 32 states – including New Mexico – have expanded Medicaid. The expansion of Medicaid to new low-income adults has resulted in a significant enrollment surge of nearly 600 percent compared to enrollment of low-income adults before the Adult Expansion. Additionally, enrollment in the Children's Health Insurance Program (CHIP) has increased by 85 percent since early 2014. Compared to other states, New Mexico has generous eligibility thresholds for both children and adults, with the CHIP program extending to 300 percent FPL for children age 0-5 and to 240% FPL for children age 6-18.

Under today's Centennial Care program, Medicaid Expansion Adults are not subject to any form of cost-sharing, and co-pays for CHIP recipients are minimal. In New Mexico, there are also minimal co-pays for individuals enrolled in the Working Disabled Individuals (WDI) program, which provides coverage for individuals up to 250 percent FPL.

For the Centennial Care waiver renewal, HSD is considering incorporating policies that will encourage greater personal responsibility and financial accountability for individuals in higher-income Medicaid categories, including the Adult Expansion, CHIP and WDI. Please note that Native Americans would be exempt from any cost-sharing proposal set forth by HSD. Ideas under consideration might include:

- **Requiring co-payments.** HSD is considering requiring co-payments for outpatient office visits, inpatient hospital stays, outpatient surgeries, and non-emergency medical transportation (in urban areas only) for Expansion Adults, CHIP and WDI enrollees. In addition, HSD is considering co-payments that would apply to most Medicaid enrollees for using certain non-preferred prescription drugs and for non-emergency utilization of the emergency room.
- **Assessing premiums for populations above 100 percent of poverty.** Premiums are the norm for private insurance and coverage on the federal marketplace, and HSD is considering whether they should be assessed to certain Medicaid populations as well. Many states are pursuing approval of premiums for the Adult Expansion population from the federal government, with some proposing to charge premiums for recipients with income as low as 50% FPL. For an

individual with income between 101-150 percent FPL, a monthly premium of one percent or less of income would be $10 monthly.

- **Minimizing appointment "no-shows".** With the Adult Expansion of Medicaid, providers have expressed serious concern about rising rates of missed appointments. Under current rules, Medicaid recipients cannot be required to pay fees or sign financial responsibility forms for missed appointments. HSD might consider whether policies should implemented under the renewed waiver to either allow providers to charge nominal fees for missed appointments or to more positively incentivize appointment adherence (i.e., expansion of the Treat First model).

Waiver Renewal Discussion Points

HSD might consider a movement toward policies that promote greater personal and financial responsibility for members, to include co-pays, premiums and ways to minimize missed appointments. Ideas for discussion include:

- **If cost-sharing (either co-pays or premiums) is imposed, how can it be structured to incentivize healthy behaviors and efficient use of the health care system?** Examples might include waiving cost-sharing requirements for members who engage in healthy behaviors, such as preventive visits and well-child checks, completion of the Health Risk Assessment (HRA) and/or Comprehensive Needs Assessment (CNA), or putting contributions into a health savings account to offset health care costs or to offer vouchers that support healthy behaviors.
- **If premiums are assessed, what type of hardship waiver should be developed?** Examples might include exemptions from premiums for individuals who are homeless, who are late paying their rent, mortgage or utilities, or who have had a large and unexpected increase in basic expenses.
- **What types of initiatives would work to reduce appointment no-shows in lieu of financial penalties?** HSD is considering expansion of the Treat First clinical model, which is designed to reduce the behavioral health missed appointment rate for second appointments. The Treat First approach emphasizes the initial clinical practice functions of establishing rapport, building trust, screening to detect possible urgencies, and providing a response to the reason the individual came to the agency during the first visit – rather than spending time at the first appointment on assessments. Results from the model show that it has reduced no-show rates and improved the quality of assessments and treatment plans over the first four encounters. How can this model be replicated? Is there an adjustment of this model that can be translated in the primary care practice environment?
- **What other ways can be used to align member engagement and value-based purchasing quality metrics?** Strategies could include member collaboration with providers to meet agreed-upon goals, such as adherence to medication, obtaining certain preventive screenings, or other outcomes that align with the member's individualized health targets.

Stakeholder Engagement Process Leading to Development of Concept Paper

5. NATAC, January 20, 2017

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

January 17, 2017

NATAC 1115 Waiver Renewal Meeting

January 20, 2017 1:30-3:30 pm

Albuquerque Area Indian Health Service
4101 Indian School Road, NE, Suite 225
Albuquerque, NM 87110

Call in Number: 1-888-394-8197
Passcode: 175512

AGENDA

I. Introductions

II. Review 1115 Waiver Renewal Areas of Focus

- A. Care Coordination
- B. Population Health
- C. Long Term Services & Supports
- D. BH & PH Integration
- E. Value Based Purchasing
- F. Member Engagement & Personal Responsibility
- G. Benefit Alignment & Provider Adequacy

III. Review November & December Presentations & Briefs

IV. NATAC Input on 1115 Waiver Renewal

V. Meeting close

HUMAN SERVICES DEPARTMENT

CENTENNIAL CARE NEXT PHASE

NATAC 1115 Waiver Renewal Subcommittee

January 20, 2017

Renewal Waiver
Areas of Focus

- Refine care coordination
- Expand value based purchasing
- Continue efforts for BH & PH integration
- Address social determinants of health
- Opportunities to enhance long term services and supports
- Provider adequacy
- Benefit alignment and member responsibility

Care Coordination
Opportunities/Goals

- Improve transitions of care: *The movement of a member from one setting of care (examples: inpatient facilities, rehabilitation settings, skilled settings and after incarceration) to another setting or home*[1]
- Focus on higher need populations
- Provider's role in care coordination

[1] Adapted from CMS' definition of terms, Eligible Professional Meaningful Use Menu Set of Measures; Measure 7 of 9; Stage 1 (2014 Definition) updated: May 2014. retrieved: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downl

Improve Transitions of Care

Feedback	Concepts	Further Discussion

➢ Communication across health providers and managed care is a challenge
➢ Real time information is critical to transitions
➢ Care Coordinator's access in hospitals is challenging
	➢ Identify funding to focus on facilities improving discharge planning
	➢ Enhanced care coordination as part of transitions (short-term):
	  ➢ Jail release
	  ➢ Inpatient stay
	  ➢ Nursing facility to community
	  ➢ Children in residential facilities
	➢ Incentives for outcomes of a successful discharge:
	  ➢ 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)
	➢ Incentives for member adherence to recommended follow-up:
	  ➢ member rewards
		1. Are there ideas here that will have more impact than others?
		2. What are good measures for defining a successful discharge?
		3. Carrot or stick for adherence to discharge plan?
		4. Any other at-risk populations we should address?

Focus on Higher Needs Populations

Feedback	Concepts	Further Discussion

➢ Improve education to members about use of public health services
➢ Increase member education and use of community supports such as public health services:
  ➢ Community Health Workers / Certified Peer Support Worker (CPSW)
  ➢ School-based health centers
  ➢ Expand Health homes
	➢ Improved engagement of family and other community supports:
	  ➢ Family/caregiver role
	  ➢ Increase use of community health workers / CPSWs
	➢ Promote creative approaches by MCOs to support unique high needs populations.
	➢ Focused education and interventions that are condition or location specific:
	  ➢ Areas with fewer providers, transportation issues and/or specific cultural aspects
	  ➢ Areas with high risk pregnancies, with high prevalence of diabetes, COPD and other chronic diseases
	➢ Use of Community Health Workers for more intensive "touch" for these members
	➢ Expand health homes
	➢ Use of population health information to develop targeted education and interventions
		1. How can we incentivize member participation in care coordination? In their healthcare? In preventative care?
		2. How can we use Community Health Workers and others as resources for a more intensive role for these members?
		3. What are some interventions to engage hard to reach members?
		4. Who are higher need populations we should consider?

Provider's Role in Care Coordination

Feedback	Concepts	Further Discussion
➢ Information sharing with local providers is key. ➢ Need for further definition of care coordination roles based on where a member is receiving care (FQHC, Senior Center, Jail, ER) ➢ Need to increase consistent use of terms (case management, care coordination, care management) ➢ Increase use of local/community supports to support MCO care coordination. More use of CPSW, peer navigator: ➢ Teen parents, cancer center	➢ Consider pilot opportunities for MCOs to incorporate local supports (regional systems, homeless, family members) into care coordination ➢ MCOs could share dollars with local programs for direct linkages to members ➢ MCO and Provider Incentives for outcomes ➢ Value-based payment approaches mean more responsibility for providers to provide care coordination to meet value based payment goals ➢ Value-based payment approaches will involve / delegate care coordination to providers	1. How do we build capacity and readiness in the provider community? 2. Where should care coordination be provided (physical location)? 3. How do you avoid duplication of efforts between MCO care coordination and provider level? 4. How do you promote communication and coordination between the MCO and provider level care coordination?

Population Health
Key Terms

- Population Health

"A population-based approach to health care and preventative services improves health outcomes for all populations and helps individuals achieve their highest health-related quality of life" [2]

- Social Determinants of Health

Factors that enhance quality of life and can have a significant influence on population health outcomes. Examples include safe and affordable housing, access to education, a safe environment, availability of healthy foods, local emergency and health services, and environments free of life-threatening toxins [3]

[2] Centers for Medicaid and Medicare, CMS Strategy: The Road Forward (2013-2017); retrieved: https://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf

[3] Adapted from :Office of Disease Prevention and Health Promotion, Health People 2020; 2020 Topics and Objectives: Social Determinants of Health. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Population Health
Starting the Discussion

Needs	Concepts	Further Discussion
➢ Food ➢ Housing ➢ Transportation (work, school, social needs) ➢ Employment	➢ Chronic disease monitoring and education ➢ Health assessments and data collection ➢ Medication compliance ➢ Condition or region specific initiatives funding and outcomes goals ➢ Housing ➢ Job coaching and support. ➢ Food pharmacies ➢ Linkages to community resources and supports beyond health services	1. What population(s) should we target? Why? 2. Which factors/determinants impact outcomes for this population? How could Medicaid address those factors? 3. How do we move the organization to population-based analysis? Do we have necessary data or analytical capability? 4. How do we create a nimble system that can respond to factors that impact population health?

LTSS Overview

Under Centennial Care all members who meet the NF LOC have access to the community benefit

- Increase in the number of unique members who have access to the community benefit:
  - 23,000 users in CY2014
  - 26,600 users in CY2015
  - 26,300 in the 9 months of CY16
  - Community benefit is included in the expansion benefit package
- Average monthly cost of a nursing home is approximately 2.8 times as expensive as the average community benefit
- Recent analysis by the LFC indicated that the overall occupancy rate at nursing facilities has been declining since 2011
- NM ranked in the 2nd best quartile overall in the 2014 national State Long Term Care Scorecard [1]

Rebalancing
LTSS Enrollment Mix (Nursing Facility vs Community)

Setting	Nursing Facility	Community Benefit
2011	18.7%	81.3%
2012	18.9%	81.1%
2013	17.3%	82.7%
2014	14.0%	86.0%
2015	13.5%	86.5%

[1] http://www.longtermscorecard.org/

LTSS
Beginning the Discussion

Needs	Concepts	Further Discussion

➢ Streamline NF LOC renewals and improve assistance to individuals
➢ Improve comparability of service offerings between community benefit options and improve transition into SDCB
➢ Continue successes of rebalancing effort between institutionalization and community care
➢ Fiscal sustainability of nursing homes
	➢ Automatic NF LOC renewal for certain members
	➢ Align benefits for ABCB and SDCB
	➢ Establish levels for ABCB and SDBC budget ranges based on need that include provisions for one time transition costs
	➢ Implement new cohort for members who use fewer PCS hours
	➢ Diversification of services provided by nursing homes
	➢ Explore provider fees / taxes:
	  ➢ Legislative process
	  ➢ CMS approval
	➢ NF LOC ADL change from 2 ADLs to 3 ADLs
	➢ Value-based purchasing arrangements with LTSS providers
		1. What other areas are important to streamline for members?
		2. What other enhancements should be considered for members to remain in the community?
		3. Nursing facility diversification

BH/PH Integration
Key Terms

Intent of Integration

- "Integration of services through the expansion of patient centered medical homes and health homes with intensive care management provided at the point of service to help recipients manage their health and their use of the health care system."
- "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."

PH-BH Integration
Opportunities/Goals

- More than mental illness and addiction
- Early onset; early death (>8 million each year)
- Medicaid = largest payer
- Provider and Plan Challenges:
  - Workforce
  - EHR capacity
  - Continuity of care gaps

Increase provider competency to serve members with co-morbid PH-BH conditions

Improve screening for BH conditions, including substance-use disorders

Leverage the emergency department information exchange to identify members who require linkage to mental health and substance abuse treatment

Improve information sharing challenges due to varied interpretations of privacy rules

PH-BH Integration
Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Increase provider's competency and capacity to manage both physical and behavioral conditions ➢ Increase behavioral health screening across the continuum of care ➢ Remove barriers to sharing information between providers ➢ Value-based payment strategies for integrated care	➢ Provider education on PH-BH integration models and best practices ➢ 3 practice structures and 6 levels of collaboration ➢ Improve identification of behavioral health and substance use issues and linkage to treatment ➢ Substance abuse treatment availability ➢ Improve physical health conditions and reduce in morbidity and mortality ➢ Direct Care management: early assessment; treatment engagement; active follow-up; structured patient education; standardized psychotherapy ➢ Linkages to community resources and population health supports beyond health services	1. Are all three practice models present in New Mexico? What is working well? 2. How can we support provider's capacity to manage co-morbid conditions? 3. How can MCOs encourage patient engagement? Provider engagement? 4. Can MCOs work with local and regional leaders to create stronger forms of integrated care that affect health outcomes? 5. Should HSD identify screening tools that they recommend providers use? 6. What ways can HSD support better information sharing? 7. Can value-based payment models address provider and plan challenges? What models are better suited for integrated providers?

Next Steps

- Next meeting February 13, 2017
- Email for follow-up questions/clarifications
  - Email Address: **HSD-PublicComment2016@state.nm.us**
  - Include "Waiver Renewal" in email subject line:
  - Include a background, proposed solution and impact in your correspondence

- **Information Links**
  - Centennial Care (CC) 1115 Waiver Submission Documents:
  - http://www.hsd.state.nm.us/Centennial_Care_Waiver_Documents.aspx

  - Centennial Care 1115 Waiver Approval Documents:
  - http://www.hsd.state.nm.us/approvals.aspx

  - Centennial Care Reports:
  - http://www.hsd.state.nm.us/reports.aspx

Stakeholder Engagement Process Leading to Development of Concept Paper

6. NATAC, February 10, 2017

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

NATAC 1115 Waiver Renewal Meeting

February 10, 2017

Human Services Department
Administrative Services Division
1474 Rodeo Road
Santa Fe, New Mexico

AGENDA

I. Introductions

II. Review Minutes, Feedback from January meeting

IV. Member Engagement & Personal Responsibility

V. Benefit & Eligibility Alignment

VI. Next Steps

VII. Meeting Close

HUMAN SERVICES DEPARTMENT

CENTENNIAL CARE NEXT PHASE

NATAC 1115 Waiver Renewal Subcommittee

February 10, 2017

Renewal Waiver
Areas of Focus

- Refine care coordination
- Expand value based purchasing
- Continue efforts for BH & PH integration
- Address social determinants of health
- Opportunities to enhance long term services and supports
- Provider adequacy
- Benefit alignment and member responsibility

Member Engagement & Personal Responsibly

Member Engagement
Centennial Rewards

Incentive program for members to engage and complete healthy activities and behaviors

Reward opportunities in the form of a credit for redemption in catalog:

- Healthy Smiles $25 annual dental visit
- Step-up Challenge $50
- Annual asthma controller Rx maintenance $60
- Healthy pregnancy $100
- Diabetes management $60
- Schizophrenia Rx maintenance $60
- Bipolar disorder Rx maintenance $60
- Bone density testing $35

Members participating in the program vs non-participants:

- Reduction in inpatient admissions
- Higher HEDIS and quality outcomes
- Higher risk members tend to participate in program
- Increase in Rx refills and medication adherence
- Increase in HbA1c testing compliance

Challenges:

- Participation and redemption rates are increasing each year but are only reaching 206k members

Member Engagement
Disease Management

The right care – at the right place – at the right time

- Diabetes Self-Management Programs
- Wellness Programs
- Disease Specific Education Classes
- Communication Coaching
- Telephonic outreach
- Wellness benefits offering up to $50 per year in health/wellness purchases
- Care coordination targeting specific chronic diseases
- Targeted Education and self-help materials

Members participating in the program :

- Learn ways to manage their Diabetes independently
- Incorporate healthier eating opportunities and exercise
- Improved understanding of condition
- Improve confidence when speaking to providers about their condition
- Support smoking cessation needs of members
- Improve health outcomes and quality of life

Additional Member Engagement:

- Member Advisory Committee
- Ombudsman Program to assist Members with MCO processes
- Care coordinators developing alternative methods to engage members who are over utilizing the Emergency Department

Member Engagement
Community Heath Workers

Community health workers role in engaging the member

The right care – at the right place – at the right time

- Improve health and health care literacy
- Make linkages to community supports
- Support care coordination
- CHW's function where the member lives

- Molina community connector
  - Vital member of care coordination team (eyes and ears)
  - Community based (member's home, providers office, statewide agencies)
  - Face-to-face, hands on with the member

- Presbyterian
  - Tribal-based public health announcements that target priority health conditions and promote health literacy
  - Agreements to have community heath representatives assist with completing HRAs
  - Help navigate healthcare systems, educate, and translate

Member Engagement & Personal Responsibility Cost Sharing – Native Americans are exempt

Copayments	Require copayments for certain services and populations
	➢ Expansion, Working disabled, CHIP
	  ➢ Inpatient stays
	  ➢ Outpatient surgeries
	  ➢ Office visits
	  ➢ Non-ER transportation (urban only)
	➢ Most populations
	  ➢ Non-emergency use of emergency room
	  ➢ Use of non-preferred drugs

Premium contribution	➢ Income based
Appointment no-shows	➢ Reduce missed appointments ➢ Expand treat first model

Member Engagement & Personal Responsibility Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Continue to encourage greater personal responsibility for members engagement in their own health.	➢ Add new areas of focus, conditions, or behaviors for Centennial Rewards. ➢ Changes to Reward values or expanded Rewards for major or sustained improvements. ➢ Allow Rewards for potential cost-sharing requirements. ➢ Improve engagement and participation in Rewards program through data mining, risk assessment, or technology.	1. How to further improve member engagement in the Rewards program? 2. Other ideas for increasing member engagement?

Benefit & Eligibility Alignment

Benefit & Eligibility Alignment
Streamlining Eligibility

Justice Involved Individuals	➢ HSD has worked to develop policies, processes and IT infrastructure to streamline Medicaid eligibility for individuals involved in the justice system
	➢ Goal is to close the gaps for individuals through:
	  ➢ Timely and automated eligibility reactivations
	  ➢ Earlier start date for eligibility (while incarcerated)

Family Planning Program	➢ In 2016 72,000 people were covered and 91% of the members did NOT use services through the program
	➢ Administratively burdensome and costly to HSD for renewal processing (approximately 6,000 cases per month)
	➢ Coverage overlaps with other insurance coverage
	➢ Considerations aim to reduce administrative costs while maintaining services for individuals who use them:
	  ➢ Narrow coverage for certain age groups
	  ➢ Narrow coverage for populations who do not have other health insurance coverage

Benefit & Eligibility Alignment
Streamlining Eligibility

Simplify Eligibility Processes	➢ HSD has developed real-time eligibility for initial and renewal determinations (roll-out Spring 2017)
	➢ Federal eligibility rules are difficult to navigate, are structurally complicated and costly
	➢ Considerations include:
	  ➢ Waive 3 month retro-active eligibility for initial applicants
	  ➢ Extending continuous eligibility to adults to reduce administrative workload associated with mid-year redeterminations resulting from reported income changes

Shorten time period for transitional Medicaid	➢ Transitional Medical Assistance (TMA), predates the ACA and was intended to provide expiring coverage for parent/caretaker adults whose income increases above the eligibility threshold for the group for up to 12 months
	➢ Considerations include:
	  ➢ Request more frequent reporting of income (i.e., quarterly)
	  ➢ Shorten period of TMA to 30 – 90 days
	  ➢ Eliminate coverage

Benefit & Eligibility Alignment
Benefit Design

Uniform Benefit Package for Parent /Caretaker adults and Medicaid Expansion

- Currently parent/caretaker adults receive a different benefit than Medicaid expansion members:
  - Parents/caretaker adults = "Standard Medicaid"
  - Alternative Benefit Plan (ABP) = "essential health benefits"; modeled on commercial health plan benefit design (approximately 260,000 Expansion adults)
  - ABP Exempt = "Standard Medicaid" for Medically Frail Expansion adults (approximately 3,500 members)
  - Expansion adults between the ages of 19-20 also receive EPSDT benefits
- Considerations include:
  - Align benefit packages for parent/caretaker adults and Medicaid expansion population
  - Allow the same option for members to opt-into ABP exempt (if qualified)
  - Request waiver to exclude EPSDT coverage requirement for Expansion members between ages 19-20

Benefit & Eligibility Alignment
Benefit Design

Benefits options	
	➢ Increase availability of long acting reversible contraceptives (LARC) through increased FMAP (90%) to maintain inventory for providers (i.e., School Based Health Centers, etc.) ➢ Allow cost-effective non-covered service alternative to opioids for pain management such as acupuncture or chiropractic services ➢ Explore affordable alternatives to full dental and vision coverage in the form of riders similar to the design available to state employees, if necessary due to cost containment

Benefit & Eligibility Alignment
Beginning the Discussion

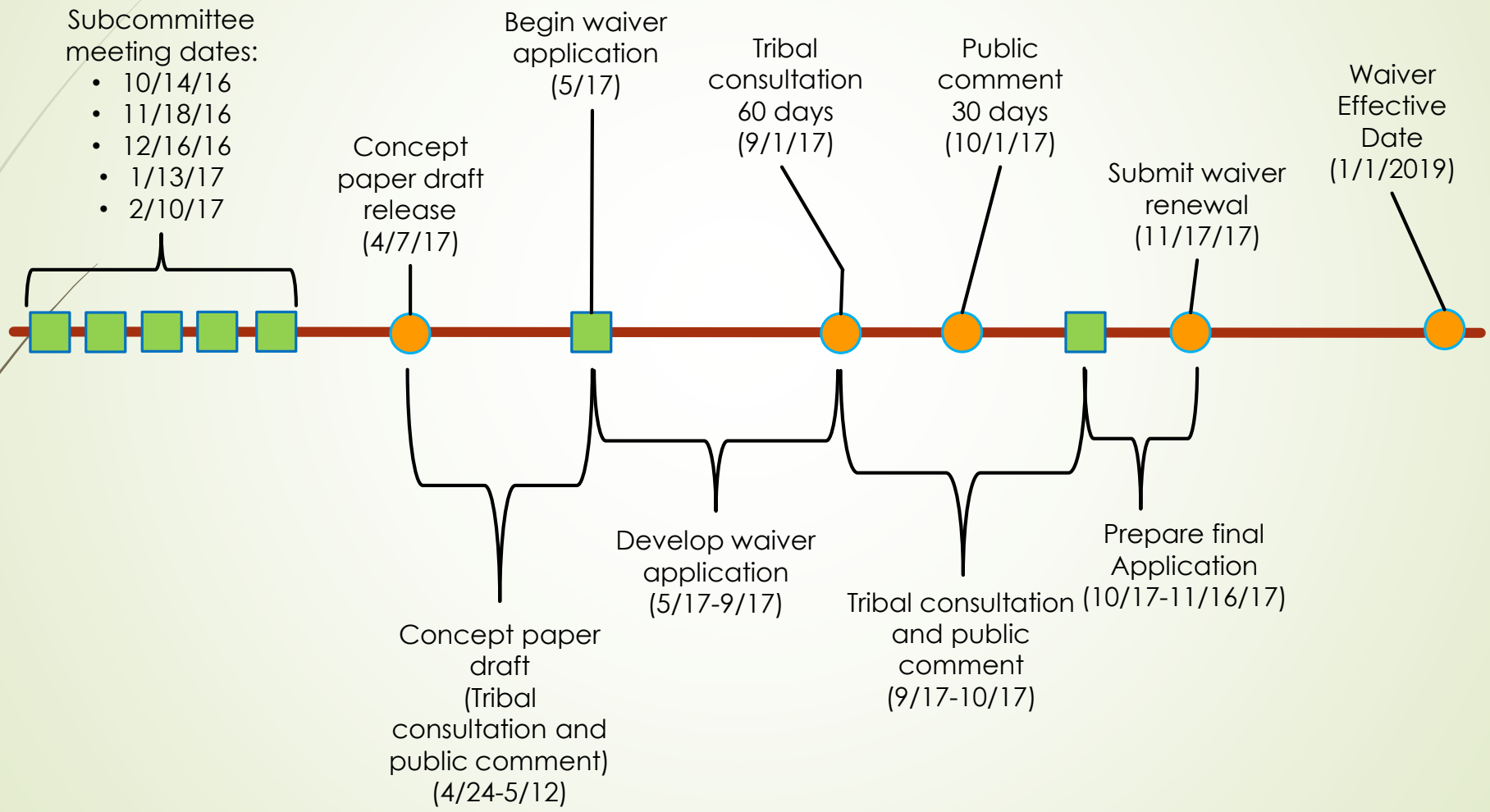
Needs	Concepts	Further Discussion
➢ Close gaps in eligibility for justice-involved individuals ➢ Achieve administrative cost savings ➢ Simplify eligibility processes ➢ Shorten time period for transitional Medicaid ➢ Uniform benefit package for most adults ➢ Benefit options ➢ Consider alternatives to service reductions	➢ Earlier start date or reactivation of eligibility (i.e., 30 days prior to release) ➢ Changes to eligibility and recertification for certain programs and policies to save administrative expenditures ➢ Align benefit packages, where appropriate to simplify operations ➢ Increase the availability of certain services ➢ Maintaining access to services that may be reduced due to cost containment	1. Are there other areas that eligibility can be streamlined to positively impact treatment for health conditions or reduce administrative burdens? 2. Are there other benefit packages or service availability that HSD should consider?

Next Steps
Summary of Process

- Consolidate recommendations from today's subcommittee meeting (due 2/17/2017)
- Consolidate and publish subcommittee and public feedback (2/24/2017)
- HSD will develop and publish draft concept paper (4/7/2017)
- Conduct concept paper stakeholder (public and Tribal) meetings (4/24-5/12/2017)
- Aggregate feedback and develop 1115 Waiver Renewal application (5/17-9/1/2017)
- Publish 1115 Waiver Renewal application and conduct stakeholder (public and Tribal meetings) (9/1/17-10/31/2017)

1115 Waiver Renewal

Updated Timeframe



Thank you for:

- Your time
- Recommendations
- Positive Feedback

Stakeholder Engagement Process Leading to Development of Concept Paper

7. MAC 1115 Waiver Renewal Subcommittee, February 10, 2017

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

AGENDA

MAC 1115 Waiver Renewal Subcommittee Meeting

NM HSD Administrative Services Division
1474 Rodeo Road, Santa Fe, NM

February 10, 2017
8:30 – 11:30AM

Topic	
Introductions	8:30 – 8:40 am
Review Minutes, Feedback from January Meeting	8:40 – 8:50 am
Eligibility and Benefit Alignment	8:50 – 10:10 am
Break	10:10 – 10:25 am
Next Steps	10:25 – 11:10 am
Public Comment & Wrap up	11:10 – 11:30 am

Medicaid 1115 Wavier Renewal Subcommittee Meeting
Meeting Minutes
February 10, 2017 — 8:30am – 11:30am
Administrative Services Division/ Human Services Department/ 1474 Rodeo Road, Santa Fe, New Mexico

Subcommittee Members:

Myles Copeland, Aging & Long-Term Services Department Van Nunley (proxy for Doris Husted), The Arc of New Mexico Bryce Pittenger, Children, Youth and Families Department Dawn Hunter, Department of Health Jim Jackson, Disability Rights New Mexico Sandra Winfrey, Indian Health Service Dave Panana, Tribal Representative, Kewa Pueblo Health Corp. Mary Kay Pera, New Mexico Alliance for School-Based Health Care Kyra Ochoa (proxy for Lauren Reichert), New Mexico Association of Counties	Teresa Turietta, New Mexico Association for Home & Hospice Care Patricia Montoya, New Mexico Coalition for Healthcare Value Linda Sechovec, New Mexico Health Care Association Rick Madden, New Mexico Medical Society David Roddy, New Mexico Primary Care Association Carolyn Montoya, University of New Mexico, School of Nursing Lisa Rossignol, Parents Reaching Out Mary Eden, MCO Representative, Presbyterian Health Plan

Absent Members:

Carol Luna-Anderson, The Life Link Christine Boerner, Legislative Finance Committee	Kris Hendricks, Dentistry for Kids Jeff Dye, New Mexico Hospital Association

Staff and Visitors Attending:

Rachel Wexler, DOH Karen Meador, HSD/BHSD Theresa Belanger, HSD/MAD Michael Nelson, HSD Kari Armijo, HSD/MAD Kim Carter, HSD/MAD Dan Clavio, HSD/MAD Angela Medrano, HSD/MAD Megan Pfeffer, HSD/MAD Nancy Smith-Leslie, HSD/MAD	Joie Glenn, Advocacy for Home and Hospice Care Melissa Garrett, Anthem, Inc. Erik Lujan, APCG Health Committee Shawna Romero, Blue Cross Blue Shield of New Mexico Ellen Pinnes, The Disability Coalition Debi Peterman, Health Insight New Mexico Leonard Thomas, M.D., Indian Health Services Deanna Talley, Molina Healthcare of New Mexico Tina Rigler, Molina Healthcare of New Mexico Liz Lacouture, Presbyterian Health Plan

Jason Sanchez, HSD/MAD Tallie Tolen, HSD/MAD Robyn Nardone, HSD/NMICSS Deidra Abbott, Mercer Jared Nason, Mercer Jessica Osborne, Mercer Son Yong Pak, Mercer Cindy Ward, Mercer	Amilia Ellis, United Healthcare Raymond Mensack, United Healthcare Angela Flores Montoya, University of New Mexico Al Galves, public member/psychologist Jake Wingard, public member

Agenda Item	Details	Discussion
I. Introductions	• Angela Medrano delivered opening comments. • Reviewed January minutes. • Feedback from the January 13, 2017 meeting. • Presented agenda overview.	• Medical Assistance Division (MAD) would like everyone to have the opportunity to contribute ideas and recommendations for the waiver renewal, and all are encouraged to use the website to submit comments. • This is the fifth and final Subcommittee Meeting related to the 1115 waiver renewal: – October 14, 2016 meeting focused on Care Coordination. – November 18, 2016 meeting focused on Population Health. – December 16, 2016 meeting focused on Long-Term Services and Supports (LTSS) and Behavioral Health/Physical Health (BH/PH) Integration. – January 13, 2017 meeting focused on Value-Based Purchasing and Member Engagement and Personal Responsibility. – Today's meeting will focus on Eligibility Alignment and Benefit Design. • Draft minutes from the January 13, 2017 meeting is included and comments are requested by February 17, 2017. – On page 9, Lisa commented that the meeting minutes need to be amended to state: Colorado families can become certified nursing assistants and receive compensation from insurance companies for performing care coordination activities. – On page 10, Lisa commented that the meeting minutes need to be amended by adding: many New Mexicans are not technically savvy and do not have access to the internet. – On page 10, Sandra commented that the meeting minutes need to be amended to state: Native

Agenda Item	Details	Discussion
		Americans do not get the opportunity to participate in the Centennial Rewards Program. – The minutes were amended to reflect the comments.
II. Eligibility Alignment	• Earlier start date or reactivation of eligibility (i.e., 30 days prior to release) for justice involved population. • Changes to eligibility and recertification for certain programs and policies to save administrative expenditures. – Narrow coverage for Family Planning Program – Waive 3 month retro-active eligibility – Extend continuous eligibility to adults – Shorten or eliminate transitional Medicaid coverage	• Bryce commented that it takes a long time to determine eligibility when a child is placed out-of-home and when a child goes into short term incarceration, the eligibility process could take weeks and the decision process could take about a month. Also, when a child needs to be placed with an out-of-state provider, the provider will not accept the child without the Medicaid eligibility affirmation. Bryce recommended a streamlined and automated eligibility process for children who are placed out-of-home. • Kari commented that former foster care youth are Medicaid eligible through age 26. After age 26, youth needs to apply for Medicaid. • Kari explained that when an individual is incarcerated for more than 30 days, his/her eligibility is suspended. However, inpatient hospital services are covered during the individual's incarceration; and eligibility is reactivated when the individual is released. • Kyra recommended establishing a memorandum of understanding between HSD and counties which allows care coordinators to enter jails and facilitate transition into the community setting prior to being released. • Lisa commented, in regards to family planning that educating members on the benefit is worthwhile to improve use of the benefit. • Dawn commented that the age band could be limited to 19 to 45 years of age and recommended coordinating family planning services with the Public Health Division at the Department of Health.

Agenda Item	Details	Discussion
		• Sandra recommended in regards to the eligibility process, that Native Americans be excluded from retroactive waiver based on the Affordable Care Act (ACA) rules. • Pat would like the committee to acknowledge that this work is going on within a period of great uncertainty with State Budget implications for Medicaid as well as the uncertainty at the federal level with a new Administration in transition, new leadership, different philosophy and not being clear on implications for the ACA, Health Insurance Exchange and Medicaid in general. • Jim recommended continuous eligibility for 12 months. • Lisa commented that she does not support eliminating the 3 months retroactive eligibility since this would have a negative impact to those individuals' receiving services. • Carolyn commented that having 3 months retroactive eligibility is critical especially to children. • Rick commented that having 3 months retroactive eligibility is not only critical to children but also to adults as well since costs accumulate in gradual ways and some individuals do not realize that they need to apply for Medicaid to continue their treatment. • In regards to reducing the time period for Transitional Medicaid, Jim commented that if HSD were to reduce the time period, then we need to ensure that all individuals have care coordinators to assist them with transitioning to Exchange benefits. • David asked for clarification on the federal poverity level (FPL) for the Transitional Medicaid population, and Kari stated it is above 138% FPL. • David recommended that the transitional period should be between 90 to 100 days.

Agenda Item	Details	Discussion
		• Lisa recommended that working individuals with disabilities should be excluded from this consideration.
III. Benefits Design	• Align benefit packages, where appropriate to simplify operations. • Increase the availability of certain services. • Maintaining access to services that may be reduced due to cost containment.	• In regards to the uniform benefit package, Jim commented that his understanding about the Medically Frail population is that once they qualify for regular Medicaid they remain eligible unless they opt-out, and Kari confirmed his understanding. Also, Kari commented that Parent/Caretaker population is not Medically Frail and this population defaults to Alternative Benefit Plan (ABP). • Lisa asked for a clarification on how HSD designates Parent/Caretaker, and Kari commented it is based on family income. • Jim commented that he does not think that care coordinators are aware of needing to assist individuals with deciding between Standard Medicaid versus ABP. Kari commented that ABP has a robust benefit package, and there may be no reason to switch. • Lisa commented that not having environmental modifications benefits for Medically Frail is concerning, and they frantically try to get environmental modifications done before they age out. • In regards to benefits options, Teresa applauded HSD for considering acupuncture and chiropractic services and stated that this is important to address as part of the opioid epidemic. • Mary Kay commented that she supports including long-acting reversible contraception (LARC). • Carolyn commented that both dental and vision services are critical to children's overall health and not treating early could last a lifetime. • Sandra recommended including acupuncture and

Agenda Item	Details	Discussion
		chiropractic services in the fee-for-service (FFS) program since 85% of Native Americans are not enrolled in managed care organizations (MCO). • Dawn commented that she also supports including LARC and echoed comments on dental and vision services. • David commented that dental services are not abused or overused, and it impacts physical health. • Lisa recommended including dental coverage for maternity services as oral health is linked to preterm deliveries. Also, she commented that according to the American Academy of Ophthalmology more than two thirds of children with the attention deficit hyperactivity disorder have vision issues. • Dave commented that the committee should be aware of different rules governing Native Americans and that the tribes want to continue the conversation about ensuring that the 1115 waiver has a carve-out for FFS for Native Americans. • Mary Kay echoed comments on vision and dental services and recommended that HSD does not reduce services for children receiving services through the school-based health centers. • Van commented that individuals with developmental disabilities are required to have dental and vision benefits. • Kari clarified that HSD is only considering limiting vision and dental services for parent/caretaker adults and expansion adults, and not children. • Dawn commented that DOH has New Mexico specific dental outcomes survey data for low income families and as well as other evidence based information that supports dental services.

Agenda Item	Details	Discussion
		• Lisa commented that behavioral health respite is only available through three institutions and recommended developing home-based respite services.
IV. Next Steps	• Develop Draft Concept Paper • Conduct Statewide Public Input Sessions • Conduct Tribal Consultation	• Jim commented that we are currently in the midst of healthcare landscape changes and encouraged HSD to consider reconvening the Subcommittee for input for additional feedback to react to changes. He also commented that the State has a revenue shortfall and the Medicaid spending per capita has decreased, so the problem is not with the Medicaid program. • Pat commented that HSD should remain nimble with the timeline given the reality of the questionable status of the ACA and Healthcare Exchange, and she encouraged HSD to inform the Governor and the legislature about how it engaged this Subcommittee for input. She also applauded the State for convening the Subcommittee under very uncertain economic challenges. • Kyra also applauded HSD for its tremendous work on community engagement and outreach to help understand what is going on at the State level. She also commented that State Innovation Models teams be revised for this project to solicit community input and have a placeholders in the waiver for this type of innovation. • Nancy commented that the State is planning to issue the final draft concept paper by mid to late April 2017. She reminded the Subcommittee that the concept paper will only address recommendations pertaining to the waiver. Non-waivers issues may get addressed through other avenues such as changes to policies and/or the MCO contract. • Nancy also commented that HSD is planning to conduct regional stakeholder meetings to discuss the draft

Agenda Item	Details	Discussion
		concept paper. She also commented that HSD will share the dates and locations as this information becomes available. – Lisa offered assistance with developing an informational video and closed captions. • Nancy also announced that HSD released the draft State Plan Amendment on co-payments through the HSD website and asked for feedback. – Rick thanked Nancy for bringing up the co-payment issue and commented that the co-payment requirement is essentially a provider tax since many individuals will not pay co-payments. • Linda asked for clarification on co-payments for the nursing facility resident's use of emergency departments (ED) and brand drugs. Nancy clarified that co-payments will apply to non-emergency use of ED and non-preferred drugs. • Nancy thanked the Subcommittee for their time and for thoughtful input.
V. Public Comments		• Al Galves requested that HSD consider supporting the Soteria House model as a Medicaid benefit in NM; he claims it is beneficial to the community as it offers a different treatment modality for individuals with behavioral health needs. • Monica Nera commented the original 1115 waiver contained expanding respite services for children with severe emotional disturbance (SED); however, this did not occur. She encouraged the State to expand respite services to support families for children with SED. • Angela Flores Montoya encouraged HSD to look at larger costs to the system rather than short term savings by reducing benefits and taxing providers.

Agenda Item	Details	Discussion
VI. Meeting Close	• Follow-up materials	• Comments on eligibility alignment and benefit design are due from Subcommittee members by February 17, 2017. • Comments should include recommendations, outcome measures, as well as measurement methods. • HSD will issue an aggregate recommendations document during the week of February 20, 2017 and comments are due from the Subcommittee by February 24, 2017.

Acronym Guide for MAD / HSD 1115 Waiver Renewal Process

ABCB – Agency-Based Community Benefit
ACEs – Adverse Childhood Experiences
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
DHI – Division of Health Improvement
D-SNP – Dual Eligible Special Need Plan
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
FIT – Family Infant Toddler Program
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
IBAC – Interagency Benefits Advisory Committee
I/DD – Intellectual and Developmental Disabilities
IHS – Indian Health Service
IP – In-patient
LEAD – Law Enforcement Assisted Diversion
LFC – Legislative Finance Committee
LOC – Level of Care
LTC – Long Term Care
LTSS – Long-Term Services and Supports

MACRA – Medicare Access and CHIP Reauthorization Act of 2015
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
NATAC – Native American Technical Advisory Committee
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
PMPM – per member per month
PMS – Presbyterian Medical Services (FQHC)
PQRS – Physician Quality Reporting System
SA – Substance Abuse
SAMHSA – Substance Abuse and Mental Health Services Administration, an agency within the US Department of Health and Human Services
SBHC – School-Based Health Center
SBIRT – Screening, Brief Intervention and Referral to Treatment
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

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CENTENNIAL CARE NEXT PHASE

1115 Waiver Renewal Subcommittee
February 10, 2017

Agenda

Introductions	8:30 – 8:40
Feedback from January meeting	8:40 – 8:50
Eligibility and benefit alignment	8:50 – 10:10
Break	10:10 – 10:25
Next steps	10:25 – 11:10
Public comment	11:10 – 11:25
Wrap up	11:25 – 11:30

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Renewal Waiver
Areas of Focus

- Refine care coordination
- Address social determinants of health
- Opportunities to enhance long-term services and supports (LTSS)
- Continue efforts for BH and PH integration
- Expand value-based purchasing
- Member engagement and personal responsibility
- Benefit & eligibility alignment

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Benefit & Eligibility Alignment

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Benefit & Eligibility Alignment

Streamlining Eligibility

Justice Involved Individuals	➢ HSD has worked to develop policies, processes and IT infrastructure to streamline Medicaid eligibility for individuals involved in the justice system
	➢ Goal is to close the gaps for individuals through:
	  ➢ Timely and automated eligibility reactivations
	  ➢ Earlier start date for eligibility (while incarcerated)

Family Planning Program	➢ In 2016 72,000 people were covered and 91% of the members did NOT use services through the program
	➢ Administratively burdensome and costly to HSD for renewal processing (approximately 6,000 cases per month)
	➢ Coverage overlaps with other insurance coverage
	➢ Considerations aim to reduce administrative costs while maintaining services for individuals who use them:
	  ➢ Narrow coverage for certain age groups
	  ➢ Narrow coverage for populations who do not have other health insurance coverage

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Benefit & Eligibility Alignment

Streamlining Eligibility

Simplify Eligibility Processes	➢ HSD has developed real-time eligibility for initial and renewal determinations (roll-out Spring 2017)
	➢ Federal eligibility rules are difficult to navigate, are structurally complicated and costly
	➢ Considerations include:
	  ➢ Waive 3 month retro-active eligibility for initial applicants
	  ➢ Extending continuous eligibility to adults to reduce administrative workload associated with mid-year redeterminations resulting from reported income changes

Shorten time period for transitional Medicaid	➢ Transitional Medical Assistance (TMA), predates the ACA and was intended to provide expiring coverage for parent/caretaker adults whose income increases above the eligibility threshold for the group for up to 12 months
	➢ Considerations include:
	  ➢ Request more frequent reporting of income (i.e., quarterly)
	  ➢ Shorten period of TMA to 30 – 90 days
	  ➢ Eliminate coverage

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Benefit & Eligibility Alignment

Benefit Design

Uniform Benefit Package for Parent /Caretaker adults and Medicaid Expansion

- Currently parent/caretaker adults receive a different benefit than Medicaid expansion members:
  - Parents/caretaker adults = "Standard Medicaid"
  - Alternative Benefit Plan (ABP) = "essential health benefits"; modeled on commercial health plan benefit design (approximately 260,000 Expansion adults)
  - ABP Exempt = "Standard Medicaid" for Medically Frail Expansion adults (approximately 3,500 members)
  - Expansion adults between the ages of 19-20 also receive EPSDT benefits
- Considerations include:
  - Align benefit packages for parent/caretaker adults and Medicaid expansion population
  - Allow the same option for members to opt-into ABP exempt (if qualified)
  - Request waiver to exclude EPSDT coverage requirement for Expansion members between ages 19-20

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Benefit & Eligibility Alignment

Benefit Design

Benefits options	➢ Increase availability of long acting reversible contraceptives (LARC) through increased FMAP (90%) to maintain inventory for providers (i.e., School Based Health Centers, etc.) ➢ Allow cost-effective non-covered service alternative to opioids for pain management such as acupuncture or chiropractic services ➢ Explore affordable alternatives to full dental and vision coverage in the form of riders similar to the design available to state employees, if necessary due to cost containment

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Benefit & Eligibility Alignment

Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Close gaps in eligibility for justice-involved individuals ➢ Achieve administrative cost savings ➢ Simplify eligibility processes ➢ Shorten time period for transitional Medicaid ➢ Uniform benefit package for most adults ➢ Benefit options ➢ Consider alternatives to service reductions	➢ Earlier start date or reactivation of eligibility (i.e., 30 days prior to release) ➢ Changes to eligibility and recertification for certain programs and policies to save administrative expenditures ➢ Align benefit packages, where appropriate to simplify operations ➢ Increase the availability of certain services ➢ Maintaining access to services that may be reduced due to cost containment	1. Are there other areas that eligibility can be streamlined to positively impact treatment for health conditions or reduce administrative burdens? 2. Are there other benefit packages or service availability that HSD should consider?

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Next Steps

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Next Steps
Summary of Process

- Consolidate recommendations from today's subcommittee meeting (due 2/17/2017)
  - Consolidate and publish subcommittee and public feedback (2/24/2017)
    - HSD will develop and publish draft concept paper (4/7/2017)
      - Conduct concept paper stakeholder (public and Tribal) meetings (4/24-5/12/2017)
        - Aggregate feedback and develop 1115 Waiver Renewal application (5/17-9/1/2017)
          - Publish 1115 Waiver Renewal application and conduct stakeholder (public and Tribal meetings) (9/1/17-10/31/2017)

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Next Steps

Waiver vs. Non-Waiver Topics

Waiver

- System Transformation: Items that require waiver authority to implement
- Eligibility changes or expansions
- Benefit packages
- Financing

Non-Waiver

- Policy or implementation issues
- New contract terms, process, or tools
- Modification of provider qualifications
- Implementation of quality strategy and monitoring approaches

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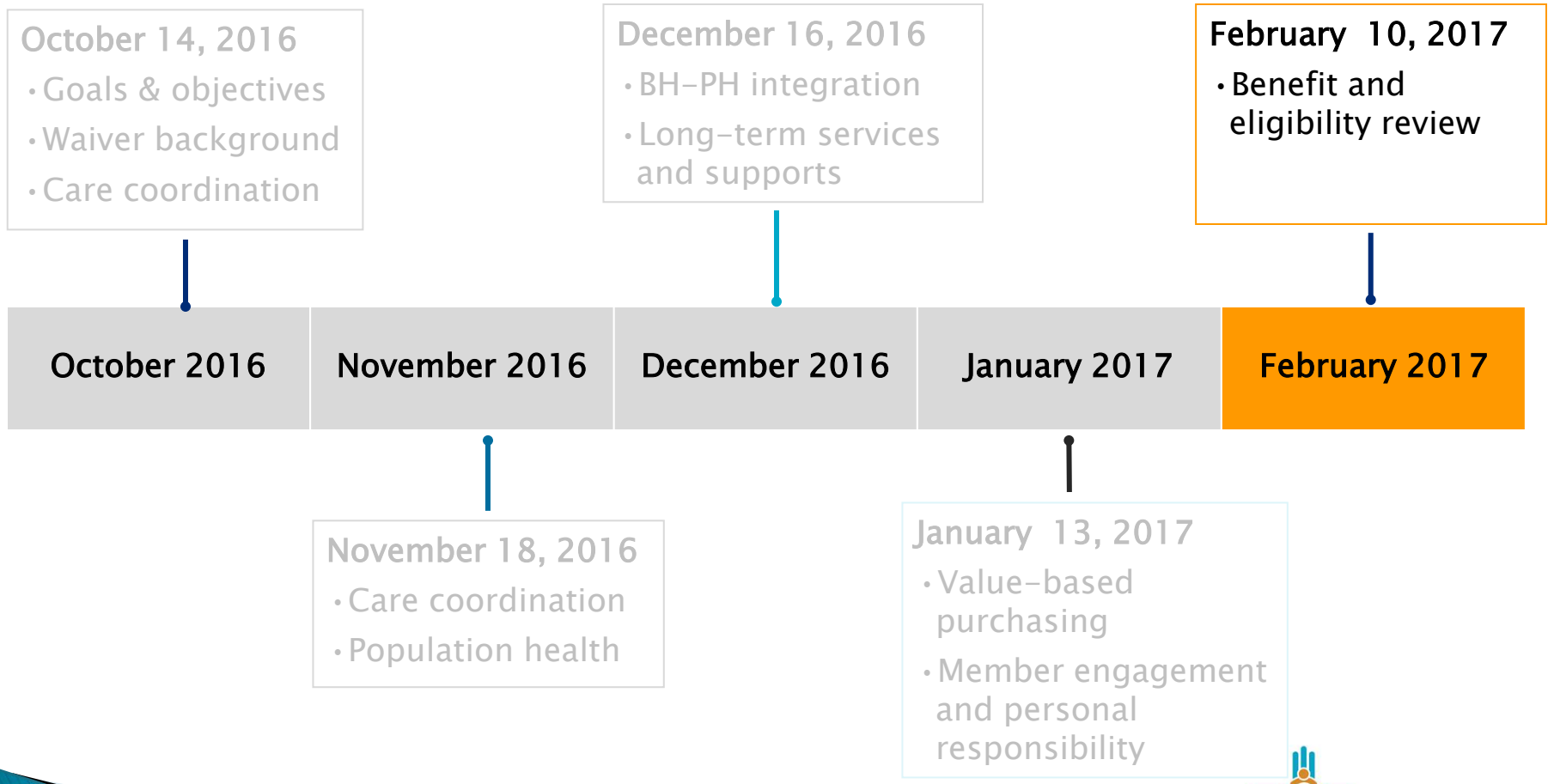
Subcommittee Meetings
Timeframe for Discussion



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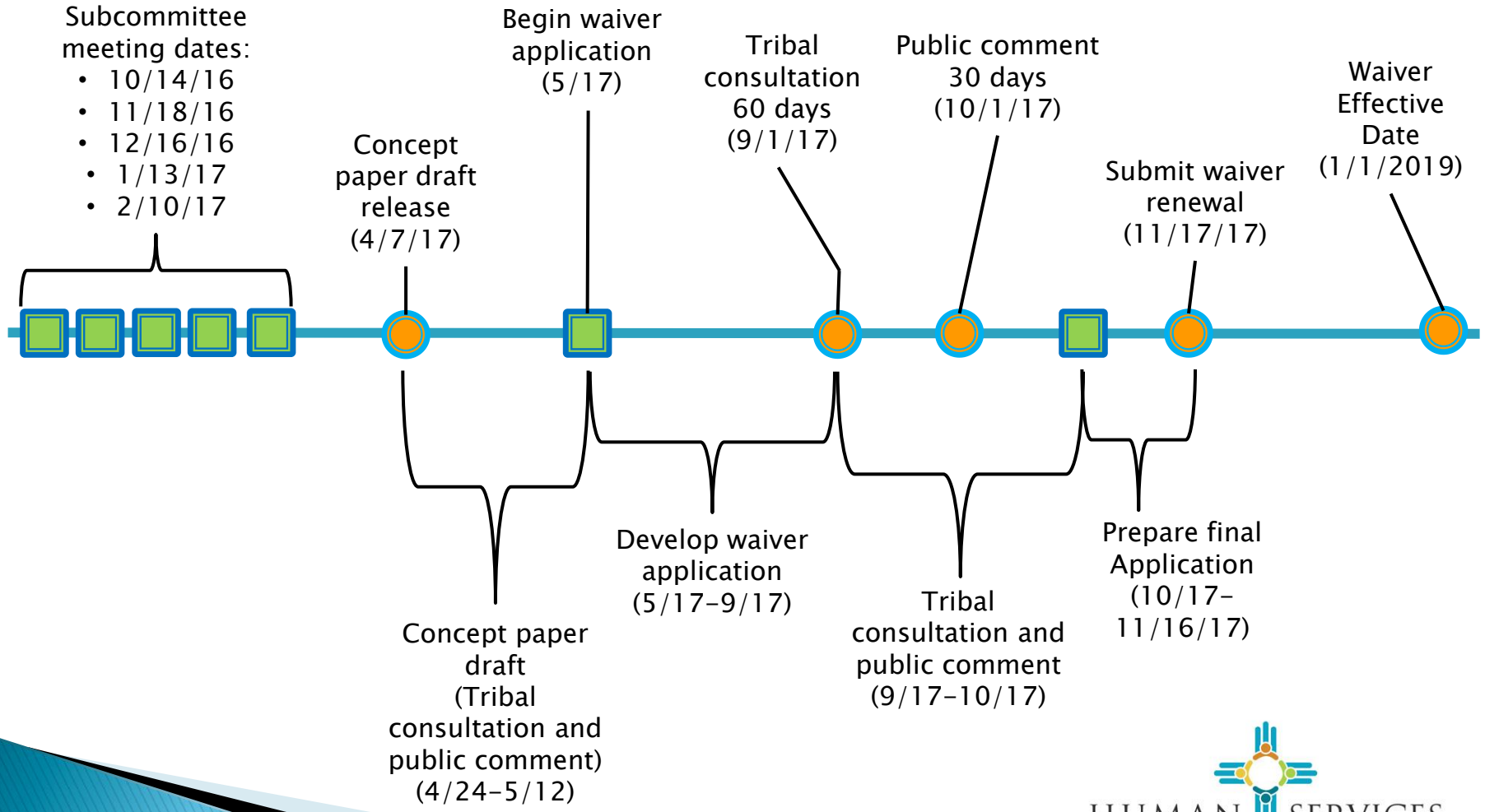
1115 Waiver Renewal

Updated Timeframe



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Thank you for:

- Your Time
- Recommendations
- Positive Feedback

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Alternative Benefit Plan (ABP)
ABP Comparison to Standard Medicaid Services

Most adults who qualify for the Medicaid category known as the "Other Adult Group" receive services under the New Mexico Alternative Benefit Plan (ABP). The ABP covers doctor visits, preventive care, hospital care, emergency department and urgent care, specialist visits, behavioral health care, substance abuse treatment, prescriptions, certain dental services, and more.

Medicaid recipients in the Other Adult Group who have special health care needs may qualify to receive Standard Medicaid services instead of the ABP. Individuals who have a serious or complex medical condition, a terminal illness, a chronic substance use disorder, a serious mental illness, or a disability that significantly impairs their ability to perform one or more activities of daily living, may choose to receive services under the ABP ***or*** under Standard Medicaid.

The table below offers a comparison of the ABP services package to the services that are covered under Standard Medicaid. Since individuals who have ABP coverage will always be ages 19-64, the comparison to Standard Medicaid coverage is for the same age range (ages 19 and above).

Benefit Category & Service	**ABP Coverage (Recipients ages 19-64)**	**Standard Medicaid Coverage (For ages 19 and above)**
Outpatient Services		
Acupuncture	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.
Cancer clinical trials	Covered	Covered (Same as ABP)
Chiropractic services	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.

Dental services (8.310.7 NMAC) • Diagnostic dental • Dental radiology • Preventive dental • Restorative dental • Prosthodontics (removable) • Oral surgery • Endodontic services for anterior teeth	Covered Preventive dental services are covered based on a periodicity schedule	Covered (Same as ABP)
Dialysis	Covered	Covered (Same as ABP)
Hearing aids and hearing aid testing	Not covered, except for recipients age 19-20	Covered
Holter monitors and cardiac event monitors	Covered	Covered (Same as ABP)
Home health care and intravenous services	Covered Home health care is limited to 100 four-hour visits per year	Covered No limitation on number of visits
Hospice care services	Covered	Covered (Same as ABP)
Infertility treatment	Not covered	Not covered
Naprapathy	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.
Non-emergency transportation	Covered	Covered (Same as ABP)
Outpatient diagnostic labs, x-ray and pathology	Covered	Covered (Same as ABP)
Outpatient surgery	Covered	Covered (Same as ABP)
Primary care to treat illness/injury	Covered	Covered (Same as ABP)
Radiation and chemotherapy	Covered	Covered (Same as ABP)
Special medical foods for inborn errors of metabolism	Not covered, except for recipients age 19-20	Coverage is the same as ABP (covered for recipients age 19-20 only)
Specialist visits	Covered	Covered (Same as ABP)
Telemedicine services	Covered	Covered (Same as ABP)
TMJ or CMJ treatment	Not covered	Not covered
Treatment of diabetes	Covered	Covered (Same as ABP)
Vision care for eye injury or disease	Covered Does not include vision refraction, except for	Covered Standard Medicaid covers vision refraction

	recipients age 19-20	and routine vision services
Vision hardware (eyeglasses or contact lenses)	Covered only following the removal of cataracts from one or both eyes. Vision hardware covered for recipients age 19-20 following a periodicity schedule.	Covered Contact lenses require prior authorization
Emergency Services		
Emergency ground or air ambulance services	Covered	Covered (Same as ABP)
Emergency department services/facilities	Covered	Covered (Same as ABP)
Urgent care services/facilities	Covered	Covered (Same as ABP)
Hospitalization		
Bariatric surgery	Covered Limited to one per lifetime	Covered No limitation on number of surgeries, as long as medical necessity is met
Inpatient medical and surgical care	Covered	Covered (Same as ABP)
Organ and tissue transplants	Covered Limited to two per lifetime	Covered No limitation on number of transplants, as long as medical necessity is met
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease	Covered	Covered (Same as ABP)
Maternity Care		
Delivery and inpatient maternity services	Covered	Covered (Same as ABP)
Non-hospital births	Covered	Covered (Same as ABP)
Pre- and post-natal care	Covered	Covered (Same as ABP)
Mental/Behavioral Health & Substance Use Disorder Services		
Inpatient hospital services in a psychiatric unit of a general hospital, including inpatient substance abuse detoxification	Covered	Covered (Same as ABP)
Medication-assisted therapy for opioid addiction	Covered	Covered (Same as ABP)
Outpatient behavioral health professional services (includes evaluation, testing, assessment, medication management and	Covered	Covered (Same as ABP)

therapy)		
Outpatient services for alcoholism and drug dependency, including Intensive Outpatient Program (IOP)	Covered	Covered (Same as ABP)
Assertive Community Treatment (ACT)	Covered	Covered (Same as ABP)
Psychosocial Rehabilitation (PSR)	Covered	Covered (Same as ABP)
Electroconvulsive Therapy (ECT)	Covered	Not covered The MCOs have the option to cover this service; check with the MCO.
Behavioral health supportive services (family support, recovery services, respite services)	Not covered	Covered when provided through a MCO
Medications		
Prescription medicines	Covered	Covered (Same as ABP)
Over-the-counter medicines	Coverage limited to prenatal drug items, and low-dose aspirin as preventive for cardiac conditions. Other OTC items may be considered for coverage only when the item is considered more medically or economically appropriate than the prescription drugs, contraceptive drugs and devices and items for treating diabetes.	Coverage limitations same as ABP
Rehabilitative & Habilitative Services and Devices		
Autism spectrum disorder	Covered for recipients age 19 or younger; or age 22 or younger when enrolled in high school. Includes physical, occupational and speech therapy and applied behavioral analysis.	Coverage ends at age 21
Cardiovascular rehabilitation	Covered Limited to 36 visits per cardiac event	Covered No limitation on visits as long as medical necessity is met
Durable medical equipment (DME), medical supplies, orthotic appliances and prosthetic	Covered Requires a provider's prescription.	Coverage is the same as ABP, except that most medically necessary disposable medical

devices, including repair or replacement	DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics including shoes and arch supports are only covered when an integral part of a leg brace, or are diabetic shoes.	supplies are also covered when prescribed by a practitioner.
Inpatient rehabilitative facilities	Covered Skilled nursing or acute rehabilitation facility	Covered (Same as ABP)
Internal prosthetics	Covered	Covered (Same as ABP)
Physical, speech and occupational therapy (rehabilitative and habilitative services)	Covered Short-term therapy limited to two consecutive months per condition. Long-term therapies are not covered	Rehabilitative services covered. No limitation on duration of therapy as long as medical necessity is met. Habilitative services are not covered.
Pulmonary therapy	Covered Limited to 36 visits per year	Covered No limitation on duration of therapy as long as medical necessity is met.
Skilled nursing	Covered primarily through home health agencies; subject to home health benefit limitations (100 four-hour visits per year).	Covered through home health agencies. No limitation on number of visits as long as medical necessity is met.
Laboratory and Radiology Services		
Diagnostic imaging	Covered	Covered (Same as ABP)
Lab tests, x-ray services and pathology	Covered	Covered (Same as ABP)
Preventive & Wellness Services and Chronic Disease Management		
Allergy testing and injections	Covered	Covered (Same as ABP)
Annual consultation to discuss lifestyle and behavior that promote health and well-being	Covered	Covered for age 19-20.
Annual physical exam	Covered Eye refractions, eyeglasses and contact lenses, are not covered, except for age 19-20. Hearing aids and hearing aid testing are not covered, except for age 19-20.	Periodic physical exams are only covered for age 19-20. Additional annual physical exams may be provided through a MCO. Vision services, including refractions, eyeglasses and contact lenses, are covered but are limited to

		a set periodicity schedule.
Chronic disease management	Covered through primary care provider services. Additional benefits may be available when provided through a MCO.	Covered through primary care provider services. Additional benefits may be available when provided through a MCO.
Diabetes equipment, supplies and education	Covered	Covered (Same as ABP)
Genetic evaluation and testing	Covered Triple serum test and genetic testing for the diagnosis or treatment of a current illness	Covered (same as ABP)
Immunizations	Covered Includes ACIP-recommended vaccines	Covered (Same as ABP)
Insertion and/or removal of contraceptive devices	Covered	Covered (Same as ABP)
Nutritional evaluations and counseling	Covered Dietary evaluation and counseling as medical management of a documented disease, including obesity.	Not covered, except for age 19-20 and during pregnancy. Additional benefits may be available when provided through a MCO.
Osteoporosis diagnosis, treatment and management	Covered	Covered (Same as ABP)
Periodic glaucoma eye test (age 35 or older)	Covered	Covered (Same as ABP)
Periodic colorectal examination (age 35 or older)	Covered	Covered (Same as ABP)
Periodic mammograms (age 35 or older)	Covered	Covered (Same as ABP)
Periodic stool examination (age 40 or older)	Covered	Covered only when medically indicated
Periodic test to determine blood hemoglobin, blood pressure, blood glucose level and blood cholesterol level or a fractionated cholesterol level	Covered	Covered (Same as ABP)
Podiatry and routine foot care	Covered when medically necessary	Covered (Same as ABP)
Preventive care	Covered Includes US Preventive Services Task Force “A” & “B” recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and preventive services for women recommended by the	Coverage is limited. Many screening services are covered when appropriate based on age or family history. Additional benefits may be available when provided through a MCO.

	Institutes of Medicine	
Screening pap tests	Covered	Covered (Same as ABP)
Sleep studies	Not covered, except for age 19-20	Covered
Smoking cessation treatment	Covered Diagnosis, counseling and prescription medicines	Covered only for recipients age 21 and under, and for pregnant women. Additional benefits may be available when provided through a MCO.
Voluntary family planning services	Covered	Covered (Same as ABP)
Weight loss programs	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.
Long-Term Services & Supports		
Community benefits	Not covered	Covered when the requirements to access these services are met, including nursing facility level of care (NF LOC) criteria
Nursing facility care	Not covered, except as a step down level of care from a hospital prior to being discharged to home when skilled nursing services on a short-term basis are medically necessary.	
Mi Via	Not covered	

Centennial Care 1115 Waiver Renewal Subcommittee
Issue Brief: Eligibility & Benefit Alignment
February 2017

Overview

One of the core principles of the New Mexico Centennial Care program is to improve administrative effectiveness and simplicity. In Medicaid, this is a difficult challenge – the program currently subsumes nearly 40 different categories of eligibility, multiple complicated eligibility determination methodologies, and manifold benefit packages for both children and adults. As the Human Services Department (HSD) seeks to renew the Centennial Care waiver, the Department is looking at opportunities to simplify some of these administrative complexities and, at the same time, is seeking innovations in program design aimed at addressing and resolving certain specific issues and concerns that are currently impeded due to limits imposed by federal regulations.

Streamlining Eligibility

- **Close gaps in eligibility for justice-involved individuals.** HSD has worked persistently to develop the IT systems, policies and processes to facilitate eligibility "suspensions" for individuals who are involved in the criminal or juvenile justice system, and to ensure timely and automated eligibility reactivations upon the release of these individuals from custody. While this process is working effectively in most instances – in particular for those in the custody of the Corrections Department – in some cases there are delays in reactivating eligibility that are due to the following issues:

    - Uncertain or undefined release date (a common problem for individuals in the county jail system)
    - Spontaneous or unplanned discharge from custody, often occurring during evening or nighttime hours
    - Postponed entry of release date into IT files coming from the prison or jail

    HSD is considering whether an eligibility waiver strategy might help to close gaps in coverage for justice-involved individuals. The State of New York has proposed allowing an earlier start-date or reactivation of eligibility – i.e., 30 days prior to release – which would ensure that individuals can have an active MCO card when they leave the facility. While HSD might consider a similar approach, concerns remain that it may not directly solve the problems noted above when the release date is either unknown or occurs spontaneously.

- **Preserve the Family Planning program for those who need it.** The Family Planning program currently covers more than 72,000 New Mexicans, providing a very limited benefit package of family planning services and contraceptives to individuals with income below 250% FPL who do not qualify for any other full coverage Medicaid category. Individuals covered under Family Planning receive those services through fee-for-service and not through Centennial Care. Only a small fraction (approximately 9 percent) of those covered under the Family Planning category actually use services or obtain contraceptives through the program. The program is administratively burdensome for HSD because all covered individuals must be renewed yearly (a volume of approximately 6,000 cases per month); in addition, many individuals are confused or

dissatisfied about the limited Family Planning benefit package and find it insufficient to meet most of their health care needs.

As it is currently structured, Family Planning operates as a limited benefit entitlement to anyone with income below the maximum threshold of 250% FPL, regardless of age or other health coverage status. HSD is considering reverting the Family Planning program to a waiver that is designed specifically for certain age groups and only for those who do not have other health insurance coverage. In effect, this would place limits on who could be covered under the Family Planning program so it would not be a catchall for everyone who does not qualify for full Medicaid. This strategy would maintain the program for those who need it but would significantly reduce the administrative burden associated with operating the program today.

- **Simplify eligibility processes.** HSD is moving toward an environment in which Medicaid eligibility – both initial determinations and renewals – is streamlined where possible. Real-Time Eligibility (RTE) is scheduled to roll-out in the Spring of 2017, meaning that many individuals will receive an eligibility determination at the point of application. However, there are some federal eligibility rules in the Medicaid environment that are structurally complicated and extremely costly for HSD to administer. HSD may consider requesting a waiver of the three-month retroactive eligibility period, which is accompanied with an intensive reconciliation process; and may also consider extending continuous eligibility to adults to reduce the administrative workload associated with mid-year redeterminations, particularly when there is a SNAP or TANF case attached to the household that results in interim reporting of income.

- **Speed up the transition off Medicaid.** Under current eligibility rules, when an individual in the Parent/Caretaker Category has earned income that increases above the eligibility threshold for that group (or the upper threshold of the Expansion Category), a 12-month Transitional Medical Assistance (TMA) eligibility span is approved. HSD may consider requesting authority from CMS for more frequent reporting of income (i.e., quarterly), a limitation of TMA to a shorter time period (i.e., 30-90 days), or elimination of the TMA program. Individuals would need to seek subsidized coverage through the Marketplace or other private insurance. It should be noted that the TMA provision pre-dates the Affordable Care Act (ACA) and was designed to protect individuals from losing coverage due to increased earned income. With other coverage options made available through the ACA, HSD believes that TMA may no longer be necessary or could be shortened to encourage individuals to obtain other coverage more quickly.

<u>Benefit Design</u>

- **Provide a uniform benefit package for most Medicaid adults.** Most adults who qualify for the Medicaid Expansion Category receive services under the Alternative Benefit Plan (ABP). The ABP is a very comprehensive benefit package that covers all services that are defined under the ACA as “essential health benefits”, including doctor visits, hospital care, emergency department and urgent care, specialist visits, behavioral health care, substance abuse treatment, prescriptions, certain dental services, and more. Medicaid recipients in the Expansion Category who have a special health care need such as a serious or complex medical condition, a terminal illness, a chronic substance use disorder, a serious mental illness, or a disability that significantly impairs their ability to perform one or more activities of daily living (ADLs) may choose to receive services under the ABP *or* under Standard Medicaid. Currently, there are approximately 3,500 individuals in the Adult Expansion who have opted to receive Standard Medicaid services

instead of the ABP due to their health condition, an indication that for most of the 260,000 individuals covered by the ABP, the benefit package satisfactorily meets their health care needs.

HSD is considering seeking waiver authority that would allow the Department to cover adults in the Parent/Caretaker Category under the ABP, with a similar opt-out process for individuals with special health care needs. This would place limitations on certain services, such as physical therapy and home health services. In addition, HSD might consider a request to waive the federal provision requiring adults age 19-20 who are in the Medicaid Expansion category to be covered under the EPSDT rule, which requires full coverage of any medically necessary service regardless of whether the service is included in the benefit package. The EPSDT rule is administratively burdensome and requires that 19-20 year-olds be treated as children, even when they are covered under an adult category.

- **Increase the availability of Long-Acting Reversible Contraceptives (LARC).** HSD has made access to LARC a high priority over the past several years, successfully "unbundling" LARC reimbursement from other services in Federally Qualified Health Centers (FQHCs), School-Based Health Centers (SBHCs) and at point of labor/delivery or during postnatal care to safeguard adequate payment and to ensure that providers are not discouraged from informing women about LARC or making it readily and immediately available. HSD is considering a request for federal waiver authority to obtain increased administrative funding (i.e., 90 percent, in line with the federal matching rate for Family Planning services and contraceptives) to maintain an inventory of LARC for certain providers, such as SBHCs. Under such a proposal, the state would incur an administrative expense to purchase a stock of LARC for the provider to use for Medicaid beneficiaries; once the entire stock is used, HSD would be able to re-stock the provider with more LARC supplies.

- **Consider allowing cost-effective non-covered services as an alternative to opioids for pain management.** Given the current risk of addiction to opioids in individuals seeking to manage pain, HSD believes it is important to consider policies that present safe and cost-effective alternatives to opioid use among Medicaid beneficiaries. HSD might consider requesting waiver authority that would allow the Centennial Care MCOs to provide services not listed in the Medicaid State Plan or in the covered services section of the MCO contracts when the use of such alternative services is both medically appropriate and cost-effective. Non-covered services that present a first-stop alternative to opioid use to manage pain might include acupuncture or chiropractic services.

- **Offer affordable alternatives to full dental and vision coverage, if necessary due to cost-containment.** HSD hopes that reductions in covered services and benefits will not be necessary, but the Department may need to scale back benefit design for adults to ensure the ongoing sustainability of the Medicaid program. Services that are considered "optional" under federal law include dental and vision coverage. Should HSD need to reduce or eliminate these types of services due to financial constraints, the Department is considering the development of dental and/or vision riders that individuals could purchase at an affordable premium, similar to the design of dental and vision coverage available to state employees. The development of any type of rider program would need to be included in the waiver to ensure the availability of federal matching funds.

Stakeholder Engagement Process Leading to Development of Concept Paper

8. New Mexico Association of Home and Hospice Care and the New Mexico Association for Home Care, March 2, 2017

HUMAN SERVICES DEPARTMENT

Presentation to the New Mexico Association of Home & Hospice Care and the New Mexico Association for Home Care

Secretary Brent Earnest

March 2, 2017

Today's Topics

- Centennial Care Update
- New Mexico's Medicaid Long Term Services and Supports
- Medicaid Budget Update
- Centennial Care Waiver Renewal

Program Successes

Principle 1

Creating a comprehensive delivery system

The right amount of care, delivered at the right time and in the most cost-effective and appropriate setting

- Care coordination
  - 950 care coordinators
  - 60,000 in care coordination L2 and L3
  - Focus on high cost/high need members
- Enrollment in the program has grown by 65% from 2014 to 2016, while per capita costs are down by 1% in same period. Costs associated with inpatient stays are lower and PCP visits and BH visits are higher.
- Increase in members served by PCMH
  - 200k to 250k between 2014 and 2015
- Telemedicine – 45% increase over 2014
- Health Home – Implemented Clovis and San Juan (SMI/SED)
- Expanding HCBS - 85.5% served in community and expanded access to community benefit services
- Implemented Electronic Visit Verification system
- Reduction in the use of ED for non-emergent conditions
  - Implementation of real-time Emergency Dept Information Exchange to notify MCOs when members at seeking care at ER

Program Successes

Principle 2

Increasing Emphasis on Payment Reforms

Ensuring that the expenditures for care and services being provided are measured in terms of quality and not quantity

- July 2015, 10 payment reform projects approved
  - Accountable Care Organizations (ACO)-like models
  - Bundled payments
  - Shared savings
- Subcapitated payment for defined population
- Three-tiered reimbursement for PCMHs
- Bundled payments for episodes of care
- PCMH Shared Savings
- Obstetrics gain sharing
- Developed standardized set of metrics that included process measures and efficiency metrics
- Implemented minimum payment reform thresholds for provider payments in CY2017 in MCO contracts—16% of provider payments must be in Value Based Purchasing (VBP) arrangements

Program Successes

Principle 3

Encouraging Personal Responsibility

Encouraging more personal responsibility of members to facilitate active participation and engagement in their own health

- Rewarding Healthy Behaviors: Centennial Rewards
  - health risk assessments
  - dental visits
  - bone density screenings
  - refilling asthma inhalers
  - diabetic screenings
  - refilling medications for bipolar disorder and schizophrenia

- 70% participation in rewards program
- Majority participate via mobile devices
- Estimated cost savings in 2015: $23 million
  - Reduced IP admissions
  - 43% higher asthma controller refill adherence
  - 40% higher HbA1c test compliance
  - 76% higher medication adherence for individuals with schizophrenia
- 70k members participating in step-up challenge

Program Successes

Principle 4

Simplify Administration

Streamline and modernize the Medicaid program to achieve greater administrative effectiveness and simplicity

- Consolidation of 11 different federal waivers that siloed care by category of eligibility; reduce number of MCOs and require each MCO to deliver the full array of benefits; and develop strategies with MCOs to reduce provider administrative burden
- One application for Medicaid and subsidized coverage through the Marketplace
- Streamlined enrollment and re-certifications
- MCO provider billing training around the State for all BH providers and Nursing Facilities
- Standardized the BH prior authorization form for managed care and FFS
- Standardized Health Risk Assessment (HRA)
- Standardized the BH level of care guidelines
- Standardized the facility/organization credentialing application
- Standardized the single ownership and controlling interest disclosure form for credentialing.
- Created FAQs for credentialing and BH provider billing

Long Term Services and Supports Key Policy Changes ➡ Expansion

- Effective 1/1/2014, two key policy changes are driving increased utilization and expenditures for Home and Community-Based Services (HCBS):
  - Centennial Care waiver allows any individual who meets a nursing facility (NF) level of care to receive HCBS waiver services, including Personal Care Services (PCS), without having to wait for a waiver slot
  - Medicaid Adult Expansion:
    - Newly eligible adults also able to receive HCBS services without waiver slot if meet nursing facility level of care criteria

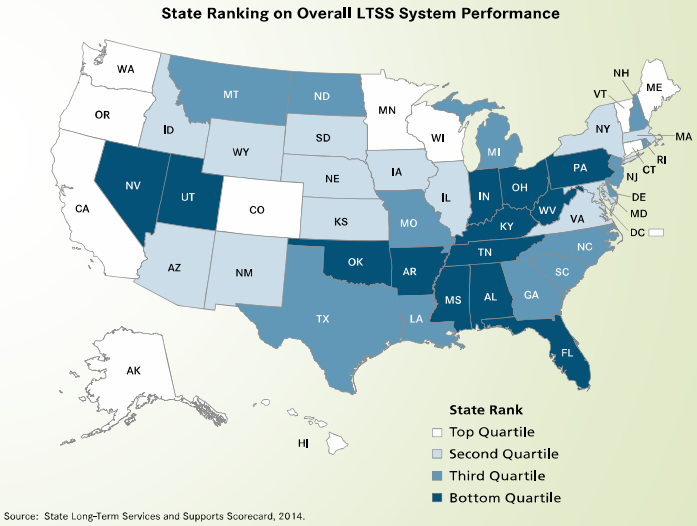
Personal Care Service (PCS) Utilization/Expenditures

Calendar Year	Users	Expenditures	Unit Cost	Average Spend per User
2013 (Pre-CC) Long Term Services & Supports (LTSS)/PCS	19,500	$ 263,072,327	$13.51	$13,491
2014 LTSS + Adult Expansion	23,645	$266,007,940	$13.89	$11,250
2015 LTSS + Adult Expansion	26,883	$280,527,396	$14.19	$10,435

Long Term Services and Supports Program

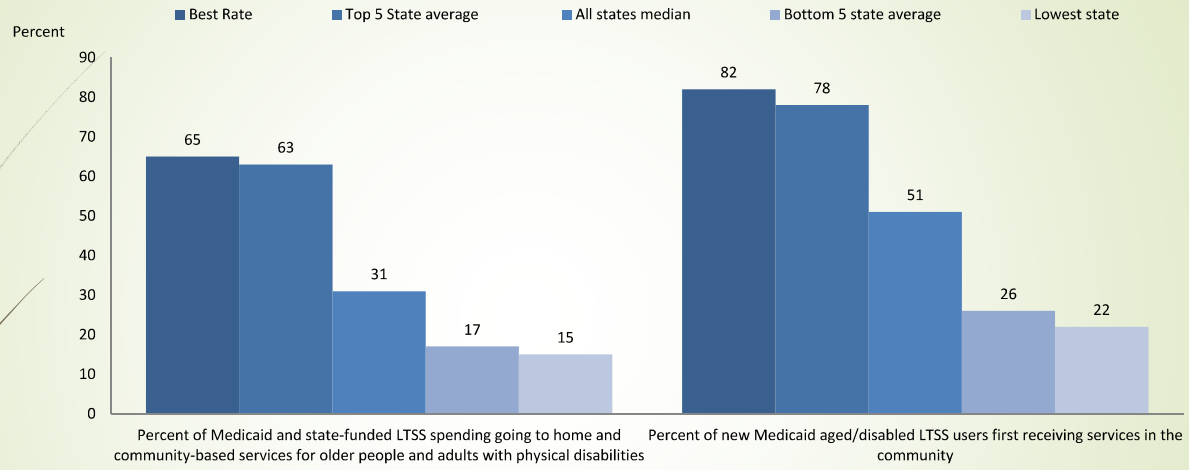
- In overall performance, New Mexico's LTSS program ranks in the second best quartile in the 2014 National State Long-Term Care (LTC) Scorecard published by the AARP and the Commonwealth Fund.

- Our LTC system is especially strong in terms of:
  - Affordability and access (top quartile)
  - Choice of setting and provider (top quartile)
  - Effective transitions across settings of care (second quartile)



Source: State Long-Term Services and Supports Scorecard, 2014.

New Mexico ranks first in the nation for spending more than 65 percent of its Medicaid LTSS dollars on home and community-based services



Top 5 states:

1 New Mexico	1 Alaska
2 Minnesota	2 Minnesota
3 Washington	3 New Mexico
4 Alaska	4 District of Columbia
5 Oregon	5 Idaho

Data: LTSS Spending - AARP Public Policy Institute analysis of Truven Health Analytics, Medicaid Expenditures for Long Term Services and Supports in 2011 (Revised October 2013); AARP Public Policy Institute Survey (2012); New Medicaid Users - Mathematica Policy Research analysis of 2008/2009 Medicaid Analytical Extract (MAX).

Nursing Facility Initiatives & Issues

- Nursing Facilities continue to play an important role in the Medicaid continuum of care
- Nursing Facilities were exempted from the 2016 provider rate reductions
- 2016 LFC recommendation: Consider payment mechanism that take into account quality and performance in nursing facilities.
- In 2017, Molina Healthcare is implementing a Nursing Facility Quality program that will financially reward facilities for achieving quality measures
- Total Nursing Facility Expenditures:
  - 2013 - $236 million
  - 2014 - $210 million
  - 2015 - $230 million
- HSD and the MCOs continue to work with the Nursing Facilities to resolve billing and eligibility issues.

Medicaid Budget in Context

- From FY14 to FY17, total Medicaid spending grew 35.8 percent, but general fund spending grew only 0.73 percent.
- Centennial Care – the state's 5-year Medicaid reform effort – focuses on care coordination, payment reform, personal responsibility and member engagement, and administrative simplification to slow the rate of growth in spending.
- Costs in Centennial Care are 1 percent lower than a year ago, on a per capita basis – i.e., how much we spend for health care services for each person on average – despite national and regional health care cost inflation.
- Following the 2016 legislative session, HSD had to take several cost containment actions:
  - Reduce MCO rates for administration and modified the Centennial Rewards program (~$2.5 million general fund savings)
  - Lowered reimbursement rates for many providers (~$22 million general fund savings) – Nursing Facility rates were not decreased and PCS rates were decreased by 1%
  - Pursuing additional federal funding for services to Native Americans (~$11.8 million general fund savings

FY18 General Fund Recommendations for the Medicaid Program

(excluding Administrative Costs)

(in millions)	House Bill 2 (as passed by the House)	Governor's Recommendation	HB 2 Over/(Under) Gov's Rec.
General Fund (GF)	$915.63	$940.17*	($24.54)*
Federal and Other Funds	$4,804.70	$4,949.4	($144.7)
Total	$5,720.33	$5,889.50	($169.24)

*Includes an additional $26 million from counties for County Supported Medicaid Fund

Key Differences In House Budget and Governor's Recommendation for Medicaid

- Governor's Budget Recommendation
  - Restructured state financing of NM Medical Insurance Pool and Health Insurance Exchange to reduce general fund spending by $8 million
  - Expand County Supported Medicaid Fund because Medicaid now covers New Mexicans who previously accessed County Indigent Programs ($26 million)
  - Additional cost containment of $7.7 million (~$37 million total)
- House Bill 2 assumes cost containment to reduce general fund spending by $15 million (~$71 million total)
  - Hepatitis C treatment
  - Expand Co-pays and add premiums
  - Other unspecified reductions to benefits, eligibility or provider rates
  - Eliminate Centennial Rewards program
  - Assumes Congress eliminates the Health Insurance Provider Fee (as part of ACA)
- Base recommendations already assumed cost containment to save $16 million of general fund spending.

Centennial Care Waiver Renewal Areas of Focus:

- Refine care coordination
- Address social determinants of health
- Opportunities to enhance long-term services and supports (LTSS)
- Continue efforts for BH and PH integration
- Expand value-based purchasing
- Member engagement and personal responsibility
- Benefit & eligibility alignment

Waiver Renewal

- Created subcommittee of Medicaid Advisory Committee to develop recommendations for waiver - October 2016 – February 2017
- Develop a Concept Paper – April 2017
- Develop Draft Waiver – July - August 2017
- Conduct Tribal Consultation – September 2017
- Submit Waiver to CMS – November 2017
- Waiver Effective – January 1, 2019

Caveat: Federal changes may require changes to this timeline.

Waiver Renewal Recommendations

- Email for recommendations:
  - Email Address: HSD-PublicComment2016@state.nm.us
  - Include “Waiver Renewal” in email subject line:
  - Include a background, proposed solution and impact in your correspondence

Stakeholder Engagement Process Leading to Development of Concept Paper

9. Tribal Consultation – Albuquerque, June 23, 2017

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Monday, June 12, 2017 11:39 AM
To: 'pyazzie@jan-riskmgmt.com'
Subject: Formal Tribal Consultation

Good morning Felicia,
The formal Tribal Consultation is:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

Please let me know if you have any questions.
Thank you.
Theresa

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

Belanger, Theresa, HSD NATAC

From: Belanger, Theresa, HSD
Sent: Tuesday, June 20, 2017 4:24 PM
To: Anthony Yepa (1rezdog@gmail.com); Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dempsey, K L (IHS/NAV); Haozous, Emily; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Brogdon, Mary, HSD; Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Robina Henry Acting EO; Rufus Greene, Jr. PhD; rvigil@puebloftesuque.org; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Harrison, Shanita R., HSD; Sharon Krantz; Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Thelma Gonzales; Zamora, Volelle; Zunie, Kelly, IAD
Cc: Earnest, Brent, HSD; Nelson, Michael, HSD; Zunie, Kelly, IAD; Smith-Leslie, Nancy, HSD; Slater-Huff, Katherine, HSD; Medrano, Angela, HSD; Vasquez, Orlando, HSD; Clavio, Daniel, HSD; Milton Bluehouse, Jr.; Barbara Ahasteen
Subject: Formal Tribal Consultation Agenda
Attachments: Tribal Consultation Agenda 6.23.17.doc

I have attached the agenda for Friday's Tribal Consultation at the Indian Pueblo Cultural Center.

Respectfully,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Friday, June 16, 2017 10:30 AM
To: Anthony Yepa (1rezdog@gmail.com); Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dempsey, K L (IHS/NAV); Emily Haozous; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Robina Henry Acting EO; Rufus Greene, Jr. PhD; 'rvigil@puebloftesuque.org'; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Shanita Harrison; Sharon Krantz; Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Thelma Gonzales; Zamora, Volelle; Zunie, Kelly, IAD
Subject: FW: Formal Tribal Consultation

Good morning NATAC members,
This is a reminder of the formal Tribal Consultation scheduled for Friday, June 23, 2017 at 9:00 am at the Indian Pueblo Cultural Center. The address is:
Indian Pueblo Cultural Center
2401 12th Street, NW
Albuquerque, NM 87104

Please let me know if you have any questions.

Respectfully submitted,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

From: Belanger, Theresa, HSD
Sent: Thursday, May 18, 2017 12:48 PM
To: Anthony Yepa; Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dempsey, K L (IHS/NAV); Emily Haozous; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Robina Henry Acting EO; Rufus Greene, Jr. PhD; 'rvigil@puebloftesuque.org'; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Shanita Harrison; Sharon Krantz; Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Thelma Gonzales; Zamora, Volelle; Zunie, Kelly, IAD
Subject: Public meetings for Centennial Care 2.0

Good afternoon NATAC members,

I wanted to let you know about the scheduled public meetings for Centennial Care 2.0. The list is below.

For additional information you can also go to our website at http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Schedule of meetings related to the waiver application development process for Centennial Care 2.0:

Public Meetings *(Presentations and Public Comments):*

- **Albuquerque: Wednesday, June 14, 2017,** 3:30 – 5:30 p.m.
  Albuquerque Public Library (501 Copper NW, Albuquerque, NM 87102)
- **Silver City: Monday, June 19, 2017,** 4:00 – 6:00 p.m.
  WNMU – GRC Auditorium (1000 W. College Ave, Silver City, NM 88061)
- **Farmington: Wednesday, June 21, 2017,** 4:30 – 6:30 p.m.
  Bonnie Dallas Senior Center (109 E La Plata St, Farmington, NM 87401)
- **Roswell: Monday, June 26, 2017,** 4:30 – 6:30 p.m.
  Roswell Public Library (301 N Pennsylvania Ave, Roswell, NM 88201)

Tribal Consultation:

- **Albuquerque: Friday, June 23, 2017,** 9:00 a.m. – 12:00 p.m.
  Indian Pueblo Cultural Center (2401 12th Street, NW, Albuquerque, NM 87104)

Respectfully,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Wednesday, May 31, 2017 9:41 AM
To: '1rezdog@gmail.com'
Subject: FW: 1115 Waiver Renewal Concept Paper

From: Belanger, Theresa, HSD
Sent: Wednesday, May 31, 2017 9:39 AM
To: Anthony Yepa
Subject: FW: 1115 Waiver Renewal Concept Paper

From: Belanger, Theresa, HSD
Sent: Wednesday, May 31, 2017 9:38 AM
To: Anthony Yepa; Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dempsey, K L (IHS/NAV); Haozous, Emily; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Robina Henry Acting EO; Rufus Greene, Jr. PhD; rvigil@pueblooftesuque.org; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Harrison, Shanita R., HSD; Sharon Krantz; Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Thelma Gonzales; Zamora, Volelle; Zunie, Kelly, IAD
Subject: 1115 Waiver Renewal Concept Paper

Good morning NATAC members,
I wanted to inform you that the pre-application concept paper for the Centennial Care 2.0 waiver renewal is posted on our website at http://www.hsd.state.nm.us/centennial-care-2-0.aspx
Please let me know if you have any questions or comments and share the link with any interested parties.
For a list of public meetings, , please scroll down the page at the link above.

Respectfully,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Jose R. Benavides
P.O. Box 1270
Isleta Pueblo, New Mexico 87022

Subject: **Formal Tribal Consultation**

Dear Governor Benavides,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael J. Nelson

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Thursday, May 18, 2017 12:54 PM
To: 'melody.Price-Yonts@ihs.gov'; 'lbenally@ansbi.org'; 'sgene@aaihb.org'; 'john.Rael@ihs.gov'; 'Maureen.Cordova@ihs.gov'; 'Barbara.Felipe@ihs.gov'; 'iris_reano@pueblodecochiti.org'; 'leslie.dye@ihs.gov'; 'vzamora@islclinic.net'; 'david.tempest@jemezpueblo.org'; 'sandra.lahi@ihs.gov'; 'kpacheco@lagunapueblo-nsn.gov'; 'alan.tatz@ihs.gov'; 'Dorlynn.Simmons@ihs.gov'; 'janay.maupin@ihs.gov'; 'alvin.rafaelito@ihs.gov'; 'csarnicky@sandiapueblo.nsn.us'; 'rgreene@sfpueblo.com'; 'Leslie.dye@ihs.gov'; 'John.Rael@ihs.gov'; 'leslie.dye@ihs.gov'; 'leslie.dye@ihs.gov'; 'dpanana@kp-hc.org'; 'losawe@southernute--nsn.gov'; 'sidney.daniel@ihs.gov'; 'Clinton.Gropp@ihs.gov'; 'John.Rael@ihs.gov'; 'jean.othole@ihs.gov'; 'leonard.thomas@ihs.gov'; 'sandra.winfrey@ihs.gov'; 'Debra.Feathers@ihs.gov'; 'linda.son-stone@fnch.org'; 'mlopez@ydsp-nsn.gov'; 'ron.tso@ihs.gov'; 'anslem.roanhorse@ihs.gov'; 'fannessa.comer@ihs.gov'; 'sandi.aretino@fdihb.org'; 'fannessa.comer@ihs.gov'; 'vida.khow@ihs.gov'; '1miche@yahoo.com'; 'leland.leonard@fdihb.org'; 'Carenda.Robinson@ihs.gov'; 'anslem.roanhorse@ihs.gov'; 'fannessa.comer@ihs.gov'; 'anslem.roanhorse@ihs.gov'; 'fannessa.comer@ihs.gov'; 'ali.ali@ihs.gov'; 'fawn.damon@ihs.gov'; 'joseph.engleken@tchealth.org'; 'dsinger@unhsinc.org'; 'john.hubbard@ihs.gov'; 'Floyd.Thompson@ihs.gov'; 'Douglas.Peter@ihs.gov'; 'sharon.brokeshoulder@ihs.gov'; 'theresa.galvan@nndoh.org'; 'k.dempsey@ihs.gov'; 'ella.dayzie@ihs.gov'; 'sally.pete@wihcc.org'; 'ron.tso@ihs.gov'; 'beverly.lewis@wihcc.org'
Subject: Public input meetings for Centennial Care 2.0

Good afternoon IHS and Tribal 638 providers,

I wanted to let you know about the scheduled public meetings on the waiver development process for Centennial Care 2.0.

For additional information you can also go to our website at http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Schedule of meetings related to the waiver application development process for Centennial Care 2.0:

Public Meetings ***(Presentations and Public Comments)***:

- **Albuquerque: Wednesday, June 14, 2017,** 3:30 – 5:30 p.m.
  Albuquerque Public Library (501 Copper NW, Albuquerque, NM 87102)
- **Silver City: Monday, June 19, 2017,** 4:00 – 6:00 p.m.
  WNMU – GRC Auditorium (1000 W. College Ave, Silver City, NM 88061)
- **Farmington: Wednesday, June 21, 2017,** 4:30 – 6:30 p.m.
  Bonnie Dallas Senior Center (109 E La Plata St, Farmington, NM 87401)
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  Roswell Public Library (301 N Pennsylvania Ave, Roswell, NM 88201)

Tribal Consultation:

- **Albuquerque: Friday, June 23, 2017,** 9:00 a.m. – 12:00 p.m.
  Indian Pueblo Cultural Center (2401 12th Street, NW, Albuquerque, NM 87104)

Respectfully,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Tuesday, May 09, 2017 4:47 PM
To: 'Alicia Ortega'
Subject: RE: APCG Meeting

Hi Alicia,
It's okay. As long as we can still hold the formal Tribal Consultation on June 23rd I am okay. Can I call you on your cell?
Thanks.
Theresa

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

From: Alicia Ortega [mailto:APCG@indianpueblo.org]
Sent: Tuesday, May 09, 2017 4:44 PM
To: Belanger, Theresa, HSD
Subject: APCG Meeting
Importance: High

Good Afternoon Theresa,

My sincerest apologies for the delay and for being the bearer of bad news but we actually just had a major shift in meeting plans as of yesterday and today and have to move the date to the 22nd and reschedule all non APCG committee meetings to July for review. We have had quite a few pressing issues that our APCG Legislative, Health and Chaco Committees have been facing and working on and at the Governor's request, they asked that the next 2 meetings be solely dedicated to dealing with the state issues that lie ahead especially with the special session reconvening on May 24th and have asked to hold off on all informational presentations for the next two months. Please let me know if you are still interested in presenting after July. I am sincerely sorry for any and all inconveniences this may cause. It's just been a chaotic time for tribes at both the federal and state levels in almost all areas impacting us. I apologize for the shift and thank you for your understanding. I will make sure that they are fully aware of the tribal consultation taking place on June 23rd from 9-12 and that we have APCG representation at that consultation meeting.

Respectfully,

Alicia Ortega
Executive Director
All Pueblo Council of Governors
2401 12th Street NW, Suite 214 S
Albuquerque, NM 87104
505.212.7041
APCG@indianpueblo.org

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Thursday, May 04, 2017 3:48 PM
To: 'Alicia Ortega'
Subject: RE: HSD Tribal Consultation

Hello Alicia,
Yes, we have scheduled it for Friday, June 23, 2017 at 9:00 -12 noon. Secretary Zuni from IAD assisted me with getting a room. I will report on it briefly at the May 18th APCG meeting if the request is approved.
Thank you for all of your help!
Theresa

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

From: Alicia Ortega [mailto:APCG@indianpueblo.org]
Sent: Thursday, May 04, 2017 3:06 PM
To: Belanger, Theresa, HSD
Subject: HSD Tribal Consultation

Good Afternoon Theresa,

I wasn't sure if you've already reached out to IPCC about the Tribal Consultation. If not, Clarissa Baca or Analisa Aragon are our contacts:

INDIAN PUEBLO CULTURAL CENTER
Gateway to the 19 Pueblos of New Mexico

Analisa A. Aragon
Sales Coordinator
Indian Pueblo Cultural Center
Indian Pueblos Marketing, Inc.
2401 12th St. NW
Albuquerque, NM 87104
Ph: (505) 724-3509/ Fax: (505) 724-3551

Thanks so much!

Respectfully,

Alicia Ortega
Policy Coordinator
All Pueblo Council of Governors
Indian Pueblo Cultural Center

2401 12th Street NW
Albuquerque, NM 87104
505.212.7041
APCG@indianpueblo.org

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Jose R. Benavides
P.O. Box 1270
Isleta Pueblo, New Mexico 87022

Subject: **Formal Tribal Consultation**

Dear Governor Benavides,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Kurt Riley
P.O. Box 309
Acoma, New Mexico 87034

Subject: **Formal Tribal Consultation**

Dear Governor Riley,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Virgil A. Siow
P.O. Box 194
Laguna Pueblo, New Mexico 87026

Subject: **Formal Tribal Consultation**

Dear Governor Siow,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Michael Nelson
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New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Peter Garcia, Jr.
P.O. Box 1099
San Juan Pueblo, New Mexico 87566

Subject: **Formal Tribal Consultation**

Dear Governor Garcia,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Phillip A. Perez
Route 1, Box 117-BB
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation**

Dear Governor Perez,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Sincerely,

Michael J. Nelson

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Anthony Ortiz
P.O. Box 4339
San Felipe Pueblo, New Mexico 87001

Subject: **Formal Tribal Consultation**

Dear Governor Ortiz,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Mark Mitchell
Route 42, Box 360-T
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation**

Dear Governor Mitchell,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Sincerely,

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Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
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Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor James R. Mountain
02 Tunyo Po
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation**

Dear Governor Mountain,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
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Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Carl Schildt
135 Capitol Square Drive
Zia Pueblo, New Mexico 87053-6013

Subject: **Formal Tribal Consultation**

Dear Governor Schildt,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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New Mexico Human Services Department

Cc:
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Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Navajo Nation
President Russell Begaye
P.O. Box 9000
Window Rock, AZ 86515

Subject: **Formal Tribal Consultation**

Dear President Begaye,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Sincerely,

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Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Ft. Sill Apache Tribe
Chairman Jeff Haozous
Route 2, Box 121
Apache, OK 73006

Subject: **Formal Tribal Consultation**

Dear Chairman Haozous,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

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Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Eugene Herrera
P.O. Box 70
Cochiti Pueblo, New Mexico 87072

Subject: **Formal Tribal Consultation**

Dear Governor Herrera,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Deputy Cabinet Secretary
New Mexico Human Services Department

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Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Craig Quanchello
P.O. Box 127
Penasco, New Mexico 87553

Subject: **Formal Tribal Consultation**

Dear Governor Quanchello,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Sincerely,

Michael J. Nelson

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

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Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Lawrence A. Montoya
2 Dove Road
Santa Ana Pueblo, New Mexico 87004

Subject: **Formal Tribal Consultation**

Dear Governor Montoya,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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New Mexico Human Services Department

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Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Val Panteah, Sr.
P.O. Box 339
Zuni, New Mexico 87327

Subject: **Formal Tribal Consultation**

Dear Governor Panteah,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor J. Michael Chavarria
P.O. Box 580
Espanola, New Mexico 87532

Subject: **Formal Tribal Consultation**

Dear Governor Chavarria,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Deputy Cabinet Secretary
New Mexico Human Services Department

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Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

President Edward Velarde
P.O. Box 507
Dulce, New Mexico 87528

Subject: **Formal Tribal Consultation**

Dear President Velarde,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Eight Northern Indian Pueblos Council
Gil L. Vigil, Executive Director
P.O. Box 969
San Juan Pueblo, New Mexico 87566

Subject: **Formal Tribal Consultation**

Dear Mr. Vigil,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Joseph A. Toya
P.O. Box 100
Jemez Pueblo, New Mexico 87024

Subject: **Formal Tribal Consultation**

Dear Governor Toya,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Joseph M. Talachy
78 Cities of Gold Road
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation**

Dear Governor Talachy,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Brian Coriz
P.O. Box 99
Santo Domingo Pueblo, New Mexico 87052

Subject: **Formal Tribal Consultation**

Dear Governor Coriz,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Malcolm Montoya
481 Sandia Loop
Bernalillo, New Mexico 87004

Subject: **Formal Tribal Consultation**

Dear Governor Montoya,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Ruben Romero
P.O. Box 1846
Taos, New Mexico 87571

Subject: **Formal Tribal Consultation**

Dear Governor Romero,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Kelly Zunie, Secretary, Indian Affairs Department
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Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

President Danny Breuninger, Sr.
P.O. Box 227
Mescalero, New Mexico 88340

Subject: **Formal Tribal Consultation**

Dear President Breuninger,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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New Mexico Human Services Department

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Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

All Indian Pueblos Council
E. Paul Torres, Chairman
2401 12th Street, NW
Albuquerque, New Mexico 87013

Subject: **Formal Tribal Consultation**

Dear Chairman Torres,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

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Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

Centennial Care 2.0
1115 Waiver Renewal Formal Tribal Consultation

Friday, June 23, 2017
9:00 to 12:00 p.m.

Location
Indian Pueblo Cultural Center
2401 12th Street, NW
Albuquerque, New Mexico 87104

Consultation Protocol: Individuals representing a Tribe, Pueblo, or Nation shall present a letter of authorization from their governor, president, or chairperson before the session begins. The letter must be on official tribal letterhead.

AGENDA

9:00	Invocation
9:10	Welcome and Introductions – Secretary Brent Earnest, Human Services Dept. and Secretary Kelly Zunie, Indian Affairs Dept. Introductions from Tribal leadership Review of consultation protocol – Milton Bluehouse
9:30	Human Services Presentation on Centennial Care 2.0 (PowerPoint) and Tribal leadership discussion
11:30	Public Comment (3 Minute Limit)
12:00	Closing

HUMAN SERVICES DEPARTMENT

NTENNIALCARE2.0

1115 Waiver Renewal
Tribal Consultation
June 23, 2017

New Mexico Human Services Department

Today's Agenda & Goals

Centennial Care 2.0 Concepts

- Provide information about Centennial Care: overview, goals, accomplishments.
- Discuss proposed improvements and reforms by identified area of focus as presented in the concept paper.

Public Comments

- Break after each area of focus to hear your comments on the ideas presented in that section.
- Consider your feedback for the federal 1115 Waiver Renewal application.

Wrap Up

- Provide Next Steps including timeframe for additional input.
- Thank you for your time and feedback.

HUMAN SERVICES DEPARTMENT

Why Are We Meeting Today?

Ideas

Our focus is on how to improve the current program so it is more effective and efficient with better quality outcomes, yet sustainable.

Perspective

How will the ideas we present impact you and your community?

Feedback

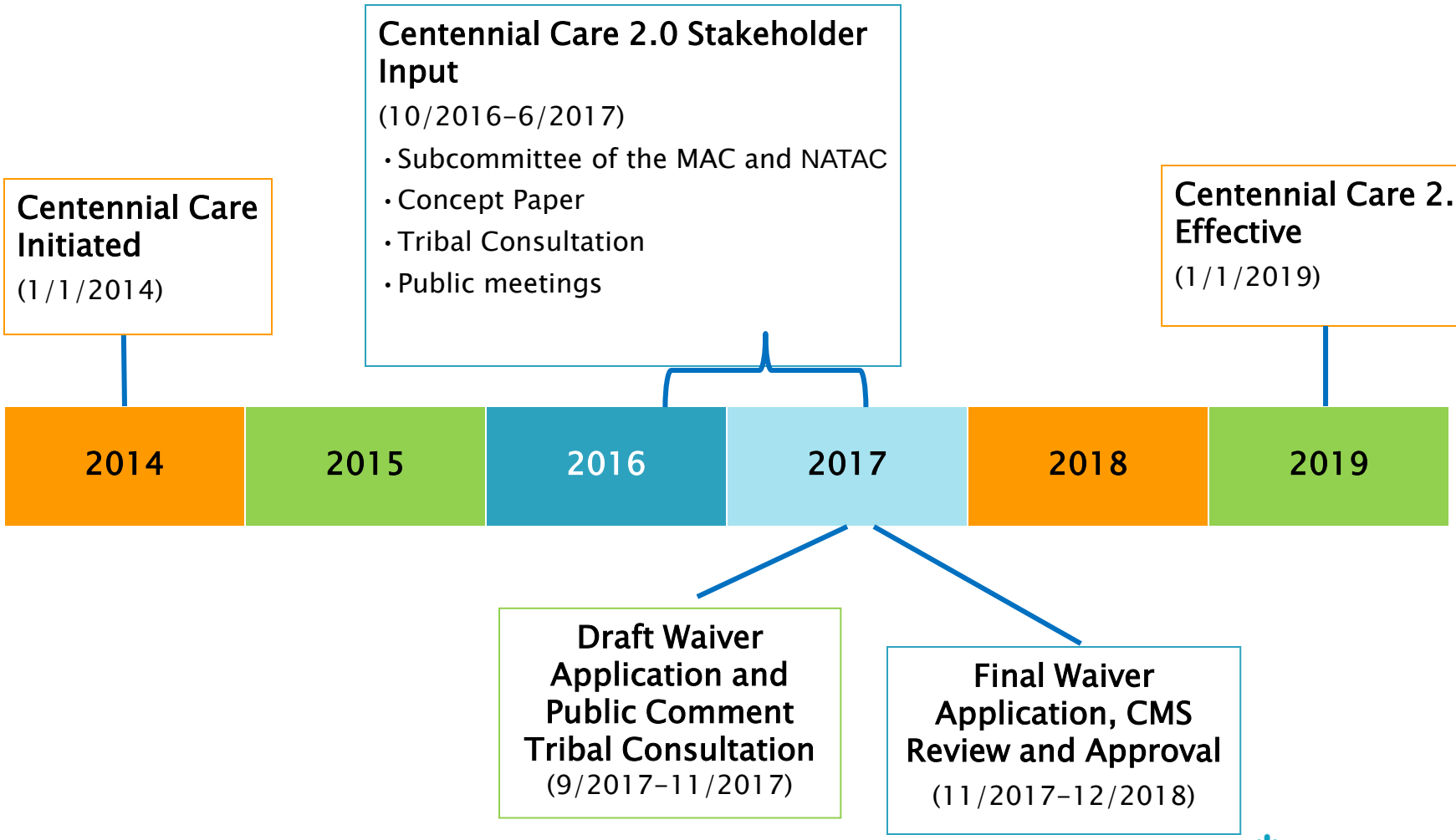
What ideas do you have?

What else should we be thinking about?

We will take comments at the end of each area of focus during the presentation.
There are note cards available, if you want to write your comments as you think of them.

HUMAN SERVICES DEPARTMENT

Centennial Care Timeline



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Pre- and Post- Centennial Care

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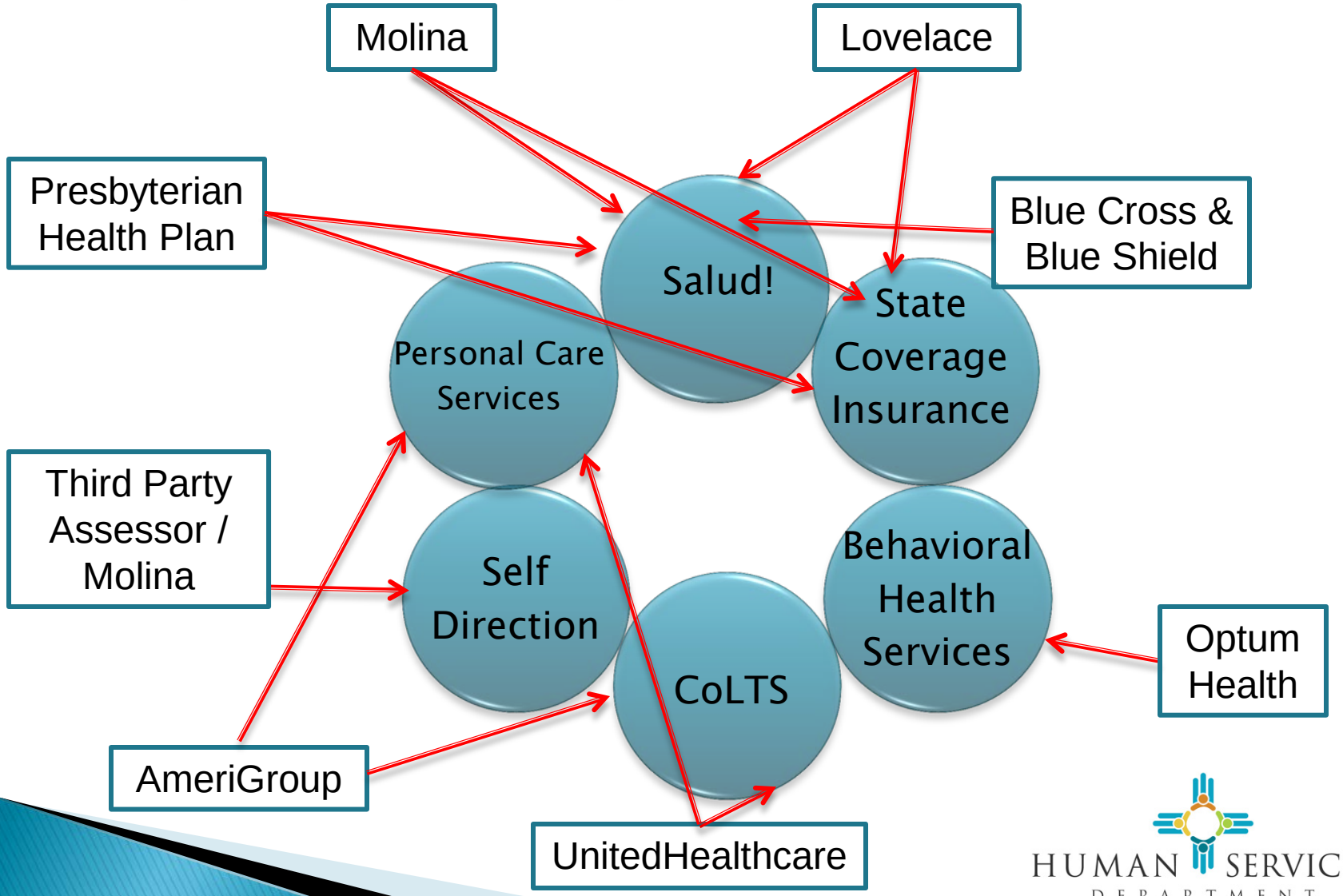
Medicaid in 2013
Pre-Centennial Care



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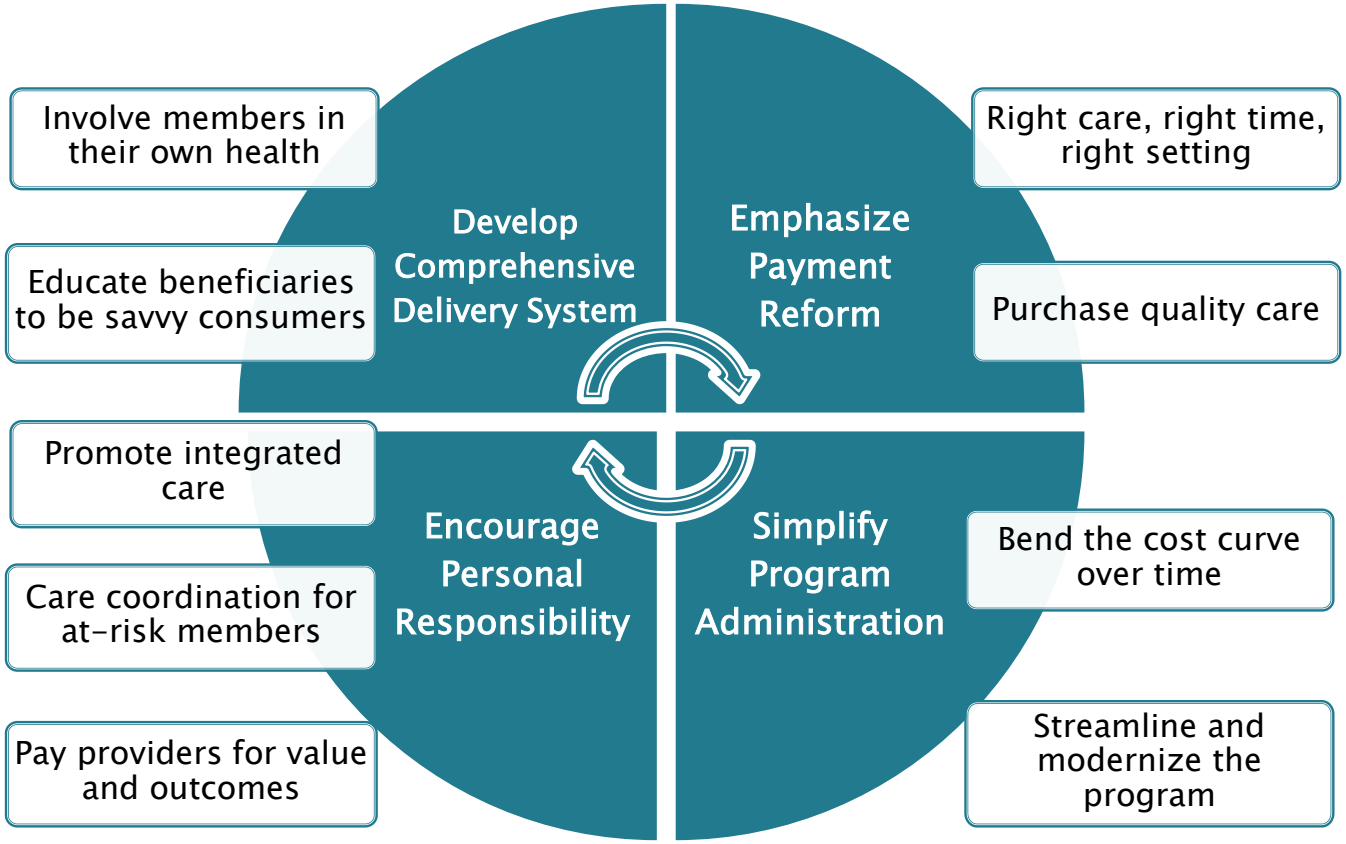
Centennial Care
Guiding Principles



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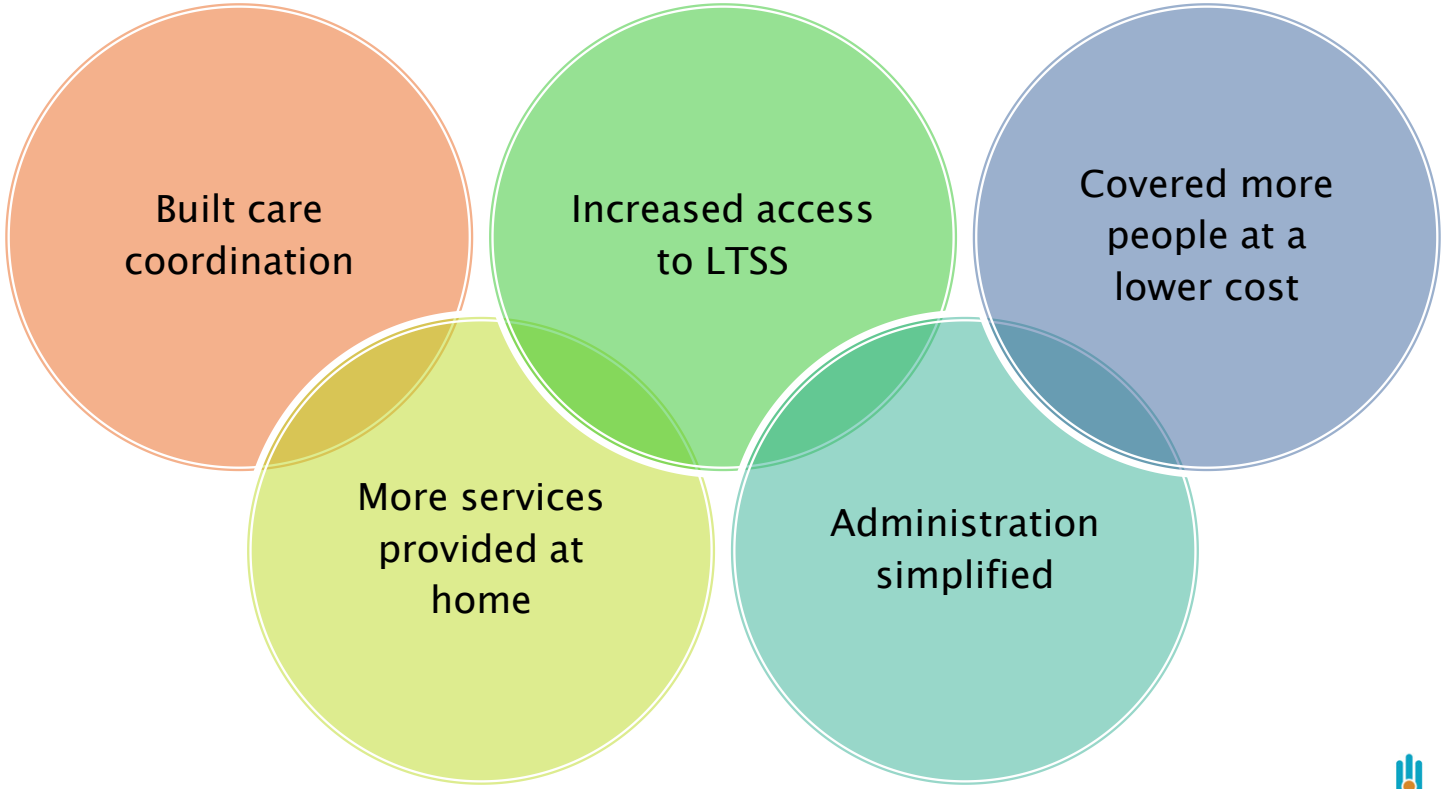
Centennial Care 1.0

Key Accomplishments 2014–2016



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Current Landscape

Federal/State Impacts to Consider

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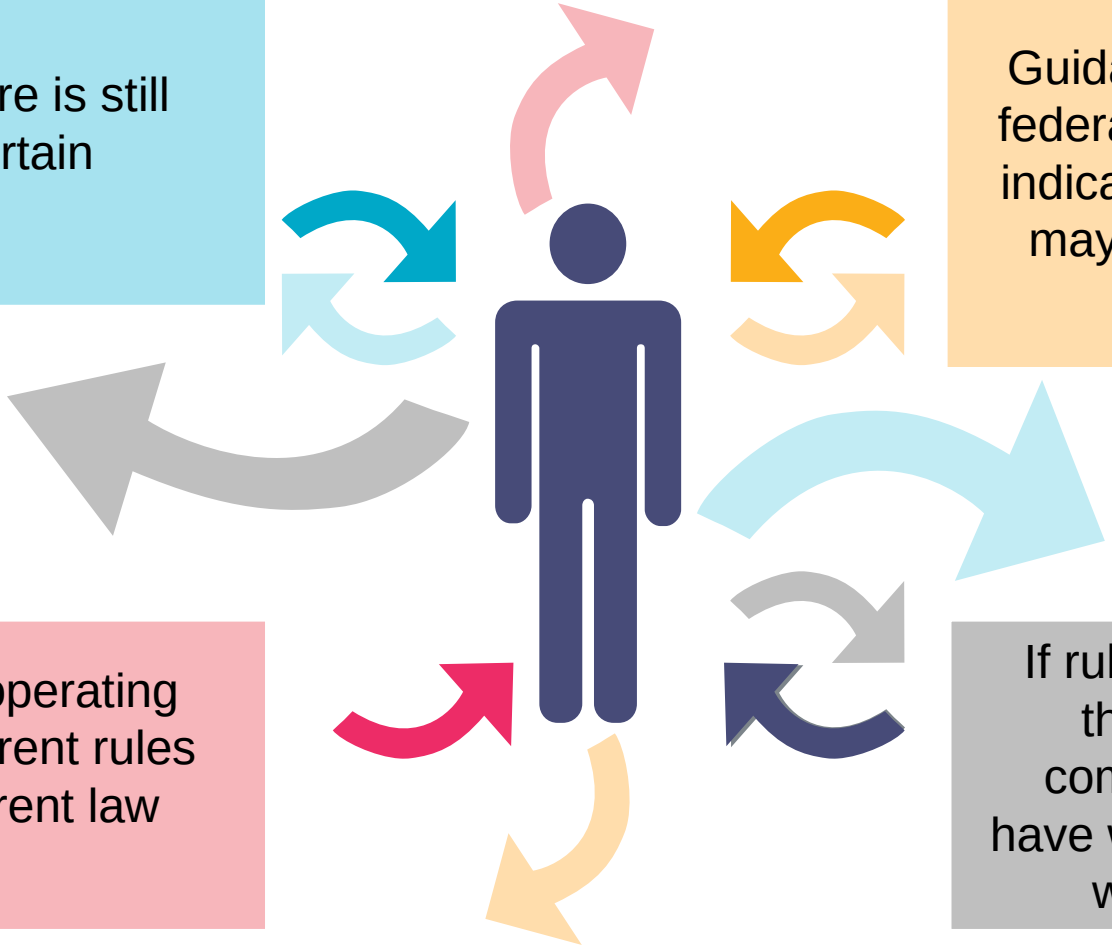
Federal Medicaid Changes

The future is still uncertain

Guidance from the federal government indicated that there may be changes



We are operating under current rules and current law

If rules do change, there may be components that have worked well that we will keep

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New Mexico Medicaid Spending

- Total Medicaid spending is increasing, primarily due to enrollment growth.
- The FY18 general fund (GF) need for Medicaid is **$ 947.5 million**, an increase of **$32.9 million** from FY17. The Legislature has appropriated **$915.6 million**, resulting in a deficit of **$31.9 million** in FY 18.

($ in millions)	FY14 Actual	FY15 Projection	FY16 Projection*	FY17 Projection*	FY18 Projection*
Total Budget	$4,200.6	$5,162.3	$5,412.4	$5,570.4	$5,859.7
General Fund Need	$901.9	$894.1	$912.9	$914.6	$947.5

*Projection data as of January 2017. The projections include all push forward amounts between SFYs. FY16 general fund includes $18 million supplemental appropriation and general fund transfers from other divisions. These figures exclude Medicaid administration.

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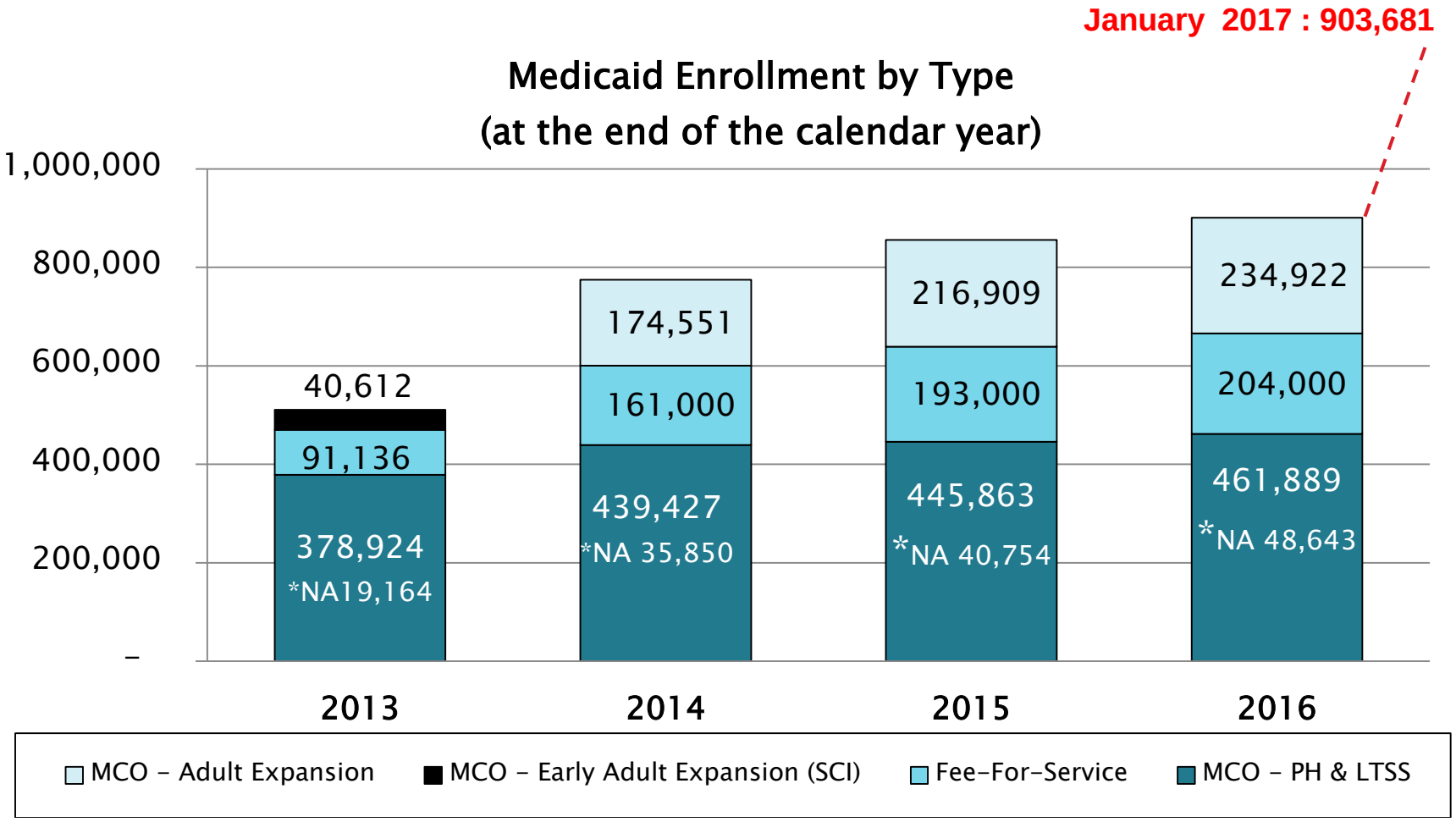
Key Driver of Costs



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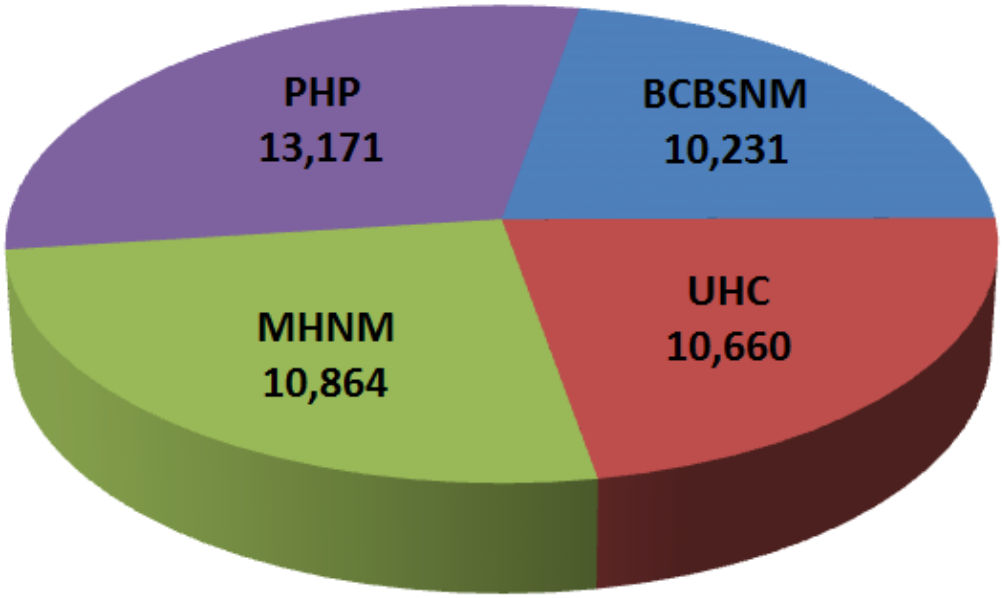
Native American Centennial Care Enrollment



Native American's in Fee for Service = 90,318 (67%)
Native American's in Managed Care = 44,926 (33%)
Total Native American's in Medicaid = 135,244

Source: Medicaid Eligibility Reports, June 1, 2017

HUMAN SERVICES DEPARTMENT

Managing Cost Growth

- Healthcare cost inflation grew an average of 2.6% in 2015 and growth averaged more than 3% in 2016
- Other national studies estimate medical cost inflation (price and utilization) at 6.5%

Centennial Care Stats

- Per capita medical services cost in Centennial Care **growing only 1.3%, driven primarily by pharmacy costs**
- Managing cost through care coordination and other efforts
- Increases in preventive services and decreases in inpatient hospital costs
- Per person costs are lower in Centennial Care

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Proposed Improvements and Reforms

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Vision for the future of Centennial Care

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Behavioral health integration
- Long-Term Services and Supports (LTSS)
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to benefits and eligibility

HUMAN SERVICES DEPARTMENT

Care Coordination

Goals

Better care coordination for members

Promote patient-centered, integrated care

Ensure right care, in the right setting

Accomplishments

950 care coordinators hired to help Members

300,000 Members served by Patient-Centered Medical Homes

Coordinated Medicare/Medicaid plans for LTSS members

Lowered inpatient costs

Reduction of non-emergent ER use

Focused on Super Utilizers

Health Homes serving Members with complex behavioral health needs

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Identified Opportunities

Opportunity #1: Increase care coordination at the provider level

- Transition care coordination functions from the health plans to providers ie. Tribal 638 Organizations
- Support approaches that increase use of community providers to conduct care coordination functions, such as Community Health Workers, Tribal organizations and Community Health Representatives (CHRs), school-based health centers and other community agencies

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Identified Opportunities

Opportunity #2: Improve transitions of care

- More help for Members during challenging care transitions:
  - Discharged from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement
- Potential changes include:
  - In-home assessments for Members who recently transitioned from a hospital or facility
  - Allow care coordination services to begin before release for Members leaving prison, jail, or juvenile detention facilities
  - Piloting wraparound services (intensive care coordination) for youth involved with the Children Youth and Families Department

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Opportunities

Opportunity #3: Expand programs working with high needs populations

- Collaborate with successful community programs such as: First Responders, wellness centers, personal care agencies and Project ECHO
- More use of Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists
- Promote use of Community Health Representatives with Tribal organizations
- Pilot a home visiting program that focuses on pre-natal care, post-partum care and early childhood services; and
- Leverage federal funding for supportive housing services

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Care Coordination

HUMAN SERVICES DEPARTMENT

Behavioral Health Integration

Goals

Promote integration of physical and behavioral health services

Expand access to care

Enhance Member engagement

Emphasize the use of technology

Accomplishments

Launched Health Home Model for Members with complex behavioral health needs

Increased number of FQHCs providing behavioral health services

Expanded access to methadone for substance use disorders

Increased tele-psychiatry services

Implemented Treat First model

Added new behavioral health services

HUMAN SERVICES DEPARTMENT

Behavioral Health Integration 2.0

Opportunities

Opportunity #1: Expanding Health Homes (CareLink NM)

- Expand Health Homes to additional providers in the state including Tribal 638 providers to provide intensive care coordination services through CareLink NM health homes for adults with Serious Mental Illness (SMI) or children with Severe Emotional Disturbance (SED)
- Currently, two Health Home sites provide comprehensive care coordination for members with complex behavioral health needs
- All of the care coordination is provided through a mental health provider who works closely with members' physical health providers

HUMAN SERVICES DEPARTMENT

Behavioral Health Integration 2.0

Opportunities

Opportunity #2: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Behavioral Health Integration

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports

Goals

Continue to serve more members in home and community settings

Ensure community benefit services are provided as authorized

Promote Member independence and satisfaction

Accomplishments

Increased access to home-and community-based services

1st in nation for spending 65% of LTSS dollars in the community

Implemented electronic visit verification system

Increased utilization of self-directed model

Implemented Independent Consumer Support System

Allowed more flexibility in use of personal care hours

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

Opportunity #1: Allow for one-time start-up goods for transitions when a member transitions from agency based to self directed

- Up to $2,000 may be added to the eligible member's annual budget to buy needed items (such as a computer and printer)

Opportunity #2: Additional caregiver respite

- Increase the current limit from 100 to 300 hours. This increase will provide eligible members with up to 30 days of respite per year

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

Opportunity #3: To continue to provide access to Community Benefit services for all eligible members meeting a NF LOC and establish some limits on costs for certain services

Self-Directed CB Service	Annual Limit
Related goods and services separate from one-time funding for start-up goods	$2,000
Non-medical transportation	$1,000
Specialized therapies such as acupuncture, chiropractic, or Native American healing	$2,000

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

Opportunity #4: Implement an automatic NF LOC approval for members whose condition is not expected to change

- MCOs would still be required to complete an annual plan of care

Opportunity #5: Partnership with nursing facilities and Project ECHO for consultation services to nursing home staff to better manage members with complex behavioral health needs

Opportunity #6: HSD will work with Tribal providers to develop their capacity to enroll as Long Term Services and Supports providers for Agency Based Community Benefits

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Long-Term Services and Supports

HUMAN SERVICES DEPARTMENT

Payment Reform

Goals

Pay for value and quality

Reward care that keeps members healthy or reduces disease

Manage costs to ensure sustainability of program

Accomplishments

Providers partnering with payers to achieve improved healthcare outcomes

16% of provider payments in value-based arrangements in 2017

Reduced Uncompensated Care by 41% for NM hospitals

Implemented hospital quality initiatives as part of the Safety Net Care Pool

HUMAN SERVICES DEPARTMENT

Payment Reform 2.0

Opportunities

Opportunity #1: Pay for better quality and value by increasing percentage of payments that are risk-based

- Expand requirements for MCOs to shift provider payments from fee per service to paying for quality and improved outcomes.
  - Improve provider readiness
  - Identify models for behavioral health, LTSS providers and smaller volume providers
  - Reduce administrative burden and improve data sharing

HUMAN SERVICES DEPARTMENT

Payment Reform 2.0

Opportunities

Opportunity #2: Use Value Based Purchasing (VBP) to drive program goals, such as: Increase care coordination at provider level, including the use of CHRs for care coordination; improve transitions of care; increase physical and behavioral health integration; and improve member engagement

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Payment Reform

HUMAN SERVICES DEPARTMENT

Member Engagement & Personal Responsibility

Goals

Engage and empower members to participate in their care

Enhance Members' ability to make informed decisions about their care

Reward healthy choices

Accomplishments

70% of Members participated in rewards program

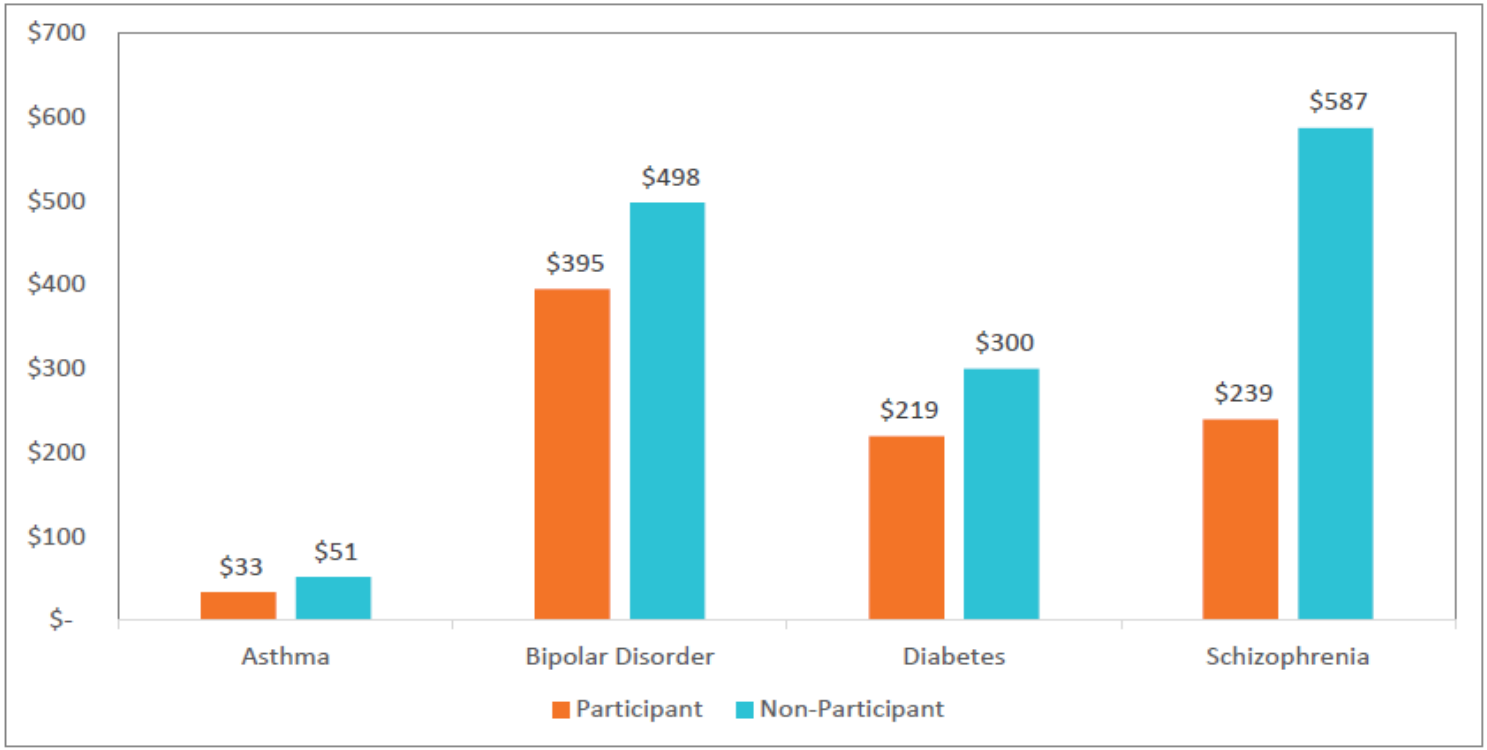
Among Members using rewards program, improved quality measures, health outcomes and lower costs

MCOs required to have disease management programs, Native American member advisory boards, Ombudsman programs and Native American liaisons

HUMAN SERVICES DEPARTMENT

Centennial Rewards

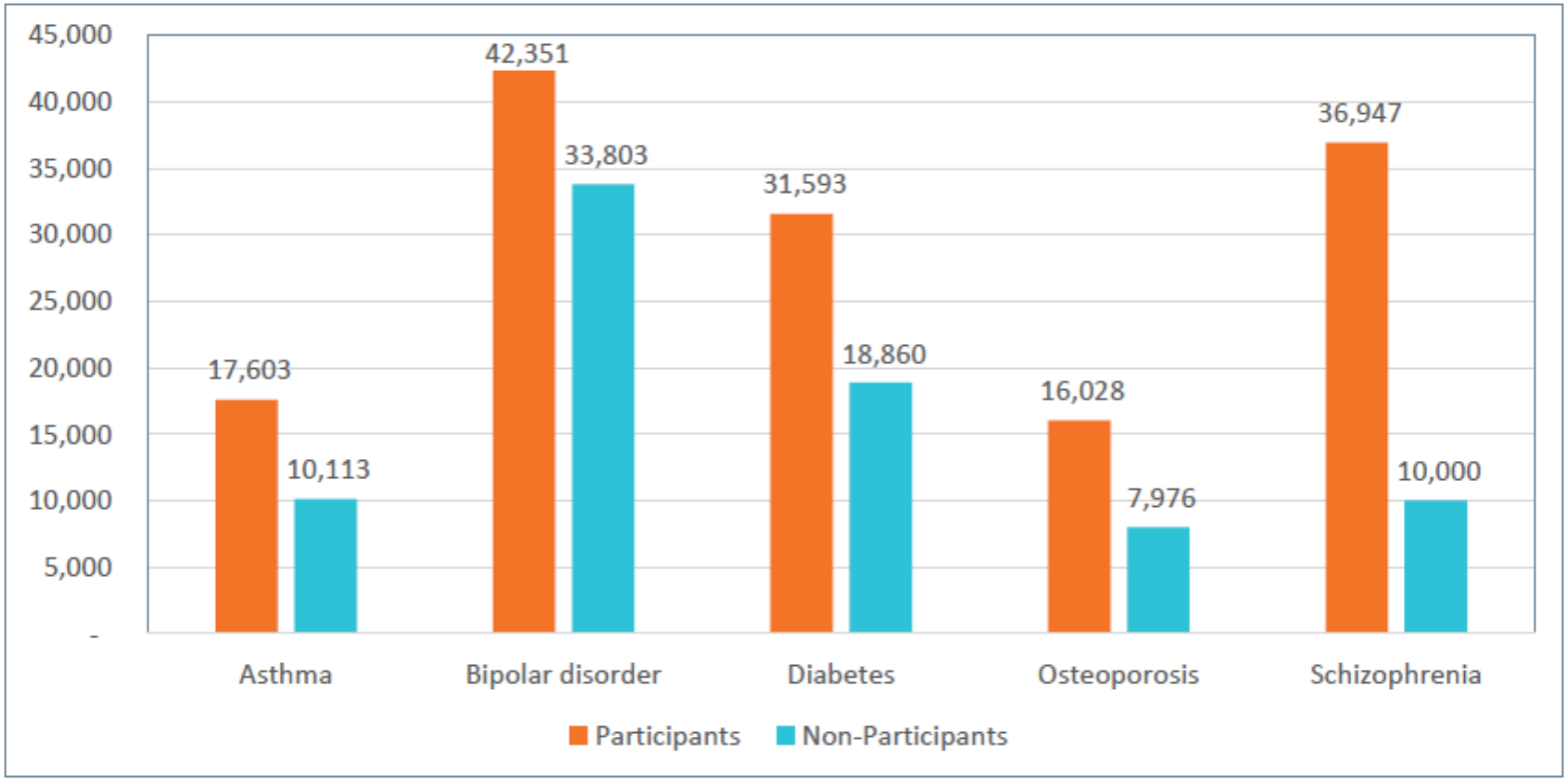
Table 1: Reduced Costs Across Conditions



HUMAN SERVICES DEPARTMENT

Centennial Rewards

Table 2: Prescription Drug Refill Rates



HUMAN SERVICES DEPARTMENT

Member Engagement and Personal Responsibility 2.0

Opportunities

Opportunity #1: Advance the Centennial Rewards Program

- Lower age to participate to 15 years old so that teens can earn rewards and bonuses
- Add mobile application technology

Opportunity #2: Allow providers to charge small fees for three or more missed appointments

- Nominal fee for missed appointments

HUMAN SERVICES DEPARTMENT

Member Engagement and Personal Responsibility 2.0

Opportunities

Opportunity #3: HSD is interested in receiving proposals from a Tribal entity partnering with a MCO to deliver Centennial Care services to Native American members, ie., Native American Managed Care Organization

- HSD is releasing an RFP 09/01/2017 to reprocure Centennial Care MCOs to provide the next iteration of Centennial Care beginning on January 1, 2019

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Member Engagement and Personal Responsibility

HUMAN SERVICES DEPARTMENT

Administrative Simplification

Goals	Accomplishments
Consolidate waiver programs to improve efficiency Reduce number of MCOs and cover full spectrum of benefits under single MCO Prepare for expanded enrollment	Consolidated nine separate federal waivers into one 1115 waiver Single MCO provides an integrated care model for all of its members Covered more individuals through expansion Established the Native American Technical Advisory Committee (NATAC)

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #1: Cover most adults under one comprehensive benefit plan

- Today, HSD administers 2 different benefit packages for most adults in Medicaid—Parent/Caretaker category and Expansion Adult category
- HSD proposes to consolidate the 2 different plans under a single, comprehensive benefit package that more closely aligns with private insurance coverage
- Individuals who are determined "medically frail" may receive the standard Medicaid benefit package, which is a process that exists today

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #2: Develop buy-in premiums for dental and vision services for adults

- If HSD needs to eliminate optional dental and/or vision services for adults to contain costs, then it proposes to offer dental and vision riders that members may purchase from the MCOs as is standard practice with most private insurance coverage

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #3: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Populations covered in FFS would be exempt from this change
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #4: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that put them over the eligibility guidelines

- Since the ACA, this program has become less needed as evidenced by declining enrollment; most individuals with increased earnings move to the Adult Group.
- In 2013: 26,000 individuals in this category

  Today: fewer than 2,000 individuals
- Individuals with income above the Adult Group guidelines can receive subsidies to purchase coverage through the Exchange

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #5: More frequent checks of income through trusted data sources

- This was not intended to result in more frequent recertification of eligibility but only to check trusted data sources more regularly to verify income
- HSD has received numerous concerns associated with this proposed change and is no longer considering it for inclusion in the waiver renewal going forward

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Administrative Simplification

HUMAN SERVICES DEPARTMENT

Public Comment

Share your comments

If you are unable to make your comment today, please submit your note cards or send via email HSD-PublicComment@state.nm.us or on the website http://www.hsd.state.nm.us/centennial-care-2-0.aspx .

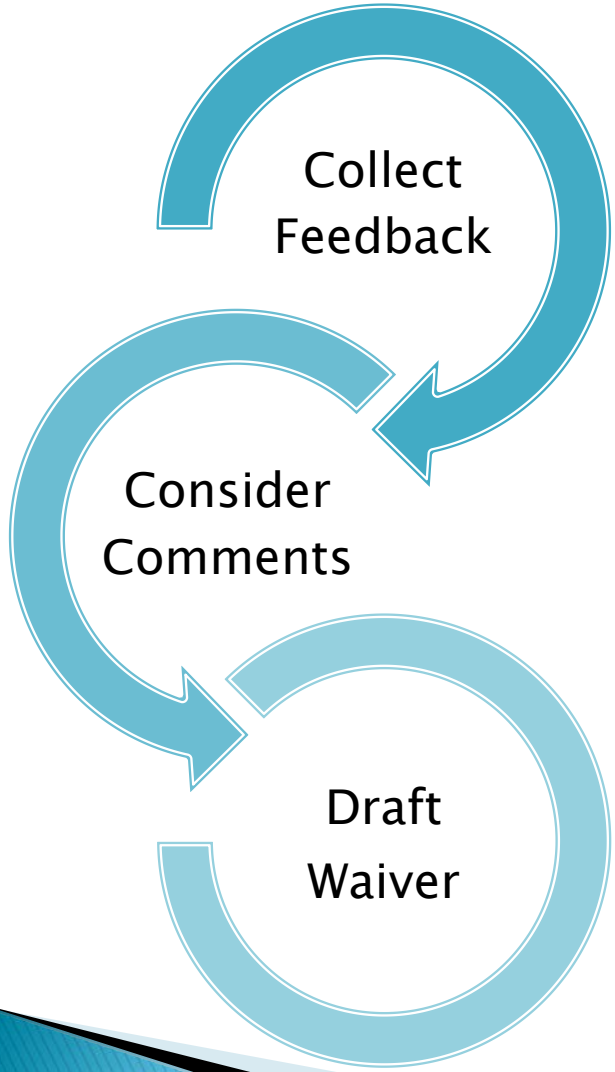
Limited time for Comments

1115 Waiver Renewal Application will be drafted this summer.

Share your comments by Saturday, July 15, 2017

HUMAN SERVICES DEPARTMENT

Next Steps



We are recording your comments today and will take additional written comments through our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Additional opportunities will be available to help shape Centennial Care after the Waiver Application is submitted and posted.

HUMAN SERVICES DEPARTMENT

THANK YOU

Your time and input are valuable

HUMAN SERVICES DEPARTMENT

Public Notice

1. HSD website

Public Information and Communications Overview

Opportunity for Public Comment

Bench Warrant Program

Centennial Care 2.0 (PROPOSED)

Centennial Care 2.0

2017 Centennial Care 2.0 MCO RFP & Procurement Library

2017-2018 Centennial Care 2.0 Procurement Schedule

Centennial Care (CURRENT)

HSD Presentations

IPRA Requests

Legislative Session

Medicaid Eligibility Reports

Newsroom

Monthly Statistical Reports

Waiver Documents

Centennial Care 2.0

Request for Comments

The Human Services Department, Medical Assistance Division (MAD), is accepting comments from the public about the Medicaid health care program known as Centennial Care and changes to the program being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. Comments will be accepted until **5:00 pm MST on Monday, November 6, 2017.** Read below to learn more about the Centennial Care waiver renewal.

The Department will hold four public hearings in different regions of the state to receive comments about the draft waiver. Please see below for the locations and times of the hearings.

To submit a comment electronically, you may complete the online form at the bottom of this page or email your comments directly to MAD at HSD-PublicComment@state.nm.us.

To submit a comment by phone, please call: (505) 827-1337

To submit a comment by mail, please send to:
Human Services Department
ATTN: HSD Public Comments
PO Box 2348
Santa Fe, NM 87504-2348

The Department has held a series of Public Hearings. The final hearing will be held in Albuquerque on October 30, 2017. The meeting will have a phone line available for any member of the public to join the public hearing or provide comments by phone. The event location and call in information is as follows.

Albuquerque – Monday, October 30, 2017
National Hispanic Cultural Center
Bank of America Theatre
1701 4th Street SW
Albuquerque, NM
5:30 pm – 7:30 pm

Call-in Information: Toll Free **1-888-757-2790**, enter participant code **991 379#**
If you have connection issues or problems joining the conference line, please call or text 505-570-7268, or email Katherine.Slater-Huff@state.nm.us

Public Hearing Presentation

Previous Public Hearings

Las Cruces – Thursday, October 12, 2017

Farm and Ranch Museum
4100 Dripping Springs Road
Las Cruces, NM
1:30 pm – 3:30 pm

Santa Fe – Monday, October 16, 2017
Medicaid Advisory Committee Meeting
NM State Library
1209 Camino Carlos Rey
Santa Fe, NM

1-4pm

Las Vegas – Wednesday, October 18, 2017
Highlands University - Student Union Building/Student Center
800 National Avenue
Las Vegas, NM
1:30 pm – 3:30 pm
A phone line will be available for the Las Vegas event on October 18 for call-in participants to listen to or provide comments via telephone.
Call (toll-free) 1-888-850-4523; participant code: 323 675#

There will also be a formal Tribal consultation conducted on Friday, October 20, 2017 at the Institute of American Indian Arts in Santa Fe at 9am. All comments will be reviewed and evaluated to inform additional modifications prior to submission of the final application to CMS.

About Centennial Care 2.0

The New Mexico Human Services Department (HSD) is looking at improvements to the Centennial Care (NM Medicaid managed care) program that can be implemented in the "second generation" of that program, which we call "Centennial Care 2.0". Those changes will be proposed with the input from – and following a thorough review by -- stakeholders throughout New Mexico, and they must be approved through a waiver issued by the federal government (CMS).

HSD has released its draft Section 1115 Demonstration Waiver renewal application for Centennial Care 2.0. The draft application outlines how the Department will modify and improve the program for its next iteration that begins in January 2019. The draft application can be reviewed at this link. **1115 Waiver Renewal - Draft Application** (revised October 6, 2017)

The public will have several opportunities to provide feedback to the Department about the changes outlined in the draft application during four public hearings in October 2017. After the hearings, the Department will develop its final waiver renewal application for submission to CMS in November 2017. CMS requires states to submit 1115 waiver applications at least one year in advance to allow for sufficient time to negotiate the final terms of the waiver.

The state released a revised draft waiver application on October 6, 2017. A summary of revisions can be found below.

Draft Waiver Application Summary of Revisions – October 6, 2017

(Original Draft Released on September 5, 2017)

Section and Page Number	Summary of Revision
Cover page	1.Revised the date from "September 5, 2017" to "Revised October 6, 2017."
Member Engagement and Cost Sharing Proposal #2: Implement premiums for populations with income that exceeds 100% FPL • Original Application Pages 29-30 • Revised Application Page 29-30	1.After receiving feedback from public that the premium enforcement policy was too vague, HSD revised the language below Table 3 to include additional detail about the premium policy and its enforcement.
Member Engagement Proposal #6: Expand opportunities for Native Americans enrolled in Centennial Care • Original Application Pages 31-32 • Revised Application Page 32-33	1.After receiving public feedback that the section about collaboration with the Navajo Nation did not provide sufficient detail, HSD revised the language to allow additional collaborations and clarify other requirements related to Indian Managed Care Entities.

Section and Page Number	Summary of Revision
Benefits and Eligibility Proposal #1: Redesign the Alternative Benefit Plan and provide a uniform benefit package for most Medicaid-covered Adults • Original Application Pages 32-33 • Revised Application Page 33-34	1.HSD revised the language in the first bullet about redesigning the ABP to clarify that it will not eliminate non-emergency medical transportation for the adult package, but instead include option to leverage new service providers, such as ride sharing companies and new technologies, such as mobile applications.
Section 3: Waiver List • Original Application Pages 36-38 • Revised Application Page 37-40	1.HSD updated the waiver authority request language.
Table 6 – Renewal Timeline • Original Application Page 45 • Revised Application Page 47	1.HSD added the public meeting scheduled on October 30, 2017 in Albuquerque in the evening. 2.HSD revised the final waiver application submission date to November 30, 2017 to extend the public comment period and allow 30 days from posting the draft waiver application revisions.

I. Program Description, Goals, and Objectives

The Centennial Care waiver renewal provides opportunities for HSD to build upon the accomplishments achieved since implementation of Centennial Care. At the same time, HSD has identified opportunities for continued progress in transforming its Medicaid program into an integrated, person-centered, value-based delivery system. Based on feedback received over the past three years at the annual Centennial Care public forums and through recent input sessions with advocacy groups and stakeholders, HSD has identified key areas of refinement for Centennial Care 2.0.

The following list is a summary of program modifications for Centennial Care 2.0 that leverage successful elements of the existing program design, expand initiatives that directly benefit members, and ensure the financial viability and sustainability of the program over the long term:

- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continue to expand access to Long-Term Services and Supports (LTSS) and maintain the progress achieved in rebalancing efforts;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Build upon and incorporate policies that seek to enhance beneficiaries' ability to become more active, responsible and involved participants in their own health care, including the introduction of modest premiums for higher income populations; and

- Further simplify administrative complexities and implement refinements in program and benefit design, some of which will be achieved with the replacement of the Medicaid Management Information System, including advanced data analytics capability. (A summary of this project may be found HERE.

II. Proposed Health Care Delivery System and Eligibility Requirements, Benefit Coverage, and Cost-Sharing

A. **Delivery System & Eligibility Requirements**

Centennial Care provides a comprehensive benefit package to eligible populations through an integrated managed care model that includes a number of innovations. The following is a description of the current eligible populations and covered benefits:

Table 1: Eligibility Groups Covered in Centennial Care

Population Group	Populations
TANF and Related	Newborns, infants, and children Children's Health Insurance Program (CHIP) Foster children Adopted children Pregnant women Low-income parent(s)/caretaker(s) and families Breast and Cervical Cancer Refugees Transitional Medical Assistance
Supplemental Security Income (SSI) Medicaid	Aged, blind and disabled Working disabled
SSI Dual Eligible	Aged, blind and disabled Working disabled
Medicaid Expansion	Adults between 19-64 years-old up to 133% of Modified Adjusted Gross Income (MAGI)

The following populations are excluded from Centennial Care:

- Qualified Medicare Beneficiaries;
- Specified Low-Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency services;
- Program of All-Inclusive Care for the Elderly (PACE);
- Individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs);
- Medically Fragile 1915(c) waiver participants for Home- and Community-Based Services (HCBS);
- Developmentally Disabled 1915(c) waiver participants for HCBS; and
- Individuals eligible for family planning services only.

B. **Benefit Coverage**

Centennial Care provides a comprehensive package of services that includes behavioral health, physical health, and long-term care services and supports (LTSS). Members meeting a Nursing Facility Level of Care (NF LOC) are able to access LTSS through Community Benefit (CB) services (i.e., home- and community-based services) without a waiver slot. The CB is available through Agency-Based Community Benefit (ABCB) services (services provided by a provider agency) and Self-Directed

Community Benefit (SDCB) services (services that a participant can control and direct). Individuals under age 21 who are enrolled in Medicaid or the Children's Health Insurance Program (CHIP) receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Under Centennial Care today, most adults who are enrolled in the Medicaid Expansion category receive services under an Alternative Benefit Plan (ABP). The ABP is a comprehensive benefit package that covers all services that are defined under the Patient Protection and Affordable Care Act (ACA) as "essential health benefits", as well as adult dental services. Centennial Care 2.0 proposes to redesign the ABP into a single, comprehensive adult benefit package that would cover both the Medicaid Expansion Category as well as Medicaid adults in the Parent/Caretaker category. The state proposes adding a limited vision benefit to the ABP, and waiving EPSDT services for 19-20 year-olds who are covered under the Adult Expansion or Parent/Caretaker categories. Adults who are considered "medically frail" are exempt from the ABP and may receive the standard Medicaid benefit package, including access to CB services and nursing facility care for individuals who meet the NF LOC criteria.

As outlined in the draft waiver application, the state has proposed some additional refinements to benefits and eligibility, including:

- Developing buy-in premiums (i.e., riders) for dental and vision services, if needed due to state financial constraints;
- Incorporating eligibility requirements of the Family Planning program into Centennial Care 2.0, so that it covers men and women through age 50 with no other health insurance (with certain exceptions);
- Eliminating the three-month retroactive eligibility period for most (non-SSI) Centennial Care members;
- Accelerating the transition off of Medicaid for individuals who are eligible for the Transitional Medical Assistance (TMA) program due to increased income;
- Addressing limitations imposed on the use of Institutions for Mental Disease (IMDs);
- Requesting federal financial participation to cover former foster care individuals up to age 26 who are former residents of other states;
- Piloting wrap-around services (intensive care coordination) for youth involved with the Children, Youth and Families Department (CYFD);
- Piloting a home visiting program that focuses on prenatal care, post-partum care and early childhood development in collaboration with CYFD and the New Mexico Department of Health;
- Securing enhanced administrative funding to expand the availability of Long-Acting Reversible Contraceptives (LARC) for certain providers;
- Expanding the health home model and developing peer-delivered, pre-tenancy and tenancy support housing services to individuals with complex behavioral health conditions;
- Continuing to provide access to Community Interveners for deaf and blind individuals;
- Continuing to allow all Medicaid-eligible members who meet a NF LOC to have access to home and community-based waiver services without the need for an allocation to the waiver;
- Implementing an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change;
- Increasing the limit of respite hours in the Community Benefit from 100 hours to 300 hours annually;
- Allowing for one-time start-up goods funding when a member transitions from the agency-based community benefit model to self-direction; and
- Establishing limits on costs for certain self-directed Community Benefit services:
    - Related Good & Services - $2,000 annual limit
    - Non-medical transportation - $1,000 annual limit
    - Specialized Therapies - $2,000 annual limit

C. Cost-Sharing

The Centennial Care 2.0 waiver renewal proposal includes new premiums (monthly payments) for higher income categories of Medicaid. Centennial Care 2.0 also refines co-payment responsibilities that are already in place for some categories of Medicaid, adds co-payments for higher-income individuals in the Adult Expansion Group, and adds new co-payments for individuals in most categories of Medicaid for non-emergency use of the hospital Emergency Department and non-

preferred prescription drugs. The charts below summarize the proposed cost-sharing under Centennial Care 2.0. Additional details may be found in the proposed waiver application.

Table 2: Proposed Premium Structure

Note: Native Americans exempt from premiums

FPL Range	Annual Household Income (Household of 1)	Aggregate Household Maximum – 5% of Income (Household of 1)	Applicable Category of Eligibility (COE)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
101-150% FPL	$12,060-$18,090	$600	• Other Adult Expansion Group (OAG) • Working Disabled Individuals (WDI) • Children's Health Insurance Program (CHIP)	$10	$20	$20	$40
151-200% FPL	$18,091-$24,120	$900	• WDI • CHIP • Transitional Medical Assistance (TMA)	$15	$30	$30	$60
201-150% FPL	$24,121-$30,150	$1,200	• WDI • CHIP • TMA	$20	$40	$40	$80
251-300% FPL	$30,151-$36,180	$1,500	• CHIP • TMA	$25	$50	$50	$100

Table 3: Proposed Co-Payment Structure

Note: Native Americans exempt from co-payments

	Children's Health Insurance Program (CHIP)	Working Disabled Individuals	Other Adult Expansion Group (OAG)	All Other Medicaid
	Age 0-5: 241-300% FPL	Up to 250% FPL	Co-pays apply if income is	

Population Characteristics & Eligibility	Age 6-18: 191-240% FPL		greater than 100% FPL	
Outpatient office visits (non-preventive) • Behavioral health exempt	$5/visit	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	$50/stay	$50/stay	$50/stay	No co-pay
Outpatient surgeries	$50/surgery	$50/surgery	$50/surgery	No co-pay
Prescription drugs, medical equipment, and supplies • Psychotropic Rx exempt • Family Planning Rx exempt • Not charged if non-preferred Rx co-pay is applied	$2/prescription	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic and Family Planning Rx exempt	$8/prescription All FPLs and Categories of Eligibility; certain exemptions will apply			
Non-emergency use of the hospital Emergency Department	$8/visit All FPLs and Categories of Eligibility; certain exemptions will apply			

III. Estimated Expected Increase or Decrease in Annual Aggregate Expenditures

The following projections utilize actual Centennial Care Demonstration Year 1-3 expenditures, aggregate per capita cost trend data, and enrollment trend data for the program, based on the populations expected to be enrolled in the Centennial Care 2.0 Demonstration.

Historical Enrollment and Expenditure Data					
	DY01 (1/1/2014 – 12/31/2014)	**DY02 (1/1/2015 – 12/31/2015)**	**DY03 (1/1/2016 – 12/31/2016)**	**DY04* (1/1/2017 – 12/31/2017)**	**DY05* (1/1/2018 – 12/31/2018)**
Members	7,360,554	8,162,036	8,660,504	8,946,301	9,241,529

Aggregate Expenditures	$4,007,889,032	$4,657,506,017	$4,571,113,953	$4,816,400,126	$5,074,848,193

**Estimated*

Centennial Care 2.0 - Demonstration Years (DY)					
	DY01 (1/1/2019 –12/31/2019)	**DY02 (1/1/2020 –12/31/2020)**	**DY03 (1/1/2021 –12/31/2021)**	**DY04 (1/1/2022 –12/31/2022)**	**DY05 (1/1/2023 –12/31/2023)**
Members	9,426,360	9,614,887	9,807,185	10,003,329	10,203,396
Aggregate Expenditures	$5,278,7691,600	$5,490,100,477	$5,707,781,670	$5,941,977,426	$6,183,257,976

IV. Hypothesis and Evaluation Parameters of the Demonstration

During Centennial Care 2.0, HSD will maintain the original hypotheses and evaluation design plan of Centennial Care, but will add new metrics in order to evaluate the impact of proposed policies and programs presented within this waiver renewal application. The table below describes these hypotheses and how HSD will evaluate the impact.

Table 4 – Quality Goals and Evaluation

	Hypothesis	**Methodology**	**Data Sources**
Goal 1: Improve Member outcomes with refinements to care coordination			
1.1	Enhancements to care coordination will result in decreases for avoidable emergency room visits and hospital readmissions.	Track and trend member utilization of avoidable emergency room visits and hospital readmissions and monitor MCO adherence to common chronic disease management and other social support services requirements for care coordination.	Claims data HEDIS reports MCO reporting
1.2	Birthing outcomes will improve with pregnant women participating in the home visiting pilot.	Track and trend low birthweight, pre-term birth, prenatal/post-partum visits and well child visits for members in pilot.	Claims data HEDIS reports MCO reporting
Goal 2: Increase Behavioral Health Integration			
2.1	Member's utilization of Health Homes will increase.	Track and trend the number of members participating in Health Homes.	Claims data MCO reporting
2.2	Treatment outcomes of members participating in Health Homes will improve.	Track and trend Health Homes' treatment outcomes of common behavioral/physical health conditions and care coordination outcomes such as avoidable emergency room visits, hospital readmissions and	Claims data HEDIS reports MCO reporting

	Hypothesis	Methodology	Data Sources
		follow up after hospitalization for mental illness.	
Goal 3: Expand member access to Long Term Services and Supports			
3.1	Allowing all Medicaid-eligible members who meet a nursing facility level of care to access the Community Benefit will maintain New Mexico's accomplishments in rebalancing efforts.	Track and trend members accessing community benefits.	Claims data
3.2	Increasing caregiver respite hours will improve member outcomes and utilization.	Track and trend member utilization and member outcomes.	Claims data HEDIS reports
3.3	Automatic Nursing Facility Level of Care (NFLOC) approvals will achieve administrative simplification for HSD, the MCOs and members.	Track and trend automatic NFLOC approvals.	MCO reporting
Goal 4: Increase quality of care with Value Based Payment (VBP) arrangements.			
4.1	Healthcare outcomes will improve for members served by providers that have VBP arrangements for the full delegation of care coordination.	Track and trend member utilization and common chronic disease management outcomes of providers with VBP arrangements that include full delegation of care coordination.	Claims data HEDIS reports MCO reporting
4.2	Implementing incremental minimum VBP requirements will support bending the cost curve of Medicaid program costs through alignment with Centennial Care 2.0 program goals of improving care coordination, focus on transitions of care.	Track and trend program expenditure.	Claims data HEDIS reports MCO reporting
Goal 5: Promoting Member Engagement and Responsibility			
5.1	Members participating in the Centennial Rewards program will continue to have improved healthcare outcomes with decreases in higher-cost services, such as inpatient stays.	Track and trend member utilization of preventive services and rewards credits.	Claims data HEDIS reports MCO/Reward Program Contractor reporting
5.2	Copayments for certain services will drive more appropriate use of services, such as reducing non-emergent use of the emergency department.	Track and trend member utilization of avoidable emergency room visits	Claims data MCO reporting

	Hypothesis	Methodology	Data Sources
5.3	Premiums will ensure member engagement and smooth the cost-sharing "cliff" between Medicaid and the commercial market.	Track and trend enrollment rates and rate of churn between Medicaid and commercial/private coverage	Enrollment data Premium collections da
Goal 6: Improve administrative effectiveness and simplicity.			
6.1	Engaging justice-involved members prior to release will improve their health outcomes and begin to reduce recidivism in time.	Track and trend health outcomes and recidivism rates for justice-involved members who are actively participating in the care coordination program.	Claims data MCO reporting HEDIS reports
6.2	Members will have increased access to inpatient services at an Institution for Mental Disease (IMD).	Track and trend member utilization of IMDs.	Claims data
Goal 7: Improve Delivery System and Access to Services			
7.1	Members will have increased access to CHWs and CHRs.	Track and trend member utilization.	MCO reporting
7.2	Members will have increased access to telehealth.	Track and trend member utilization.	Claims data
7.2	Members will have increased access to Patient Centers Medical Homes.	Track and trend member utilization.	MCO reporting

V. Waiver and Expenditure Authorities

A. Title XIX Waiver Requests

1.	**Reasonable Promptness**	**Section 1902(a)(8)**
Consistent with existing Home- and Community-Based Services (HCBS) waiver authority (Section 1915(c) of the Social Security Act), to the extent necessary to enable the State to establish enrollment targets for certain HCBS for those who are not otherwise eligible for Medicaid. The State will take into account current demand and utilization rates and will look to increase such enrollment targets in order to appropriately meet the long term care needs of the community. To the extent necessary to enable the State to begin benefit coverage on the first day of the first month following receipt of the required premium by the premium due date for individuals in a Medicaid category of eligibility that requires premiums. To the extent necessary to enable the State to prohibit reenrollment for 3 months for individuals who fail to pay required premiums.		
2.	**Amount, Duration and Scope of Services**	**Section 1902(a)(10)(B)** **42 CFR 400 Subpart B**
To the extent necessary to enable the State to permit managed care plans to offer different value added services or cost-effective alternative benefits to enrollees in Centennial Care.		

To the extent necessary to enable the State to offer certain HCBS and care coordination services to individuals who are Medicaid eligible and who meet nursing facility level of care.

To the extent necessary to allow the State to place expenditure boundaries on HCBS and personal care options.

To permit the State to serve adults in the Parent/Caretaker category under the same benefit package as Expansion adults using Secretary-approved ABP coverage.

3.	**Recipient Rewards**	**Section 1902(a)(10)(C)(i)**

To the extent necessary to enable the State to exclude funds provided through recipient reward programs from income and resource tests established under State and Federal law for purposes of establishing Medicaid eligibility.

4.	**Freedom of Choice**	**Section 1902(a)(23)** **42 CFR 431.51**

To enable the State to require participants to receive benefits through certain providers and to permit the State to require that individuals receive benefits through managed care providers who could not otherwise be required to enroll in managed care.

Moreover, all services will be provided through managed care including behavioral health, HCBS and institutional services, except for services received under the existing Developmental Disabilities 1915(c) waiver, Medically Fragile 1915(c) waiver, and the accompanying Mi Via Self-Directed 1915(c) waiver, individuals in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and individuals in the Program of All-Inclusive Care for the Elderly (PACE).

Consistent with the current demonstration, mandatory enrollment of American Indians/Alaska Natives is only permitted for receipt of LTSS.

5.	**Cost Sharing**	**Sections 1902(a)(14) and 1916** **42 CFR 447.51-447.56**

To permit the State to impose co-payments for non-emergency use of the emergency room and non-preferred prescription drugs for most categories and income levels; and to impose co-payments on certain populations with household incomes above 100% of the federal poverty level. Co-payments will not be imposed on individuals for whom Indian health care providers, as specified in section 1932(h) of the SSA, have the responsibility to treat.

To permit the State to impose an alternative tracking methodology for the aggregate limit on cost-sharing.

To permit Centennial Care providers to impose missed appointment fees on members.

6.	**Self-Direction of Care**	**Section 1902(a)(32)**

To permit persons receiving certain services to self-direct their care for such services.

7.	**Retroactive Eligibility**	**Section 1902(a)(34)** **42 CFR 435.914**
To enable the State, beginning on January 1, 2019, to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made for Medicaid for some eligibility groups.		
8.	**Transitional Medical Assistance (TMA)**	**Section 1902(e)**
To permit the state to waive participation in the TMA program for individuals who lose eligibility due to increased earnings.		
9.	**Long-Acting Reversible Contraception (LARC)**	
To permit the State to provide enhanced administrative funding for LARC to certain Medicaid providers.		
10.	**EPSDT for Adults (19-20 years old)**	**Section 1905(a)(4)(B)**
To permit the State to waive the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements for adults in the Expansion Adult and Parent/Caretaker categories who are 19–20 years-old.		
11.	**Premiums**	**Section 1902(a) (14), 1916, 1916A** **42 CFR 447.55, 42 CFR 447.56(f)**
To permit the State to impose premiums on certain populations. To permit the State to impose an alternative tracking methodology for the aggregate limit on premiums.		
12.	**Alternative Benefit Package**	**Section 1902(k)(1) and 1937(b)** **42 CFR 440.347**
To enable the State to not provide coverage for habilitative services to the new adult population.		
13.	**Nursing Facility Level of Care Redeterminations**	**Section 1902(a)(10)(A)(ii)(IV)** **42 CFR 441.302(c)(2)**
To enable to State to grant Members that meet specified criteria ongoing NF LOC determination.		

B. Expenditure Authority Requests

Under the authority of the Social Security Act (SSA), Section 1115(a)(2), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under Section 1903 shall, for the period of this demonstration, be regarded as expenditures under the Medicaid State Plan but are further limited by the special terms and conditions for the Section 1115 demonstration.

1. Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the SSA specified below. Managed care plans participating in the demonstration will have to meet all the requirements of Section 1903(m), except the following:
    - Section 1903(m)(2)(H) and Federal regulations at 42 CFR 438.56(g), but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90-days or less in the same managed care plan from which the individual was previously enrolled.
2. Expenditures for recipient reward programs.

3. To the extent necessary, expenditures for valued added services and/or cost-effective alternative services to the extent those services are provided in compliance with federal regulations and the 1115 demonstration.
4. Expenditures for direct payments made by the State to the Safety Net Care Pool (SNCP), where hospitals receive payments out of a pool.
5. Expenditures under contracts with managed care entities where either the State or the managed care entity will provide for payment for Indian health care providers as specified in Section 1932(h) of the SSA for covered services furnished to Centennial Care managed care plan recipients at the Office of Management and Budget (OMB) rates.
6. Expenditures for Centennial Care recipients who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under SSA Section 1902(a)(10)(A)(ii)(VI) and 42 CFR §435.217 in conjunction with SSA section 1902(a)(10)(A)(ii)(V), if the services they receive under Centennial Care were provided under an Home and Community-Based Services (HCBS) waiver granted to the State under SSA Section 1915(c) as of the initial approval date of this demonstration. This includes the application of spousal impoverishment eligibility rules.
7. Expenditures to provide HCBS not included in the Medicaid State Plan to individuals who are eligible for Medicaid.

Centennial Care 2.0 Concept Paper

Since October of 2016, the Department has been soliciting ideas and feedback from various stakeholders (and the public) to inform the changes it plans to implement. A pre-application Concept Paper was released in May 2017 and numerous public input sessions were held throughout the state in June 2017 to receive comments about the concepts presented in the paper. The Department incorporated feedback received into the development of the draft waiver application.

The pre-application Concept Paper and presentation for the Centennial Care 2.0 waiver renewal can be found here:

- **Centennial Care 2.0 Concept Paper**
- **Centennial Care 2.0 Presentation**
- **Centennial Care 2.0 Tribal Meeting Presentation**

Proposed changes in Centennial Care are explained in the concept paper, and they will be discussed further in public meetings around the state (see schedule below). Additionally, the public is welcome to submit comments to HSD using the link below.

Other documents related to the waiver renewal application development process for Centennial Care 2.0:

- MAC Subcommittee Member Recommendations
- NATAC Recommendations
- Public Comments from Subcommittee Process
- MMIS Replacement Project Overview

Schedule of past meetings related to the waiver application development process for Centennial Care 2.0:

Public Meetings *(Presentations and Public Comments):*

Centennial Care Waiver Renewal Concept Paper Presentation

- **Albuquerque: Wednesday, June 14, 2017,** 3:30 – 5:30 p.m.
  CNM Workforce Training Center (5600 Eagle Rock Ave. NE, Albuquerque, NM 87113)
  - Albuquerque Meeting Notes
- **Silver City: Monday, June 19, 2017,** 4:00 – 6:00 p.m.
  WNMU – GRC Auditorium (1000 W. College Ave., Silver City, NM 88061)
  - Silver City Meeting Notes
- **Farmington: Wednesday, June 21, 2017,** 4:30 – 6:30 p.m.
  Bonnie Dallas Senior Center (109 E. La Plata St., Farmington, NM 87401)
  - Farmington Meeting Notes
- **Roswell: Monday, June 26, 2017,** 4:30 – 6:30 p.m.
  Roswell Public Library (301 N. Pennsylvania Ave., Roswell, NM 88201)
  - Roswell Meeting Notes

Tribal Consultation:

Centennial Care Waiver Renewal Tribal Consultation Presentation

- **Albuquerque: Friday, June 23, 2017,** 9:00 a.m. – 12:00 p.m.
  Indian Pueblo Cultural Center (2401 12th Street NW, Albuquerque, NM 87104)
  - Tribal Consultation Meeting Notes

Meetings and documents related to the Centennial Care 2.0 waiver renewal application process:

February 10, 2017, 1115 Waiver Renewal Subcommittee

- Agenda
- Minutes
- Presentation
- Other Meeting Documents
- Recommendations
- NATAC Recommendations
- Public Comments

January 13, 2017, 1115 Waiver Renewal Subcommittee

- Agenda
- Presentation
- Minutes
- Value-Based Purchasing
- Member Engagement

December 16, 2016, 1115 Waiver Renewal Subcommittee

- Agenda
- Minutes
- Presentation
- Long-Term Care
- Behavioral Health Integration

November 14, 2016, 1115 Waiver Renewal Subcommittee

- Agenda
- Meeting Documents
- HCV Presentation
- Audio Recording
- Minutes / Español

October 14, 2016, 1115 Waiver Renewal Subcommittee

- Agenda
- Minutes
- Presentation
- Care Coordination Brief

Submit a comment:

HSD continues to welcome input from New Mexicans regarding the Centennial Care program. To submit a comment, please fill out the online form below. You may also email it directly to HSD-PublicComment@state.nm.us or send it by mail to:

Human Services Department
ATTN: HSD Public Comments
P.O. Box 2348
Santa Fe, NM 87504-2348

What are your ideas? Type here or upload a file using the button below.

	File Upload:	Upload a file
	Name:	
	Email:	
	Address 1:	
	Address 2:	
	City/Town:	
	Zip Code:	
*	State:	New Mexico

Submit

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OUR STRATEGIC GOALS:

Goal 2: Slow the Growth Rate of Health Care Costs and Improve Health Outcomes

HUMAN SERVICES DEPARTMENT

Designed and Developed by RealTimeSolutions

Public Notice

2. Public notice (abbreviated notice) in the state's newspaper

In October, 2017, HSD held a series of Public Hearings to record public comments on the Centennial Care waiver renewal. These sessions were held in four different locations in the state and were publicized via legal notice advertisements. A toll-free call in number was also available for participants for the Albuquerque event to listen to the proceedings and provide comments via phone.

Publication Name	**Publication Dates**	**Event City/Date**
Albuquerque Journal	September 6, 2017 September 27, 2017 October 22, 2017	Albuquerque/ October 30, 2017
Las Cruces Sun News	September 5, 2017 September 24, 2017	Las Cruces / October 12, 2017
Las Vegas Optic `	September 8, 2017 October 25, 2017 October 29, 2017	Las Vegas / October 18, 2017
Santa Fe New Mexican	September 5, 2017 October 22, 2017	Santa Fe / October 16, 2017

In addition to legal notices, all event dates were posted on the HSD web site. Hand-out cards with web site information were distributed at all events. The web site information included the on-line access to the full draft waiver application.

The call-in number for the Albuquerque event had the ability to host a maximum of 300 callers. During the course of the meeting, a total of 29 calls were received.

Public Notice

Print This Notice

Search in this notice, CTRL+F or APPLE+F

NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: Bernalillo
Printed In: Albuquerque Journal
Printed On: 2017/10/22

Return to Found List | New Search | Return To Current Search Criteria

Public Notice:

The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place: Albuquerque, NM: Monday, October 30, 2017, 5:30 p.m. â€" 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM) Participate in this Public Hearing Event By Phone: Monday, October 30, 2017, 5:30 p.m. â€" 7:30 p.m. A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. Call toll-free 1-888-757-2790 and enter participant code 991 379. If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slater-Huff@ state.nm.us The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252. Journal: October 22, 2017

Public Notice ID: 24405081

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Public Notice

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NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: Bernalillo
Printed In: Albuquerque Journal
Printed On: 2017/09/27

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Public Notice:

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place: Las Cruces, NM: Thursday, October 12, 2017, 1:30 p.m. â€" 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM). Santa Fe, NM: Monday, October 16, 2017, 1:00 p.m. â€" 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM). Las Vegas, NM: Wednesday, October 18, 2017, 1:30 p.m. â€" 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM). Albuquerque, NM: Monday, October 30, 2017, 5:30 p.m. â€" 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM) Participate in a Public Hearing Event By Phone: Wednesday, October 18, 2017, 1:30 p.m. â€" 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-888-850-4523 and enter participant code: 323675#. The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
Journal: September 27, 2017

Public Notice ID: 24364876

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Public Notice

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NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: Bernalillo
Printed In: Albuquerque Journal
Printed On: 2017/09/06

Public Notice:

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place: Las Cruces, NM: Thursday, October 12, 2017, 1:30 p.m. â€" 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM). Santa Fe, NM: Monday, October 16, 2017, 1:00 p.m. â€" 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM). Las Vegas, NM: Wednesday, October 18, 2017, 1:30 p.m. â€" 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM). Participate in a Public Hearing Event By Phone: Wednesday, October 18, 2017, 1:30 p.m. â€" 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-888-850-4523 and enter participant code: 323675#. The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252. Journal: September 6, 2017

Public Notice ID: 24328994

Public Notice

Print This Notice

Search in this notice, CTRL+F or APPLE+F

NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: Dona Ana
Printed In: Las Cruces Sun-News
Printed On: 2017/10/22

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Public Notice:

The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place:

Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in this Public Hearing Event By Phone:
Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m.
A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. **Call toll-free 1-888-757-2790 and enter participant code 991 379.**

If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slater-Huff @state.nm.us
The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
Pub#1217970
Run Date: Oct. 22, 2017

Public Notice ID: 24405055

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Public Notice

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NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: Dona Ana
Printed In: Las Cruces Sun-News
Printed On: 2017/09/24

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Public Notice:

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place:

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Las Vegas, NM:
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If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
Pub#1212933
Run Date: Sept. 24, 2017

Public Notice ID: 24359918

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Public Notice

County: Dona Ana
Printed In: Las Cruces Sun-News
Printed On: 2017/09/05

Public Notice:

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Pub#1209172
Run Date: Sept. 5, 2017

Public Notice ID: 24327017

Public Notice

County: San Miguel
Printed In: Las Vegas Optic
Printed On: 2017/10/29

Public Notice:

NOTICE
The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place:
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PUB: Las Vegas Optic, Oct 25, 29, 2017
#29856

Public Notice ID: 24414615

Public Notice

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NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: San Miguel
Printed In: Las Vegas Optic
Printed On: 2017/10/25

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Public Notice:

NOTICE
The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place:
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PUB: Las Vegas Optic, Oct 25, 29, 2017
#29856

Public Notice ID: 24407606

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Public Notice

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NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: San Miguel
Printed In: Las Vegas Optic
Printed On: 2017/09/08

Return to Found List | New Search | Return To Current Search Criteria

Public Notice:

PUBLIC HEARING
The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place:
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PUB: Las Vegas Optic, Sept 8, 2017
#29764

Public Notice ID: 24332720

Print This Notice

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www.lcsun-news.com

LAS CRUCES SUN-NEWS

PROOF OF PUBLICATION

I, being duly sworn, Rynni Henderson deposes and says that she is the President, a newspaper published daily in the county of Dona Ana, State of New Mexico; that the 1209172 is an exact duplicate of the notice that was published once a week/day in regular and entire issue of said newspaper and not in any supplement thereof for 1 consecutive week(s)/day(s), the first publication was in the issue dated September 5, 2017, the last publication was September 5, 2017. Despondent further states this newspaper is duly qualified to publish legal notice or advertisements within the meaning of Sec. Chapter 167, Laws of 1937.

Signed

President
Official Position

STATE OF NEW MEXICO
ss.
County of Dona Ana
Subscribed and sworn before me this
6th **day of** September 2017

Maria Isabel Del Villar
Notary Public in and for
Dona Ana County, New Mexico

September 16, 2020
My Term Expires

OFFICIAL SEAL
MARIA ISABEL DEL VILLAR
Notary Public
State of New Mexico
My Comm. Expires 9/16/20

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Pub#1209172
Run Date: Sept. 5, 2017

HUMAN SERVICES DEPARTMENT

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Journal: September 6, 2017

AFFIDAVIT OF PUBLICATION

STATE OF NEW MEXICO

County of Bernalillo SS

Anita L. Montoya, the undersigned, on oath states that she is an authorized Representative of The Albuquerque Journal, and that this newspaper is duly qualified to publish legal notices or advertisements within the meaning of Section 3, Chapter 167, Session Laws of 1937, and that payment therefore has been made of assessed as court cost; that the notice, copy of which hereto attached, was published in said paper in the regular daily edition, for 1 time(s) on the following date(s):

09/06/2017

Anita L. Montoya

Sworn and subscribed before me, a Notary Public, in and for the County of Bernalillo and State of New Mexico this 6 day of September of 2017

OFFICIAL SEAL
Sandra B. Gutierrez
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 2-18-21

Sandra B. Gutierrez

PRICE $49.44

Statement to come at the end of month.

ACCOUNT NUMBER 1009565

Legal
29764

AFFIDAVIT OF PUBLICATION

COUNTY OF SAN MIGUEL
STATE OF NEW MEXICO } ss.

Jason Brooks, being first duly sworn,
(publisher)

on oath states: that he is the General Manager of the Las Vegas Optic, a tri-weekly newspaper of general paid circulation and of general circulation in San Miguel County, New Mexico, entered under the second class postal privilege in said county, being the county in which the notice hereto attached is required to be published and said paper has been published in said San Miguel County continuously and uninterruptedly during a period of six months prior to the first issue thereof containing said notice. That the notice of which a copy as published is hereto attached and hereby made a part hereof was published in the English language in said newspaper once each week for ____ consecutive weeks on the following dates, to wit:

First Publication on the Sept day of Sept, 2017.

Second Publication on the ____ day of ____, 20____.

Third Publication on the ____ day of ____, 20____.

Fourth Publication on the ____ day of ____, 20____.

That such notice is a legal notice and was published in said newspaper duly qualified for that purpose within the meaning of the provisions of Chapter 167, session Laws of 1937, and that payment therefor has been made —assessed as Court costs.

Jason W. Brooks
General Manager Publisher

Subscribed and sworn to before me this 8th day of September 2017

Maria S. Sanchez
Notary Public

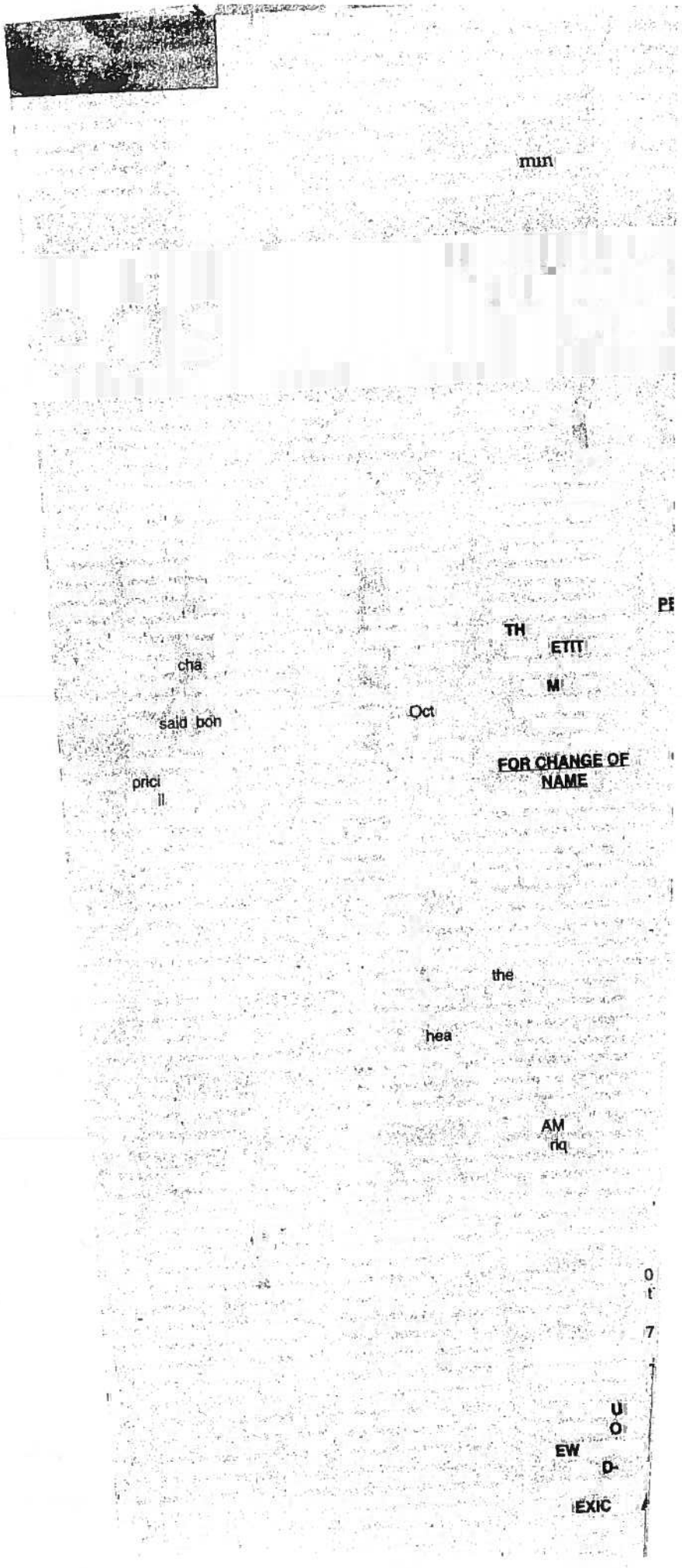
5/30/2021
Expires

SPC35432

Official Seal
MARIA S. SANCHEZ
Notary Public
State of New Mexico
My Commission Expires 5/30/21

PUBLISHER'S BILL

554
____ lines one time @ ____ $ 300
____ lines @ ____ $ 375
____ Tax ____ $ 7419.
Total ____
Received payment.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www.lcsun-news.com

LAS CRUCES SUN-NEWS

PROOF OF PUBLICATION

I, being duly sworn, Rynni Henderson deposes and says that she is the President, a newspaper published daily in the county of Dona Ana, State of New Mexico; that the 1212933 is an exact duplicate of the notice that was published once a week/day in regular and entire issue of said newspaper and not in any supplement thereof for 1 consecutive week(s)/day(s), the first publication was in the issue dated September 24, 2017, the last publication was September 24, 2017. Despondent further states this newspaper is duly qualified to publish legal notice or advertisements within the meaning of Sec. Chapter 167, Laws of 1937.

Signed

President
Official Position

STATE OF NEW MEXICO
ss.
County of Dona Ana
Subscribed and sworn before me this

27th **day of** September 2017

Maria Isabel Del Villar

Notary Public in and for
Dona Ana County, New Mexico

September 16, 2020
My Term Expires

OFFICIAL SEAL
MARIA ISABEL DEL VILLAR
Notary Public
State of New Mexico
My Comm. Expires 9/16/20

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place:

Las Cruces, NM:
Thursday, October 12, 2017, 1:30 p.m. - 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM).

Santa Fe, NM:
Monday, October 16, 2017, 1:00 p.m. - 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM).

Las Vegas, NM:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM).

Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in a Public Hearing Event By Phone:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-888-850-4523 and enter participant code: 323675#.

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
Pub#1212933
Run Date: Sept. 24, 2017

AFFIDAVIT OF PUBLICATION

STATE OF NEW MEXICO

County of Bernalillo SS

Bernadette Gonzales , the undersigned, on oath states that she is an authorized Representative of The Albuquerque Journal, and that this newspaper is duly qualified to publish legal notices or advertisements within the meaning of Section 3, Chapter 167, Session Laws of 1937, and that payment therefore has been made of assessed as court cost; that the notice, copy of which hereto attached, was published in said paper in the regular daily edition, for 1 time(s) on the following date(s):

09/27/2017

OFFICIAL SEAL
Sandra B. Gutierrez
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 2-18-21

Sworn and subscribed before me, a Notary Public, in and for the County of Bernalillo and State of New Mexico this 27 day of September of 2017

PRICE $54.86

Statement to come at the end of month.

ACCOUNT NUMBER 1009565

HUMAN SERVICES DEPARTMENT

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place:

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Las Vegas, NM:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM).

Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in a Public Hearing

Event By Phone:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m.: A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. **Call toll-free 1-888-850-4523 and enter participant code: 323675#.**

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

Journal: September 27, 2017

HUMAN SERVICES

The Human Services Department (Department) has filed an emergency rule in order to implement the Department of Health and Human Services (HHS) updates to the Federal Poverty Level (FPL) income guidelines for the Medical Assistance Program (MAP) Categories of eligibility to be effective September 14, 2017, as required by (HHS). The FPL is used in determining monthly income standards for MAP categories of eligibility and these FPL guidelines are contained in 8.200.520 NMAC and 8.291.430 NMAC. The Department is holding a public hearing on October 26, 2017 to receive testimony on the emergency rules of 8.200.520 NMAC and 8.291.430 NMAC and to receive written, recorded, or electronic comments.

Summary of Changes

- Sections 11 of 8.200.520 NMAC Medicaid Eligibility - Income Standards will be amended to reflect current FPL mandates.
- Section 10 of 8.291.430 NMAC Medicaid Eligibility - Affordable Care will be amended to reflect current FPL mandates.

A current recipient or new applicant's eligibility for a MAP category of eligibility may be affected based on updated income limits.

NM Stat Section 9-8-6 NMSA 1978 (2016) authorizes the Department Secretary to promulgate rules and regulations that may be necessary to carry out the duties of the Department and its divisions.

The register for these emergency amendments to these rules will be available September 14, 2017 on the HSD web site at http://www.hsd.state.nm.us/LookingForInformation/registers.aspx or at http://www.hsd.state.nm.us/public-notices-proposed-rule-and-waiver-changes-and-opportunities-to-comment.aspx

If you do not have internet access, a copy of the proposed rules may be requested by contacting MAD in Santa Fe at 505-827-6252.

A public hearing to receive testimony on these rules will be held in Hearing Room 1, Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, New Mexico, 87505 on Thursday, October 26, 2017 from 10 a.m to 11 a.m. Mountain Daylight Time (MDT).

Interested parties may submit written comments directly to: Human Services Department, Office of the Secretary, ATT: Medical Assistance Division Public Comments, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. Recorded comments may be left by calling (505) 827-1337. Electronic comments may be submitted to madrules@state.nm.us. Written, electronic and recorded comments will be given the same consideration as oral testimony made at the public hearing. All comments must be received no later than 5:00 p.m. MDT, October 26, 2017.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact MAD in Santa Fe at 505-827-6252. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the MAD upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

Journal: September 26, 2017

HUMAN SERVICES

The Human Services Department Medical Assistance Division (MAD) has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place.

Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre, (1701 4th Street SW, Albuquerque, NM)

Participate in this Public Hearing Event By Phone:
Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m.
A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. Call toll-free 1-888-757-2790 and enter participant code 991 379.

If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Staler-Hall@state.nm.us.

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

Journal: October 22, 2017

AFFIDAVIT OF PUBLICATION

STATE OF NEW MEXICO

County of Bernalillo SS

Bernadette Gonzales , the undersigned, on oath states that she is an authorized Representative of The Albuquerque Journal, and that this newspaper is duly qualified to publish legal notices or advertisements within the meaning of Section 3, Chapter 167, Session Laws of 1937, and that payment therefore has been made of assessed as court cost; that the notice, copy of which hereto attached, was published in said paper in the regular daily edition, for 1 time(s) on the following date(s):

10/22/2017

OFFICIAL SEAL
Sandra B. Gutierrez
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 2-18-21

Sandra B. Gutierrez

Sworn and subscribed before me, a Notary Public, in and for the County of Bernalillo and State of New Mexico this 22 day of October of 2017

PRICE $44.70

Statement to come at the end of month.

ACCOUNT NUMBER 1009565

SANTA FE NEW MEXICAN

Founded 1849

NM HSD MEDICAL ASSIST DIV COMM A
P O BOX 2348
SANTA FE, NM 87504-2348

ACCOUNT: 13964
AD NUMBER: 0000207828
LEGAL NO 83157 P.O. #: 63000-000003047

1 TIME(S)	95.76
AFFIDAVIT	10.00
TAX	8.79
TOTAL	114.55

AFFIDAVIT OF PUBLICATION

STATE OF NEW MEXICO
COUNTY OF SANTA FE

I, W. Barnard, being first duly sworn declare and say that I am Legal Advertising Representative of THE SANTA FE NEW MEXICAN, a daily newspaper published in the English language, and having a general circulation in the Counties of Santa Fe, Rio Arriba, San Miguel, and Los Alamos, State of New Mexico and being a newspaper duly qualified to publish legal notices and advertisements under the provisions of Chapter 167 on Session Laws of 1937; that the Legal No 83157 a copy of which is hereto attached was published in said newspaper 1 day(s) between 09/05/2017 and 09/05/2017 and that the notice was published in the newspaper proper and not in any supplement; the first date of publication being on the 5th day of September, 2017 and that the undersigned has personal knowledge of the matter and things set forth in this affidavit.

/S/_____
LEGAL ADVERTISEMENT REPRESENTATIVE

Subscried and sworn to before me on this 5th day of September, 2017

Notary Ofelia Martinez

Commission Expires: 10/25/20

OFFICIAL SEAL
OFELIA MARTINEZ
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 10/25/20

SANTA FE NEW MEXICAN
Founded 1849

LEGAL #83157

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public

Continued...

hearings will take place:

Las Cruces, NM:
Thursday, October 12, 2017, 1:30 p.m. – 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM).

Santa Fe, NM:
Monday, October 16, 2017, 1:00 p.m. – 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209

Continued...

Camino Carlos Rey, Santa Fe, NM).

Las Vegas, NM:
Wednesday, October 18, 2017, 1:30 p.m. – 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM).

Participate in a Public Hearing Event By Phone:
Wednesday, October 18, 2017, 1:30 p.m. – 3:30 p.m. A

Continued...

phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-888-850-4523 and enter participant code: 323675#.

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-

Continued...

care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

Published in the Santa Fe New Mexican on September 5, 2017.

SANTA FE NEW MEXICAN

Founded 1849

NM H S D POLICY AND PROGRAMS DE
2009 S PACHECO POLLON PLAZA
SANTA FE, NM 87504

ACCOUNT: 19247
AD NUMBER: 0000211895
LEGAL NO 83383 P.O. #: 63000-000003060

1 TIME(S)	85.68
AFFIDAVIT	20.00
TAX	7.95
TOTAL	103.63

AFFIDAVIT OF PUBLICATION

STATE OF NEW MEXICO
COUNTY OF SANTA FE

I, S. Jaramillo, being first duly sworn declare and say that I am Legal Advertising Representative of THE SANTA FE NEW MEXICAN, a daily newspaper published in the English language, and having a general circulation in the Counties of Santa Fe, Rio Arriba, San Miguel, and Los Alamos, State of New Mexico and being a newspaper duly qualified to publish legal notices and advertisements under the provisions of Chapter 167 on Session Laws of 1937; that the Legal No 83383 a copy of which is hereto attached was published in said newspaper 1 day(s) between 10/22/2017 and 10/22/2017 and that the notice was published in the newspaper proper and not in any supplement; the first date of publication being on the 22nd day of October, 2017 and that the undersigned has personal knowledge of the matter and things set forth in this affidavit.

/S/ S. Jaramillo
LEGAL ADVERTISEMENT REPRESENTATIVE

Subscried and sworn to before me on this 24th day of October, 2017

Notary Ofelia Martinez
Commission Expires: 10/25/20

OFFICIAL SEAL
OFELIA MARTINEZ
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 10/25/20

THE SANTA FE
NEW MEXICAN
Founded 1849

be effective on January 1, 2019. The last of these public hearings will take place:

Albuquerque, NM: Monday, October 30, 2017, 5:30 p.m. – 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in this Public Hearing Event By Phone: Monday, October 30, 2017, 5:30 p.m. – 7:30 p.m.
A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. **Call toll-free 1-888-757-2790 and enter participant code 991 379.**

If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slater-Huff@state.nm.us

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

Published in the Santa Fe New Mexican on October 22, 2017.

LEGAL #83383

The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will

Continued...

Legal
29856

AFFIDAVIT OF PUBLICATION

COUNTY OF SAN MIGUEL
STATE OF NEW MEXICO } ss.

Jason Brooks (publisher), being first duly sworn, on oath states: that he is the General Manager of the Las Vegas Optic, a tri-weekly newspaper of general paid circulation and of general circulation in San Miguel County, New Mexico, entered under the second class postal privilege in said county, being the county in which the notice hereto attached is required to be published and said paper has been published in said San Miguel County continuously and uninterruptedly during a period of six months prior to the first issue thereof containing said notice. That the notice of which a copy as published is hereto attached and hereby made a part hereof was published in the English language in said newspaper once each week for _____ consecutive weeks on the following dates, to wit:

First Publication on the Oct day of 25th, 20 17.
Second Publication on the Oct day of 26th, 20 17.
Third Publication on the _____ day of _____, 20 ___.
Fourth Publication on the _____ day of _____, 20 ___.

That such notice is a legal notice and was published in said newspaper duly qualified for that purpose within the meaning of the provisions of Chapter 167, session Laws of 1937, and that payment therefor has been made—assessed as Court costs.

General Manager _____ Publisher

Subscribed and sworn to before me this 30th day of October 2017

Maria Sanchez Notary Public

5/30/2021 Expires

Official Seal
MARIA S. SANCHEZ
Notary Public
State of New Mexico
My Commission Expires 5/30/21

SPC35432

PUBLISHER'S BILL

_____ lines one time @ _____ $ 58.48
_____ lines @ _____ $ 26.00
_____ Tax _____ $ 9.61
_____ Total _____ $ 12.409
Received payment.

ssified ad call: 505-42
nline, go to: www.publicnotice

p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM).
Participate in this Public Hearing Event By Phone:
Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m.
A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. Call toll-free 1-888-757-2790 and enter participant code 991 379.
If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slater-Huff@state.nm.us.
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PUB: Las Vegas Optic, Oct25, 29, 2017

tion date, judgment default will be entered against you.
DAVIS MILES GUIRE GARDNER PLLC
Kelley L. Thurston
Attorneys for Plaintiff
320 Gold Ave. SW, Suite 1111
Albuquerque, New Mexico 87102
Telephone No. 948-5050
kthurston@davismiles.com
PUB: Las Vegas Optic, Oct 29, 2017

Legal Notice
The Northeast Regional Education Cooperative Governing Board will meet on Wednesday, November 8, 2017 at 11:00 a.m. at Y3 Ranch, 1803 7th Street, Las Vegas, NM.
PUB: Las Vegas Optic, Oct 29, Nov 3, 5, 2017

Informal Request For Proposals
Presidential Search Firm/Consulting Services
Luna Community College invites proposals from firms or individuals capable of providing consulting services for the recruitment and selection process of the College's next President who will assume office on or about July 1, 2018.
The College will receive electronic proposals until 2:00 p.m. on November 10, 2017. Proposals must be submitted via e-mail to Ricky A. Serna, Interim President at rserna@luna.edu.
General Provisions

patio, landscaping grey-water, garage. $900/MO. 575-421-3487

3 bedroom, 2 bath. Contact Isabel 429-1737. $750 plus utilities

725 Manufactured Homes for Rent

2 br, 1 bath, mobile home, 429-7353/425-5340.

2 bed, 1 bath, Mobile Home for Rent. 429-2961

Clean 2 br, 1 ba, fenced & gated off-street parking $500/mo. $400/dep. 1988 Century Limited Buick. Reliable for Sale. 454-0607

#28647

NOTICE

The Human Services Department Medical Assistance Division (MAD) has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place:
Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. - 7:30

Public Notice

3. Proposal posting (abbreviated notice) via the State’s electronic mail lists

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

September 7, 2017

Dear Interested Parties:

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. **Comments will be accepted until 5:00pm MST on Wednesday, October 18, 2017.**

The public hearings will take place:

Las Cruces, NM:
Thursday, October 12, 2017, 1:30 p.m. – 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM).

Santa Fe, NM:
Monday, October 16, 2017, 1:00 p.m. – 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM).

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Wednesday, October 18, 2017, 1:30 p.m. – 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. **Call toll-free 1-888-850-4523 and enter participant code: 323675#.**

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. You may submit a comment by using the online form available through the website. You may also email comments directly to MAD at HSD-PublicComment@state.nm.us or mail your comments to:

Human Services Department
ATTN: HSD Public Comments
PO Box 2348
Santa Fe, NM 87504-2348

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

HUMAN SERVICES DEPARTMENT

October 6, 2017

Dear Interested Parties:

The Human Services Department, Medical Assistance Division (HSD/MAD) has issued a revised draft of the 1115 Centennial Care waiver application. The revised draft waiver application is posted on HSD's website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. A summary of HSD/MAD's proposed revisions can be found below.

Please note that the comment period has been extended until **5:00pm Mountain Time on Monday, November 6, 2017**. Comments may be submitted through HSD's website, by email to HSD-PublicComment@state.nm.us, or by postal mail to: Human Services Department, ATTN: HSD Public Comments, PO Box 2348, Santa Fe, NM 87504-2348.

Public hearing dates to receive comments about the draft waiver application have not changed and are posted on HSD's website.

Draft Waiver Application Summary of Revisions – October 6, 2017
(Original Draft Released on September 5, 2017)

Section and Page Number	Summary of Revision
Cover page	1. Revised the date from "September 5, 2017" to "Revised October 6, 2017."
Member Engagement and Cost Sharing Proposal #2: Implement premiums for populations with income that exceeds 100% FPL • Original Application Pages 29-30 • Revised Application Page 29-30	1. After receiving feedback from public that the premium enforcement policy was too vague, HSD revised the language below Table 3 to include additional detail about the premium policy and its enforcement.
Member Engagement Proposal #6: Expand opportunities for Native Americans enrolled in Centennial Care • Original Application Pages 31-32 • Revised Application Page 32-33	1. After receiving public feedback that the section about collaboration with the Navajo Nation did not provide sufficient detail, HSD revised the language to allow additional collaborations and clarify other requirements related to Indian Managed Care Entities.
Benefits and Eligibility Proposal #1: Redesign the Alternative Benefit Plan and provide a	1. HSD revised the language in the first bullet about redesigning the ABP to clarify that it will not eliminate non-emergency

Section and Page Number	Summary of Revision
uniform benefit package for most Medicaid-covered Adults • Original Application Pages 32-33 • Revised Application Page 33-34	medical transportation for the adult package, but instead include option to leverage new service providers, such as ride sharing companies and new technologies, such as mobile applications.
Section 3: Waiver List • Original Application Pages 36-38 • Revised Application Page 37-40	1. HSD updated the waiver authority request language.
Table 6 – Renewal Timeline • Original Application Page 45 • Revised Application Page 47	1. HSD added the public meeting scheduled on October 30, 2017 in Albuquerque in the evening. 2. HSD revised the final waiver application submission date to November 30, 2017 to extend the public comment period and allow 30 days from posting the draft waiver application revisions.

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place:

Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. – 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in this Public Hearing Event By Phone:
Monday, October 30, 2017, 5:30 p.m. – 7:30 p.m.
A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. **Call toll-free 1-888-757-2790 or 1-719-359-9722 and enter participant code 991 379.**

If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slater-Huff@state.nm.us

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

Public Hearings on the 1115 Waiver Application

1. Public Hearing Materials
    e. Las Cruces, October 12, 2017
    f. Santa Fe, October 16, 2017
    g. Las Vegas, October 18, 2017
    h. Albuquerque, October 30, 2017

HUMAN SERVICES
DEPARTMENT

Centennial Care 2.0
1115 Demonstration Waiver Renewal Application – Public Hearings
October 2017
Las Cruces, Las Vegas, Santa Fe, & Albuquerque

Formal Public Hearing

- The Department is accepting comments from the public about the Medicaid program known as Centennial Care and changes to the program being considered as part of the renewal of the Centennial Care federal 1115 waiver that will be effective on January 1, 2019.
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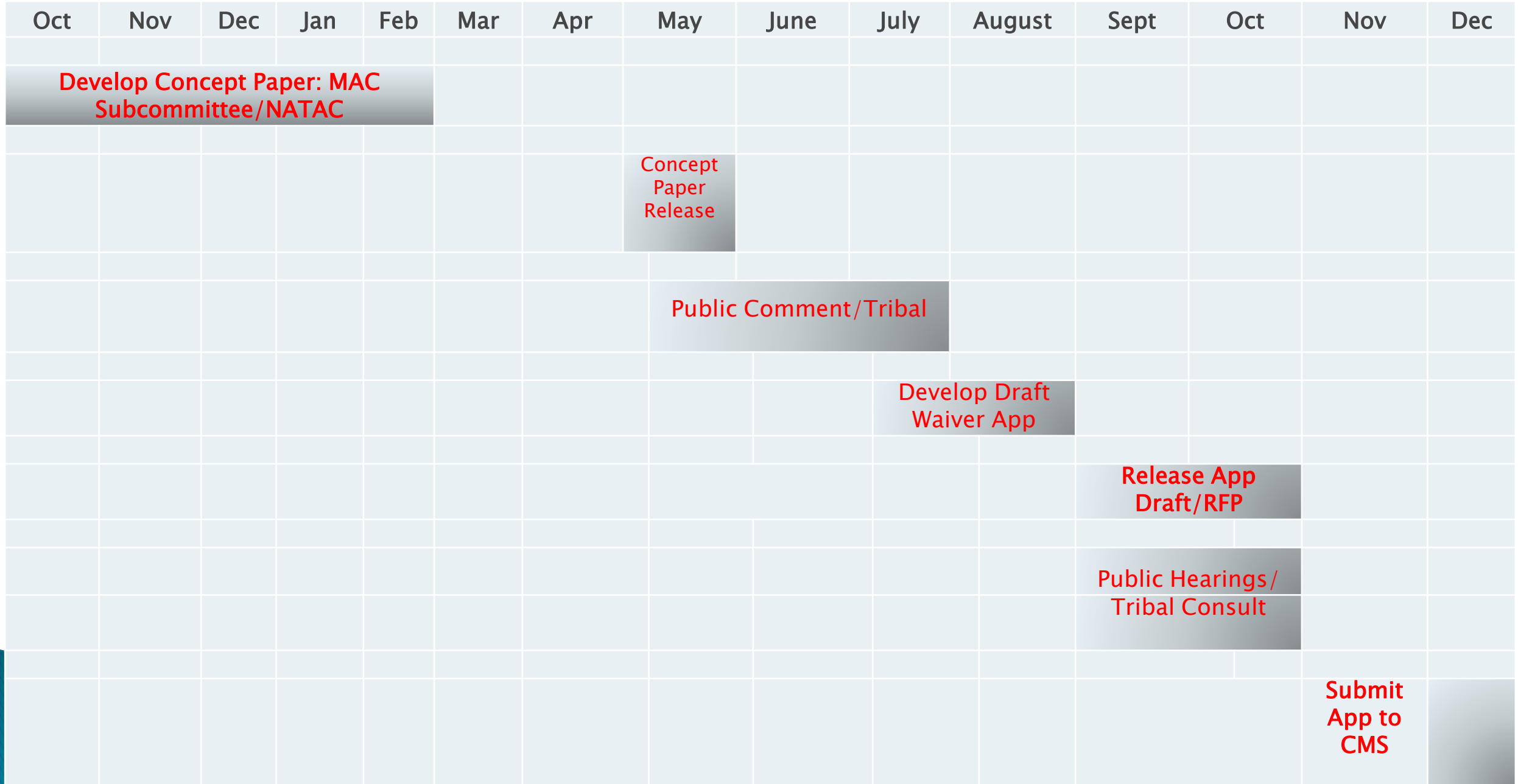

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Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

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- Care coordination
- Benefit and delivery system modifications
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to eligibility

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- Incrementally shift the funding ratio between the Uncompensated Care Pool and the Hospital Quality Improvement Incentive Pool so that more dollars are directed toward improved hospital quality initiatives
- Expand participation to all willing hospitals and allow other providers to participate, such as nursing facilities
- Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network

Member Engagement and Personal Responsibility

Proposals

#1: Advance the Centennial Rewards Program that rewards members for completing healthy activities, such as obtaining preventive screenings

#2: Implement premiums for populations with income that exceeds 100% of the Federal Poverty Level (FPL).

- Applies to three categories of eligibility:
  1) Adults in the Expansion with income greater than 100%
  2) CHIP program (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
  3) Working Disabled Individuals (WDI) Category (income extends to 250% FPL)
- Revised premium amounts to be lower in initial years (1% of household income) with flexibility to be higher in out-years (up to 2% of income)
- Included a household rate
- Annual maximum of 5% of household income

Proposed Premium Structure

Annual Household Income (Household of 1)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
$12,060 – $18,090	$10	$20	$20	$40
$18,091 – $24,120	$15	$30	$30	$60
$24,121 – $30,150	$20	$40	$40	$80
$30,151 – $36,180	$25	$50	$50	$100

Proposed Premium Policies

- The state seeks to develop premium enforcement policies based on its experience operating a premium-based program known as State Coverage Insurance
- Individuals in a category of eligibility that requires premiums must pay the monthly premium to maintain benefits
- Effective date of coverage is prospective—on the first day of the first month following receipt of the required premium
- Failure to pay the premium will result in a loss of benefits after a 90-day grace period
- Failure to pay will result in a 3 month lock out from the program
- Eligibility will be suspended rather than terminated
- Individuals may begin receiving services after the 3 month lock out upon receipt of required premiums

Member Engagement and Personal Responsibility

Proposals

#3: Require co-payments for certain populations

- Seeking to streamline copayments across populations
- HSD currently has copayment requirements for the Children's Health Insurance Program and for Working Disabled Individuals
- Add copayments for the adult expansion population with income greater than 100% FPL
- Most Centennial Care members will have copayments for non-preferred prescription drugs and for non-emergent use of the Emergency Department
- The following populations would be exempt from all copayments:
  - Native Americans
  - Intermediate Care Facility for Individuals with Intellectual Disabilities
  - QMB/SLIMB/QI1 individuals
  - Individuals on Family Planning only
  - Individuals in the Program of All Inclusive Care for the Elderly
  - Individuals on the Developmental Disabilities and Medically Fragile waivers
  - People receiving hospice care

Proposed Co-Payment Structure

	CHIP	WDI	Expansion Adults	All Other Medicaid
Population Characteristics and Service	Age 0-5: 241-300% FPL Age 6-18: 191-240% FPL	Up to 250% FPL	If income is greater than 100% FPL	
Outpatient office visits (non-preventive) • BH visits are exempt	$5/visit	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	$50/stay	$50/stay	$50/stay	No co-pay
Outpatient surgeries	$50/surgery	$50/surgery	$50/surgery	No co-pay
Prescription drugs, medical equipment and supplies • Psychotropic Rx- exempt • Family Planning Rx- exempt • Not charged if non-preferred drug co-pay is applied	$2/prescription	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic and Family Planning Rx exempt	$8/prescription All Categories of Eligibility; certain exemptions will apply			
Non-emergency ER visits	$8/visit All Categories of Eligibility; certain exemptions will apply			

Outpatient office visits – $5/visit	Exempt Services • Community benefits and waiver services • Family planning visits/procedures • Preventive visits (ie, Well Child and immunizations) • Preventive dental • BH outpatient • Maternity, prenatal, postnatal care • Diagnostic lab/x-ray • Treatment related to Diabetes
Inpatient hospital stays – $50/stay	Exempt Services • BH inpatient • NF stays • Labor and delivery; pregnancy-related care
Outpatient surgeries – $50/procedure	Exempt Services • Family planning procedures • Pregnancy-related care
Prescription drugs, medical equipment and supplies – $2/prescription	Exempt Items • Psychotropic drugs • Pregnancy-related drug items, including tobacco cessation and prenatal drug items • Family planning items/contraceptives • Not charged if non-preferred co-pay is applied
Non-preferred prescription drugs – $8/prescription	Exempt Items • Psychotropic drugs (legend drugs that are classified as psychotropic drugs to treat BH conditions) • Pregnancy-related/prenatal drug items • Family planning items/contraceptives • Drugs that are determined by the provider as medically necessary
Non-emergency use of the ER – $8/visit	Exempt Services • Emergency services

Member Engagement and Personal Responsibility

Proposals

#4: Modify tracking requirements for cost sharing

- Request authority to track the out-of-pocket maximum cost sharing amounts on an annual basis rather than quarterly or monthly
- Apply an annual out-of-pocket maximum based on four FPL tiers

#5: Allow providers to charge small fees for three or more missed appointments

#6: Expand opportunities for Native American members in Centennial Care

- Require MCOs to expand contractual or employment arrangements with Community Health Representatives throughout the state
- Work with Tribal providers to develop capacity to enroll as Long Term Services and Supports providers and/or health home providers
- Seek authority to collaborate with Indian Managed Care Entities (IMCE), including a pilot project with the Navajo Nation. An IMCE may operate in a defined geographic service area, but would be required to meet all other aspects of federal and state managed care requirements

Administration Simplification through Refinements to Eligibility

Proposals

#1: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services
- Does not include retroactive status changes processed by the Social Security Administration
- Native Americans and individuals residing in nursing facilities would be exempt from this provision

#2: Implement an automatic NF LOC re-approval for certain members whose condition is not expected to change

Administration Simplification through Refinements to Eligibility

Proposals

#3: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that result in ineligibility per income guidelines

- The individuals previously using the category are now either transitioned to the adult expansion category or are eligible to receive subsidies to purchase coverage through the federal Exchange
- Since the implementation of the Affordable Care Act, use of the category dropped from 26,000 individuals to 2,000 (most Parent/Caretaker individuals with increased earnings now covered under the Adult Expansion)

Administration Simplification through Refinements to Eligibility

Proposals

#4: Incorporate eligibility requirements of the Family Planning program

- Benefits are limited to reproductive health care, contraceptives and related services—not comprehensive coverage
- 6% of population on Family Planning utilize coverage today
- HSD proposes to better target this program by designing it for men and women who are through the age of 50 who do not have other insurance (with certain exceptions)

#5: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

Thank you for attending and participating in the public hearing process

We will now receive and record your feedback related to the information presented

Public Hearings on the 1115 Waiver Application

2. MAC Meeting — Santa Fe, October 16, 2017

MEDICAID ADVISORY COMMITTEE MEETING

Monday, October 16, 2017

AGENDA

Time: 1:00pm-4:00pm **Location**: Garrey Carruthers State Library, 1205 Camino Carlos Rey, Santa Fe 87507

MAC Chairperson: Larry Martinez, Presbyterian Medical Services
Committee Support Persons: Maria Roybal-Varela, HSD/MAD

Committee Members:

Sylvia Barela, Santa Fe Recovery Center
Michael Batte, Public Member
Natalyn Begay, Ohkay Owingeh
Jim Copland, NM Department of Health
Ramona Dillard, Pueblo of Laguna
Jeff Dye, NM Hospital Association
Mary Eden, Presbyterian Healthcare Services
Michael Hely, NM Legislative Council Service
Kristin Hendricks, Pediatric Dentist
Ruth Hoffman, Lutheran Advocacy Ministry NM
Jim Jackson, Disability Rights
Monique Jacobson, NM Children, Youth, and Families Department
Kim Jevertson, Public Member
KyKy Knowles, Aging & Long Term Services Department
Meggin Lorino, NM Association for Home and Hospice Care
Carol Luna-Anderson, The Life Link/Behavioral Health Planning Council
Richard Madden, NM Chapter of the American Academy of Family Physicians
Steve McKernan, UNM Hospital
Carolyn Montoya, UNM College of Nursing
Eileen Goode, NM Primary Care Association
Linda Sechovec, NM Health Care Association
Laurence Shandler, Pediatrician
Dale Tinker, NM Pharmacists Association
Gene Varela, AARP New Mexico

HSD Representatives:

Nancy Smith-Leslie, HSD/MAD Director
Angela Medrano, HSD/MAD Deputy Director
Jason Sanchez, HSD/MAD Deputy Director
Kari Armijo, HSD/MAD Deputy Director
Brent Earnest, HSD Secretary
Michael Nelson, HSD Deputy Secretary

DISCUSSION ITEM	DISCUSSION LEADER	DESCRIPTION	TIME
I. Introductions	Larry Martinez, MAC Chairperson	Introduction of all committee members, staff and guests	**1:00**
II. Approval of Agenda	Larry Martinez, MAC Chairperson	Approval of agenda	**1:05**
III. Approval of Minutes	Larry Martinez, MAC Chairperson	Committee approval of minutes from previous meetings held July 24, 2017	**1:10**
IV. Medicaid Budget Projections	Jason Sanchez, Deputy Director, Medical Assistance Division, Human Services Department	Updated budget projection presentation	**1:15**
V. Director's Update • 1115 Waiver Renewal Presentation	Nancy Smith-Leslie, Director Medical Assistance Division, Human Services Department	Update on Centennial Care program and 1115 Waiver Renewal Presentation	**1:45**
VI. Centennial Care 2.0 Public Hearing	Nancy Smith-Leslie, Director, Medical Assistance Division, Human Services Department	Opportunity for the public to comment on Centennial Care 2.0	**2:15**
VII. Adjournment	Larry Martinez, MAC Chairperson		**4:00**

HUMAN SERVICES
DEPARTMENT

Centennial Care 2.0
1115 Demonstration Waiver Renewal Application – Public Hearings
October 2017
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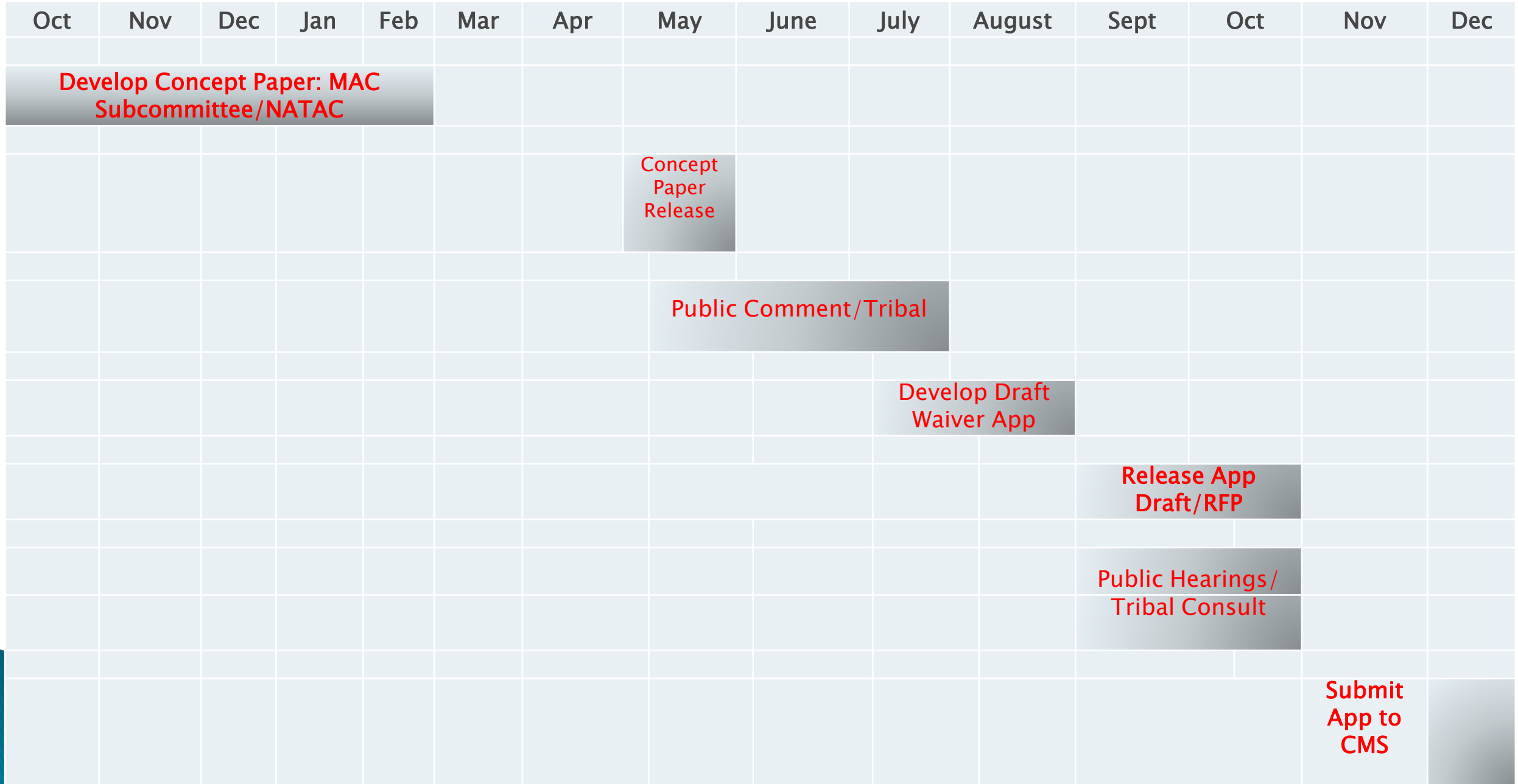

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#3: Advance Safety-Net Care Pool Initiatives

- Incrementally shift the funding ratio between the Uncompensated Care Pool and the Hospital Quality Improvement Incentive Pool so that more dollars are directed toward improved hospital quality initiatives
- Expand participation to all willing hospitals and allow other providers to participate, such as nursing facilities
- Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network

Member Engagement and Personal Responsibility

Proposals

#1: Advance the Centennial Rewards Program that rewards members for completing healthy activities, such as obtaining preventive screenings

#2: Implement premiums for populations with income that exceeds 100% of the Federal Poverty Level (FPL).

- Applies to three categories of eligibility:
  1) Adults in the Expansion with income greater than 100%
  2) CHIP program (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
  3) Working Disabled Individuals (WDI) Category (income extends to 250% FPL)
- Revised premium amounts to be lower in initial years (1% of household income) with flexibility to be higher in out-years (up to 2% of income)
- Included a household rate
- Annual maximum of 5% of household income

Proposed Premium Structure

Annual Household Income (Household of 1)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
$12,060 – $18,090	$10	$20	$20	$40
$18,091 – $24,120	$15	$30	$30	$60
$24,121 – $30,150	$20	$40	$40	$80
$30,151 – $36,180	$25	$50	$50	$100

Proposed Premium Policies

- The state seeks to develop premium enforcement policies based on its experience operating a premium-based program known as State Coverage Insurance
- Individuals in a category of eligibility that requires premiums must pay the monthly premium to maintain benefits
- Effective date of coverage is prospective—on the first day of the first month following receipt of the required premium
- Failure to pay the premium will result in a loss of benefits after a 90-day grace period
- Failure to pay will result in a 3 month lock out from the program
- Eligibility will be suspended rather than terminated
- Individuals may begin receiving services after the 3 month lock out upon receipt of required premiums

Member Engagement and Personal Responsibility

Proposals

#3: Require co-payments for certain populations

- Seeking to streamline copayments across populations
- HSD currently has copayment requirements for the Children's Health Insurance Program and for Working Disabled Individuals
- Add copayments for the adult expansion population with income greater than 100% FPL
- Most Centennial Care members will have copayments for non-preferred prescription drugs and for non-emergent use of the Emergency Department
- The following populations would be exempt from all copayments:
  - Native Americans
  - Intermediate Care Facility for Individuals with Intellectual Disabilities
  - QMB/SLIMB/QI1 individuals
  - Individuals on Family Planning only
  - Individuals in the Program of All Inclusive Care for the Elderly
  - Individuals on the Developmental Disabilities and Medically Fragile waivers
  - People receiving hospice care

Proposed Co-Payment Structure

	CHIP	WDI	Expansion Adults	All Other Medicaid
Population Characteristics and Service	Age 0-5: 241-300% FPL Age 6-18: 191-240% FPL	Up to 250% FPL	If income is greater than 100% FPL	
Outpatient office visits (non-preventive) • BH visits are exempt	$5/visit	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	$50/stay	$50/stay	$50/stay	No co-pay
Outpatient surgeries	$50/surgery	$50/surgery	$50/surgery	No co-pay
Prescription drugs, medical equipment and supplies • Psychotropic Rx- exempt • Family Planning Rx- exempt • Not charged if non-preferred drug co-pay is applied	$2/prescription	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic and Family Planning Rx exempt	$8/prescription All Categories of Eligibility; certain exemptions will apply			
Non-emergency ER visits	$8/visit All Categories of Eligibility; certain exemptions will apply			

Outpatient office visits – $5/visit	Exempt Services • Community benefits and waiver services • Family planning visits/procedures • Preventive visits (ie, Well Child and immunizations) • Preventive dental • BH outpatient • Maternity, prenatal, postnatal care • Diagnostic lab/x-ray • Treatment related to Diabetes
Inpatient hospital stays – $50/stay	Exempt Services • BH inpatient • NF stays • Labor and delivery; pregnancy-related care
Outpatient surgeries – $50/procedure	Exempt Services • Family planning procedures • Pregnancy-related care
Prescription drugs, medical equipment and supplies – $2/prescription	Exempt Items • Psychotropic drugs • Pregnancy-related drug items, including tobacco cessation and prenatal drug items • Family planning items/contraceptives • Not charged if non-preferred co-pay is applied
Non-preferred prescription drugs – $8/prescription	Exempt Items • Psychotropic drugs (legend drugs that are classified as psychotropic drugs to treat BH conditions) • Pregnancy-related/prenatal drug items • Family planning items/contraceptives • Drugs that are determined by the provider as medically necessary
Non-emergency use of the ER – $8/visit	Exempt Services • Emergency services

Member Engagement and Personal Responsibility

Proposals

#4: Modify tracking requirements for cost sharing

- Request authority to track the out-of-pocket maximum cost sharing amounts on an annual basis rather than quarterly or monthly
- Apply an annual out-of-pocket maximum based on four FPL tiers

#5: Allow providers to charge small fees for three or more missed appointments

#6: Expand opportunities for Native American members in Centennial Care

- Require MCOs to expand contractual or employment arrangements with Community Health Representatives throughout the state
- Work with Tribal providers to develop capacity to enroll as Long Term Services and Supports providers and/or health home providers
- Seek authority to collaborate with Indian Managed Care Entities (IMCE), including a pilot project with the Navajo Nation. An IMCE may operate in a defined geographic service area, but would be required to meet all other aspects of federal and state managed care requirements

Administration Simplification through Refinements to Eligibility

Proposals

#1: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services
- Does not include retroactive status changes processed by the Social Security Administration
- Native Americans and individuals residing in nursing facilities would be exempt from this provision

#2: Implement an automatic NF LOC re-approval for certain members whose condition is not expected to change

Administration Simplification through Refinements to Eligibility

Proposals

#3: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caretakers with increased earnings that result in ineligibility per income guidelines

- The individuals previously using the category are now either transitioned to the adult expansion category or are eligible to receive subsidies to purchase coverage through the federal Exchange
- Since the implementation of the Affordable Care Act, use of the category dropped from 26,000 individuals to 2,000 (most Parent/Caretaker individuals with increased earnings now covered under the Adult Expansion)

Administration Simplification through Refinements to Eligibility

Proposals

#4: Incorporate eligibility requirements of the Family Planning program

- Benefits are limited to reproductive health care, contraceptives and related services—not comprehensive coverage
- 6% of population on Family Planning utilize coverage today
- HSD proposes to better target this program by designing it for men and women who are through the age of 50 who do not have other insurance (with certain exceptions)

#5: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

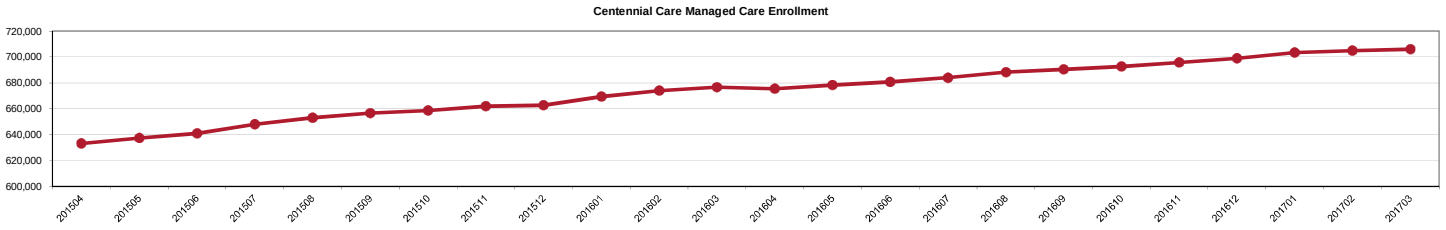
Thank you for attending and participating in the public hearing process

We will now receive and record your feedback related to the information presented

State of New Mexico - All MCOs
All Centennial Care Populations
Centennial Care Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Centennial Care Monthly Enrollment



2. Total Centennial Care Dollars and Member Months by Program

Aggregate Member Months by Program

Population	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	4,763,223	4,933,747	4%
Long Term Services and Supports	573,218	593,078	3%
Other Adult Group	2,535,904	2,771,677	9%
Total Member Months	**7,872,345**	**8,298,502**	**5%**

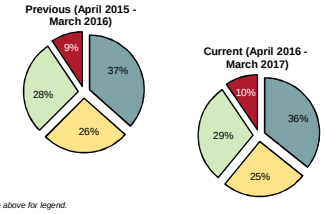
Aggregate Medical Costs by Program

Programs	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	$ 1,245,916,497	$ 1,268,160,787	2%
Long Term Services and Supports	$ 883,544,015	$ 892,892,521	1%
Other Adult Group Physical Health	$ 955,821,072	$ 1,047,329,283	10%
Behavioral Health - All Members	$ 319,652,064	$ 338,134,929	6%
Total Medical Costs	**$ 3,404,933,649**	**$ 3,546,517,520**	**4%**
Aggregate Non-Medical Costs			
Admin, care coordination, Centennial Rewards	$ 371,292,953	$ 352,538,974	-5%
NMMIP Assessment	$ 53,676,377	$ 61,941,886	15%
Premium Tax - Net of NIMMP Offset	$ 133,873,146	$ 142,126,353	6%
Total Non-Medical Costs	**$ 558,842,476**	**$ 556,607,214**	**0%**
Estimated Total Centennial Care Costs	**$ 3,963,776,125**	**$ 4,103,124,734**	**4%**

Per Capita Medical Costs by Program (PMPM)

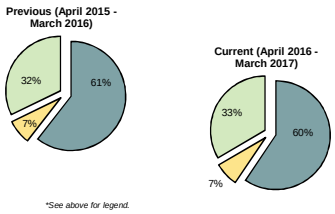
Programs	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	$ 261.57	$ 257.04	-2%
Long Term Services and Supports	$ 1,541.38	$ 1,505.52	-2%
Other Adult Group Physical Health	$ 376.92	$ 377.87	0%
Behavioral Health - All Members	$ 40.60	$ 40.75	0%
Total Medical Costs	**$ 432.52**	**$ 427.37**	**-1%**
Aggregate Non-Medical Costs			
Admin, care coordination, Centennial Rewards	$ 47.16	$ 42.48	-10%
NMMIP Assessment	$ 6.82	$ 7.46	9%
Premium Tax - Net of NIMMP Offset	$ 17.01	$ 17.13	1%
Total Non-Medical Costs	**$ 70.99**	**$ 67.07**	**-6%**
Estimated Total Centennial Care Costs	**$ 503.51**	**$ 494.44**	**-2%**

Centennial Care Medical



*See above for legend.

Centennial Care Member Months



*See above for legend.

3. Total Program Medical/Pharmacy Dollars

Aggregate Costs by Service Categories

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 3,051,771,754	$ 3,142,469,362	3%
Pharmacy	$ 353,161,894	$ 404,048,158	14%
Total	**$ 3,404,933,649**	**$ 3,546,517,520**	**4%**

Per Capita Medical Costs by Program (PMPM)

	Previous (12 mon)	Current (12 mon)	% Change
	$ 387.66	$ 378.68	-2%
	$ 44.86	$ 48.69	9%
	$ 432.52	**$ 427.37**	**-1%**

Aggregate Costs by Service Categories

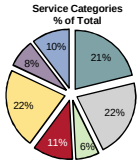
Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Acute Inpatient	$ 721,794,228	$ 746,641,122	3%
Acute Outp/Phy	$ 733,096,102	$ 753,649,351	3%
Nursing Facility	$ 218,561,107	$ 213,948,031	-2%
Community Benefit/PCO	$ 373,609,690	$ 382,695,362	2%
Other Services	$ 745,368,264	$ 771,981,507	4%
Behavioral Health	$ 259,342,364	$ 273,553,989	5%
Pharmacy (All)	$ 353,161,894	$ 404,048,158	14%
Total Costs	**$ 3,404,933,649**	**$ 3,546,517,520**	**4%**

Per Capita Medical Costs by Program (PMPM)

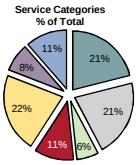
Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Acute Inpatient	$ 91.69	$ 89.97	-2%
Acute Outp/Phy	$ 93.12	$ 90.82	-2%
Nursing Facility	$ 27.76	$ 25.78	-7%
Community Benefit/PCO	$ 47.46	$ 46.12	-3%
Other Services	$ 94.68	$ 93.03	-2%
Behavioral Health	$ 32.94	$ 32.96	0%
Pharmacy (All)	$ 44.86	$ 48.69	9%
Total Costs	**$ 432.52**	**$ 427.37**	**-1%**

** Per capita not normalized for case mix changes between periods.*

Previous (12 mon) service distribution



Current (12 mon) service distribution



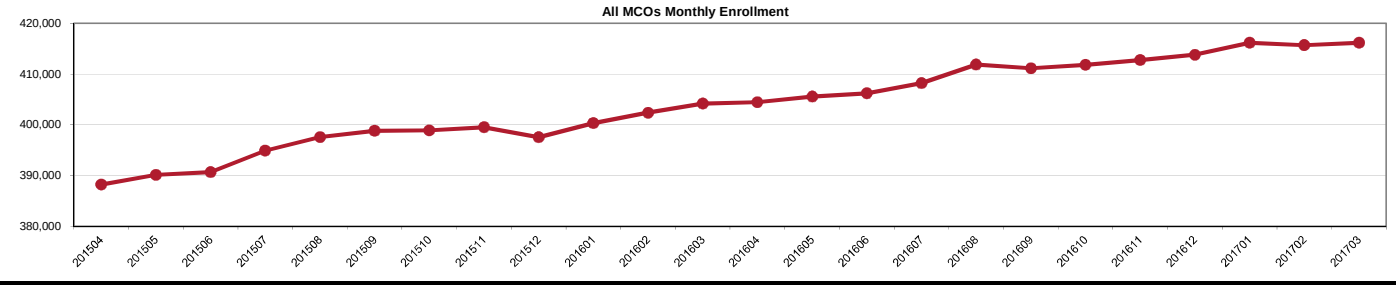
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.
2. Other Adult Group continues to see enrollment growth. Dollar comparisons between previous and current periods reflect this significant change in enrollment.
3. Other Services includes, but is not limited to, the following services emergency department utilization, emergent transportation, non-emergent transportation, vision, and dental.

State of New Mexico - All MCOs
Total Population (TANF, Aged, Blind, Disabled, CYFD, Pregnant Women)
Physical Health Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

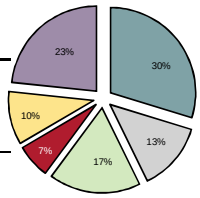
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,128,087,718	$ 1,139,903,833	1%
Pharmacy	$ 117,828,779	$ 128,256,954	9%
Total	**$ 1,245,916,497**	**$ 1,268,160,787**	**2%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 378,469,103	$ 377,069,157	0%
Outpatient (OP)	$ 164,563,298	$ 165,188,345	0%
Physician (PH)	$ 220,038,234	$ 220,034,572	0%
Emergency Department (ED)	$ 82,340,934	$ 81,687,303	-1%
Pharmacy (RX)	$ 117,828,779	$ 128,256,954	9%
Other (OTH)	$ 282,676,149	$ 295,924,457	5%
Total Population Costs	**$ 1,245,916,497**	**$ 1,268,160,787**	**2%**
Per Capita Cost (PMPM)	**$ 261.57**	**$ 257.04**	**-2%**
Total Member Months	**4,763,223**	**4,933,747**	**4%**

Service Categories % of Cost

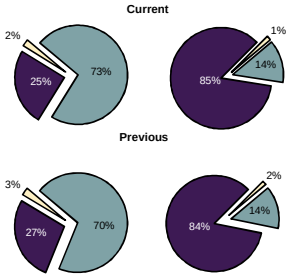


3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 82,491,877	$ 93,225,043	13%
Generic	$ 32,376,263	$ 32,060,824	-1%
Other Rx	$ 2,960,640	$ 2,971,087	0%
Total	**$ 117,828,779**	**$ 128,256,954**	**9%**

% of Rx Spend **% of Scripts**



** "Other Rx" represents supplies such as diabetic test strips.*

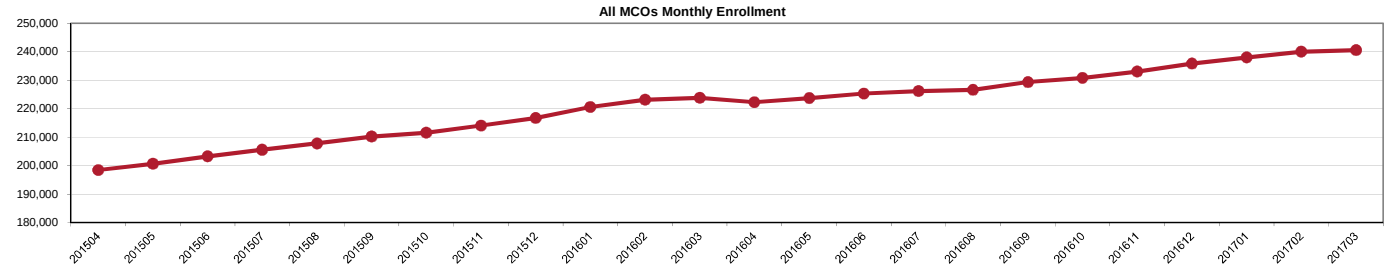
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
Total Population
Other Adult Group Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



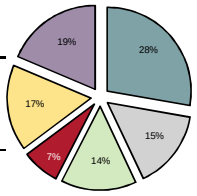
2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 811,939,299	$ 873,364,266	8%
Pharmacy	$ 143,881,774	$ 173,965,018	21%
Total	**$ 955,821,072**	**$ 1,047,329,283**	**10%**

Aggregate Costs by Service Categories

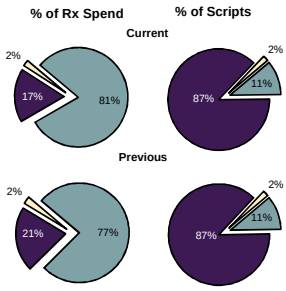
Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 262,634,396	$ 290,667,060	11%
Outpatient (OP)	$ 151,507,284	$ 159,666,364	5%
Physician (PH)	$ 144,534,402	$ 152,337,821	5%
Emergency Department (ED)	$ 73,932,072	$ 75,831,483	3%
Pharmacy (RX)	$ 143,881,774	$ 173,965,018	21%
Other (OTH)	$ 179,331,144	$ 194,861,538	9%
Total Population Costs	**$ 955,821,072**	**$ 1,047,329,283**	**10%**
Per Capita Cost (PMPM)	**$ 376.92**	**$ 377.87**	**0%**
Total Member Months	**2,535,904**	**2,771,677**	**9%**



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 110,020,422	$ 140,110,160	27%
Generic	$ 30,362,722	$ 30,320,490	0%
Other Rx	$ 3,498,630	$ 3,534,368	1%
Total	**$ 143,881,774**	**$ 173,965,018**	**21%**



** "Other Rx" represents supplies such as diabetic strips.*

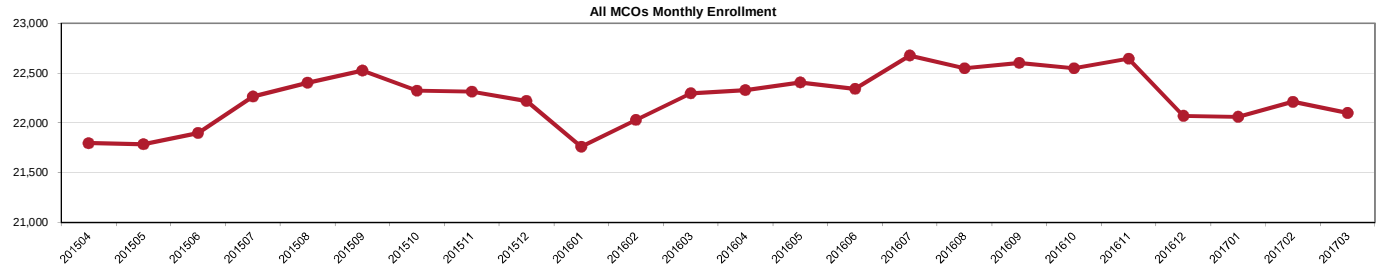
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
LTSS - Healthy Dual Population
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

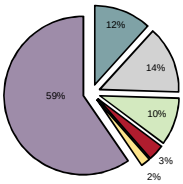
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 64,031,626	$ 56,667,189	-12%
Pharmacy	$ 1,224,592	$ 1,118,502	-9%
Total	**$ 65,256,218**	**$ 57,785,690**	**-11%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 7,553,850	$ 6,771,490	-10%
Outpatient (OP)	$ 8,256,393	$ 7,945,896	-4%
Physician (PH)	$ 5,718,171	$ 5,612,554	-2%
Emergency Department (ED)	$ 2,056,886	$ 1,920,612	-7%
Pharmacy (RX)	$ 1,224,592	$ 1,118,502	-9%
Other (OTH)	$ 40,446,326	$ 34,416,637	-15%
Total Population Costs	**$ 65,256,218**	**$ 57,785,690**	**-11%**
Per Capita Cost (PMPM)	**$ 245.68**	**$ 215.18**	**-12%**
Total Member Months	**265,620**	**268,544**	**1%**

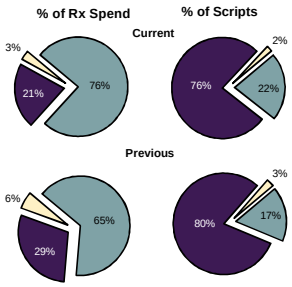
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 797,748	$ 845,724	6%
Generic	$ 358,379	$ 238,340	-33%
Other Rx	$ 68,465	$ 34,437	-50%
Total	**$ 1,224,592**	**$ 1,118,502**	**-9%**



** "Other Rx" represents supplies such as diabetic strips.*

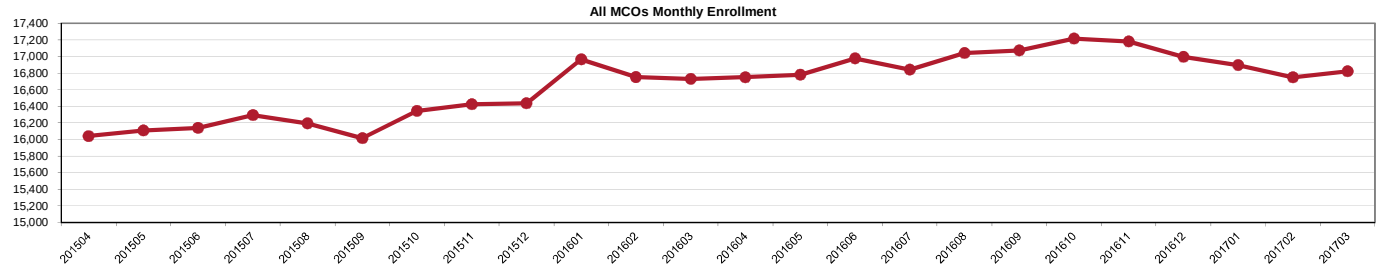
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
LTSS - Nursing Facility Level of Care Dual Population
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

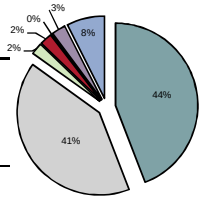
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 466,740,955	$ 466,121,896	0%
Pharmacy	$ 941,784	$ 870,157	-8%
Total	**$ 467,682,739**	**$ 466,992,053**	**0%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 205,461,826	$ 206,140,277	0%
Nursing Facility (NF)	$ 192,424,049	$ 190,428,427	-1%
Inpatient (IP)	$ 13,455,802	$ 10,632,636	-21%
Outpatient (OP)	$ 10,527,163	$ 11,254,145	7%
Pharmacy (RX)	$ 941,784	$ 870,157	-8%
HCBS	$ 11,120,743	$ 12,887,497	16%
Other (OTH)	$ 33,751,372	$ 34,778,914	3%
Total Population Costs	**$ 467,682,739**	**$ 466,992,053**	**0%**
Per Capita Cost (PMPM)	**$ 2,380.62**	**$ 2,296.93**	**-4%**
Total Member Months	**196,454**	**203,311**	**3%**

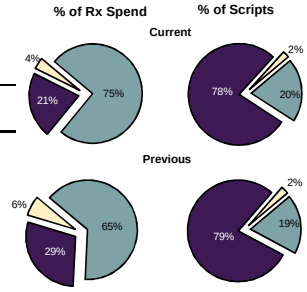
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 609,003	$ 651,022	7%
Generic	$ 271,943	$ 185,957	-32%
Other Rx	$ 60,838	$ 33,178	-45%
Total	**$ 941,784**	**$ 870,157**	**-8%**



** "Other Rx" represents supplies such as diabetic test strips.*

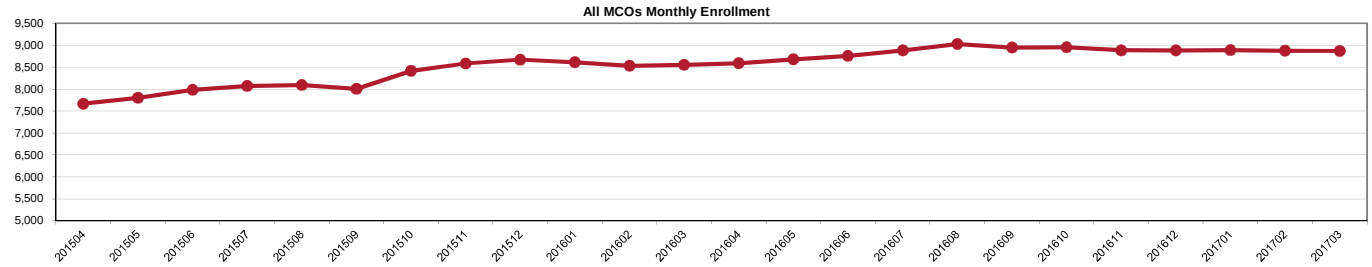
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
LTSS - Nursing Facility Level of Care Medicaid Only Population
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

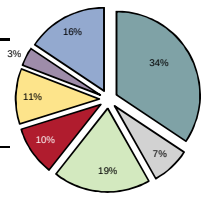
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 274,184,393	$ 279,778,435	2%
Pharmacy	$ 27,858,396	$ 33,445,128	20%
Total	**$ 302,042,789**	**$ 313,223,563**	**4%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 107,374,411	$ 107,593,552	0%
Nursing Facility (NF)	$ 25,853,284	$ 23,309,900	-10%
Inpatient (IP)	$ 57,475,310	$ 59,057,568	3%
Outpatient (OP)	$ 26,751,753	$ 29,862,794	12%
Pharmacy (RX)	$ 27,858,396	$ 33,445,128	20%
HCBS	$ 8,926,436	$ 11,056,184	24%
Other (OTH)	$ 47,803,200	$ 48,898,437	2%
Total Population Costs	**$ 302,042,789**	**$ 313,223,563**	**4%**
Per Capita Cost (PMPM)	**$ 3,051.25**	**$ 2,948.29**	**-3%**
Total Member Months	**98,990**	**106,239**	**7%**

Service Categories % of Cost

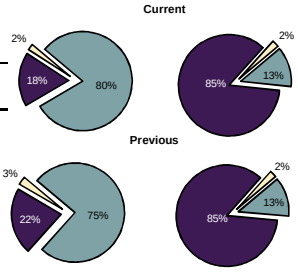


3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 21,031,894	$ 26,899,140	28%
Generic	$ 6,065,195	$ 5,871,533	-3%
Other Rx	$ 761,307	$ 674,455	-11%
Total	**$ 27,858,396**	**$ 33,445,128**	**20%**

% of Rx Spend **% of Scripts**



** "Other Rx" represents supplies such as diabetic test strips.*

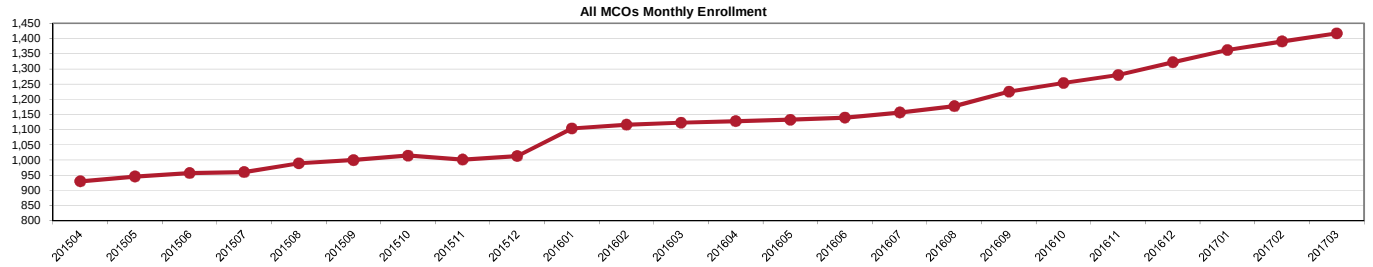
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
LTSS - Self Directed Population
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

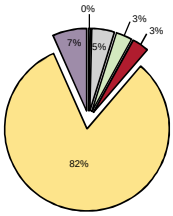
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 47,445,400	$ 53,079,754	12%
Pharmacy	$ 1,116,870	$ 1,811,461	62%
Total	**$ 48,562,269**	**$ 54,891,215**	**13%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Nursing Facility (NF)	$ 283,774	$ 209,704	-26%
Inpatient (IP)	$ 2,205,768	$ 2,443,210	11%
Outpatient (OP)	$ 1,199,403	$ 1,746,861	46%
Pharmacy (RX)	$ 1,116,870	$ 1,811,461	62%
HCBS	$ 40,726,274	$ 45,017,852	11%
Other (OTH)	$ 3,030,181	$ 3,662,126	21%
Total Population Costs	**$ 48,562,269**	**$ 54,891,215**	**13%**
Per Capita Cost (PMPM)	**$ 3,995.58**	**$ 3,663.32**	**-8%**
Total Member Months	**12,154**	**14,984**	**23%**

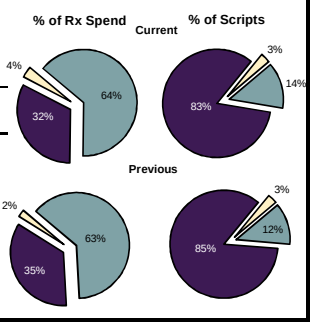
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 703,872	$ 1,161,843	65%
Generic	$ 388,472	$ 587,285	51%
Other Rx	$ 24,525	$ 62,332	154%
Total	**$ 1,116,870**	**$ 1,811,461**	**62%**



** "Other Rx" represents supplies such as diabetic test strips.*

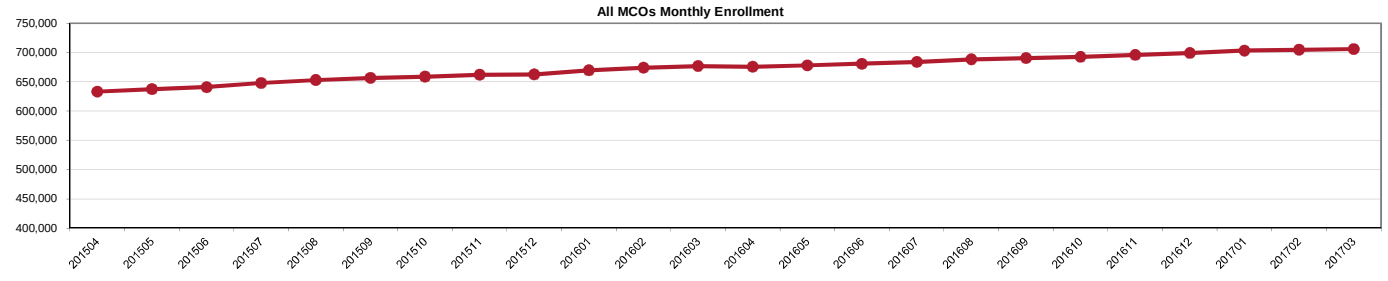
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
Total Population (Physical Health, Long Term Services and Support, and Other Adult Group)
Behavioral Health Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

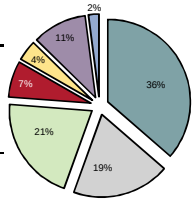
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 259,342,364	$ 273,553,989	5%
Pharmacy	$ 60,309,700	$ 64,580,939	7%
Total	**$ 319,652,064**	**$ 338,134,929**	**6%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Outpatient/Clinic (OP/CL)	$ 106,453,969	$ 123,111,055	16%
Pharmacy (RX)	$ 60,309,700	$ 64,580,939	7%
Res. Treatment Ctr. (RTC)	$ 74,819,449	$ 69,954,963	-7%
Behavioral Health Prov (BHP)	$ 23,436,133	$ 23,912,955	2%
Core Service Agencies (CSA)	$ 14,987,778	$ 13,696,896	-9%
Inpatient (IP)	$ 30,129,389	$ 35,922,599	19%
Other (OTH)	$ 9,515,648	$ 6,955,523	-27%
Total Population Costs	**$ 319,652,064**	**$ 338,134,929**	**6%**
Per Capita Cost (PMPM)	**$ 40.60**	**$ 40.75**	**0%**
Total Member Months	**7,872,345**	**8,298,502**	**5%**

Services Categories % of Cost

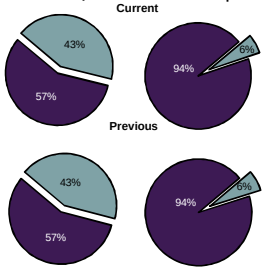


3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 25,918,799	$ 27,591,506	6%
Generic	$ 34,390,901	$ 36,989,433	8%
Total	**$ 60,309,700**	**$ 64,580,939**	**7%**

% of Rx Spend **% of Scripts**



4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
Medical Assistance Division

FY 17 Lag Model with Centennial Care and Medicaid Expansion with Actual Data Thru June 2017 ($000s)

No.	Description	FY 16 Title XIX Projection	FY 17 % Completion	Title XIX Actual YTD	Actual Paid Lump Sum/ Others YTD	Projected Lump Sum	Others	FY 17 Title XIX Projection	% Change from FY 16	CHIP Actual Paid YTD	CHIP Projection	FY 17 TOTAL Medicaid Projection	Mar 2016 Data Projection	Change from Previous	No.
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1	Inpatient Hospital	88,428	78.93%	60,609	-	-	-	76,722	-13.24%	352	513	77,236	76,549	687	1
2	DSH	31,516	75.01%	23,566	23,566	31,417	-	31,417	-0.32%	-	-	31,417	31,417	-	2
3	GME	10,015	100.00%	18,500	18,500	18,500	-	18,500	84.72%	-	-	18,500	18,500	-	3
4	IME	72,799	75.00%	64,219	64,219	85,625	-	85,625	17.62%	-	-	85,625	83,630	1,995	4
5	Safety Net Care	68,856	75.00%	51,667	51,667	68,889	-	68,889	0.05%	-	-	68,889	68,889	-	5
6	HQII Pool	2,824	100.00%	7,359	7,359	7,359	-	7,359	160.55%	-	-	7,359	5,765	1,594	6
7	Physician Services	38,996	87.21%	34,354	3,902	5,525	-	39,407	1.06%	427	476	39,883	40,681	(798)	7
8	IHS Hospital	116,302	87.26%	109,258	-	-	-	125,213	7.66%	-	-	125,213	125,425	(212)	8
9	ICF-IID	26,988	92.38%	25,571	-	-	-	27,680	2.56%	-	-	27,680	28,427	(747)	9
10	Clinic Services	46,264	30.54%	14,185	-	-	-	49,837	7.72%	1,581	1,787	51,624	52,277	(653)	10
11	Federal Qualified Health Centers	3,882	78.66%	3,630	-	-	-	4,615	18.89%	77	98	4,713	4,671	42	11
12	Other Practitioners	28,854	90.92%	27,676	-	-	-	30,439	5.49%	956	1,052	31,490	31,253	237	12
13	Outpatient Hospital	41,974	89.56%	36,966	-	-	-	41,285	-1.64%	487	535	41,820	42,493	(673)	13
14	PACE	12,116	99.85%	11,912	-	-	-	11,930	-1.53%	-	-	11,930	12,278	(348)	14
15	Others	39,438	93.23%	45,828	(2,245)	(4,365)	2,219	49,187	24.72%	1,523	1,600	50,787	53,489	(2,702)	15
16	BH FFS	34,370	87.56%	32,901	-	-	-	37,570	9.31%	665	764	38,334	37,878	456	16
17	**Subtotal**	**663,622**	**80.60%**	**568,202**	**166,968**	**212,950**	**2,219**	**705,675**	**6.34%**	**6,068**	**6,825**	**712,500**	**713,623**	**(1,123)**	17
18	Traditional DD and MF Waiver (DOH)	280,516	61.05%	170,830	663	149	514	279,821	-0.25%	-	-	279,821	278,647	1,174	18
19	Mi Via Waivers (DOH)	69,617	96.51%	83,966	3,982	59	3,923	87,001	24.97%	-	-	87,001	86,138	863	19
20	**Subtotal**	**350,133**	**69.46%**	**254,796**	**4,646**	**208**	**4,437**	**366,822**	**4.77%**	**-**	**-**	**366,822**	**364,785**	**2,037**	20
21	Centennial Care-Physical Health	1,420,772	99.03%	1,406,708	-	30,818	(18,370)	1,420,914	0.01%	81,950	82,290	1,503,203	1,509,876	(6,673)	21
22	Centennial Care-LTSS	1,069,101	98.42%	1,049,940	-	12,195	-	1,066,765	-0.22%	1,112	1,112	1,067,876	1,073,805	(5,928)	22
23	Centennial Care-Behavioral Health	318,520	98.95%	322,619	-	3,044	-	326,021	2.36%	18,959	19,191	345,212	344,498	714	23
24	**Subtotal**	**2,808,393**	**98.80%**	**2,779,267**	**-**	**46,057**	**(18,370)**	**2,813,699**	**0.19%**	**102,020**	**102,592**	**2,916,292**	**2,928,179**	**(11,887)**	24
25	Medicare Part A	1,300	100.00%	1,710	-	-	-	1,710	31.53%	-	-	1,710	1,774	(64)	25
26	Medicare Part B	109,909	100.00%	131,716	-	-	-	131,716	19.84%	-	-	131,716	131,722	(6)	26
27	Medicare Part D	36,702	100.00%	43,958	-	-	-	43,958	19.77%	-	-	43,958	43,915	43	27
28	**Subtotal**	**147,911**	**100.00%**	**177,384**	**-**	**-**	**-**	**177,384**	**71.14%**	**-**	**-**	**177,384**	**177,411**	**(27)**	28
29	Utilization	4,326	50.25%	2,512	2,512	-	5,000	5,000	15.57%	-	-	5,000	5,000	-	29
30	HIT	9,100	100.00%	23,725	23,725	23,725	-	23,725	160.70%	-	-	23,725	21,933	1,791	30
31	Contracts	-	0.00%	-	-	1,970	-	1,970	--	-	-	1,970	1,970	-	31
32	**Subtotal**	**13,427**	**85.48%**	**26,237**	**26,237**	**25,695**	**5,000**	**30,695**	**128.61%**	**-**	**-**	**30,695**	**28,904**	**1,791**	32
33	Rate Increase for Primary Care Services	12,732	100.00%	233	233	233	-	233	-98.17%	-	-	233	233	-	33
34	Health Insurance Providers Fee	90,219	--	-	-	-	-	-	-100.00%	-	-	-	-	-	34
35	**Subtotal**	**102,951**	**100.00%**	**233**	**233**	**233**	**-**	**233**	**-99.77%**	**-**	**-**	**233**	**233**	**-**	35
36	Medicaid Expansion - Physical Health	1,027,441	110.02%	1,318,424	-	22,318	(144,920)	1,198,385	16.64%	-	-	1,198,385	1,202,273	(3,888)	36
37	Medicaid Expansion - Behavioral Health	101,098	98.03%	110,431	-	2,005	-	112,650	11.43%	-	-	112,650	112,980	(330)	37
38	**Subtotal**	**1,128,539**	**108.99%**	**1,428,855**	**-**	**24,323**	**(144,920)**	**1,311,035**	**16.17%**	**-**	**-**	**1,311,035**	**1,315,253**	**(4,218)**	38
39															39
40	**Prior Years Charged to Current Year**	**113,467**	**na**	**-**	**-**	**-**	**43,502**	**43,502**	**-61.66%**	**-**	**-**	**43,502**	**42,012**	**1,490**	40
41	**Current Year Charged to Future Year**	**(43,502)**	**na**	**-**	**-**	**-**		**-**	**-100.00%**	**-**	**-**	**-**	**-**	**-**	41
42															42
43	**Grand Total**	**5,284,942**	**96.12%**	**5,234,973**	**198,083**	**309,466**	**(108,132)**	**5,449,045**	**3.11%**	**108,088**	**109,417**	**5,558,463**	**5,570,399**	**(11,936)**	43

Notes:

1. (Line 10)Clinic Services consists primarily of Medicaid School-Based Services (MSBS) with small amounts also going to clinics providing a variety of services.
2. (Line 15) Others contains: Transportation, Lab/X-Ray, Prosthetics, RHC, Hospice, Home Health, Medical Supplies, Prescribed Drugs, Dental Services, EPSDT, Nursing Facility, Maintenance, Family Planning.
3. (Lines 21-23, 37-38, Columns E and K) Actual YTD payments are from the MCO database, instead of Share Accounting Detailed File (SADF), because SADF doesn't show payments by programs.
4. (Lines 21, 37, Column H) Others under the managed care projection lines reflect retroactive eligibility reconciliation and Medicaid Expansion risk corridor for CY16, Hepatitis-C reconciliation.
5. (Line 34) Health Home budget has been built into the MCO rates starting from April 2016 for Behavior Health program for both Medicaid Base and Expansion population, so the expenditures on Health Home is not shown in this line.
6. (Line 35) Health Insurance Providers Fee is suspended for the 2016 data year, but will be resumed for data year 2017 and forward.

8/2/2017

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT — **FY 17 Lag Model with Centennial Care and Medicaid Expansion with Actual Data Thru June 2017 ($000s)**
Medical Assistance Division

No.	Description	FY 17 Projection	Federal Medicaid Expenditure Type and Federal Financial Participation Rates: HIT, IHS, Refugees, Medicaid Expansion (100% FFP) [1]	Medicaid Expansion (95% FFP) [1]	Health Homes, Sterilization & Family Planning Services (90% FFP) [2]	Breast & Cervical Cancer (EFMAP) [3]	Title XXI CHIP (EFMAP) [4]	Utilization Review (75% FFP) [5]	Title XIX Medicaid (FMAP) [6]	Admin and Fees (50% FFP) [7]	Non-Federal Financial Participation Expenses (0% FFP) [8]	Federal Share	% of Composite Federal Share
A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	Inpatient Hospital	77,236	18,625	15,491	169	76	513	-	42,361	-	-	64,156	83.06%
2	DSH	31,417	-	-	-	-	-	-	31,417	-	-	22,347	71.13%
3	GME	18,500	-	-	-	-	-	-	18,500	-	-	13,159	71.13%
4	IME	85,625	-	-	-	-	-	-	85,625	-	-	60,905	71.13%
5	Safety Net Care	68,889	-	-	-	-	-	-	68,889	-	-	49,001	71.13%
6	HQII Pool	7,359	-	-	-	-	-	-	7,359	-	-	5,235	71.13%
7	Physician Services	39,883	5,632	5,643	-	17	476	-	28,028	-	87	31,388	78.70%
8	IHS Hospital	125,213	123,973	-	-	-	-	-	1,240	-	-	124,855	99.71%
9	ICF-IID	27,680	71	162	-	-	-	-	27,447	-	-	19,705	71.19%
10	Clinic Services	51,624	111	190	-	-	1,787	-	49,535	-	-	37,302	72.26%
11	Federal Qualified Health Centers	4,713	393	801	(1)	0	98	-	3,422	-	-	3,681	78.10%
12	Other Practitioners	31,490	353	520	-	0	1,052	-	29,566	-	-	22,892	72.69%
13	Outpatient Hospital	41,820	7,126	6,550	-	24	535	-	27,585	-	-	33,488	80.08%
14	PACE	11,930	-	-	-	-	-	-	11,930	-	-	8,462	70.93%
15	Others	50,787	9,735	7,724	1,889	99	1,667	-	29,657	-	16	40,681	80.10%
16	BH FFS	38,334	16,578	2,075	0	3	764	-	18,903	-	10	32,740	85.41%
17	**Subtotal**	**712,500**	**182,598**	**39,156**	**2,057**	**220**	**6,891**	**-**	**481,465**	**-**	**113**	**569,996**	**80.00%**
18	Traditional DD and MF Waiver (DOH)	279,821	-	-	-	-	-	514	278,720	587	-	198,515	70.94%
19	Mi Via Waivers (DOH)	87,001	-	-	-	-	-	1,926	82,991	2,084	-	61,427	70.60%
20	**Subtotal**	**366,822**	**-**	**-**	**-**	**-**	**-**	**2,440**	**361,712**	**2,670**	**-**	**259,941**	**70.86%**
21	Centennial Care-Physical Health	1,503,203	30,613	-	13,696	1,193	82,290	-	1,375,413	-	-	1,101,938	73.31%
22	Centennial Care-LTSS	1,067,876	12,195	-	-	720	1,112	-	1,053,850	-	-	761,483	71.31%
23	Centennial Care-Behavioral Health	345,212	3,044	-	1,529	121	19,191	-	321,327	-	-	251,633	72.89%
24	**Subtotal**	**2,916,292**	**45,851**	**-**	**15,224**	**2,034**	**102,592**	**-**	**2,750,590**	**-**	**-**	**2,115,054**	**72.53%**
25	Medicare Part A	1,710	-	-	-	-	-	-	1,710	-	-	1,216	71.13%
26	Medicare Part B	131,716	5,379	-	-	-	-	-	110,982	-	15,355	84,125	63.87%
27	Medicare Part D	43,958	-	-	-	-	-	-	-	-	43,958	-	0.00%
28	**Subtotal**	**177,384**	**5,379**	**-**	**-**	**-**	**-**	**-**	**112,691**	**-**	**59,313**	**85,341**	**48.11%**
29	Utilization	5,000	-	-	-	-	-	5,000	-	-	-	3,750	75.00%
30	HIT	23,725	23,725	-	-	-	-	-	-	-	-	23,725	100.00%
31	Contracts	1,970	-	-	-	-	-	-	376	1,595	-	1,065	54.03%
32	**Subtotal**	**30,695**	**23,725**	**-**	**-**	**-**	**-**	**5,000**	**376**	**1,595**	**-**	**28,539**	**92.98%**
33	Rate Increase for Primary Care Services	233	31	-	-	-	-	-	201	-	-	174	75.04%
34	**Subtotal**	**233**	**31**	**-**	**-**	**-**	**-**	**-**	**201**	**-**	**-**	**174**	**75.04%**
35	Medicaid Expansion - Physical Health	1,198,385	524,531	673,854	-	-	-	-	-	-	-	1,164,693	97.19%
36	Medicaid Expansion - Behavioral Health	112,650	56,208	56,442	-	-	-	-	-	-	-	109,828	97.49%
37	**Subtotal**	**1,311,035**	**580,739**	**730,296**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,274,521**	**97.21%**
38													
39	**Prior Years Charged to Current Year**	**43,502**	**-**	**-**	**-**	**-**	**-**	**-**	**43,502**	**-**	**-**	**30,612**	**70.37%**
40	**Current Year Charged to Future Year**												
41													
42	**Grand Total**	**5,558,463**	**838,323**	**769,452**	**17,282**	**2,254**	**109,484**	**7,440**	**3,750,537**	**4,265**	**59,427**	**4,364,179**	**78.51%**

State Share Revenues:	**FY 17 Op. Budget**	**Billed Amount**	**Collection YTD**	**HSD Projection**	**Change from Previous**
Department of Health (Line 18 & 19) [9,16]	103,360	90,403	90,285	105,103	(128)
Department of Health Additional Need /(Surplus)			-	463	229
Department of Health for Early Intervention	8,062	7,177	6,531	8,292	
Department of Health for FQHCs	462	462	462	560	
Department of Health for EC	1			1	
Children, Youth and Families	-			-	
County Supported Medicaid Fund	33,533	25,081	23,454	31,835	2,090
Tobacco Settlement Revenue, Base	27,319		27,319	27,319	
Tobacco Settlement Revenue	-			-	
UNM IGT	43,007	40,600	35,900	40,600	
Total Operating Transfers In	**215,744**	**163,723**	**183,952**	**214,173**	**2,191**
Physician UPL UNM	1,993	1,160	1,160	1,605	
Safety Net Care [11]	-			-	
County Supported Hospital Payments [11]	26,618	23,259	23,210	23,259	
Additional County Supported Hospital Payments [12]	-			-	
Miner's Colfax [14]	771				(1,036)
County Contribution for Incarcerated Population [15]	-				
Drug Rebates	20,434		28,413	28,413	(489)
Fraud	872		322	375	
Income Diversion Trust	486		639	800	
Buy-In Recovery	215		15	20	
Cost Settlement	500		174	250	
Estate Recovery	9		9	9	
Misc. Revenue			336	336	236
HMS-RAC-TPL/Subrogation	500				
Total Other Revenues	**52,398**		**54,277**	**55,067**	**(1,289)**
General Fund Need				**910,722**	(3,926)
HB 2 / SFC				**913,637**	
DSH Settlement				**16,806**	
BHSD Previous Year Reversion				**500**	
Transfer to support MMISR				**(5,000)**	
State Revenue Surplus / (Shortfall)				**15,220**	**3,926**

PROJECTED REVENUES	
Federal Revenues	4,364,179
Federal Disallowance [10]	11,607
MSBS CPE [13]	14,322
IHS Referral 100% FFP	11,607
All State Revenues	1,179,962

Notes:

1. HIT, IHS, QI-1 Medicare Part B premiums, Refugees, Medicaid Expansion are eligible for 100% FFP. Under ACA, the Medicaid Expansion population will be federally funded 100% in CY2016 and 95% in CY2017.
2. Health Homes, sterilization and family planning service costs are eligible for 90% FFP.
3. Breast and cervical cancer (BCC) program with enhanced FMAP.
4. CHIP is a Title XXI program with enhanced FMAP. FY17 will have 100% FFP. Under the ACA beginning Oct. 2015, Medicaid will receive 100% match for CHIP kids through FFY2019.
5. Utilization review is federally matched at 75%; admin. expenses.
6. Title XIX expenditures with regular FMAP. The FFY 2017 FMAP is from FFIS, released September 2015, based on revised income data.
7. Administration expenditures are eligible for 50% FFP.
8. Pregnancy termination, special needs, state only buy-in for Medicare Part B and all Medicare Part D buy-ins (Claw back) expenditures are not eligible for federal financial participation.
9. DOH for Medicaid DD traditional and Mi Via waiver services; projected revenue is without the 3% for admin. MF GF appropriation is under HSD.
10. Includes potential disallowance for 100% IHS referral.
11. The sum of lines 62 and 63 is the 1/12th% of the gross receipts tax contributed by the counties to support the Safety Net Care Pool and Hospital Payments.
12. Line 64 represents the additional county support to fully fund the Safety Net Care Pool.
13. Starting from FY16, school districts will contribute the state share of Medicaid School Based Services through Certified Public Expenditures.
14. Miner's Colfax hospital will contribute the state share of Safety Net Care Pool supplemental payments. The current estimate is for payments issued in CY2016.
15. Senate Bill 42 stated that counties will contribute the state share of payments for fee-for-service inpatient services for their respective incarcerated populations.
16. DOH Budget request is for Developmental Disabled waiver only, budget request for Medically Fragile waiver is through HSD.

8/2/2017

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
Medical Assistance Division

FY 18 Trend Model with Centennial Care and Medicaid Expansion ($000s)

No.	Description	FY 17 Title XIX Projection	FY 17 Title XIX Projected Claims	Δ Price	$ Impact	Δ Recipient	$ Impact	Δ Utilization	$ Impact	Projected Lump Sum	Others	FY 18 Title XIX Projection	% Change from FY 17	FY 17 Title XXI Projection	FY 18 Title XXI Projection	FY 18 Total Medicaid Projection	March 2017 Data Projection	Change from Previous	No.
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	Inpatient Hospital	76,722	76,722	0.00%	-	1.26%	963	0.00%	-	-	-	77,685	1.26%	513	522	78,208	77,843	365	1
2	DSH	31,417	-	--	-	--	-	--	-	31,275	-	31,275	-0.45%	-	-	31,275	31,275	-	2
3	GME	18,500	-	--	-	--	-	--	-	18,926	-	18,926	2.30%	-	-	18,926	18,926	(1)	3
4	IME	85,625	-	--	-	--	-	--	-	85,625	-	85,625	0.00%	-	-	85,625	84,526	1,099	4
5	Safety Net Care	68,889	-	--	-	--	-	--	-	68,889	-	68,889	0.00%	-	-	68,889	68,889	-	5
6	HQII Pool	7,359	-	--	-	--	-	--	-	8,826	-	8,826	19.93%	-	-	8,826	8,826	-	6
7	Physician Services	39,407	33,883	0.00%	-	2.38%	806	0.00%	-	5,525	-	40,214	2.05%	476	484	40,698	41,282	(584)	7
8	IHS Hospital	125,213	125,213	2.30%	2,880	-0.75%	(964)	0.00%	-	-	-	127,129	1.53%	-	-	127,129	128,309	(1,180)	8
9	ICF-IID	27,680	27,680	0.00%	-	-0.05%	(15)	0.00%	-	-	-	27,665	-0.05%	-	-	27,665	28,515	(850)	9
10	Clinic Services	49,837	49,837	0.00%	-	2.21%	1,102	0.00%	-	-	-	50,938	2.21%	1,787	1,819	52,757	52,757	-	10
11	Federal Qualified Health Centers	4,615	4,615	2.69%	124	-0.64%	(30)	0.00%	-	-	678	5,387	16.72%	98	101	5,488	5,475	13	11
12	Other Practitioners	30,439	30,439	0.00%	-	1.66%	505	0.00%	-	-	-	30,944	1.66%	1,052	1,071	32,015	31,813	202	12
13	Outpatient Hospital	41,285	41,285	0.00%	-	2.39%	988	0.00%	-	-	-	42,273	2.39%	535	544	42,818	43,220	(402)	13
14	PACE	11,930	11,930	0.00%	-	0.00%	-	0.00%	-	-	-	11,930	0.00%	-	-	11,930	12,278	(348)	14
15	Others	49,187	51,332	0.00%	-	5.59%	2,870	0.00%	-	(4,115)	100	50,187	2.03%	1,600	1,629	51,816	52,363	(547)	15
16	BH FFS	37,569	37,569	0.05%	18	1.27%	476	0.00%	-	-	-	38,063	1.31%	764	778	38,841	38,416	425	16
17	**Subtotal**	**705,675**	**490,505**	**0.62%**	**3,022**	**1.36%**	**6,701**	**0.00%**	**-**	**214,951**	**778**	**715,957**	**1.46%**	**6,825**	**6,949**	**722,906**	**724,715**	**(1,809)**	17
18	Traditional DD and MF Waiver (DOH)	279,821	279,158	0.00%	-	-0.27%	(753)	0.00%	2	152	523	279,083	-0.26%	-	-	279,083	277,911	1,172	18
19	Mi Via DD and MF Waiver (DOH)	87,001	83,019	0.00%	-	5.74%	4,764	0.86%	755	60	3,989	92,586	6.42%	-	-	92,586	91,674	912	19
20	**Subtotal**	**366,822**	**362,176**	**0.00%**	**-**	**1.11%**	**4,012**	**0.21%**	**757**	**212**	**4,512**	**371,669**	**1.32%**	**-**	**-**	**371,669**	**369,585**	**2,084**	20
21	Centennial Care-Physical Health	1,420,914	1,408,466	0.00%	-	-0.42%	(5,945)	1.30%	18,172	30,856	478	1,452,027	2.19%	82,290	83,004	1,535,031	1,556,417	(21,387)	21
22	Centennial Care-LTSS	1,066,765	1,054,570	0.00%	-	1.83%	19,313	0.80%	8,637	12,195	3,046	1,097,761	2.91%	1,112	257	1,098,018	1,149,239	(51,221)	22
23	Centennial Care-Behavioral Health	326,021	322,977	0.00%	-	-0.18%	(583)	-3.94%	(12,687)	3,044	5,341	318,092	-2.43%	19,191	17,897	335,989	336,720	(731)	23
24	**Subtotal**	**2,813,699**	**2,786,013**	**0.00%**	**-**	**0.46%**	**12,784**	**0.50%**	**14,122**	**46,095**	**8,866**	**2,867,880**	**1.93%**	**102,592**	**101,158**	**2,969,039**	**3,042,377**	**(73,338)**	24
25	Medicare Part A	1,710	1,710	1.38%	24	-1.48%	(26)	0.00%	-	-	-	1,708	-0.12%	-	-	1,708	1,772	(65)	25
26	Medicare Part B	131,716	131,716	2.86%	3,770	2.06%	2,791	0.00%	-	-	-	138,277	4.98%	-	-	138,277	138,281	(3)	26
27	Medicare Part D	43,958	43,958	2.51%	1,103	6.59%	2,968	0.00%	-	-	-	48,029	9.26%	-	-	48,029	48,866	(837)	27
28	**Subtotal**	**177,384**	**177,384**	**2.76%**	**4,897**	**3.15%**	**5,733**	**0.00%**	**-**	**-**	**-**	**188,014**	**5.99%**	**-**	**-**	**188,014**	**188,919**	**(905)**	28
29	Utilization	5,000	-	--	-	--	-	--	-	-	5,000	5,000	0.00%	-	-	5,000	5,000	-	29
30	HIT	23,725	-	--	-	--	-	--	-	20,000	-	20,000	-15.70%	-	-	20,000	9,000	11,000	30
31	Contracts	1,970	-	--	-	--	-	--	-	1,970	-	1,970	0.00%	-	-	1,970	1,970	-	31
32	**Subtotal**	**30,695**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**21,970**	**5,000**	**26,970**	**-12.13%**	**-**	**-**	**26,970**	**15,970**	**11,000**	32
33	Health Insurance Providers Fee	-	-	--	-	--	-	--	-	-	88,338	88,338	--	-	2,849	91,187	93,028	(1,841)	33
34	**Subtotal**	-	-	**--**	**-**	**--**	-	**--**	**-**	-	**88,338**	**88,338**	**--**	**-**	**2,849**	**91,187**	93,028	**(1,841)**	34
35	Medicaid Expansion - Physical Health	1,198,385	1,320,987	0.00%	-	1.41%	18,616	-3.07%	(41,180)	22,318	970	1,321,711	10.29%	-	-	1,321,711	1,356,504	(34,792)	35
36	Medicaid Expansion - Behavioral Health	112,650	110,646	0.00%	-	1.41%	1,559	3.68%	4,127	2,005	1,650	119,987	6.51%	-	-	119,987	123,879	(3,892)	36
37	**Subtotal**	**1,311,035**	**1,431,632**	**-**	**-**	**1.41%**	**20,175**	**-2.55%**	**(37,053)**	**24,323**	**2,620**	**1,441,698**	**9.97%**	**-**	**-**	**1,441,698**	**1,480,383**	**(38,685)**	37
38																			38
39	**Prior Years Charged to Current Year**	**43,502**	**-**	**na**	**-**	**na**	**-**	**na**	**-**	**-**		**-**	**-100.00%**	**-**	**-**	**-**	**-**	**-**	39
40	**Additional Cost Containment**										**-**	**-**	**--**			**-**	**(55,325)**	**55,325**	40
41																			41
42	**Grand Total**	**5,448,812**	**5,247,711**	**0.15%**	**7,919**	**0.94%**	**49,405**	**-0.42%**	**(22,174)**	**307,551**	**110,114**	**5,700,527**	**4.62%**	**109,417**	**110,956**	**5,811,482**	**5,859,652**	**(48,170)**	42

Notes:

1. (Line 10) Clinic Services consists primarily of Medicaid School-Based Services (MSBS) with small amounts also going to clinics providing a variety of services.
2. (Line 15) Others contains: Transportation, Lab/X-Ray, Prosthetics, RHC, Hospice, Home Health, Medical Supplies, Prescribed Drugs, Dental Services, EPSDT, Nursing Facility, Maintenance, Family Planning, PCO .
3. (Lines 21-23, 36-37, Column L) Others under the managed care projection lines reflect the cost of additional NMMIP for second half of FY18, retroactive eligibility reconciliation.

8/2/2017

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
Medical Assistance Division

FY 18 Trend Model with Centennial Care and Medicaid Expansion ($000s)

No.	Description	FY 18 Projection	Federal Medicaid Expenditure Type and Federal Financial Participation Rates											
			HIT, IHS, Refugees (100% FFP) [1]	Medicaid Expansion (95% FFP)[2]	Medicaid Expansion (94% FFP)[2]	Health Homes, Sterilization & Family Planning Services (90% FFP) [3]	Breast & Cervical Cancer, CCBHC Program (EFMAP) [4]	Title XXI CHIP (EFMAP) [5]	Utilization Review (75% FFP) [6]	Title XIX Medicaid (FMAP) [7]	Admin and Fees (50% FFP) [8]	Non-Federal Financial Participation Expenses (0% FFP) [9]	Federal Share	% of Composite Federal Share
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Inpatient Hospital	78,208	407	13,691	14,831	187	-	522	-	48,570	-	-	63,015	80.57%
2	DSH	31,275	-	-	-	-	-	-	-	31,275	-	-	22,568	72.16%
3	GME	18,926	-	-	-	-	-	-	-	18,926	-	-	13,657	72.16%
4	IME	85,625	-	-	-	-	-	-	-	85,625	-	-	61,787	72.16%
5	Safety Net Care	68,889	-	-	-	-	-	-	-	68,889	-	-	49,711	72.16%
6	HQII Pool	8,826	-	-	-	-	-	-	-	8,826	-	-	6,369	72.16%
7	Physician Services	40,698	67	5,127	5,554	-	17	484	-	29,364	-	85	31,795	78.13%
8	IHS Hospital	127,129	127,129	-	-	-	-	-	-	(0)	-	-	127,129	100.00%
9	ICF-IID	27,665	-	114	123	-	-	-	-	27,429	-	-	19,959	72.14%
10	Clinic Services	52,757	-	138	149	-	-	1,819	-	50,628	-	24	38,603	73.17%
11	Federal Qualified Health Centers	5,488	-	575	623	-	-	101	-	4,189	-	-	4,249	77.42%
12	Other Practitioners	32,015	-	399	433	-	-	1,071	-	30,112	-	-	23,531	73.50%
13	Outpatient Hospital	42,818	144	6,251	6,772	-	23	544	-	29,083	-	-	33,948	79.29%
14	PACE	11,930	-	-	-	-	-	-	-	11,904	-	26	8,560	71.76%
15	Others	51,816	3,955	6,871	7,444	2,274	29	1,629	-	29,614	-	-	42,484	81.99%
16	BH FFS	38,841	12,247	3,271	3,544	-	2	778	-	18,998	-	-	33,149	85.35%
17	**Subtotal**	**722,906**	**143,949**	**36,437**	**39,473**	**2,460**	**71**	**6,949**	**-**	**493,432**	**-**	**135**	**580,513**	**80.30%**
18	Traditional DD and MF Waiver (DOH)	279,083	-	-	-	-	-	-	523	277,968	592	-	200,714	71.92%
19	Mi Via DD and MF Waiver (DOH)	92,586	-	-	-	-	-	-	1,958	88,510	2,118	-	66,263	71.57%
20	**Subtotal**	**371,669**	**-**	**-**	**-**	**-**	**-**	**-**	**2,481**	**366,478**	**2,710**	**-**	**266,977**	**71.83%**
21	Centennial Care-Physical Health	1,535,031	30,613	-	-	13,696	1,203	83,004	-	1,406,272	-	244	1,138,159	74.15%
22	Centennial Care-LTSS	1,098,018	12,195	-	-	-	-	257	-	1,085,566	-	-	793,083	72.23%
23	Centennial Care-Behavioral Health	335,989	3,044	-	-	2,506	86	18,016	-	312,337	-	-	247,986	73.81%
24	**Subtotal**	**2,969,039**	**45,851**	**-**	**-**	**16,202**	**1,289**	**101,277**	**-**	**2,804,175**	**-**	**244**	**2,179,228**	**73.40%**
25	Medicare Part A	1,708	-	-	-	-	-	-	-	1,708	-	-	1,228	71.90%
26	Medicare Part B	138,277	5,716	-	-	-	-	-	-	116,644	-	15,917	89,595	64.79%
27	Medicare Part D	48,029	-	-	-	-	-	-	-	-	-	48,029	-	0.00%
28	**Subtotal**	**188,014**	**5,716**	**-**	**-**	**-**	**-**	**-**	**-**	**118,351**	**-**	**63,946**	**90,823**	**48.31%**
29	Utilization	5,000	-	-	-	-	-	-	5,000	-	-	-	3,750	75.00%
30	HIT	20,000	20,000	-	-	-	-	-	-	-	-	-	20,000	100.00%
31	Contracts	1,970	-	-	-	-	-	-	-	376	1,595	-	1,068	54.23%
32	**Subtotal**	**26,970**	**20,000**	**-**	**-**	**-**	**-**	**-**	**5,000**	**376**	**1,595**	**-**	**24,818**	**92.02%**
33	Health Insurance Providers Fee	91,187	-	35,782	-	-	-	2,849	-	52,556	-	-	74,766	81.99%
34	**Subtotal**	**91,187**	**-**	**35,782**	**-**	**-**	**-**	**2,849**	**-**	**52,556**	**-**	**-**	**74,766**	**81.99%**
35	Medicaid Expansion - Physical Health	1,321,711	22,318	584,775	714,618	-	-	-	-	-	-	-	1,249,596	94.54%
36	Medicaid Expansion - Behavioral Health	119,987	2,005	53,174	64,808	-	-	-	-	-	-	-	113,440	94.54%
37	**Subtotal**	**1,441,698**	**24,323**	**637,950**	**779,425**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,363,035**	**94.54%**
38														
39	**Prior Years Charged to Current Year**	**-**	**-**	**-**		**-**	**-**	**-**	**-**	**-**	**-**		**-**	**-**
40	**Additional Cost Containment**	**-**								**-**			**-**	**71.08%**
41														
42	**Grand Total**	**5,811,482**	**239,840**	**710,169**	**818,899**	**18,662**	**1,360**	**111,075**	**7,481**	**3,835,368**	**4,304**	**64,325**	**4,580,161**	**78.81%**

	State Share Revenues:	**FY 18 Op Budget**	**HSD Projection**	**Change from Previous**
47	Department of Health (Line 18 & 19) [10,17]	103,360	102,216	-
48	Department of Health Additional Need /(Surplus)		2,177	1,083
49	Department of Health for Early Intervention	8,292	8,292	-
50	Department of Health for FQHCs	560	560	-
51	Department of Health for EC	1	1	-
52	Children, Youth and Families	-	-	-
53	County Supported Medicaid Fund	28,515	28,515	1,241
54	Tobacco Settlement Revenue, Base	29,319	29,319	-
55	Tobacco Settlement Revenue	-	-	-
56	UNM IGT	44,482	42,347	-
57	**Total Operating Transfers In**	**214,529**	**213,428**	2,324
58				-
59	Physician UPL UNM	1,681	1,605	-
60	Safety Net Care [12]	-	-	-
61	County Supported Hospital Payments [12]	22,790	22,585	-
62	Additional County Supported Hospital Payments [13]	-	-	-
63	Miner's Colfax[15]	500		(500)
64	County Contribution for Incarcerated Population[16]			-
65	Drug Rebates	28,867	30,792	440
66	Fraud	872	872	-
67	Income Diversion Trust	486	486	-
68	Buy-In Recovery	215	215	-
69	Cost Settlement	500	500	-
70	Estate Recovery	9	9	-
71	HMS-RAC-TPL/Subrogation	500	-	-
72	**Total Other Revenues**	**56,420**	**57,064**	(60)
73				-
74	**General Fund Need**		**938,280**	**(9,239)**
75				-
76	**FY 2018 Appropriation**	**915,637**	**915,637**	-
77				-
78	**State Revenue Surplus/(Shortfall)**		**(22,643)**	**9,239**

PROJECTED REVENUES	
Federal Revenues	4,580,161
Federal Disallowance [11]	-
MSBS CPE[14]	14,155
IHS Referral 100% FFP[18]	8,394
All State Revenues	1,208,772

Notes:

1. HIT, IHS, QI-1 Medicare Part B premiums, Refugees are eligible for 100% FFP.
2. Under ACA, the Medicaid Expansion population will be federally funded 95% in CY2017 and 94% in CY2018.
3. Health Homes, sterilization and family planning service costs are eligible for 90% FFP.
4. Breast and cervical cancer (BCC) program with enhanced FMAP. Certified Community Behavioral Health Clinics program with enhanced FMAP.
5. CHIP is a Title XXI program with enhanced FMAP. FY18 will have 100% FFP. Under the ACA beginning Oct. 2015, Medicaid will receive 100% match for CHIP kids through FFY2019.
6. Utilization review is federally matched at 75%; admin. expenses.
7. Title XIX expenditures with regular FMAP. The FFY 2018 final FMAP is from FFIS, released September 2016, based on revised income data.
8. Administration expenditures are eligible for 50% FFP.
9. Pregnancy termination, special needs and state only buy-in for Medicare Part B and all Medicare Part D buy-ins (Claw back) expenditures are not eligible for federal financial participation.
10. DOH for Medicaid DD, MF and Mi Via waiver services; projected revenue is without the 3% for admin.
11. Includes potential disallowance for 100% IHS Referral
12. The sum of lines 62 and 63 is the 1/12th% of the gross receipts tax contributed by the counties to support the Safety Net Care Pool and Hospital Payments.
13. Line 64 represents the additional county support to fully fund the Safety Net Care Pool.
14. Starting from FY16, school districts will contribute the state share of Medicaid School-Based Services through Certified Public Expenditures.
15. Miner's Colfax hospital will contribute the state share of Safety Net Care Pool supplemental payments. The current estimate is for services provided in CY2017.
16. Senate Bill 42 stated that counties will contribute the state share of payments for fee-for-service inpatient services for their respective incarcerated populations.
17. DOH Budget request is for Developmental Disabled waiver only, budget request ($1.4 million) for Medically Fragile waiver is through HSD.
18. This amount is pending, subject to approval of 100% FFP for IHS Referrals.

8/2/2017

STATE OF NEW MEXICO DRAFT
HUMAN SERVICES DEPARTMENT
Medical Assistance Division **FY 19 Trend Model with Centennial Care and Medicaid Expansion ($000s)**

No.	Description	FY 18 Title XIX Projection	FY 18 Title XIX Projected Claims	Δ Price	$ Impact	Δ Recipient	$ Impact	Δ Utilization	$ Impact	Projected Lump Sum	Others	FY 19 Title XIX Projection	% Change from FY 18	FY 18 Title XXI Projection	FY 19 Title XXI Projection	FY 19 TOTAL Medicaid Projection	FY18 Projection	Change from FY18	No.
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	Inpatient Hospital	77,685	77,685	0.00%	-	0.03%	20	0.00%	-	-	-	77,706	0.03%	522	527	**78,233**	**78,208**	25	1
2	DSH	31,275	-	--	-	--	-	--	-	31,275	-	31,275	0.00%	-	-	**31,275**	**31,275**	-	2
3	GME	18,926	-	--	-	--	-	--	-	18,926	-	18,926	0.00%	-	-	**18,926**	**18,926**	(1)	3
4	IME	85,625	-	--	-	--	-	--	-	85,625	-	85,625	0.00%	-	-	**85,625**	**85,625**	-	4
5	Safety Net Care	68,889	-	--	-	--	-	--	-	68,889	-	68,889	0.00%	-	-	**68,889**	**68,889**	-	5
6	HQII Pool	8,826	-	--	-	--	-	--	-	12,012	-	12,012	36.10%	-	-	**12,012**	**8,826**	3,186	6
7	Physician Services	40,214	34,689	0.00%	-	2.34%	811	0.00%	-	5,525	-	41,025	2.02%	484	493	**41,518**	**40,698**	820	7
8	IHS Hospital	127,129	127,129	2.30%	2,924	0.93%	1,208	0.00%	-	-	-	131,261	3.25%	-	-	**131,261**	**127,129**	4,132	8
9	ICF-IID	27,665	27,665	0.00%	-	3.32%	919	0.00%	-	-	-	28,584	3.32%	-	-	**28,584**	**27,665**	919	9
10	Clinic Services	50,938	50,938	0.00%	-	0.53%	268	0.00%	-	-	-	51,206	0.53%	1,819	1,852	**53,058**	**52,757**	301	10
11	Federal Qualified Health Centers	5,387	4,709	2.69%	127	-0.38%	(18)	0.00%	-	-	678	5,495	2.01%	101	103	**5,599**	**5,488**	111	11
12	Other Practitioners	30,944	30,944	0.00%	-	0.26%	79	0.00%	-	-	-	31,023	0.26%	1,071	1,090	**32,113**	**32,015**	98	12
13	Outpatient Hospital	42,273	42,273	0.00%	-	1.55%	654	0.00%	-	-	-	42,928	1.55%	544	554	**43,482**	**42,818**	664	13
14	PACE	11,930	11,930	0.00%	-	0.00%	-	0.00%	-	-	-	11,930	0.00%	-	-	**11,930**	**11,930**	-	14
15	Others	50,187	54,202	0.00%	-	1.74%	944	0.00%	-	(4,100)	100	51,146	1.91%	1,629	1,658	**52,804**	**51,816**	988	15
16	BH FFS	38,063	38,063	0.05%	18	-0.31%	(120)	0.00%	-	-	-	37,962	-0.27%	778	792	**38,754**	**38,841**	(87)	16
17	**Subtotal**	**715,957**	**500,228**	**0.61%**	**3,069**	**0.95%**	**4,766**	**0.00%**	**-**	**218,152**	**778**	**726,993**	**1.54%**	**6,949**	**7,070**	**734,063**	**722,906**	**11,157**	17
18	Traditional DD Waiver (DOH)	279,083	278,408	0.00%	-	-0.36%	(1,010)	0.00%	-	76	523	277,996	-0.39%	-	-	**277,996**	**279,083**	(1,087)	18
19	Mi Via DD Waiver (DOH)	92,586	88,537	0.00%	-	0.00%	-	0.00%	-	59	3,841	92,438	-0.16%	-	-	**92,438**	**92,586**	(148)	19
20	**Subtotal**	**371,669**	**366,945**	**0.00%**	**-**	**-0.28%**	**(1,010)**	**0.00%**	**-**	**135**	**4,364**	**370,434**	**-0.33%**	**-**	**-**	**370,434**	**371,669**	**(1,235)**	20
21	Centennial Care-Physical Health	1,452,027	1,420,692	0.00%	-	0.00%	-	0.74%	10,576	30,856	3,590	1,465,715	0.94%	83,004	83,622	**1,549,337**	**1,535,031**	14,306	21
22	Centennial Care-LTSS	1,073,261	1,082,520	0.00%	-	3.40%	36,828	0.75%	8,343	12,195	(18,408)	1,121,478	4.49%	257	257	**1,121,735**	**1,098,018**	23,717	22
23	Centennial Care-Behavioral Health	318,092	309,707	0.00%	-	0.37%	1,152	0.70%	2,187	3,044	6,333	322,423	1.36%	17,897	18,224	**340,647**	**335,989**	4,658	23
24	**Subtotal**	**2,843,380**	**2,812,919**	**0.00%**	**-**	**1.35%**	**37,979**	**0.74%**	**21,106**	**46,095**	**(8,484)**	**2,909,615**	**2.33%**	**101,158**	**102,103**	**3,011,719**	**2,969,039**	**42,680**	24
25	Medicare Part A	1,708	1,708	0.00%	-	1.20%	20	0.00%	-	-	-	1,728	1.20%	-	-	**1,728**	**1,708**	20	25
26	Medicare Part B	138,277	138,277	-0.72%	(996)	2.80%	3,838	0.00%	-	-	-	141,120	2.06%	-	-	**141,120**	**138,277**	2,843	26
27	Medicare Part D	48,029	48,029	2.01%	965	2.53%	1,240	0.00%	(2)	-	-	50,232	4.59%	-	-	**50,232**	**48,029**	2,203	27
28	**Subtotal**	**188,014**	**188,014**	**-0.02%**	**(30)**	**2.71%**	**5,098**	**0.00%**	**(2)**	**-**	**-**	**193,080**	**2.69%**	**-**	**-**	**193,080**	**188,014**	**5,066**	28
29	Utilization	5,000	-	--	-	--	-	--	-	-	5,000	5,000	0.00%	-	-	**5,000**	**5,000**	-	29
30	HIT	20,000	-	--	-	--	-	--	-	8,000	-	8,000	-60.00%	-	-	**8,000**	**20,000**	(12,000)	30
31	Contracts	1,970	-	--	-	--	-	--	-	1,970	-	1,970	0.00%	-	-	**1,970**	**1,970**	-	31
32	**Subtotal**	**26,970**	**-**	**--**	**-**	**--**	**-**	**--**	**-**	**9,970**	**5,000**	**14,970**	**-44.49%**	**-**	**-**	**14,970**	**26,970**	**(12,000)**	32
33	Rate Increase for Primary Care Services	-	-	--	-	--	-	--	-	-	-	-	--	-	-	**-**		-	33
34	Health Home	-	-	--	-	--	-	--	-	-	-	-	--	-	-	**-**		-	34
35	Health Insurance Providers Fee	88,338	-	--	-	--	-	--	-	-	89,732	89,732	1.58%	2,849	2,875	**92,607**	**91,187**	1,420	35
36	**Subtotal**	**88,338**	**-**	**--**	**-**	**--**	**-**	**--**	**-**	**-**	**89,732**	**89,732**	**1.58%**	**2,849**	**2,875**	**92,607**	**91,187**	**1,420**	36
37	Medicaid Expansion - Physical Health	1,321,711	1,298,423	0.00%	-	1.35%	17,491	0.74%	9,796	22,318	4,903	1,352,931	2.36%	-	-	**1,352,931**	**1,321,711**	31,220	37
38	Medicaid Expansion - Behavioral Health	119,987	116,332	0.00%	-	1.35%	1,567	0.74%	878	2,005	1,650	122,432	2.04%	-	-	**122,432**	**119,987**	2,445	38
39	**Subtotal**	**1,441,698**	**1,414,755**	**-**	**-**	**1.35%**	**19,058**	**0.74%**	**10,673**	**24,323**	**6,553**	**1,475,363**	**2.34%**	**-**	**-**	**1,475,363**	**1,441,698**	**33,665**	39
40																			40
41	**Additional Cost Containment**	**-**	**-**	**na**	**-**	**na**	**-**	**na**	**-**	**-**		**-**	**--**	**-**	**-**	**-**			41
42																			42
43																			43
44	**Grand Total**	**5,676,027**	**5,282,861**	**0.06%**	**3,038**	**1.25%**	**65,892**	**0.59%**	**31,778**	**298,676**	**97,943**	**5,780,188**	**1.84%**	**110,956**	**112,049**	**5,892,236**	**5,811,482**	**80,754**	44

Notes:

1. (Line 10) 1. (Line 10) Clinic Services consists primarily of Medicaid School-Based Services (MSBS) with small amounts also going to clinics providing a variety of services.
2. (Line 15) Others contains: Transportation, Lab/X-Ray, Prosthetics, RHC, Hospice, Home Health, Medical Supplies, Prescribed Drugs, Dental Services, EPSDT, Nursing Facility, Maintenance, Family Planning, PCO .
3. (Lines 21-23, 36-37 - Column L) Others under the managed care projection lines reflect the additional cost of NMMIP.

8/22/2017

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
Medical Assistance Division

FY 19 Trend Model with Centennial Care and Medicaid Expansion ($000s)

No.	Description	FY 19 Projection	Federal Medicaid Expenditure Type and Federal Financial Participation Rates: HIT, IHS, Refugees (100% FFP) [1]	Medicaid Expansion (94% FFP)[2]	Medicaid Expansion (93% FFP)[2]	Health Homes, Sterilization & Family Planning Services (90% FFP) [3]	Breast & Cervical Cancer Program (EFMAP) [4]	Title XXI CHIP (FMAP) [5]	Utilization Review (75% FFP) [6]	Title XIX Medicaid (FMAP) [7]	Admin and Fees (50% FFP) [8]	Non-Federal Financial Participation Expenses (0% FFP) [9]	Federal Share	% of Composite Federal Share
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Inpatient Hospital	78,233	411	13,793	14,943	187	-	527	-	48,372	-	-	62,727	80.18%
2	DSH	31,275	-	-	-	-	-	-	-	31,275	-	-	22,568	72.16%
3	GME	18,926	-	-	-	-	-	-	-	18,926	-	-	13,657	72.16%
4	IME	85,625	-	-	-	-	-	-	-	85,625	-	-	61,787	72.16%
5	Safety Net Care	68,889	-	-	-	-	-	-	-	68,889	-	-	49,711	72.16%
6	HQII Pool	12,012	-	-	-	-	-	-	-	12,012	-	-	8,668	72.16%
7	Physician Services	41,518	68	5,166	5,596	-	17	493	-	30,094	-	85	32,213	77.59%
8	IHS Hospital	131,261	131,261	-	-	-	-	-	-	-	-	-	131,261	100.00%
9	ICF-IID	28,584	-	115	125	-	-	-	-	28,344	-	-	20,677	72.34%
10	Clinic Services	53,058	-	139	150	-	-	1,852	-	50,893	-	24	38,330	72.24%
11	Federal Qualified Health Centers	5,599	-	591	640	-	-	103	-	4,265	-	-	4,302	76.85%
12	Other Practitioners	32,113	-	402	436	-	-	1,090	-	30,185	-	-	23,351	72.72%
13	Outpatient Hospital	43,482	145	6,298	6,823	-	23	554	-	29,638	-	-	34,216	78.69%
14	PACE	11,930	-	-	-	-	-	-	-	11,930	-	-	8,609	72.16%
15	Others	52,804	4,026	6,923	7,500	2,274	29	1,658	-	30,369	-	26	42,688	80.84%
16	BH FFS	38,754	12,357	3,296	3,571	-	2	792	-	18,726	-	9	32,862	84.80%
17	**Subtotal**	**734,063**	**148,268**	**36,722**	**39,783**	**2,460**	**71**	**7,070**	**-**	**499,545**	**-**	**144**	**587,627**	**80.05%**
18	Traditional DD Waiver (DOH)	277,996	-	-	-	-	-	-	523	276,909	564	-	200,526	72.13%
19	Mi Via DD Waiver (DOH)	92,438	-	-	-	-	-	-	1,840	88,511	2,087	-	66,292	71.71%
20	**Subtotal**	**370,434**	**-**	**-**	**-**	**-**	**-**	**-**	**2,362**	**365,421**	**2,651**	**-**	**266,818**	**72.03%**
21	Centennial Care-Physical Health	1,549,337	30,613	-	-	13,696	1,212	83,622	-	1,419,951	-	244	1,128,868	72.86%
22	Centennial Care-LTSS	1,121,735	12,195	-	-	-	-	257	-	1,109,283	-	-	812,839	72.46%
23	Centennial Care-Behavioral Health	340,647	3,044	-	-	1,756	87	18,224	-	317,535	-	-	246,974	72.50%
24	**Subtotal**	**3,011,719**	**45,851**	**-**	**-**	**15,452**	**1,299**	**102,103**	**-**	**2,846,769**	**-**	**244**	**2,188,680**	**72.67%**
25	Medicare Part A	1,728	-	-	-	-	-	-	-	1,728	-	-	1,247	72.16%
26	Medicare Part B	141,120	5,780	-	-	-	-	-	-	119,511	-	15,829	92,019	65.21%
27	Medicare Part D	50,232	-	-	-	-	-	-	-	-	-	50,232	-	0.00%
28	**Subtotal**	**193,080**	**5,780**	**-**	**-**	**-**	**-**	**-**	**-**	**121,239**	**-**	**66,061**	**93,266**	**48.30%**
29	Utilization	5,000	-	-	-	-	-	-	5,000	-	-	-	3,750	75.00%
30	HIT	8,000	8,000	-	-	-	-	-	-	-	-	-	8,000	100.00%
30	Contracts	1,970	-	-	-	-	-	-	-	376	1,595	-	1,068	54.23%
31	**Subtotal**	**14,970**	**8,000**	**-**	**-**	**-**	**-**	**-**	**5,000**	**376**	**1,595**	**-**	**12,818**	**85.63%**
32	Rate Increase for Primary Care Services	-	-	-	-	-	-	-	-	-	-	-	-	
33	Health Home	-	-	-	-	-	-	-	-	-	-	-	-	
34	Health Insurance Providers Fee	92,607	-	36,534	-	-	-	2,875	-	53,197	-	-	74,804	80.78%
35	**Subtotal**	**92,607**	**-**	**36,534**	**-**	**-**	**-**	**2,875**	**-**	**53,197**	**-**	**-**	**74,804**	**80.78%**
36	Medicaid Expansion - Physical Health	1,352,931	22,318	572,507	758,106	-	-	-	-	-	-	-	1,265,514	93.54%
37	Medicaid Expansion - Behavioral Health	122,432	2,005	51,899	68,528	-	-	-	-	-	-	-	114,521	93.54%
38	**Subtotal**	**1,475,363**	**24,323**	**624,406**	**826,634**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,380,034**	**93.54%**
39														
40														
41	**Additional Cost Containment**	**-**	**-**	**-**		**-**	**-**	**-**	**-**	**-**	**-**		**-**	**0.00%**
42														
43														
44	**Grand Total**	**5,892,236**	**232,222**	**697,663**	**866,417**	**17,912**	**1,370**	**112,049**	**7,362**	**3,886,547**	**4,245**	**66,449**	**4,604,048**	**78.14%**

	State Share Revenues:	FY 19 Budget Request	HSD Projection
###	Department of Health (Line 18 & 19) [10,17]	103,616	103,616
50	Department of Health for Early Intervention	7,662	7,662
51	Department of Health for FQHCs	560	560
52	Department of Health for EC	1	1
53	Children, Youth and Families	-	-
54	County Supported Medicaid Fund	26,176	26,176
55	Tobacco Settlement Revenue, Base	26,319	26,319
56	Tobacco Settlement Revenue	-	-
57	UNM IGT	42,347	42,347
58	UNM IGT Additional Revenue		
59	**Total Operating Transfers In**	**206,682**	**206,682**
60			-
61	Physician UPL UNM	1,605	1,605
62	Safety Net Care [12]	-	-
63	County Supported Hospital Payments [12]	22,585	22,585
64	Additional County Supported Hospital Payments [13]	-	-
65	Miner's Colfax [15]	1,036	1,036
66	SB 42 Inpatient Services-Counties [16]		
67	Drug Rebates	33,265	33,265
68	Fraud	872	872
69	Income Diversion Trust	486	486
70	Buy-In Recovery	215	215
71	Cost Settlement	500	500
72	Estate Recovery	9	9
73	HMS-RAC-TPL/Subrogation		
74	**Total Other Revenues**	**60,573**	**60,573**
75			
76	**General Fund Need**		**997,184**
77			
78	**FY 2018 Appropriation**		**915,637**
79			
80	**State Revenue Surplus/(Shortfall)**		**(81,547)**

8/22/2017

PROJECTED REVENUES	
Federal Revenues	4,604,048
Federal Disallowance [11]	-
IHS Referrals at 100% FFP	8,394
MSBS CPE [14]	15,355
All State Revenues	1,264,439

Notes:

1. HIT, IHS, QI-1 Medicare Part B premiums, Refugees are eligible for 100% FFP.
2. Under ACA, the Medicaid Expansion population will be federally funded 94% in CY2018 and 93% in CY2019.
3. Health Homes, sterilization and family planning service costs are eligible for 90% FFP.
4. Breast and cervical cancer (BCC) program with enhanced FMAP.
5. CHIP is a Title XXI program with enhanced FMAP. However is assumed FY19 will have regular FMAP Medicaid was originally expected to receive 100% match for CHIP kids through FFY2019.
6. Utilization review is federally matched at 75%; admin. expenses.
7. Title XIX expenditures with regular FMAP. The FFY 2018 FMAP is from FFIS, released March 2016, based on preliminary income data.
8. Administration expenditures are eligible for 50% FFP.
9. Pregnancy termination, special needs and state only buy-in for Medicare Part B and all Medicare Part D buy-ins (Claw back) expenditures are not eligible for federal financial participation.
10. DOH for Medicaid DD, MF and Mi Via waiver services; projected revenue is without the 3% for admin.
11. There is a placeholder for potential federal disallowances.
12. The sum of lines 61 and 62 is the 1/12th% of the gross receipts tax contributed by the counties to support the Safety Net Care Pool and Hospital Payments.
13. Line 63 represents the additional county support fo fully fund the Safety Net Care Pool.
14. Starting from FY16, school districts will contribute the state share of Medicaid School-Based Services through Certified Public Expenditures.
15. Miner's Colfax hospital will contribute the state share of Safety Net Care Pool supplemental payments. The current estimate is for services provided in CY2018.
16. SB 42 stated that counties will contribute the state share of payments for fee-for-service inpatient services for their respective incarcerated populations.
17. DOH Budget request is for Developmental Disabled waiver only, budget request ($1.4 million) for Medically Fragile waiver is through HSD.

Public Hearings on the 1115 Waiver Application

3. Tribal consultation — Santa Fe, October 20, 2017

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Tuesday, October 17, 2017 12:34 PM
To: Anthony Yepa (1rezdog@gmail.com); Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dee Hutchison; Dempsey, K L (IHS/NAV); Haozous, Emily; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Brogdon, Mary, HSD; Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Rufus Greene, Jr. PhD; rvigil@pueblooftesuque.org; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Shije, Suzette, IAD; Terrie Chavarria; Thelma Gonzales; Zamora, Volelle
Cc: Shije, Suzette, IAD; Earnest, Brent, HSD
Subject: Agenda for Tribal Consultation 10/20/2017
Attachments: Tribal Consultation Agenda10.20.2017.pdf; IAIA_CampusMap_v71217.pdf

Importance: High

Good afternoon NATAC members,
This consultation will be at IAIA at the Center for Lifelong Education (CLE) on the second floor. See map attached.

Respectfully,
Theresa Belanger

Theresa Belanger, LBSW, MA Medical Assistance Division
Native American Liaison (Chippewa)
Office: 505-827-3122 *Theresa.belanger@state.nm.us*

"Do a good deed daily"

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Friday, October 06, 2017 4:53 PM
To: Carla Martinez, Jicarilla Apache Nation; Chairman Jeff Haozous; Govenor Lawrence Montoya; Sandoval, Sheri; Governor Brian Coriz; Governor Carl Schildt; Archuleta, Sherry; DryWater, Janine; Mountain, James; Governor Jose Benavidez; Governor Joseph Talachy; Governor Joseph Toya; Riley, Kurt; Quintana, Charlene; Governor Michael Chavarria; Ortiz, Nancy; Perez, Phillip A.; Governor Ruben Romero; Governor Val Panteah, Sr.; Pino, Tina; Mark Freeland (m.freeland@navajo-nsn.gov); President Danny Breuninger, Sr.; President Edward Velarde
Cc: Anthony Yepa (1rezdog@gmail.com); Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dee Hutchison; Dempsey, K L (IHS/NAV); Haozous, Emily; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Brogdon, Mary, HSD; Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Rufus Greene, Jr. PhD; rvigil@pueblooftesuque.org; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Shije, Suzette, IAD; Terrie Chavarria; Thelma Gonzales; Zamora, Volelle
Subject: Revised Draft Waiver Application
Attachments: NoticetoInterestedParties_AmendedDraft_100617.pdf

Importance: High

Good afternoon Honorable Tribal Leaders,
This email is to inform you that the Human Services Department/Medical Assistance Division has issued a revised draft of the 1115 Centennial Care waiver application. The website as well as a summary of the proposed revisions are in the above attachment and can also be found at on HSD's website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please note that the comment period has been extended until **5:00 pm Mountain Time on Monday, November 6, 2017**. Comments may be submitted through HSD's website, by email to HSD-PublicComment@state.nm.us, or by postal mail to: Human Services Department, ATTN: HSD Public Comments, PO Box 2348, Santa Fe, NM 87504-2348.

The formal Tribal Consultation will still be held on Friday, October 20, 2017 at 9:00 a.m. at the Institute of American Indian Arts in Santa Fe.

Please let me know if you have any questions.

Respectfully submitted,
Theresa Belanger

Theresa Belanger, LBSW, MA Medical Assistance Division
Native American Liaison (Chippewa)
Office: 505-827-3122 Theresa.belanger@state.nm.us

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Kurt Riley
Pueblo of Acoma
P.O. Box 309
Acoma, New Mexico 87034

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Riley,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program— Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Tuesday, September 05, 2017 3:39 PM
To: 'Alicia Ortega'
Subject: RE: Connecting

Importance: High

Hi Alicia,
No problem. I have been working with Erik Lujan on a date. We agreed to hold the Tribal consultation on **Friday, October 20, 2017 at 9:00 a.m. at IAIA.**
I will send APCG a copy of the announcement soon. All the governors received a Save the Date letter last week.

Who should I ask from APCG for a formal appointment to the MAC (Medicaid Advisory Committee) meetings? Currently Ramona Dillard is the APCG representative, but she would like APCG to appoint someone to this important committee as well as an alternate appointee. Thank you Alicia.

Best,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

From: Alicia Ortega [mailto:APCG@indianpueblo.org]
Sent: Friday, September 01, 2017 1:43 PM
To: Belanger, Theresa, HSD
Subject: Connecting

Hello Theresa,

I am so sorry for the delay. Things have gotten extremely busy and I'm just trying to keep afloat lately. My apologies. I hope you have been able to connect with Erik on the matter as well. Have you all decided on a date(s) or have an idea of what time/where? October 16th?

Respectfully,

Alicia Ortega

Executive Director
All Pueblo Council of Governors
2401 12th Street NW, Suite 214 S
Albuquerque, NM 87104
505.212.7041
APCG@indianpueblo.org

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Monday, August 28, 2017 2:04 PM
To: Anthony Yepa (1rezdog@gmail.com); Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dempsey, K L (IHS/NAV); Emily Haozous; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Mary Brogdon; Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Robina Henry Acting EO; Rufus Greene, Jr. PhD; 'rvigil@pueblooftesuque.org'; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Shanita Harrison; Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Terrie Chavarria; Thelma Gonzales; Zamora, Volelle; Zunie, Kelly, IAD
Cc: Clavio, Daniel, HSD; Roybal-Varela, Maria, HSD
Subject: Save the Date Announcement for next Tribal Consultation

This email is to inform you that the Human Services Department along with the Medical Assistance Division has scheduled a formal Tribal Consultation to review the draft 1115 Demonstration Waiver Application for the Centennial Care program. It is scheduled for:

Friday, October 20, 2017
9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

You will be notified of the website address where you can review the draft 1115 Demonstration Waiver application in the next few days. **This Tribal consultation will take the place of our October NATAC meeting so there will not be a meeting on October 16th.**

Please let me know if you have any questions.

Respectfully submitted,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Monday, August 28, 2017 1:57 PM
To: Carla Martinez, Jicarilla Apache Nation; Chairman Jeff Haozous; Govenor Lawrence Montoya; Governor Anthony Ortiz; Governor Brian Coriz; Governor Carl Schildt; Governor Craig Quanchello; Governor Eugene Herrera; Governor James Mountain; Governor Jose Benavidez; Governor Joseph Talachy; Governor Joseph Toya; Governor Kurt Riley; Governor Mark Mitchell; Governor Michael Chavarria; Governor Peter Garcia, Jr.; Governor Phillip Perez; Governor Ruben Romero; Governor Val Panteah, Sr.; Governor Virgil Siow; Mark Freeland (m.freeland@navajo-nsn.gov); President Danny Breuninger, Sr.; President Edward Velarde
Cc: Earnest, Brent, HSD; Nelson, Michael, HSD; Michelle N. Trujillo (michellen.trujillo@state.nm.us); Smith-Leslie, Nancy, HSD (Nancy.Smith-Leslie@state.nm.us); Medrano, Angela, HSD; Clavio, Daniel, HSD; Belanger, Theresa, HSD; Roybal-Varela, Maria, HSD; Sanchez, Jason S, HSD; Armijo, Kari, HSD; Pearson, Sean, HSD; Shije, Suzette, IAD; 'Philip Cooney'
Subject: SAVE the DATE for Tribal Consultation

Importance: High

* **Save the Date** *

This email is to inform you that the Human Services Department along with the Medical Assistance Division has scheduled a formal Tribal Consultation to review the draft 1115 Demonstration Waiver Application for the Centennial Care program. It is scheduled for:

Friday, October 20, 2017
9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

You will be notified of the website address where you can review the draft 1115 Demonstration Waiver application in the next few days along with a formal invite to the consultation.

Please let me know if you have any questions.

Respectfully submitted,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Monday, August 21, 2017 12:23 PM
To: 'Erik Lujan'
Subject: RE: second Tribal Consultation

Thanks Erik. This helps a lot.
Theresa

From: Erik Lujan [mailto:elujan78@gmail.com]
Sent: Monday, August 21, 2017 12:06 PM
To: Belanger, Theresa, HSD
Subject: Re: second Tribal Consultation

Hi, Theresa,

In that week Fridays (10/20) are usually best, Wednesday (10/18) would be my next suggestion.

Erik Lujan
Health Policy Consultant
(505) 280-2811

On Mon, Aug 21, 2017 at 9:25 AM, Belanger, Theresa, HSD <Theresa.Belanger@state.nm.us> wrote:

Good morning Erik,

We are looking at scheduling the second Tribal consultation on the Centennial Care 2.0 renewal sometime the week of October 16th at IAIA in Santa Fe. I have asked Alicia Ortega with APCG to see if a day that week works for Tribal leadership. I would also like to ask you the same. Could you assist me with finding a good day that week for the Tribal consultation?

Many thanks Erik.

Theresa

Theresa Belanger, LBSW, MA

Native American Liaison (Chippewa)

Medical Assistance Division

505-827-3122

Theresa.belanger@state.nm.us

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Thursday, August 10, 2017 4:20 PM
To: Alicia Ortega
Subject: scheduling formal Tribal Consultation

Good afternoon Alicia,
I hope you have had a chance to enjoy the summer before it's over!
I would like to schedule a formal Tribal Consultation for the week of October 16th. Could you please provide me with some dates that work for the AIPC Governors? I know Laguna has a feast on October 17th.
The venue will be somewhere in Albuquerque most likely. We could schedule it in the morning or afternoon based on the Governors' wishes.
Many thanks for your help on this Alicia.

Sincerely,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Kurt Riley
Pueblo of Acoma
P.O. Box 309
Acoma, New Mexico 87034

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Riley,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Jose R. Benavides
Pueblo of Isleta
P.O. Box 1270
Isleta Pueblo, New Mexico 87022

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Benavides,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Virgil A. Siow
Pueblo of Laguna
P.O. Box 194
Laguna Pueblo, New Mexico 87026

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Siow,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Peter Garcia Jr.
Ohkay Owingeh
P.O. Box 1099
San Juan, New Mexico 87566

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Garcia Jr.,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Eugene Herrera
Pueblo of Cochiti
P.O. Box 70
Cochiti, New Mexico 87072

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Herrera,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Joseph A. Toya
Pueblo of Jemez
P.O. Box 100
Jemez Pueblo, New Mexico 87024

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Toya,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Phillip A. Perez
Pueblo of Nambe
Route 1, Box 117-BB
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Perez,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Craig Quanchello
Pueblo of Picuris
P.O. Box 127
Penasco, New Mexico 87553

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Quanchello,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

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Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Joseph M. Talachy
Pueblo of Pojoaque
78 Cities of Gold Road
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Talachy,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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New Mexico Human Services Department

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Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Anthony Ortiz
Pueblo of San Felipe
P.O. Box 4339
San Felipe Pueblo, New Mexico 87001

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Ortiz,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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New Mexico Human Services Department

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Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Brian Coriz
Pueblo of Santo Domingo
P.O. Box 99
Santo Domingo, New Mexico 87052

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Coriz,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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New Mexico Human Services Department

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Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Val Panteah, Sr.
Pueblo of Zuni
P.O. Box 339
Zuni, New Mexico 87327

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Panteah,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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New Mexico Human Services Department

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Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Malcolm Montoya
Pueblo of Sandia
481 Sandia Loop
Bernalillo, New Mexico 87004

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Montoya,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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83 Avan Nu Po Road
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New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor J. Michael Chavarria
Pueblo of Santa Clara
P.O. Box 580
Espanola, New Mexico 87532

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Chavarria,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

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Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Ruben Romero
Pueblo of Taos
P.O. Box 1846
Taos, New Mexico 87571

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Romero,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

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Sincerely,

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New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Carl Schildt
Pueblo of Zia
135 Capitol Square Drive
Zia Pueblo, New Mexico 87053-6013

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Schildt,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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Institute of American Indian Arts (IAIA)
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Santa Fe, NM 87508

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New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

President Edward Velarde
Jicarilla Apache Nation
P.O. Box 507
Dulce, New Mexico 87528

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear President Velarde,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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Institute of American Indian Arts (IAIA)
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Santa Fe, NM 87508

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New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

September 5, 2017

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

President Danny Breuninger, Sr.
Mescalaro Apache Tribe
P.O. Box 227
Mescalero, New Mexico 88340

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear President Breuninger,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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Santa Fe, NM 87508

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Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

President Russell Begaye
Navajo Nation
P.O. Box 9000
Window Rock, Arizona 86515

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear President Begaye,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Chairman Jeff Haozous
Fort Sill Apache Tribe
Route 2, Box 121
Apache, Oklahoma 73006

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Chairman Haozous,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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Suzette Shije, Acting Secretary, Indian Affairs Department
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Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Executive Director Gil Vigil
Eight Northern Indian Pueblos Council
P.O. Box 969
San Juan Pueblo, New Mexico 87566

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Mr.Vigil,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Mark Mitchell
Pueblo of Tesuque
Route 42, Box 360-T
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Mitchell,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor James Mountain
Pueblo of San Ildefonso
02 Tunyo Po
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Mountain,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Lawrence A. Montoya
Pueblo of Santa Ana
2 Dove Road
Santa Ana Pueblo, New Mexico 87004

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Montoya,

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New Mexico Human Services Department

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Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Chairman E. Paul Torres
All Indian Pueblo Council
2401 12th Street, NW
Albuquerque, New Mexico 87103

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Chairman Torres,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

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Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

Centennial Care 2.0
Draft Application for Renewal of Section 1115 Demonstration Waiver
Tribal Consultation

Friday, October 20, 2017
9:00 AM

Location
Institute of American Indian Arts (IAIA) – Center for Lifelong Education
83 Avan Nu Po Road
Santa Fe, NM 87508

Consultation Protocol: Individuals representing a Tribe, Pueblo, or Nation shall present a letter of authorization from their governor, president, or chairperson before the session begins. The letter must be on official Tribal letterhead.

AGENDA

9:00 Invocation – Former Governor Rick Vigil, Tesuque Pueblo

9:10 Welcome and Introductions – Secretary Brent Earnest, Human Services Dept.
Suzette Shije, Acting Cabinet Secretary, Indian Affairs Dept.

Introductions from Tribal leadership

Review of consultation protocol – Theresa Belanger, Tribal Liaison, Medical Assistance Division

9:30 HSD Presentation on Centennial Care 2.0 Draft Application for Renewal of Section 1115 Demonstration Waiver (PowerPoint)

Tribal leadership discussion

11:30 Public Comment (3 Minute Limit)

Adjourn

HUMAN SERVICES DEPARTMENT

Centennial Care 2.0: 1115 Demonstration Waiver Renewal Application

Tribal Consultation

October 20, 2017
Santa Fe, NM

Today's Agenda & Goals

Centennial Care 2.0 Concepts

- Discuss recent changes in current managed care program
- Discuss proposed changes for Centennial Care 2.0 by area of focus as presented in the draft 1115 waiver renewal application.

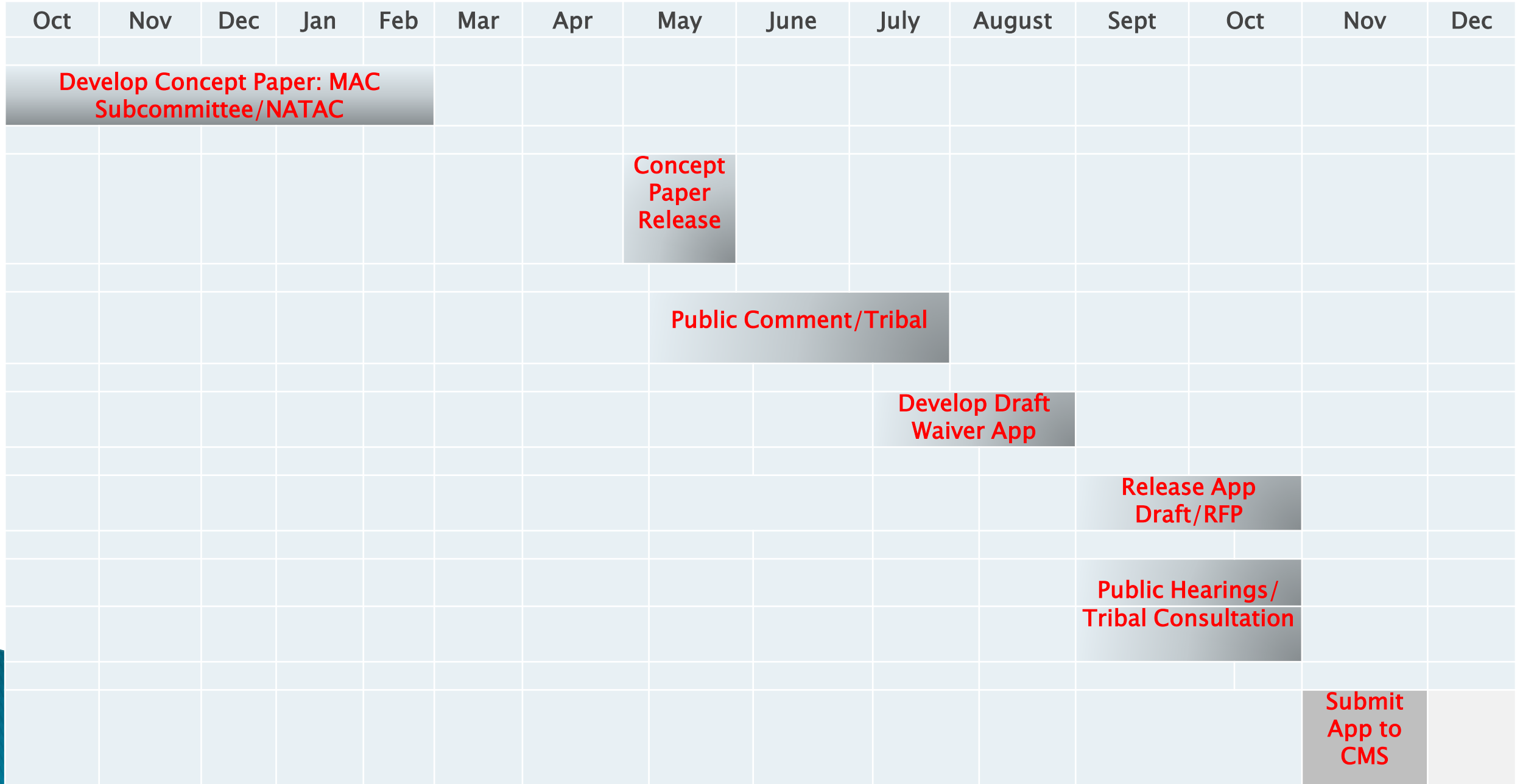
Comments/Discussion

- Consider your feedback and recommendations for Centennial Care 2.0 final waiver application.

Wrap Up

- Present timeframe for public comment.
- Thank you for your time and feedback.

Centennial Care 2.0 Waiver Renewal



Year-Long Public Input Process

Public Input Opportunities in the Development of Concept Paper (before May 2017)	Public Input Meetings about Draft Concept Paper (after May 2017)	Other Input Opportunities
Medicaid Advisory Subcommittee: October 14, 2016 – 29 attendees (Santa Fe) November 18, 2016 – 34 attendees (ABQ) December 16, 2016 – 62 attendees (Santa Fe) January 13, 2017 – 55 attendees (ABQ) February 10, 2017 – 50 attendees (Santa Fe) *Public Comment at end of each meeting*	**Statewide Public Input Sessions & Attendees:** **Albuquerque** – June 14, 2017 – 160 attendees **Silver City** – June 19, 2017 – 22 attendees **Farmington** – June 21, 2017 – 41 attendees **Roswell** – June 26, 2017 – 30 attendees	**Written Comments:** May – July 2017 – 21 letters received
Native American Technical Advisory Committee: December 5, 2016 – NATAC Membership (Santa Fe) January 20, 2017 – NATAC Membership (ABQ) February 10, 2017 – NATAC Membership (Santa Fe) April 10, 2017 – NATAC Membership (ABQ)	**Formal Tribal Consultation** June 23, 2017 – 12 tribal officials/reps & 85 attendees – Albuquerque **Native American Technical Advisory Committee**: July 10, 2017 – NATAC Membership	**HSD Email Address Established:** Ongoing from October 2016– July 2017 137 emails received
MAC Meetings with Public Input: November 2016 – 77 attendees (Santa Fe) April 2017 – 55 attendees (Santa Fe)	**MAC Meetings with Public Input:** July 24, 2017 – (Santa Fe)	**Public Hearings to be held in October 2017:** • Las Cruces • Las Vegas • Santa Fe • Albuquerque **Formal Tribal Consultation** – Oct 20, 2017

Waiver Versus Non-Waiver Topics

- Broad changes to the Medicaid program may require waiver authority from CMS to implement while other changes may be implemented through contractual provisions with the managed care organizations (MCOs) or rule promulgation

Waiver

- System Transformation: Items that require waiver authority to implement
- Eligibility changes or expansions
- New benefit packages
- Financing

Non-Waiver

- Policy or implementation issues
- New contract terms or processes
- Modification of provider qualifications
- Implementation of monitoring approaches

Waiver Versus Non-Waiver Topics

- Several recommendations received from Tribal organizations are being implemented through changes to the MCO contracts:
- Effective CY 2018:

Expanding the use of Community Health Representatives (CHRs):

- A minimum of 10% increase in number of members served by CHWs, CHRs, and/or Certified Peer Support Workers for activities such as care coordination, home visiting, health education, health literacy, translation support
- The MCO's project plan for its delivery system improvements must include efforts to create a sustainable funding stream for CHWs/CHRs/CPSWs
- The MCOs must provide quarterly reports to HSD that indicate the number of CHRs supported at Tribal 638 facilities

Native American members requesting a Native American care coordinator:

4.4.12.11: If a Native American Member requests assignment to a Native American care coordinator, the MCO must employ or contract with a Native American care coordinator or CHR to serve as the care coordinator

CENTENNIALCARE2.0

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Benefit and delivery system modifications
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to eligibility

Person-Centered Initiatives in Centennial Care 2.0

- MCO Care Coordinators focused on High-Need Members
- 300,000 Members Served in Patient -Centered Medical Homes
- Care Coordination at Provider Level
- Home Visiting Pilot for Prenatal, Post Partum and Early Childhood Services
- Full Delegation Model with Value Based Purchasing Arrangements
- Shared Functions Model with Providers and Community Partners
- Health Homes for Members with Complex Behavioral Health Needs
- Use of Community Health Workers, Community Health Reps and Peer Support Specialists
- Supportive Housing Specialists and Justice-Involved Liaisons
- Expanded Access to Home and Community Based Services

Care Coordination

Proposals

#1: Increase care coordination at the provider level

- Full Delegation Model for providers entering into Value-Based Purchasing agreements to manage total cost of members' care and Shared Functions Model for providers and/or community partners conducting more limited care coordination activities—using local resources to assist with care coordination, including **Community Health Representatives**

#2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

#3: Expand programs working with high needs populations

- First Responders, wellness centers, personal care agencies and Project ECHO (Extension for Community Health Outcomes) ;
- Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists

Care Coordination

Proposals

#4: Initiate care coordination for justice-involved prior to release from incarceration

- Allowing care coordination activities to be conducted by county/facility prior to release
- Strengthening MCO contract requirements regarding after-hour transitions and requiring a dedicated staff person at each MCO to serve as a liaison with the facilities and facilitate the care coordination, including for Native American members transitioning from incarceration

#5: Obtain 100% federal funding for Native American members for services received through Indian Health Services (IHS) and/or Tribal 638 facilities to leverage CMS's reinterpretation of federal guidance

Benefit and Delivery System Modifications

Proposals

#1: Cover most adults under one comprehensive benefit plan

- Consolidate two different adult benefit plans under a single comprehensive benefit package by redesigning the Alternative Benefit Plan (ABP) for adult expansion population to also cover the Parent/Caretaker adult population
- Individuals with higher needs who are determined to meet the "medically frail" criteria may receive the standard Medicaid benefit package and not the ABP
- Eliminate habilitative services from the ABP, but add a limited vision benefit similar to the standard Medicaid package vision benefit, expanding access for the 250,000 members currently enrolled
- Expand service providers for the non-emergent medical transportation benefit to include ride sharing companies and leverage new technologies such as mobile apps

#2: Waive federal EPSDT rule for 19-20 year olds enrolled in the single adult plan to further streamline the benefit package so that all adults receive the same comprehensive benefits

#3: Develop buy-in premiums for dental and vision services for adults (if necessary due to budgetary shortfall)

Benefit and Delivery System Modifications

Proposals

#4: Allow for one-time, start-up funding for Community Benefit members who transition from the agency-based model to self-directed model -- up to $2,000

#5: Increase caregiver Community Benefit respite limit (from 100 hours to up to 300 hours annually) for caregivers of both adults and children

#6: Continue expanded access to Community Benefit services for all eligible members who meet a Nursing Facility Level of Care (NF LOC) but establish annual limits on costs for certain home and community-based services in Self-Directed model:

- Related Goods & Services - $2,000 annual limit
- Non-medical transportation - $1,000 annual limit for carrier pass & mileage only
- Specialized Therapies - $2,000 annual limit

Based on 2016 data, 17 Native American members would be impacted by the new limitations

Benefit and Delivery System Modifications

Proposals

#7: Pilot a home-visiting program focused on pre-natal, post-partum and early childhood development services

- Collaborate with the Dept. of Health and Children, Youth & Families Dept. to implement a home visiting pilot in designated counties to provide Medicaid-reimbursable services to eligible pregnant women

#8: Develop Peer-Delivered, Pre-Tenancy and Tenancy Supportive Housing Services

- Create a supportive housing service that provides some peer-delivered tenancy support services to participants with complex behavioral health needs

#9: Request waiver from limitations imposed on the use of Institutions of Mental Disease (IMD)

- Request expenditure authority for members in both managed care and fee-for-service to receive inpatient services in an IMD so long as the cost is the same as, or more cost effective, than a setting that is not an IMD.

Benefit and Delivery System Modifications

Proposals

#10: Expand Health Homes (CareLink NM) for individuals with complex behavioral health needs who may require more intensive care coordination services

- HSD has approved Kewa Pueblo Health Clinic as a new Health Home Provider beginning next year

#11: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

#12: Request waiver authority for enhanced administrative funding to expand availability of Long Acting Reversible Contraception (LARC) for certain providers

- Requesting authority to receive increased administrative funding to expand availability of LARC by reimbursing DOH or other sponsoring agencies for the cost of purchasing and maintaining LARCs

Payment Reform

Proposals

#1: Pay for improved healthcare outcomes for members by requiring better quality and value from providers and increasing the percentage of provider payments that are risk-based (providers responsible for total cost of care of assigned members)

- Expand requirements for MCOs to shift provider payments from fee-for-service that pays for volume of services to paying more for quality and improved member outcomes

#2: Use Value Based Purchasing to drive program goals, such as:

- Increasing care coordination at provider level, expanding the health home model, improving transitions of care, and improving provider shortage issues.
- Include nursing facilities in Value Based Purchasing arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff

Payment Reform

Proposals

#3: Advance Safety-Net Care Pool Initiatives

- Incrementally shift the funding ratio between the Uncompensated Care Pool and the Hospital Quality Improvement Incentive Pool so that more dollars are directed toward improved hospital quality initiatives
- Expand participation to all willing hospitals and allow other providers to participate, such as nursing facilities
- Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network

Member Engagement and Personal Responsibility

Proposals

#1: Advance the Centennial Rewards Program that rewards members for completing healthy activities, such as obtaining preventive screenings

#2: Implement premiums for populations with income that exceeds 100% of the Federal Poverty Level (FPL).

- **Applies to three categories of eligibility:**
  1) Adults in the Expansion with income greater than 100%
  2) CHIP program (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
  3) Working Disabled Individuals (WDI) Category (income extends to 250% FPL)

Native American members are exempt from all cost-sharing

Proposed Premium Structure (not applicable)

Annual Household Income (Household of 1)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
$12,060 – $18,090	$10	$20	$20	$40
$18,091 – $24,120	$15	$30	$30	$60
$24,121 – $30,150	$20	$40	$40	$80
$30,151 – $36,180	$25	$50	$50	$100

Member Engagement and Personal Responsibility

Proposals

#3: Require co-payments for certain populations

- Seeking to streamline copayments across populations
- HSD currently has copayment requirements for the Children's Health Insurance Program and for Working Disabled Individuals
- Add copayments for the adult expansion population with income greater than 100% FPL
- Most Centennial Care members will have copayments for non-preferred prescription drugs and for non-emergent use of the Emergency Department
- The following populations would be exempt from all copayments:
  - Native Americans
  - Intermediate Care Facility for Individuals with Intellectual Disabilities
  - QMB/SLIMB/QI1 individuals
  - Individuals on Family Planning only
  - Individuals in the Program of All Inclusive Care for the Elderly
  - Individuals on the Developmental Disabilities and Medically Fragile waivers
  - People receiving hospice care

Member Engagement and Personal Responsibility

Proposals

#4: Allow providers to charge small fees for three or more missed appointments

#5: Expand opportunities for Native American members in Centennial Care

- Require MCOs to expand contractual or employment arrangements with Community Health Representatives throughout the state
- Work with Tribal providers to develop capacity to enroll as Long Term Services and Supports providers and/or health home providers
- Seek authority to collaborate with Indian Managed Care Entities (IMCE), including a pilot project with the Navajo Nation. An IMCE may operate in a defined geographic service area, but would be required to meet all other aspects of federal and state managed care requirements, including but not limited to financial solvency, licensing, provider network adequacy and access requirements. An ICME must be able to demonstrate compliance with the requirements in the Centennial Care managed care agreement, including delivery of all covered services. Implementation may require several phases during the waiver.

Administration Simplification through Refinements to Eligibility

Proposals

#1: Eliminate the three month retroactive eligibility period for most Centennial Care members

- Native American members and individuals residing in nursing facilities would be exempt from this provision

#2: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caretakers who have increased earnings that make them ineligible for the program

- The individuals previously using the category are now either transitioned to the adult expansion category or are eligible to receive subsidies to purchase coverage through the federal Exchange
- Since the implementation of the Affordable Care Act, use of the category dropped from 26,000 individuals to 2,000 (most Parent/Caretaker individuals with increased earnings now covered under the Adult Expansion)
- **Currently, there are 326 Native American members in this category**

Administration Simplification through Refinements to Eligibility

Proposals

#3: Implement an automatic NF LOC re-approval for certain members whose condition is not expected to change

#4: Incorporate eligibility requirements of the Family Planning program

- Benefits are limited to reproductive health care, contraceptives and related services—not comprehensive coverage
- 6% of population on Family Planning utilize coverage today
- HSD proposes to better target this program by designing it for men and women who are through the age of 50 who do not have other insurance (with certain exceptions)

#5: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

Public Comment

- The Department is accepting comments from the public about the Medicaid program known as Centennial Care and changes to the program being considered as part of the renewal of the Centennial Care federal 1115 waiver that will be effective on January 1, 2019.
- Comments will be accepted until **5:00 pm MST on Monday, November 6, 2017.**
- We are conducting four public hearings in different regions of the state:

Las Cruces – Thursday, October 12, 2017
Farm and Ranch Museum (1:30 pm – 3:30 pm)

Santa Fe – Monday, October 16, 2017
Medicaid Advisory Committee Meeting
NM State Library (1–4pm)

Las Vegas – Wednesday, October 18, 2017
Highlands University – Student Union Building/Student Center (1:30 pm – 3:30 pm)

Albuquerque – Monday, October 30, 2017
National Hispanic Cultural Center
Albuquerque, NM (5:30 pm – 7:30 pm)
Call toll-free 1-888-757-2790 or 1-719-359-9722 and enter participant code 991 379.

Public Comment

- Comments are also being accepted directly at HSD-PublicComment@state.nm.us or by mail:

  Human Services Department
  ATTN: HSD Public Comments
  PO Box 2348
  Santa Fe, NM 87504-2348

  More information about the waiver renewal and public comment process may be found on the Department's website:

  http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Thank you

Your time and input are valuable

Presentation to State Legislative Committees

1. Presentation to the Legislative Finance Committee, June 7, 2017

HUMAN SERVICES DEPARTMENT

Presentation to LFC: Behavioral Health Collaborative Strategic Plan, SFY2015-SFY2017

Wayne Lindstrom, CEO, BH Collaborative

June 7, 2017

Strengthening NM's Behavioral Health Service Delivery System

New Mexico's behavioral health service delivery system cannot sufficiently make necessary quality gains while continually being overstressed by the demands associated with complex regulations, inflexible financial incentives, and an inadequate workforce

HUMAN SERVICES DEPARTMENT

Strategic Planning Process

- Planning Session held July 30, 2015
- Diverse group of stakeholders included:
  - Senior managers from BH Collaborative agencies
  - Two cabinet secretaries (Indian Affairs and Veteran Services)
  - Three deputy secretaries (HSD, PED, CYFD)
  - County Commissioners
  - Behavioral Health Planning Council
  - Local Collaboratives
  - MCOs
  - Behavioral Health Providers Association
  - Other BH professional associations
  - UNM partners
  - Peers and family members
  - Legislative Finance Committee
  - Association of Counties

HUMAN SERVICES DEPARTMENT

Initial Steps

- December 2015 – draft report completed
- January 2016 – final plan adopted by Behavioral Health Collaborative
- Work groups formed and goals identified in three areas:
  - Finance
  - Regulations
  - Workforce
- Executive Team created with reps from BHSD, MAD and CYFD
  - Meets bi-monthly to monitor implementation

HUMAN SERVICES DEPARTMENT

Finance Goals

I. To increase the productivity, efficiency, and effectiveness of New Mexico's current behavioral health delivery system.

II. To implement a value-based purchasing system that supports integrated care and reinforces better health outcomes.

III. To identify, develop, and promote the implementation of effective strategies for state, counties, and municipalities to work together to fund the provision of better BH care, especially for high utilizers.

HUMAN SERVICES DEPARTMENT

Accomplishments – Finance

- Strengthening Sustainability of Services:
  - Medicaid Rule Change to be promulgated in Summer, 2017 to streamline service and staffing requirements
  - CCSS will no longer require certification
  - Recovery Services to be delivered for both individuals & groups
  - ACT regulations modified to broaden staffing
  - IOP certification process simplified
  - Training & TA for peers in CCSS & supervision of CSWs
  - Reimbursing Nursing-based services in BH settings

HUMAN SERVICES DEPARTMENT

Accomplishments – Finance

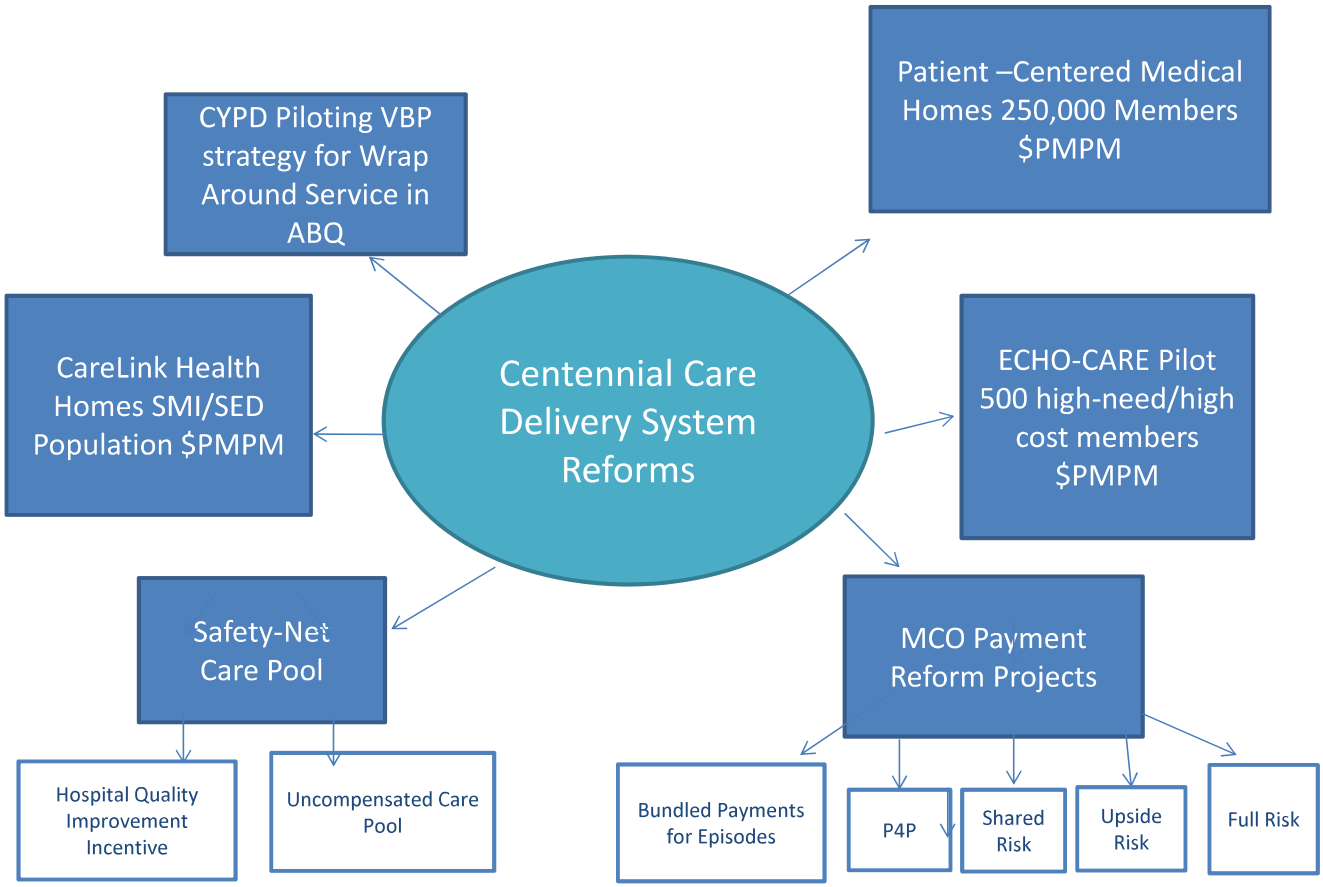
- Implementing Evidence-Based Practices:
  - Wrap Around
  - Infant Mental Health
  - Multi-Systemic Therapy
  - Dialectical Behavioral Therapy
  - Assertive Community Treatment
- Implementing Innovations:
  - Integrated Quality Services Review
  - CareLink
  - Treat First
  - Opioid State Targeted Response

HUMAN SERVICES DEPARTMENT

Value-Based Purchasing

HUMAN SERVICES DEPARTMENT

Pathways to Value-Based Purchasing



Accomplishments – Finance

- Supporting EMR Infrastructure Development:
  - Emergency Department Information Exchange (EDIE) now implemented in 8 hospitals statewide and expanding
  - Expanded Care Link advancing payment reform through capitated payments for 6 services in selected CMCH's & 2 FQHC's

- Partnering with Counties & Municipalities to fund better provision of behavioral health services:
  - The January 2017 Association of Counties Conference showcased BH innovations in the counties of McKinley, Rio Arriba, Bernalillo, and Dona Ana. Program is set for AOC's June conference and focuses on opioid crisis with attendees receiving Naloxone kits.

HUMAN SERVICES DEPARTMENT

Accomplishments – Finance

- Developed and funded two Investment Zones; Rio Arriba County has implemented county-wide Pathways care coordination system; McKinley County has renovated the Gallup Detox center, converted old hospital into a SUD RTC.
- Bernalillo County approved $16 million to fund behavioral health services, and 4 BHSD staff have received certificates of appreciation for participating in the 4 subcommittees.

HUMAN SERVICES DEPARTMENT

Regulations Goals

I. To identify, align, and eliminate inconsistencies in BH statutes, regulations, data, and policies in order to allow for a more effective and efficient operation of the publicly funded service delivery system.

II. Increase the adoption of person-centered interventions.

HUMAN SERVICES DEPARTMENT

Accomplishments – Regulations

- MMISR to be completed by 2018; progress on six-module RPF:
  - 2 Proposals being submitted (Data system & Integration platform)
  - 2 RFP's in review stage (Financial services & Quality assurance)
  - 2 RFP's to be developed (Population Health Mgmt & Unified Public Interface)
- Collaboration by DOH, CYFD, and BHSD on joint standards for Crisis Triage Centers
- *Treat First* operating across 13 agencies in 18 local communities. In 15 months, 2,600 clients served. "No Show" rate is only 17.7% (compared to previous range of 20-45%)

HUMAN SERVICES DEPARTMENT

Accomplishments – Regulations

- BHSD policy will reflect acceptance of adult RTC national accreditation

- Current challenges: Consolidating provider audit processes
  - Medicaid parity review may impact strategies
  - NCQA requirement a barrier to MCO centralized certification and consolidation of audits
  - Contractual language on standard credentialing deferred for upcoming 1115 waiver application and procurement cycle

HUMAN SERVICES DEPARTMENT

Workforce Goals

I. Support the development of behavioral health practitioners.
II. Build a more multidisciplinary and competent BH workforce.
III. Promote the future of excellence in the BH workforce and prepare for integrated care.
IV. Improve the public image of BH professions, raise awareness of its impact of the population, and promote the effectiveness of the service delivery system.

HUMAN SERVICES DEPARTMENT

Accomplishments – Workforce

- Supporting BH Interns
  - PED establishing a web-based clearinghouse for internship opportunities
  - BH Workforce Subcommittee has reviewed other states and provided recommendations given to the NM Health Care Workforce Committee
- Reciprocity
  - Each of the professional boards is undertaking steps toward reciprocity through rule changes
- Building a more competent, multidisciplinary workforce
  - Promoting cross-disciplinary supervision

HUMAN SERVICES DEPARTMENT

Accomplishments – Workforce

- A BH Clinical Practice Provider Guide has been developed and presentations will be given to senior classes at all major universities
- Have posted job opportunities on the NM Network of Care website
- Presented at workforce booths at the National Council on Behavioral Health, the National Association of Social Workers, NM Counseling Association Conference and the NASW-NM Conference
- A NM Behavioral Health Workforce Development Summit is planned for Fall, 2017 bringing together disciplines in academia and BH & primary care practitioners

HUMAN SERVICES DEPARTMENT

Accomplishments – Workforce

- A gap analysis conducted to determine EHR usage across BH providers. Sponsored an EHR Vendor event.
- CBHTR developing tele-supervision statewide for Social Workers working towards independent licensure
- *Pay It Forward* campaign to identify certified practitioners willing to volunteer as Supervisors.
- Completed Clinical Supervision Certification. Expands ability to fund non-independently licensed therapists.
- CMS approved NM State Plan amendment for the FQHC Community-based psychiatric Residency Program in Dona Ana County
- BH Collaborative to submit an MOU to NM Credentialing Board for BH Professionals – creates a joint credential on behalf of CYFD & BHSD for peer and family support specialists.

HUMAN SERVICES DEPARTMENT

For More Information

- Detailed Strategic Plan Implementation document will be posted on the New Mexico Network of Care website in mid-July, 2017
- Plan will be presented to BH Collaborative on July 13, 2017
- http://newmexico.networkofcare.org

HUMAN SERVICES DEPARTMENT

New Mexico Behavioral Health Collaborative: Strengthening New Mexico's Behavioral Health Service Delivery System

New Mexico's behavioral health service delivery system cannot sufficiently make necessary quality gains while continually being overstressed by the demands associated with complex regulations, inflexible financial incentives, and an inadequate workforce.

Finance	Regulations	Workforce
Goal:	***Goal:***	***Goal:***
I. To increase the productivity, efficiency, and effectiveness of New Mexico's current behavioral health delivery system.	***I. To identify, align, and eliminate inconsistencies in BH statutes, regulations, data, and policies in order to allow for a more effective and efficient operation of the publicly funded service delivery system.***	***I. Support the development of behavioral health practitioners.***
II. To implement a value-based purchasing system that supports integrated care and reinforces better health outcomes.	***II. Increase the adoption of person-centered interventions.***	***II. Build a more multidisciplinary and competent BH workforce.***
III. To identify, develop, and promote the implementation of effective strategies for state, counties, and municipalities to work together to fund the provision of better BH care, especially for high utilizers.		***III. Promote the future of excellence in the BH workforce and prepare for integrated care.***
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HUMAN SERVICES DEPARTMENT

Presentation to LFC: Behavioral Health Collaborative Strategic Plan, SFY2015-SFY2017

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HUMAN SERVICES DEPARTMENT

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HUMAN SERVICES DEPARTMENT

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Value-Based Purchasing

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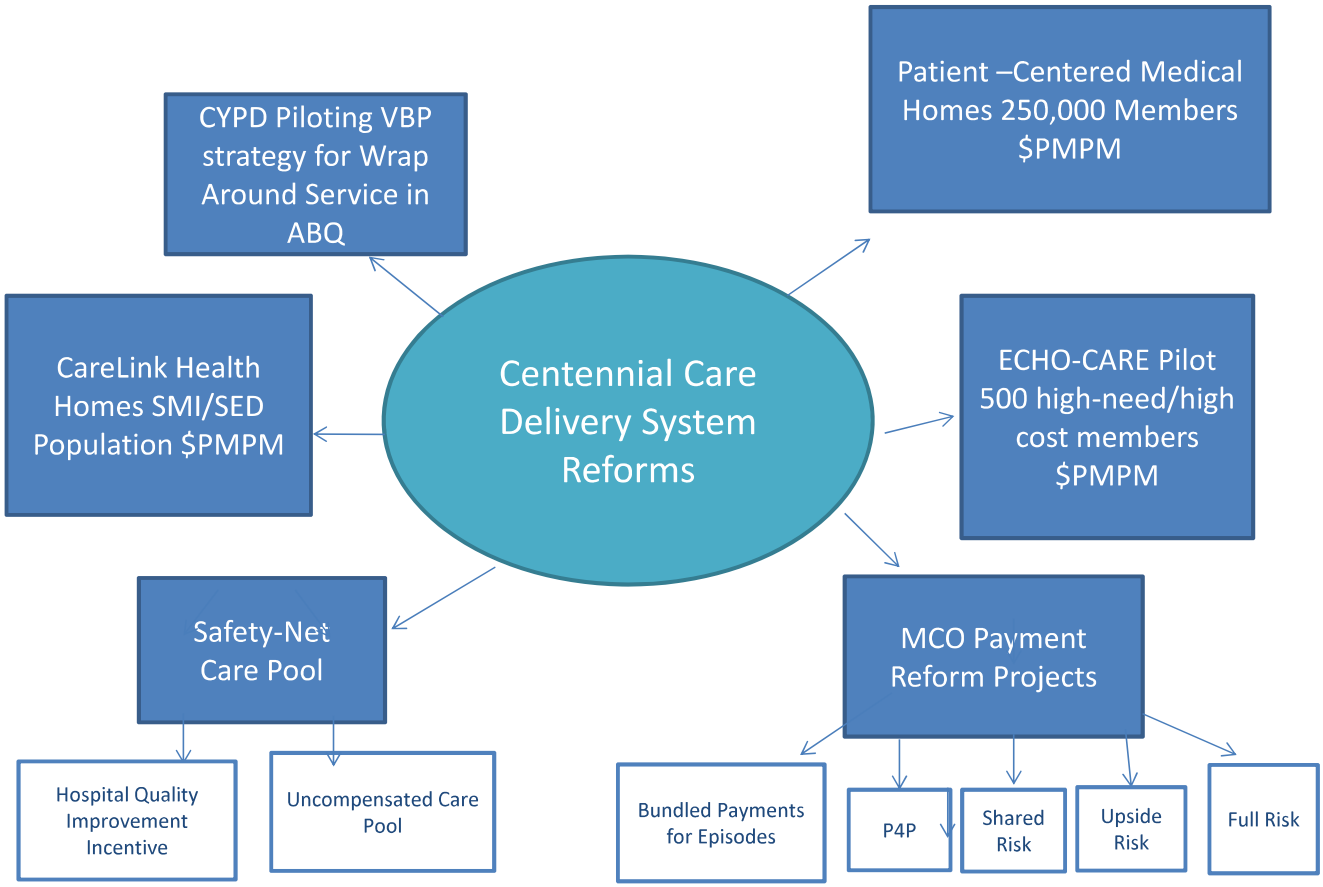
Pathways to Value-Based Purchasing



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Regulations Goals

I. To identify, align, and eliminate inconsistencies in BH statutes, regulations, data, and policies in order to allow for a more effective and efficient operation of the publicly funded service delivery system.

II. Increase the adoption of person-centered interventions.

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Accomplishments – Regulations

- MMISR to be completed by 2018; progress on six-module RPF:
  - 2 Proposals being submitted (Data system & Integration platform)
  - 2 RFP's in review stage (Financial services & Quality assurance)
  - 2 RFP's to be developed (Population Health Mgmt & Unified Public Interface)
- Collaboration by DOH, CYFD, and BHSD on joint standards for Crisis Triage Centers
- *Treat First* operating across 13 agencies in 18 local communities. In 15 months, 2,600 clients served. "No Show" rate is only 17.7% (compared to previous range of 20-45%)

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Accomplishments – Regulations

- BHSD policy will reflect acceptance of adult RTC national accreditation

- Current challenges: Consolidating provider audit processes
  - Medicaid parity review may impact strategies
  - NCQA requirement a barrier to MCO centralized certification and consolidation of audits
  - Contractual language on standard credentialing deferred for upcoming 1115 waiver application and procurement cycle

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Workforce Goals

I. Support the development of behavioral health practitioners.
II. Build a more multidisciplinary and competent BH workforce.
III. Promote the future of excellence in the BH workforce and prepare for integrated care.
IV. Improve the public image of BH professions, raise awareness of its impact of the population, and promote the effectiveness of the service delivery system.

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Accomplishments – Workforce

- Supporting BH Interns
  - PED establishing a web-based clearinghouse for internship opportunities
  - BH Workforce Subcommittee has reviewed other states and provided recommendations given to the NM Health Care Workforce Committee
- Reciprocity
  - Each of the professional boards is undertaking steps toward reciprocity through rule changes
- Building a more competent, multidisciplinary workforce
  - Promoting cross-disciplinary supervision

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Accomplishments – Workforce

- A BH Clinical Practice Provider Guide has been developed and presentations will be given to senior classes at all major universities
- Have posted job opportunities on the NM Network of Care website
- Presented at workforce booths at the National Council on Behavioral Health, the National Association of Social Workers, NM Counseling Association Conference and the NASW-NM Conference
- A NM Behavioral Health Workforce Development Summit is planned for Fall, 2017 bringing together disciplines in academia and BH & primary care practitioners

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Accomplishments – Workforce

- A gap analysis conducted to determine EHR usage across BH providers. Sponsored an EHR Vendor event.
- CBHTR developing tele-supervision statewide for Social Workers working towards independent licensure
- *Pay It Forward* campaign to identify certified practitioners willing to volunteer as Supervisors.
- Completed Clinical Supervision Certification. Expands ability to fund non-independently licensed therapists.
- CMS approved NM State Plan amendment for the FQHC Community-based psychiatric Residency Program in Dona Ana County
- BH Collaborative to submit an MOU to NM Credentialing Board for BH Professionals – creates a joint credential on behalf of CYFD & BHSD for peer and family support specialists.

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For More Information

- Detailed Strategic Plan Implementation document will be posted on the New Mexico Network of Care website in mid-July, 2017
- Plan will be presented to BH Collaborative on July 13, 2017
- http://newmexico.networkofcare.org

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Presentation to State Legislative Committees

2. Presentation to the Legislative Health and Human Services Committee, June 16, 2017

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Update on Medicaid
Presentation to the Legislative Health & Human Services Committee

Brent Earnest, Secretary, HSD
Nancy Smith-Leslie, Director, Medical Assistance Division, HSD
June 16, 2017

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New Mexico Medicaid Spending

- Total Medicaid spending is increasing, primarily due to enrollment growth.

- The FY18 general fund (GF) need for Medicaid is **$ 947.5 million**. The Legislature appropriated **$915.6 million**, resulting in a deficit of **$31.9 million** in FY 18.

($ in millions)	FY14 Actual	FY15 Projection	FY16 Projection*	FY17 Projection*	FY18 Projection*
Total Budget	$4,200.6	$5,162.3	$5,412.4	$5,570.4	$5,859.7
General Fund Need	$901.9	$894.1	$912.9	$914.6	$947.5

*Projection data as of January 2017. The projections include all push forward amounts between SFYs. FY16 general fund includes $18 million supplemental appropriation and general fund transfers from other divisions. These figures exclude Medicaid administration. FY18 General Fund projection some cost containment.

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Medicaid FY18 General Fund Budget Details

	GAA	Current Projection
Full Medicaid GF need	971.83	963.54
GF Cost Containment/Changes in Projection*N1	(16.00)	(7.71)
Medicaid Projection GF	**955.83**	**955.83**
Proposed Changes		
Additional Tobacco Revenue	(4.23)	(1.50)
Additional I.H.S. Revenue	(4.00)	-
Federal Delay in Health Insurers fee*	(17.00)	-
Additional Copays and Premiums*	(3.00)	-
Discontinue Centennial Rewards*	(2.00)	-
Other Cost Containment*	(4.10)	(38.63)
Reduce Hep C Treatment*	(5.80)	-
Total Proposed Changes	**(40.13)**	**(40.13)**
GAA General Fund Appropriation	**915.70**	**915.70**

*Cost Containment Item

N1 - Slightly lower enrollment growth and lower spending due to proposed co-pays are included in the projection

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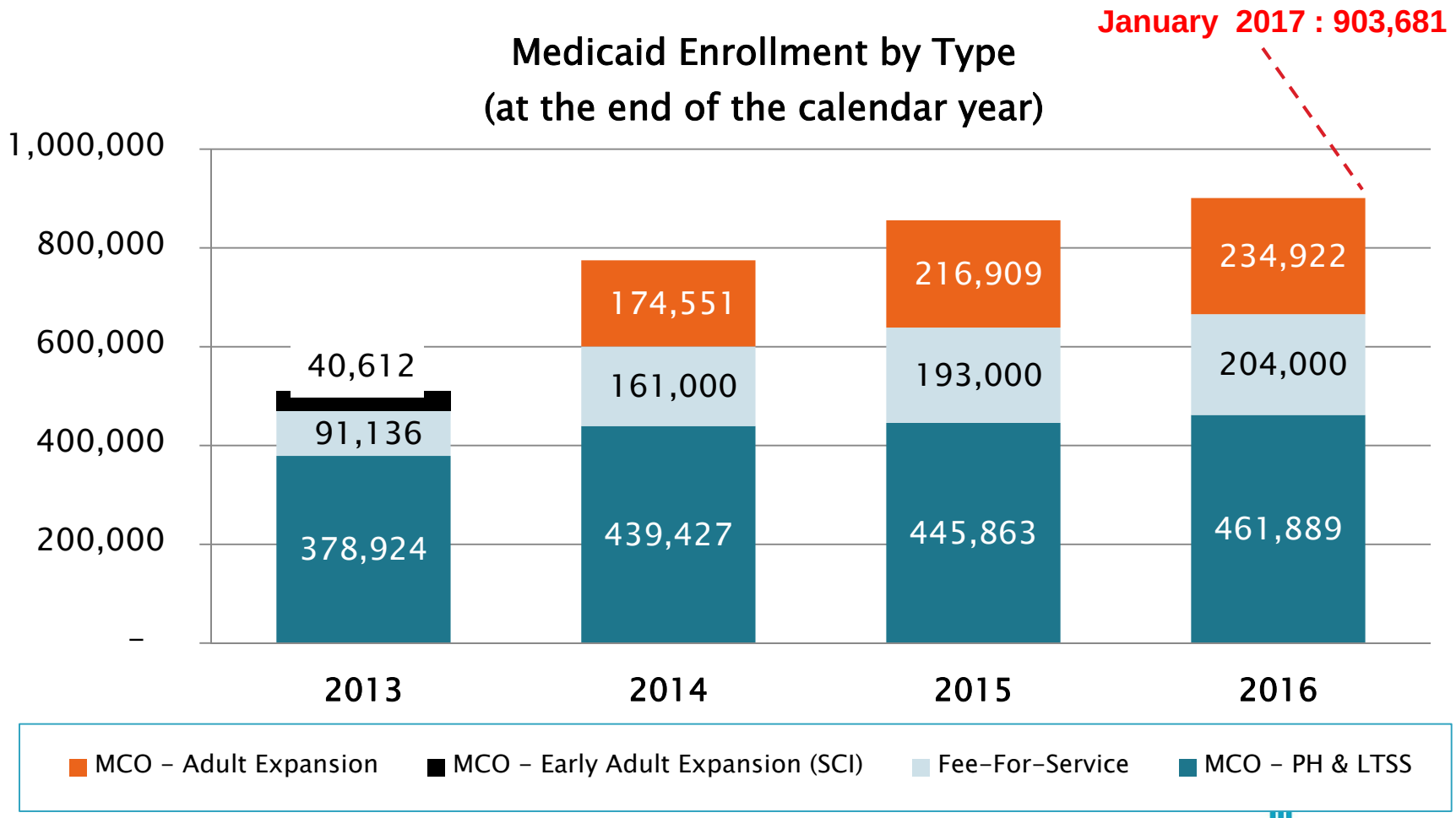
Key Driver of Costs



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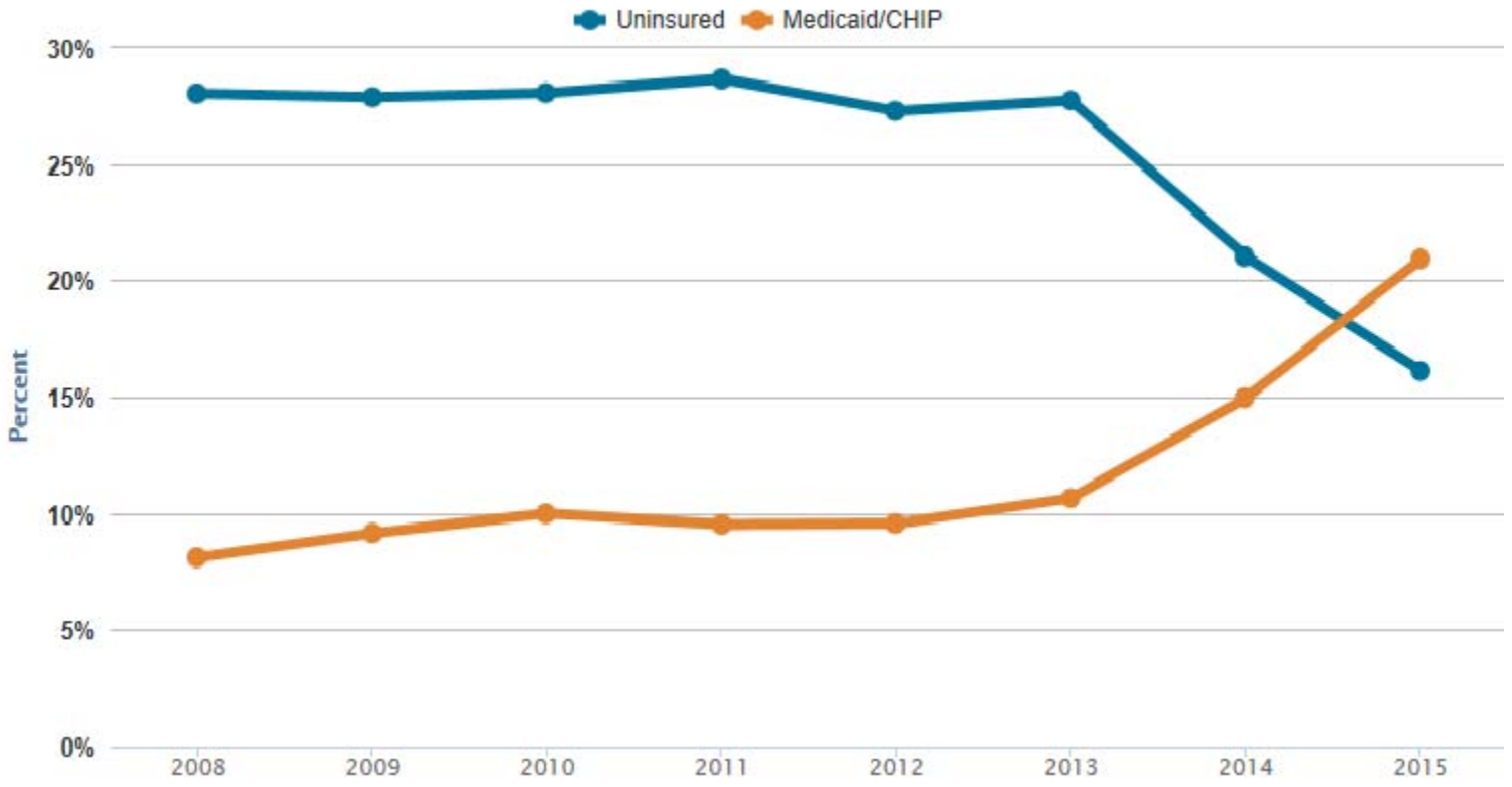
New Mexico Uninsured and Medicaid-Insured (19-64 population)



Source: SHADAC State Health Compare, University of Minnesota

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Managing Cost Growth

- Healthcare cost inflation grew an average of 2.6% in 2015 and growth averaged more than 3% in 2016
- Other national studies estimate medical cost inflation (price and utilization) at 6.5%

Centennial Care Stats

- Per capita medical services cost in Centennial Care **growing only 1.3%, driven primarily by increased enrollment and pharmacy costs**
- Managing cost through care coordination and other efforts
- Increases in preventive services and decreases in inpatient hospital costs
- Per person costs are lower in Centennial Care

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UPDATE: CO-PAYS FOR CY17

Note: Native Americans exempt from all co-pays. Notice of Proposed Rulemaking published on 6/13/17; public hearing scheduled on 7/14/17. Proposed rules are posted at www.hsd.state.nm.us/LookingforInformation/registers.aspx. Effective date 10/1/17.

	CHIP Age 0-5: 241-300% FPL Age 6-18: 191-240% FPL	**WDI** Up to 250% FPL	**Expansion Adults** Co-pays only for individuals with income greater than 100% FPL	**Other Medicaid**
Outpatient office visits • Preventive visits exempt • BH outpatient exempt	**$5/visit**	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	**$50/stay**	$50/stay	$50/stay	No co-pay
Outpatient surgeries	**$50/procedure**	$50/procedure	$50/procedure	No co-pay
Prescription drugs, medical equipment and supplies • Psychotropic drugs and family planning drugs/supplies exempt • Not charged if non-preferred drug co-pay is applied	**$2/prescription**	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic drugs and family planning drugs/supplies exempt	$8/prescription All FPLs and COEs, certain exemptions will apply			
Non-emergency ER visits	$8/visit All FPLs and COEs, certain exemptions will apply			

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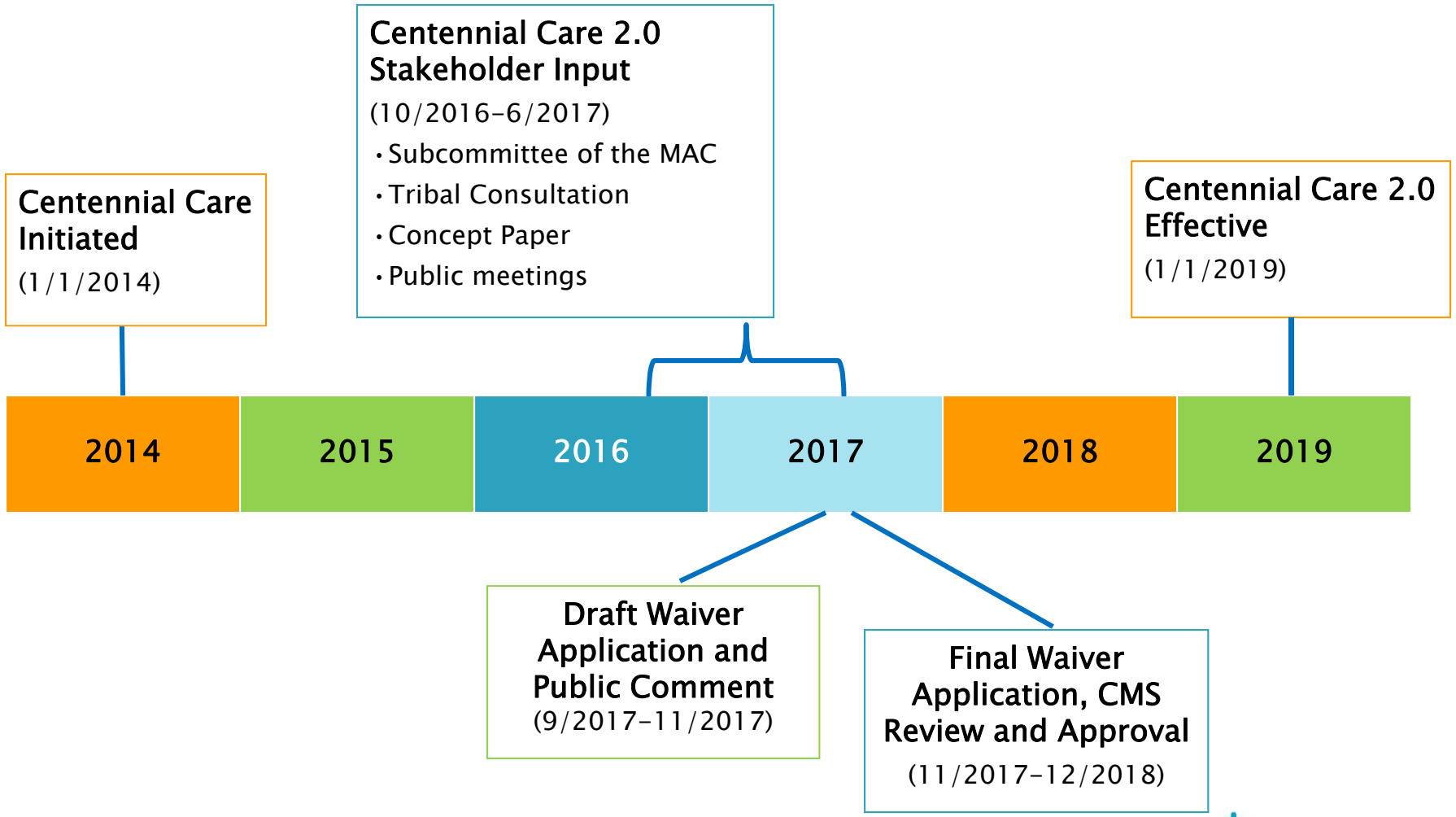
ENTENNIALCARE2.0

Centennial Care Timeline



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Vision for the future of Centennial Care

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Behavioral health integration
- Long-Term Services and Supports (LTSS)
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to benefits and eligibility

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Care Coordination 2.0

Identified Opportunities

Opportunity #1: Increase care coordination at the provider level

Opportunity #2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

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Care Coordination 2.0

Opportunities

Opportunity #3: Expand programs working with high needs populations

- Collaborate with successful community programs such as: First Responders, wellness centers, personal care agencies and Project ECHO
- More use of Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists
- Pilot a home visiting program that focuses on pre-natal care, post-partum care and early childhood services; and
- Leverage federal funding for supportive housing services

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Behavioral Health Integration 2.0

Opportunities

Opportunity #1: Expanding Health Homes (CareLink NM)

Opportunity #2: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

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Long-Term Services and Supports 2.0

Opportunities

Opportunity #1: Allow for one-time start-up goods for transitions when a member transitions from agency based to self directed

Opportunity #2: Increase caregiver respite hours

- Increase the current limit from 100 to 300 hours.

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Long-Term Services and Supports 2.0

Opportunities

Opportunity #3: In order to continue to provide access to the Community Benefit services for all eligible members who meet a NF LOC, establish some limits on costs for certain Community Benefits

Self-Directed CB Service	Annual Limit
Related goods and services separate from one-time funding for start-up goods	$2,000
Non-medical transportation	$1,000
Specialized therapies such as acupuncture or chiropractic	$2,000

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Long-Term Services and Supports 2.0

Opportunities

Opportunity #4: Implement an automatic NF LOC approval for members whose condition is not expected to change

Opportunity #5: Include nursing facilities in Value Based Purchasing (VBP) arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff.

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Payment Reform 2.0

Opportunities

Opportunity #1: Pay for better quality and value by increasing percentage of providers payments that are risk-based

- Expand requirements for MCOs to shift provider payments from fee per service to paying for quality and improved outcomes.

Opportunity #2: Use Value Based Purchasing (VBP) to drive program goals, such as:

- Increasing care coordination at provider level, improving transitions of care, increasing physical and behavioral health integration and improving member engagement.

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Member Engagement and Personal Responsibility 2.0

Opportunities

Opportunity #1: Advance the Centennial Rewards Program

Opportunity #2: Allow providers to charge small fees for three or more missed appointments

Opportunity #3: Premiums for populations with income that exceeds 100% FPL (applies only to 3 categories of eligibility)

- Adults in the Expansion with income greater than 100%
- CHIP children (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
- Working Disabled Individuals

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Member Engagement and Personal Responsibility

- Proposed premium amounts

FPL Range	Annual Income (Household of 1)	Approximate Monthly Premium
101-150% FPL	$11,881-$16,404	$20
151-200% FPL	$16,405-$23,760	$30
201% FPL and up	$23,761-$29,700	$40

- Premiums could be 'paid' by participating in healthy behaviors through the Centennial Rewards program

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Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #1: Cover most adults under one comprehensive benefit plan

- Today, HSD administers 2 different benefit packages for most adults in Medicaid—Parent/Caretaker category and Expansion Adult category
- HSD proposes to consolidate the 2 different plans under a single comprehensive benefit package that more closely aligns with private insurance coverage (similar to the Alternative Benefit Plan we have today for Expansion)
- Individuals who are determined "medically frail" may receive the standard Medicaid benefit package

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Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #2: Develop buy-in premiums for dental and vision services for adults

- If HSD needs to eliminate optional dental and/or vision services for adults to contain costs, then it proposes to offer dental and vision riders that members may purchase from their MCO as is standard practice with most private insurance coverage

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Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #3: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Populations covered in FFS would be exempt from this change
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services

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Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #4: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that put them over the eligibility guidelines

- Since the ACA, this program has become less needed as evidenced by declining enrollment; most individuals with increased earnings move to the Adult Expansion Group.
- In 2013: 26,000 individuals in this category

  Today: fewer than 2,000 individuals
- Individuals with income above the Adult Group guidelines may receive subsidies to purchase coverage through the Exchange

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Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #5: More frequent checks of income through trusted data sources

- This was not intended to result in more frequent recertification of eligibility but only to check trusted data sources on a more regular basis to verify income
- HSD has listened to numerous concerns associated with this proposed change and is no longer considering it for inclusion in the renewal going forward

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Public Comment

Share your comments

If you are unable to make your comment today, please submit your note cards or send via the website www.hsd.state.nm.us/Meetings.aspx.

Limited time for Comments

1115 Waiver Renewal Application will be drafted this summer.

Share your comments by Saturday, July 15, 2017

HUMAN SERVICES DEPARTMENT

Presentation to State Legislative Committees

3. Presentation to the Legislative Finance Committee, August 16, 2017

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Medicaid Reform, Controlling Costs and Improving Quality
Hearing before the Legislative Finance Committee
August 16, 2017

Brent Earnest, Secretary, HSD

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Today's Topics

- Centennial Care
  - Medicaid reforms reducing per person costs, expanding access, driving performance and quality improvements
- Centennial Care 2.0
  - Opportunities and process for the second five-year waiver agreement
- Federal Outlook
  - Health care reform legislation
  - Possible FY19 Budget Impacts

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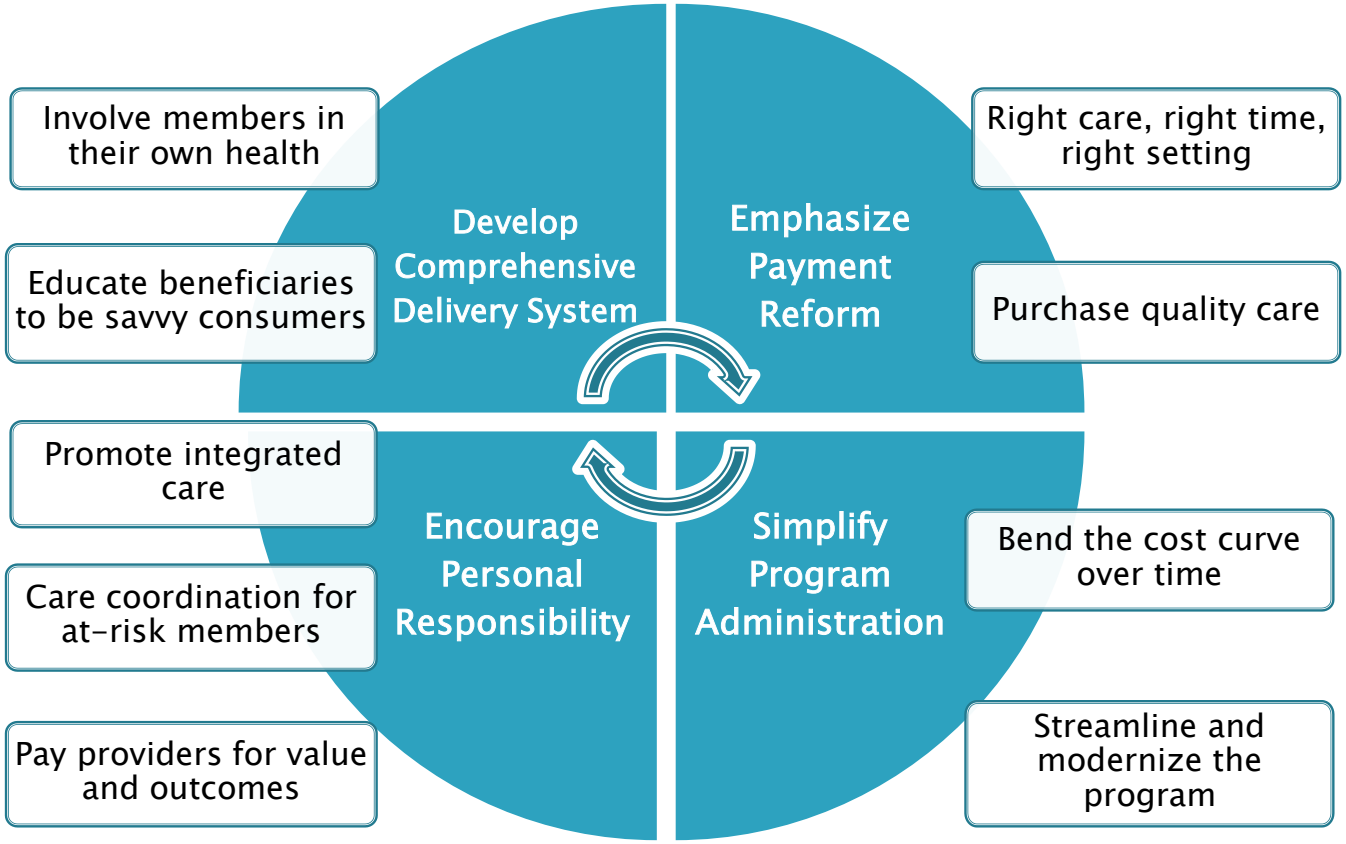
Centennial Care

Guiding Principles for Medicaid Reform



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Centennial Care: Reforming Medicaid

- A Comprehensive Service Delivery System
  - Managed Care Organizations are responsible for integrating care to address all health needs of the member through robust care coordination
- Personal Responsibility
  - Engage recipients in their personal health decisions through incentives and disincentives
- Payment Reform
  - Use innovative payment methodologies to reward quality care and improve health outcomes instead of the quantity of care
- Administrative Simplification
  - Combine all Medicaid waivers (except the Developmental Disabilities waiver) into a single, comprehensive 1115 waiver

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Centennial Care: Reforming Medicaid

Principle 1

Creating a comprehensive delivery system

Build a care coordination infrastructure for members with more complex needs that coordinates the full array of services in an ***integrated, person-centered model of care***

- Care coordination
  - 950 care coordinators
  - 60,000 in care coordination L2 and L3
  - Focus on high cost/high need members
- Health risk assessment
  - Standardized HRA across MCOs
  - 610,000 HRAs
- Increased use of community health workers
  - ~100 employed by MCOs
- Increase in members served by Patient Centered Medical Homes
  - 334,000 members now receiving services through a PCMH
- Health Homes – Two pilot sites for adults and kids with co-occurring behavioral health diagnoses
- Expanding home and community based services
  - Implemented electronic visit verification for personal care services
- Reduction in the use of ER for non-emergent conditions

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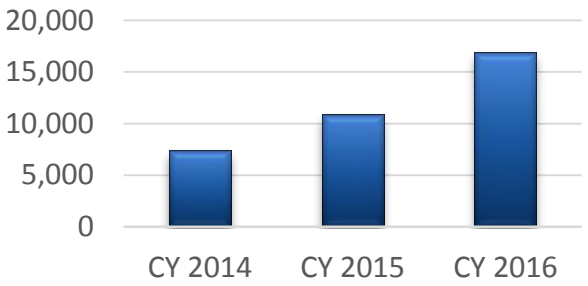
Centennial Care: Reforming Medicaid

Principle 1

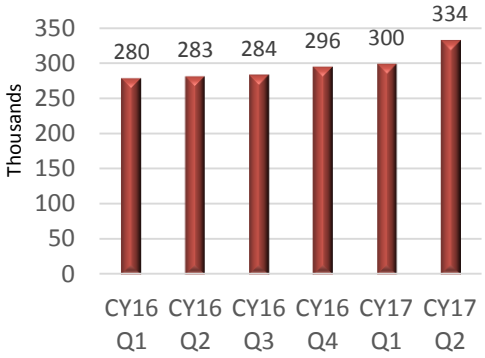
Creating a comprehensive delivery system

Build a care coordination infrastructure for members with more complex needs that coordinates the full array of services in an ***integrated, person-centered model of care***

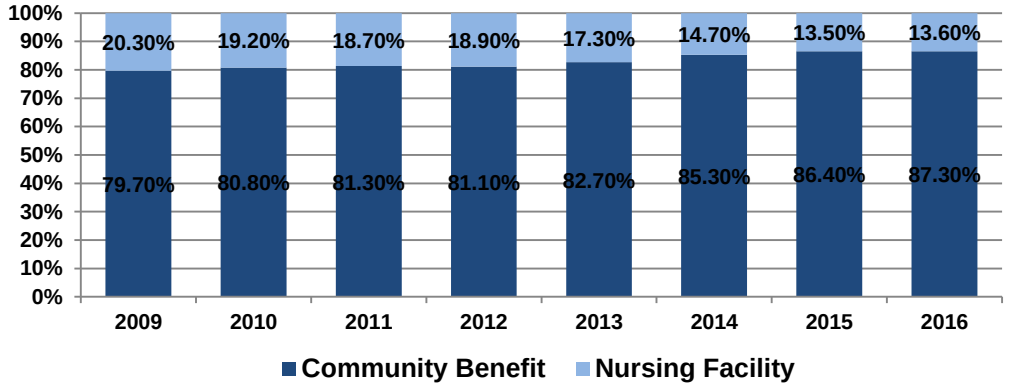
Number of visits through Telehealth in rural and frontier counties



Number Served Through a PCMH



Long Term Services and Supports Enrollment – Setting of Care



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Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer a member rewards program to incentivize members to ***engage in healthy behaviors***

- Centennial Rewards
  - health risk assessments
  - dental visits
  - bone density screenings
  - refilling asthma inhalers
  - diabetic screenings
  - refilling medications for bipolar disorder and schizophrenia

- 70% participation in rewards program
- Majority participate via mobile devices
- Estimated cost savings in 2015: $23 million
  - Reduced hospital admissions
  - 43% higher asthma controller refill adherence
  - 40% higher test compliance for diabetes
  - 76% higher medication adherence for individuals with schizophrenia
- 70k members participating in step-up challenge

- Co-pays to drive better health care decisions

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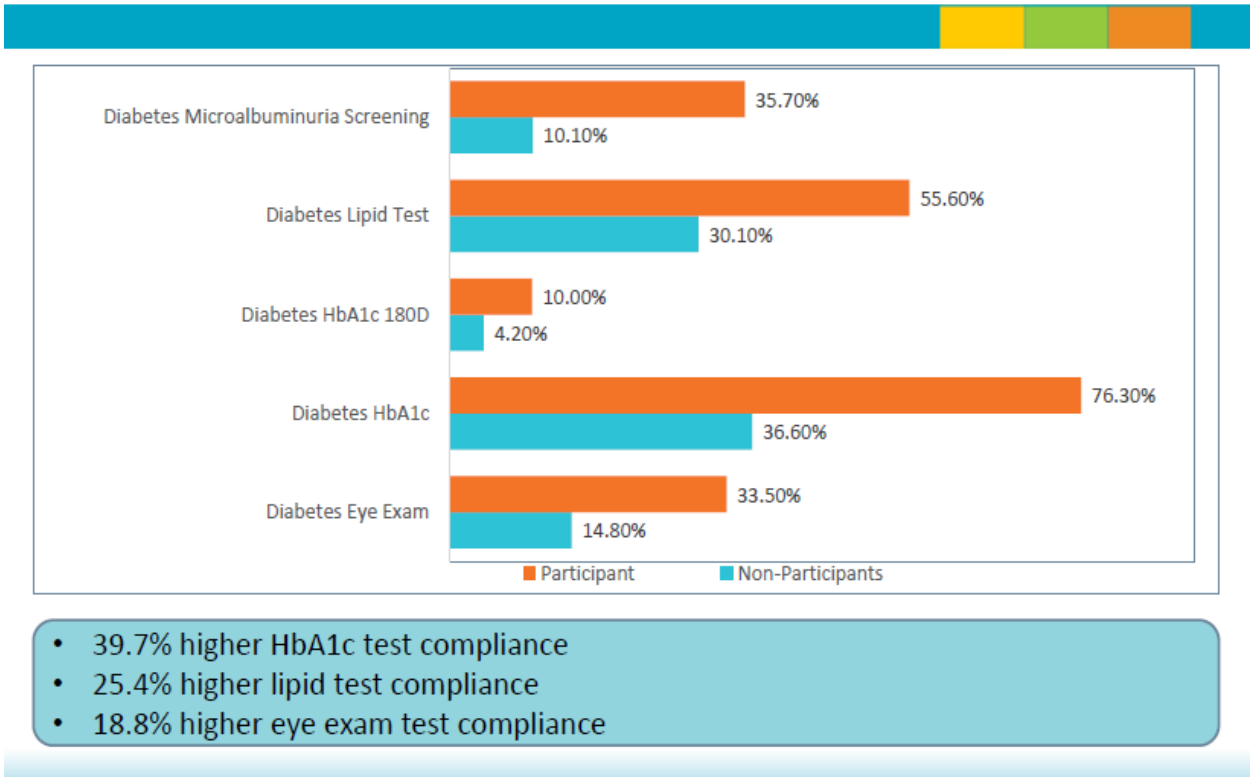
Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer **a member rewards program** to incentivize members to ***engage in healthy behaviors***

Quality/Compliance Summary – Diabetes



- 39.7% higher HbA1c test compliance
- 25.4% higher lipid test compliance
- 18.8% higher eye exam test compliance

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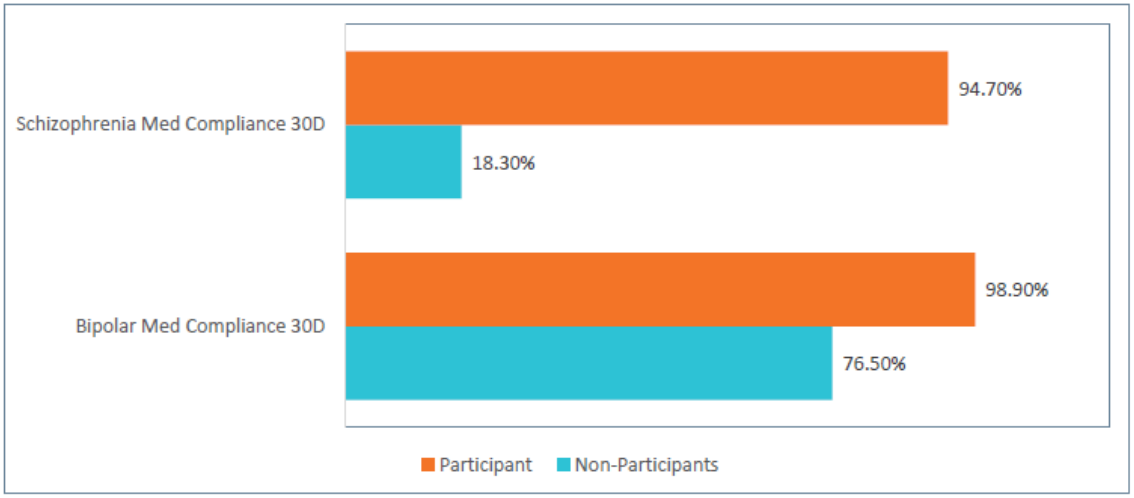
Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer a **member rewards program** to incentivize members to ***engage in healthy behaviors***

Quality/Compliance Summary – Behavioral Health



Medication adherence is substantially higher for participants in the bipolar and schizophrenia programs compared to non-participants.

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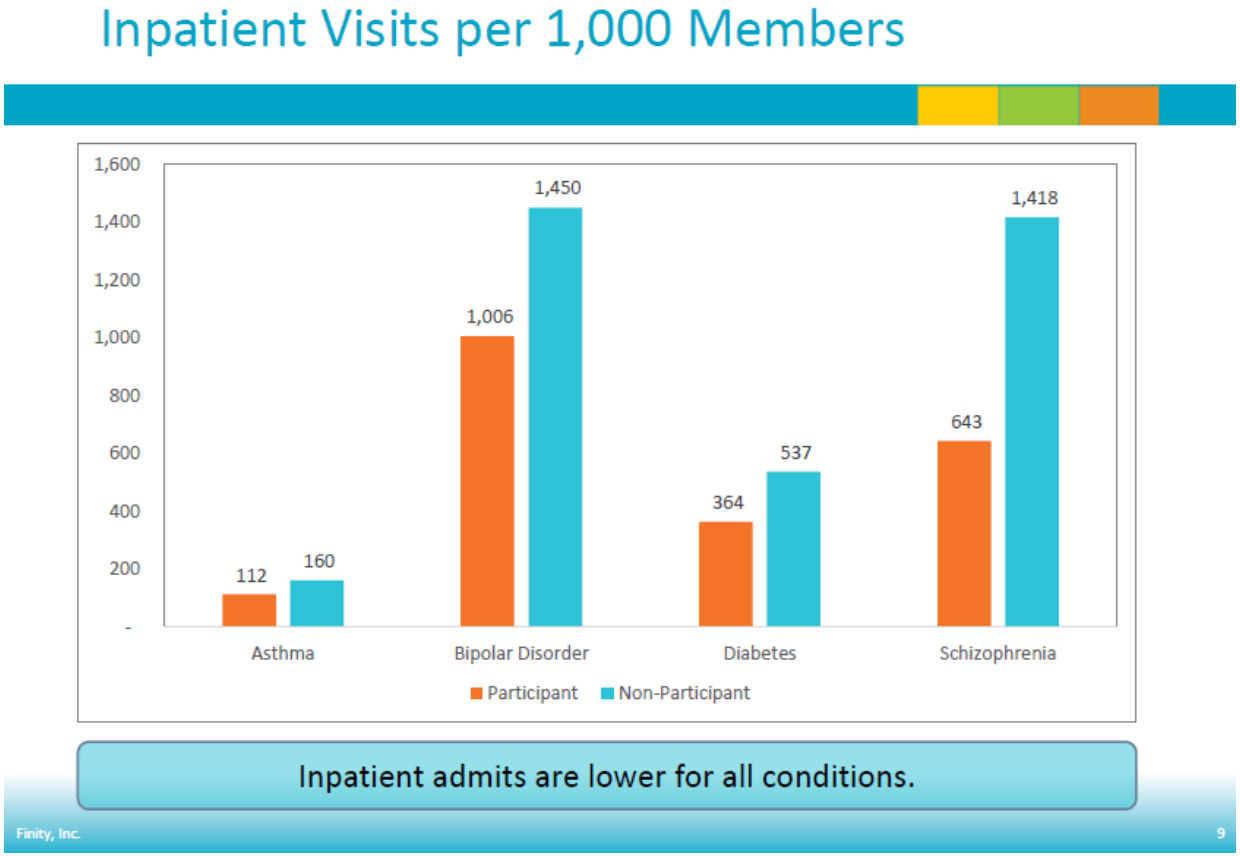
Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer a **member rewards program** to incentivize members to ***engage in healthy behaviors***



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Centennial Care: Reforming Medicaid

Principle 3

Increasing Emphasis on Payment Reforms

Create an incentive payment structures that ***reward providers for high quality of care to improve members' health***

- July 2015, 10 pilot projects approved
  - Accountable care organization (ACO)-like models
  - Bundled payments for all services related to a condition
  - Shared savings

- Developed quarterly reporting templates and agreed-upon set of metrics that included process measures and efficiency metrics

- Sub capitated Payment for Defined Population
- Three-tiered Reimbursement for PCMHs
- Bundled Payments for Episodes of Care
- PCMH Shared Savings
- Obstetrics Gain Sharing

- Implemented minimum payment reform thresholds for provider payments in CY2017 in MCO contracts

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Centennial Care: Reforming Medicaid

Principle 4

Simplify Administration

Create a coordinated delivery system that focuses on ***integrated care and improved health outcomes***; increases accountability for more limited number of MCOs and ***reduces administrative burden*** for both providers and members

- Consolidation of 11 different federal waivers that siloed care by category of eligibility; reduce number of MCOs and require each MCO to deliver the full array of benefits; streamline application and enrollment processes for members; and develop strategies with MCOs to reduce provider administrative burden
- One application for Medicaid and subsidized coverage through the Health Insurance Exchange Marketplace
- Streamlined enrollment and re-certifications, added more online application tools
- Fewer Managed Care Organizations
- Standardizing forms and procedures
  - BH Prior Authorization Form for Managed Care and FFS
  - BH Level of Care Guidelines
  - Facility/Organization Credentialing Application
  - Single Ownership and Controlling Interest Disclosure Form for credentialing.
- Created FAQs for Credentialing and BH Provider Billing

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Centennial Care: Managing Cost Growth

2. Total Centennial Care Dollars and Member Months by Program

Aggregate Member Months by Program

Population	Previous (12 mon)	Current (12 mon)	%Change
Physical Health	4,763,194	4,918,215	3%
Long Term Services and Supports	572,988	589,577	3%
Other Adult Group	2,536,906	2,757,481	9%
Total Member Months	**7,873,088**	**8,265,273**	**5%**

Aggregate Medical Costs by Program

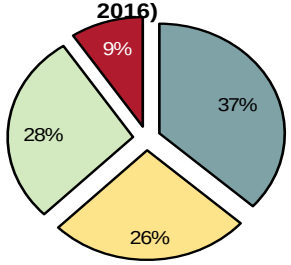
Per Capita Medical Costs by Program (PMPM)

Programs	Previous (12 mon)	Current (12 mon)	%Change	Previous (12	Current (12 mon)	%Change
Physical Health	$ 1,245,916,497	$ 1,262,498,696	1%	$ 261.57	$ 256.70	-2%
Long Term Services and Supports	$ 883,544,015	$ 898,665,309	2%	$ 1,541.99	$ 1,524.25	-1%
Other Adult Group Physical Health	$ 955,821,072	$ 1,054,867,891	10%	$ 376.77	$ 382.55	2%
Behavioral Health - All Members	$ 319,161,964	$ 335,419,279	5%	$ 40.54	$ 40.58	0%
Total Medical Costs	**$ 3,404,443,548**	**$ 3,551,451,175**	**4%**	**$ 432.42**	**$ 429.68**	**-1%**

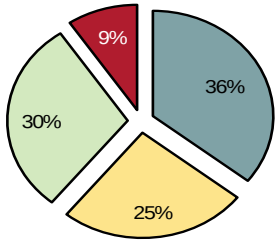
Aggregate Non-Medical Costs	Previous (12 mon)	Current (12 mon)	%Change	Previous (12	Current (12 mon)	%Change
Admin, care coordination, Centennial Rewards	$ 371,292,953	$ 351,377,344	-5%	$ 47.16	$ 42.51	-10%
NMMIP Assessment	$ 53,676,377	$ 61,948,430	15%	$ 6.82	$ 7.50	10%
Premium Tax - Net of NIMMP Offset	$ 133,873,146	$ 142,065,842	6%	$ 17.00	$ 17.19	1%
Total Non-Medical Costs	**$ 558,842,476**	**$ 555,391,616**	**-1%**	**$ 70.98**	**$ 67.20**	**-5%**
Estimated Total Centennial Care Costs	**$ 3,963,286,024**	**$ 4,106,842,791**	**4%**	**$ 503.40**	**$ 496.88**	**-1%**

Centennial Care Medical Expenditures

Previous (April 2015 - March 2016)



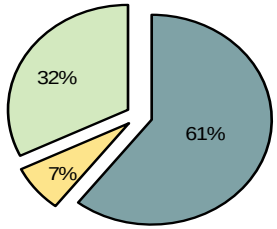
Current (April 2016 - March 2017)



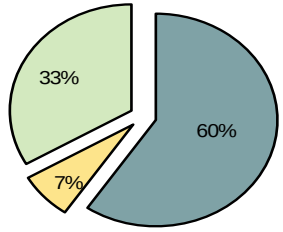
*See above for legend.

Centennial Care Member Months

Previous (April 2015 - March 2016)

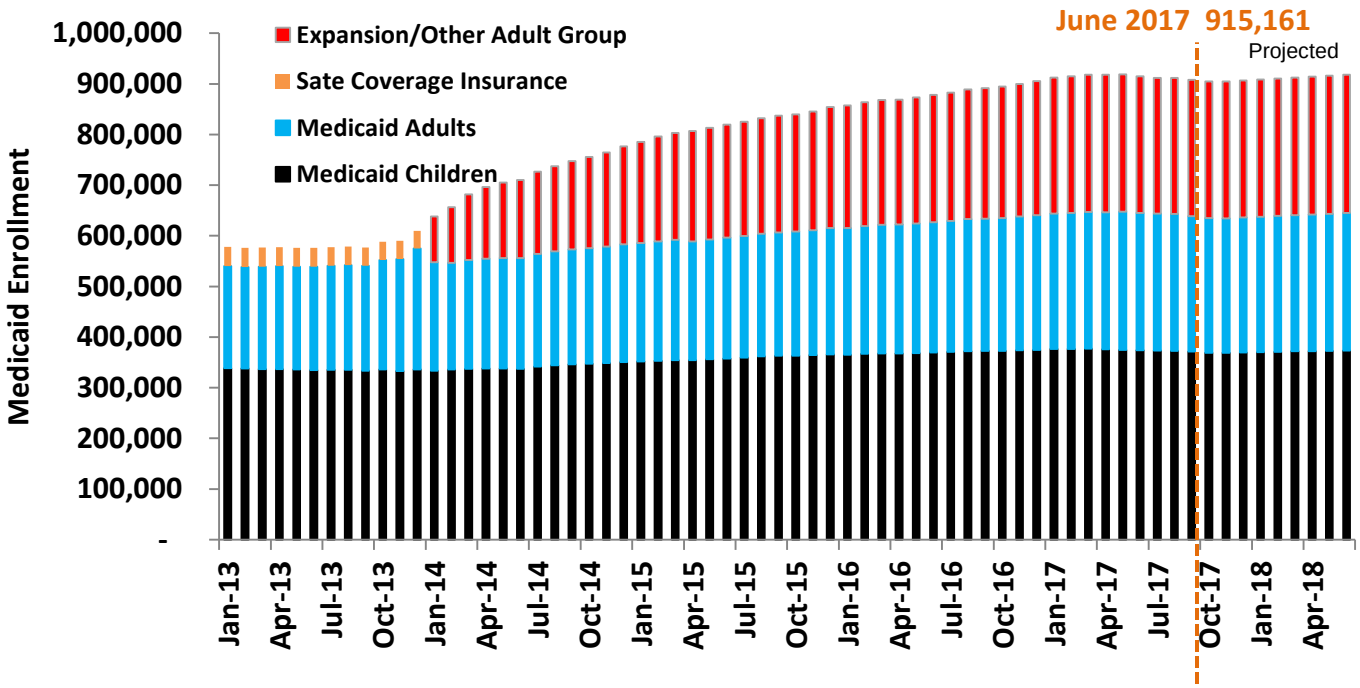


Current (April 2016 - March 2017)



*See above for legend.

Medicaid Enrollment



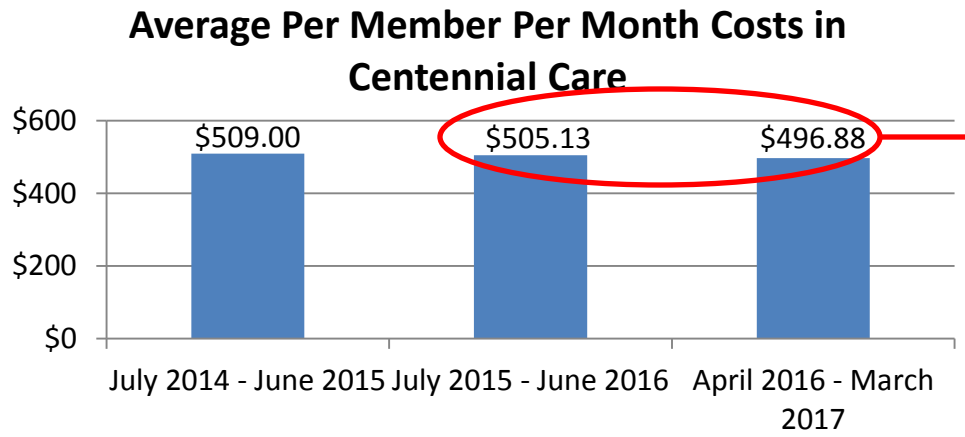
June 2018 Projected Enrollment

OAG: 272,954*

Medicaid Adults: 271,609

Medicaid Children: 373,390*

*children 19-21 y.o. counted in OAG



Reduced spending by $68.2 million

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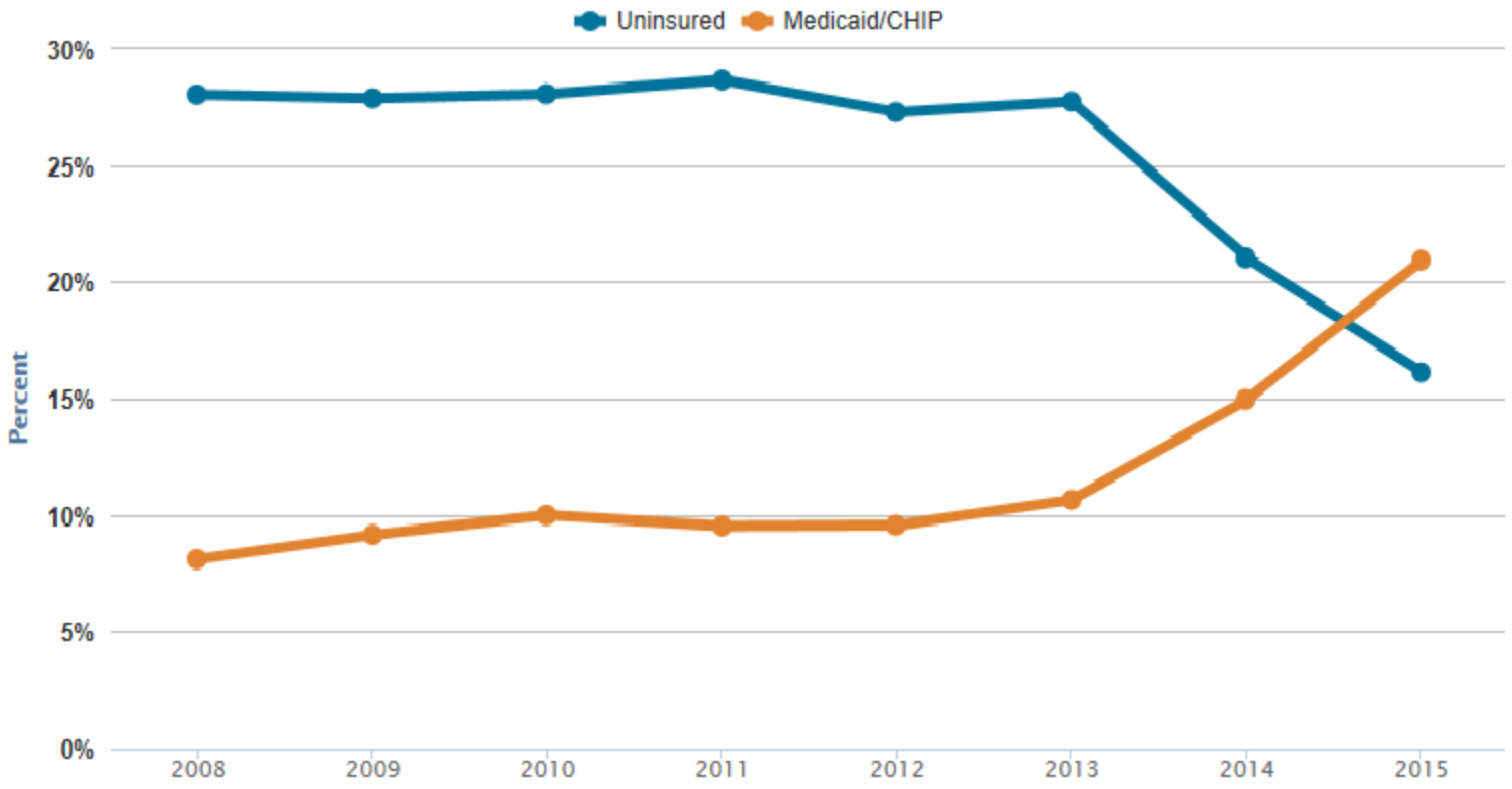
New Mexico Uninsured and Medicaid-Insured (19-64 population)



Source: SHADAC State Health Compare, University of Minnesota

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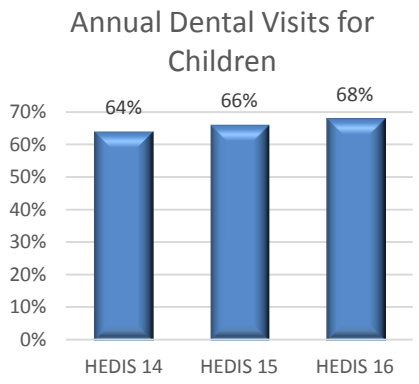
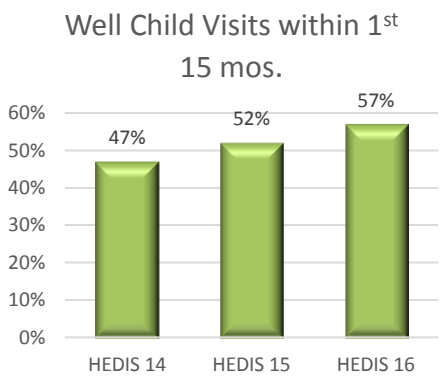
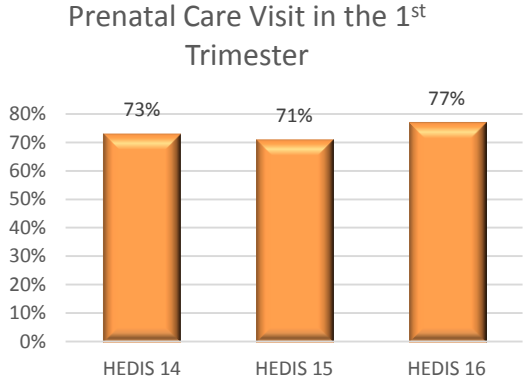
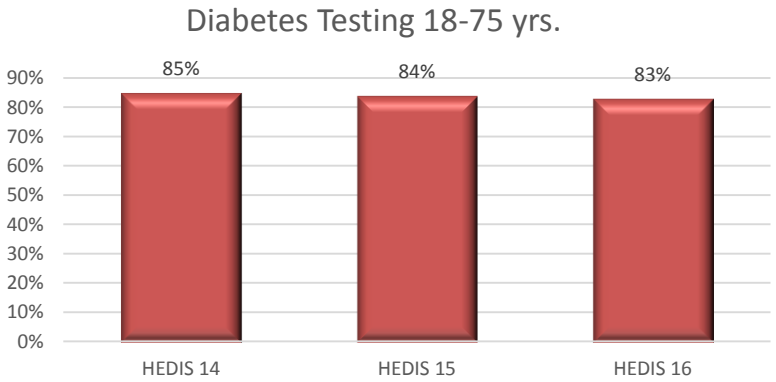
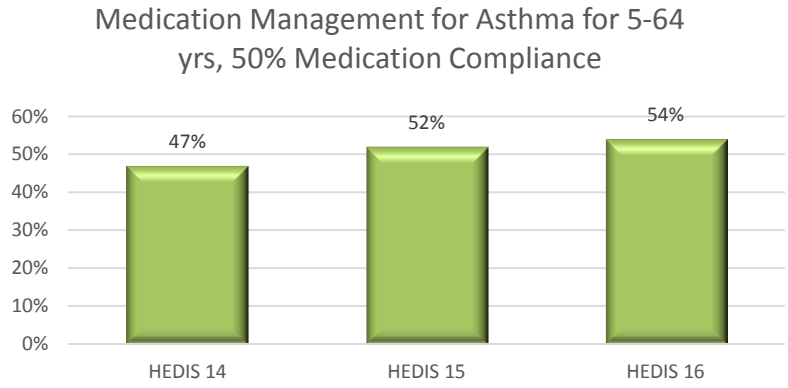
Centennial Care: HEDIS Performance











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ENTENNIALCARE2.0

Vision for the future of Centennial Care

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Behavioral health integration
- Long-Term Services and Supports (LTSS)
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to benefits and eligibility

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Care Coordination 2.0

Identified Opportunities

#1: Increase care coordination at the provider level

#2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

#3: Expand programs working with high needs populations:

- First Responders, wellness centers, personal care agencies and Project ECHO;
- Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists
- Pilot a home visiting program; and
- Expand supportive housing.

HUMAN SERVICES DEPARTMENT

Behavioral Health Integration 2.0

Opportunities

Opportunity #1: Expanding Health Homes (CareLink NM)

Opportunity #2: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

#1: Allow for one-time start-up goods for transitions when a member transitions from agency-based to self-directed care

#2: Increase caregiver respite hours (from 100 to 300 hours).

#3: In order to continue to provide access to the Community Benefit services for all eligible members who meet a NF LOC, establish some limits on costs for certain Community Benefits

#4: Implement an automatic NF LOC approval for members whose condition is not expected to change

#5: Include nursing facilities in Value Based Purchasing (VBP) arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff.

HUMAN SERVICES DEPARTMENT

Payment Reform 2.0

Opportunities

Opportunity #1: Pay for better quality and value by increasing percentage of providers payments that are risk-based

- Expand requirements for MCOs to shift provider payments from fee-for-service to paying for quality and improved outcomes.

Opportunity #2: Use Value Based Purchasing (VBP) to drive program goals, such as:

- Increasing care coordination at provider level, improving transitions of care, increasing physical and behavioral health integration and improving member engagement.

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Member Engagement and Personal Responsibility 2.0

Opportunities

#1: Advance the Centennial Rewards Program

#2: Allow providers to charge small fees for three or more missed appointments

#3: Premiums for populations with income that exceeds 100% FPL (applies only to three categories of eligibility)

- Adults in the Expansion with income greater than 100%
- CHIP program (income guideline extends to 300% FPL for children age 0–5 and to 240% FPL for children age 6–18)
- Working Disabled Individuals

FPL Range	Annual Income (Household of 1)	Monthly Premium
101–150% FPL	$11,881–$16,404	$20
151–200% FPL	$16,405–$23,760	$30
201% FPL and up	$23,761–$29,700	$40

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Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#1: Cover most adults under one comprehensive benefit plan

- HSD proposes to consolidate the two different plans under a single comprehensive benefit package that more closely aligns with private insurance coverage
  - similar to the Alternative Benefit Plan we have today for the Other Adult Group (a.k.a., expansion population)

- Individuals who are determined "medically frail" may receive the standard Medicaid benefit package

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Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#2: Develop buy-in premiums for dental and vision services for adults (if necessary)

#3: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Populations covered in FFS would be exempt from this change
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services

#4: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that put them over the eligibility guidelines

- Use of the category dropped from 26,000 individuals to 2,000
- Individuals with income above the Adult Group guidelines may receive subsidies to purchase coverage through the Exchange

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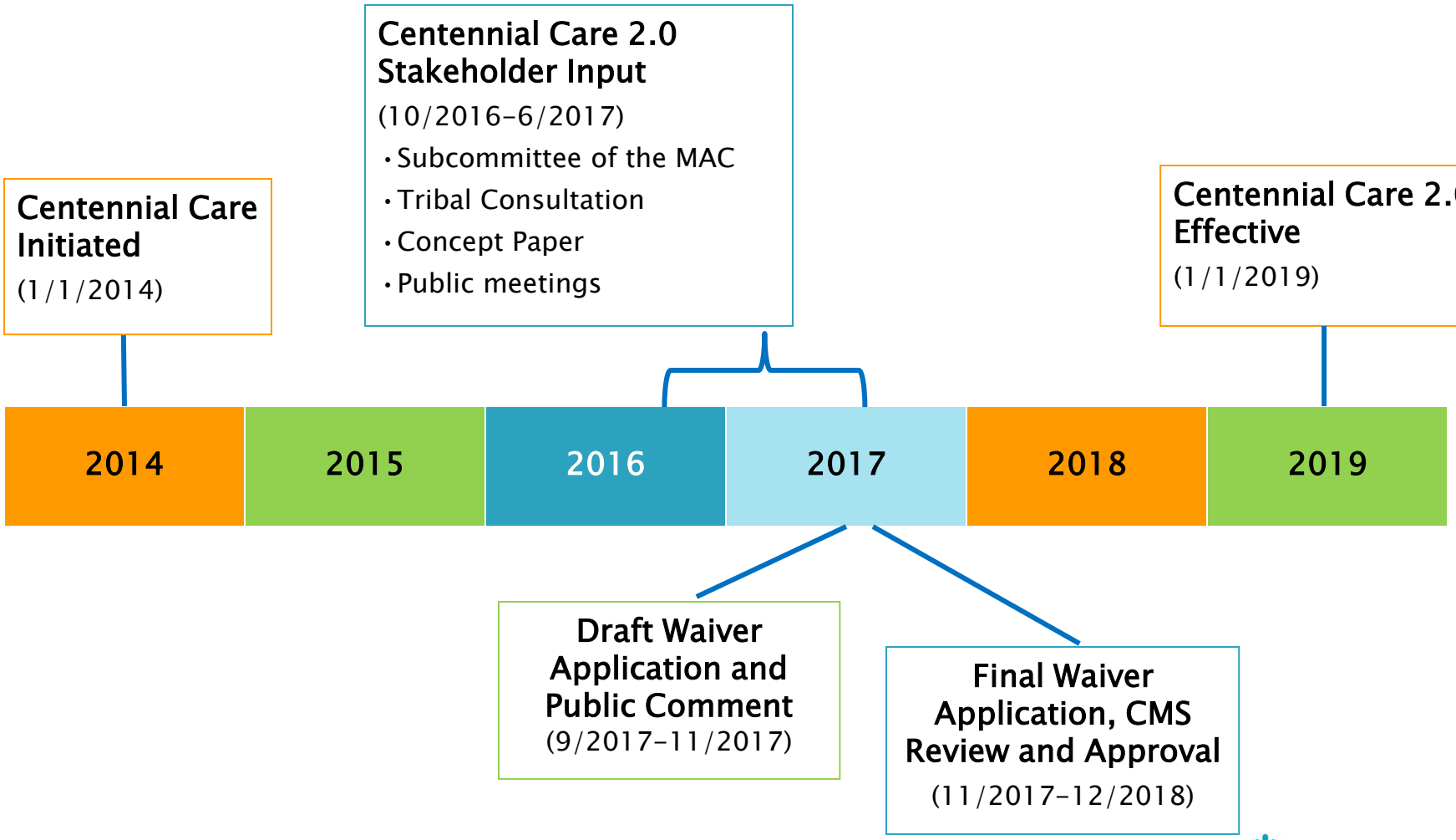
Centennial Care Timeline



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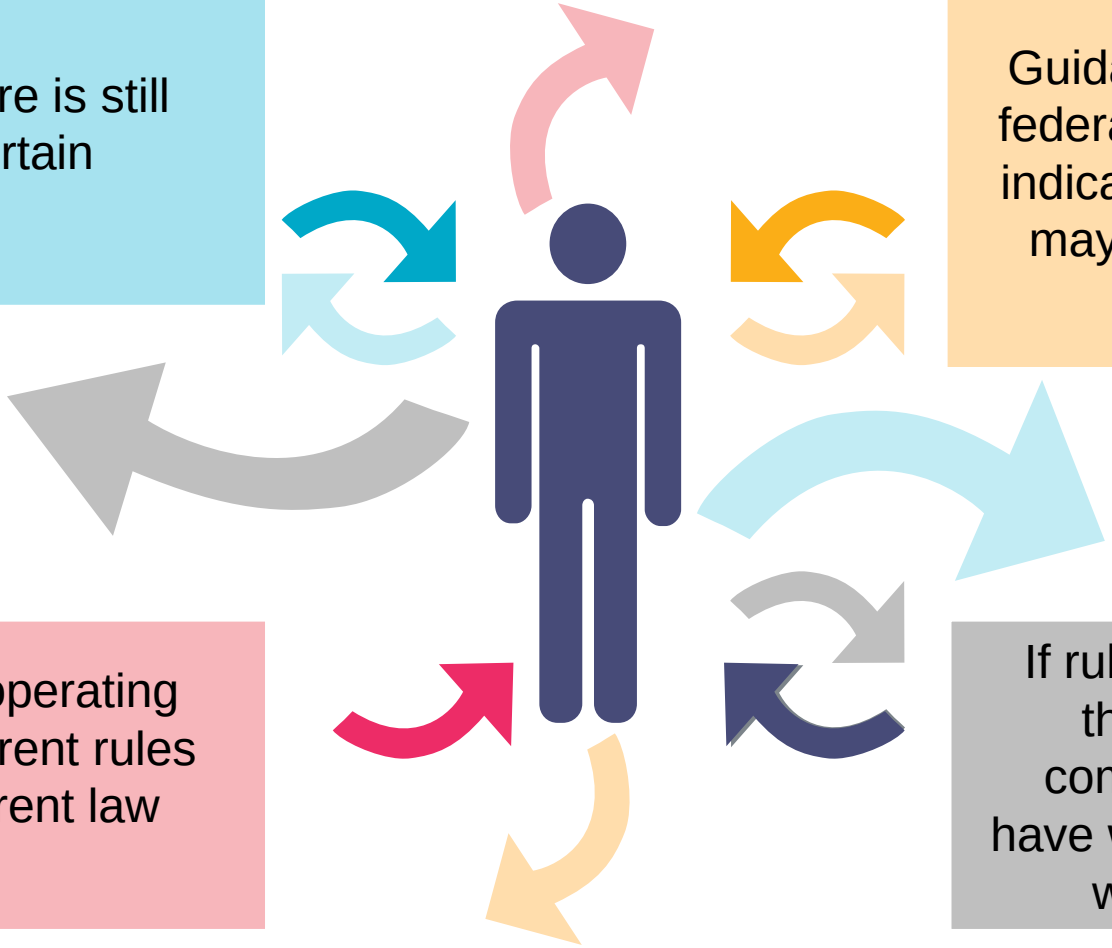
Federal Medicaid Changes

The future is still uncertain

Guidance from the federal government indicated that there may be changes



We are operating under current rules and current law

If rules do change, there may be components that have worked well that we will keep

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Federal Outlook

- AHCA, BCRA, "Skinny" BCRA, Other proposals
  - Application of Per Capita Caps / Block Grants
  - Reduced federal spending for Medicaid
  - Budget impacts are more significant in the out years (three to six years)
- Changes in policy and practice likely at CMS
- Federal budget likely vehicle for other changes
- Efficient programs like NM's do not have a large margin to absorb health care cost inflation changes in a per capita cap or block grant proposal

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Federal Outlook
(FY19 Budget Issues)

- Expansion FMAP steps down again on January 1, 2018, to 93%
- Regular FMAP rates expected to improve slightly for NM
- CHIP Reauthorization "up in the air"
  - Expires September 30, 2017
  - Scenarios:
    - No action/reauthorization
    - Full reauthorization (including higher ACA matching rate)
    - Reauthorization at regular or lower FMAP rates

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Other State Responses and Options

- Restructure financing and responsibility for state and county health care services
  - With the expansion of Medicaid, counties' responsibility for indigent health care has been reduced while the state's responsibility has increased
  - Financing and funding has not followed this change
- Reduce Medicaid's responsibility for other care programs for higher income populations
  - Health Insurance Exchange
  - NM Medical Insurance Pool (High Risk Pool)

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Questions?

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Presentation to State Legislative Committees

4. Presentation to the Legislative Health and Human Services Committee, September 20, 2017

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Centennial Care 2.0 Update
Legislative Health and Human Services Committee

Brent Earnest, Secretary
Nancy Smith-Leslie, Director, Medical Assistance Division
September 20, 2017

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Today's Topics

- Update on 1115 Waiver Renewal
  - Renewal process
  - Centennial Care—first 4 years
  - Centennial Care 2.0
- Medicaid Budget Update
  - FY19 Appropriation Request
  - Federal update
- Overview of 1115 Waiver Authority

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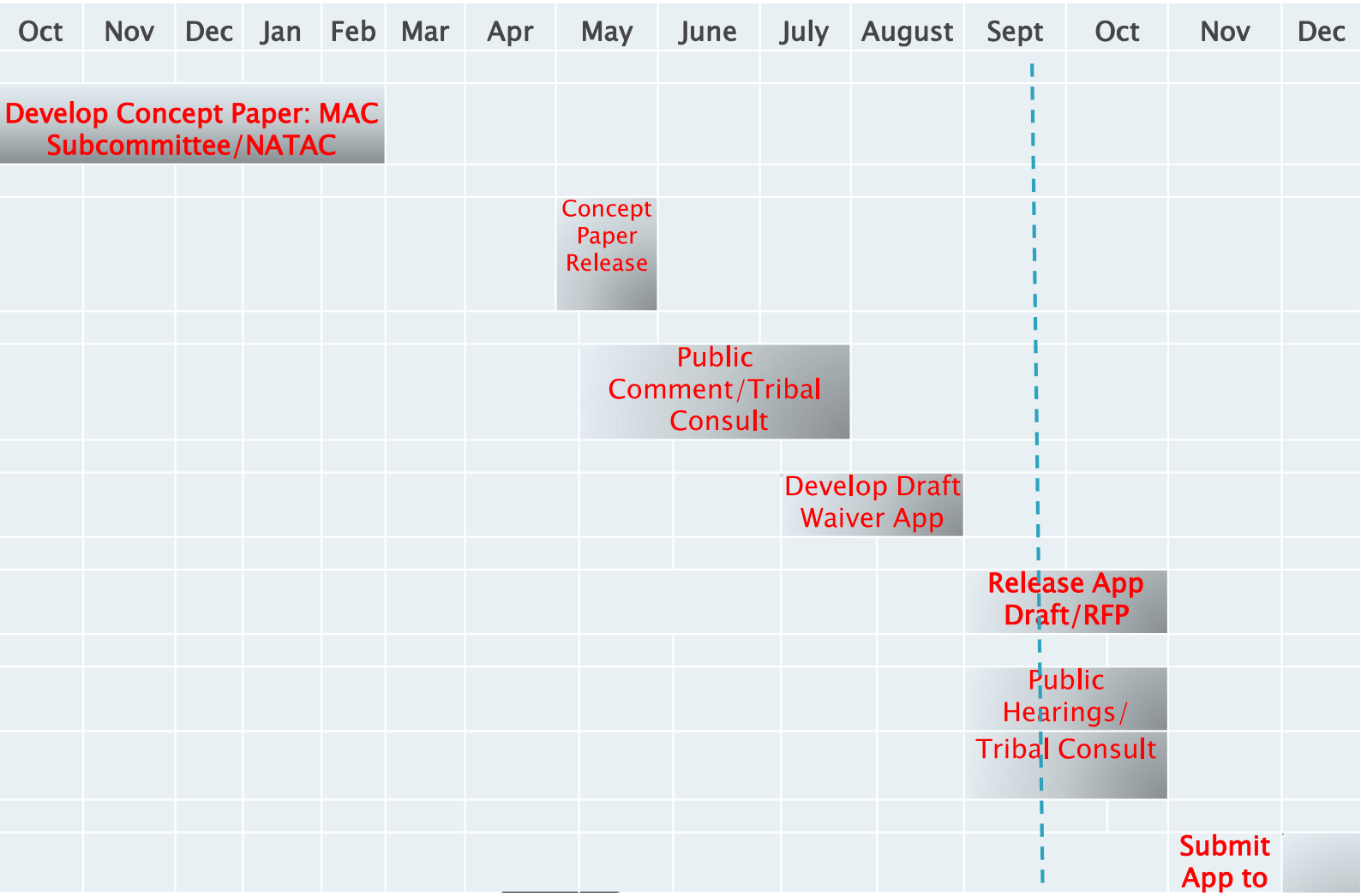
Centennial Care 2.0 Waiver Renewal



Waiver Renewal Public Input Meetings

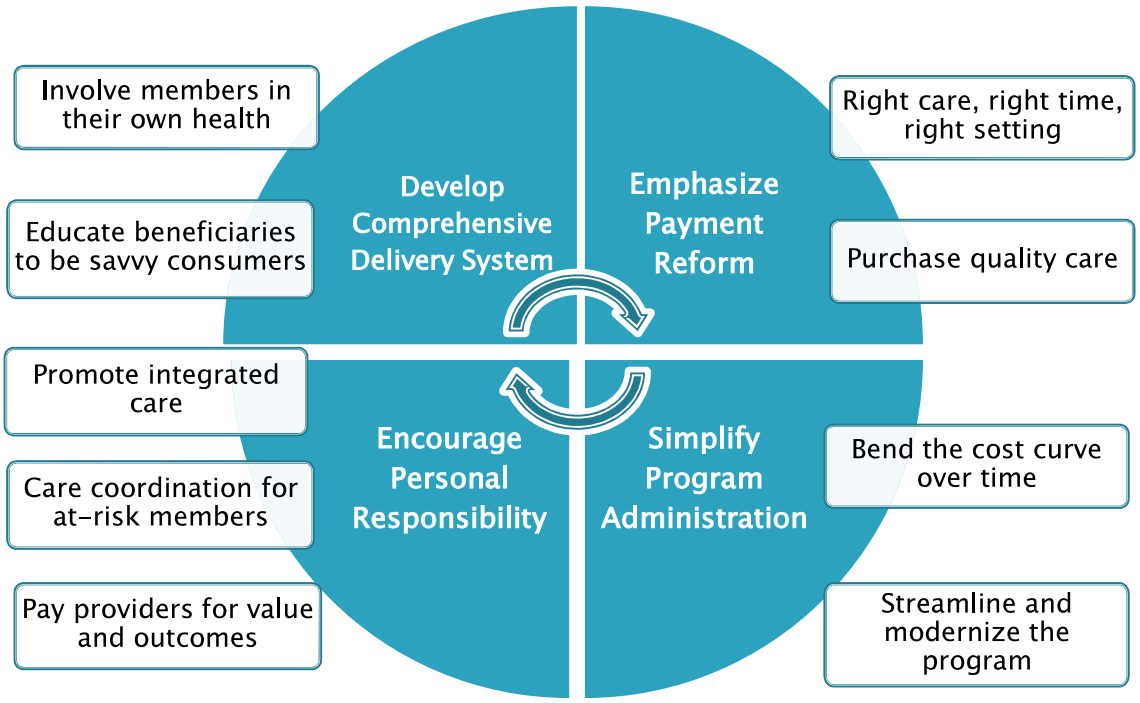
Public Input Opportunities Prior to Development of Concept Paper (before May 2017)	Public Input Meetings on Draft Concept Paper (after May 2017)	Other Input Opportunities
Medicaid Advisory Subcommittee: October 14, 2016 – 29 attendees (Santa Fe) November 18, 2016 – 34 attendees (ABQ) December 16, 2016 – 62 attendees (Santa Fe) January 13, 2017 – 55 attendees (ABQ) February 10, 2017 – 50 attendees (Santa Fe) *Public Comment at end of each meeting*	**Statewide Public Input Sessions & Attendees:** **Albuquerque** – June 14, 2017 – 160 attendees **Silver City** – June 19, 2017 – 22 attendees **Farmington** – June 21, 2017 – 41 attendees **Roswell** – June 26, 2017 – 30 attendees	**Written Comments:** May – July 2017 – 21 letters received
Native American Technical Advisory Committee: December 5, 2016 – NATAC Membership (Santa Fe) January 20, 2017 – NATAC Membership (ABQ) February 10, 2017 – NATAC Membership (Santa Fe) April 10, 2017 – NATAC Membership (ABQ)	**Formal Tribal Consultation** June 23, 2017 – 12 tribal officials/reps & 85 attendees – Albuquerque **Native American Technical Advisory Committee:** July 10, 2017 – NATAC Membership	**HSD Email Address Established:** Ongoing from October 2016– July 2017 137 emails received
MAC Meetings with Public Input: November 2016 – 77 attendees (Santa Fe) April 2017 – 55 attendees (Santa Fe)	**MAC Meetings with Public Input:** July 24, 2017 – (Santa Fe)	**Public Hearings to be held in October 2017:** • Las Cruces • Las Vegas • Santa Fe

Centennial Care:

CY 2014 - 2017

Centennial Care

Guiding Principles for Medicaid Reform



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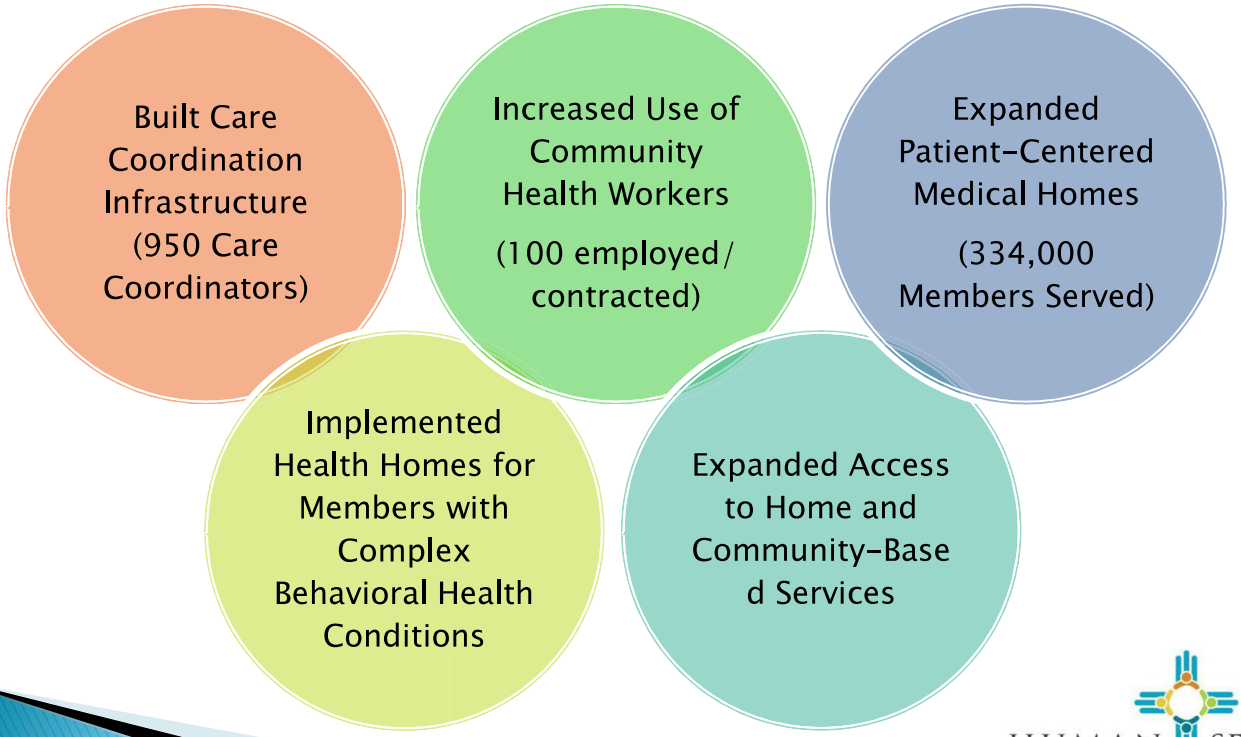
Centennial Care

Create a Comprehensive Delivery System



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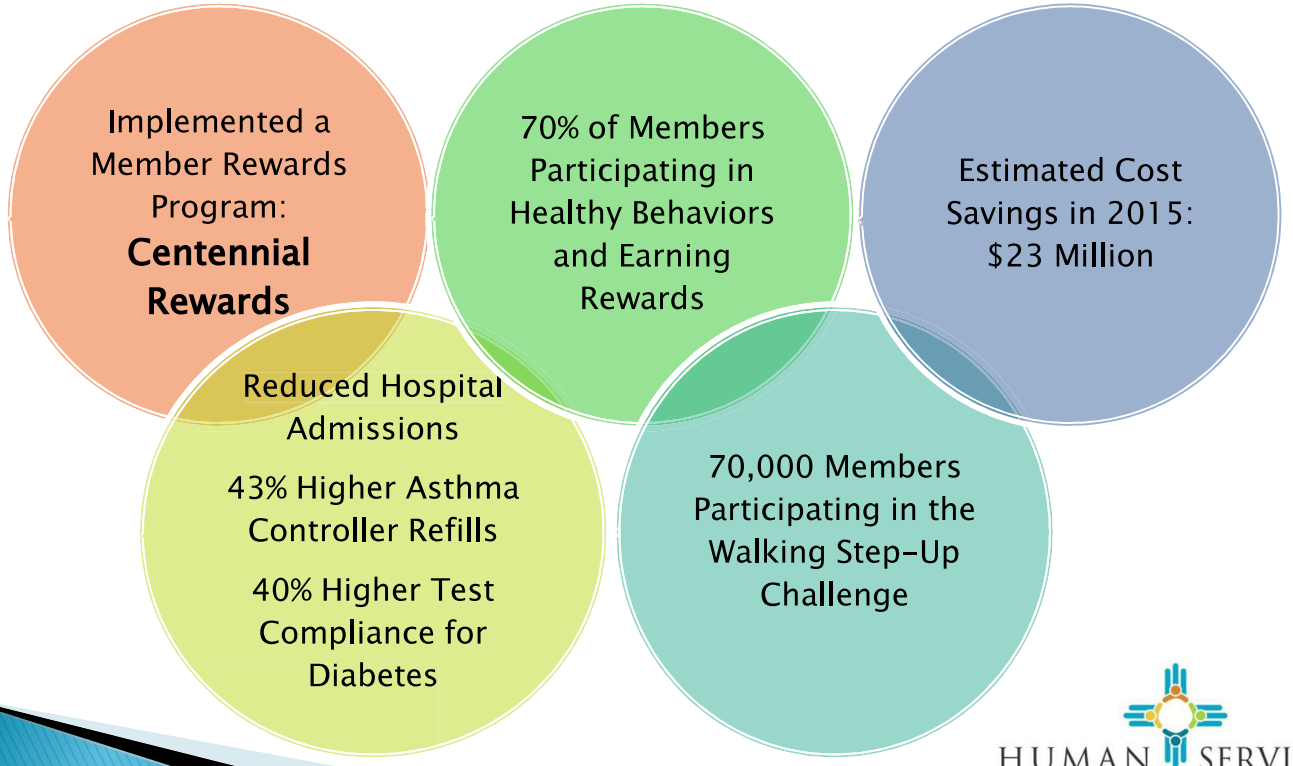
Centennial Care

Encourage Personal Responsibility



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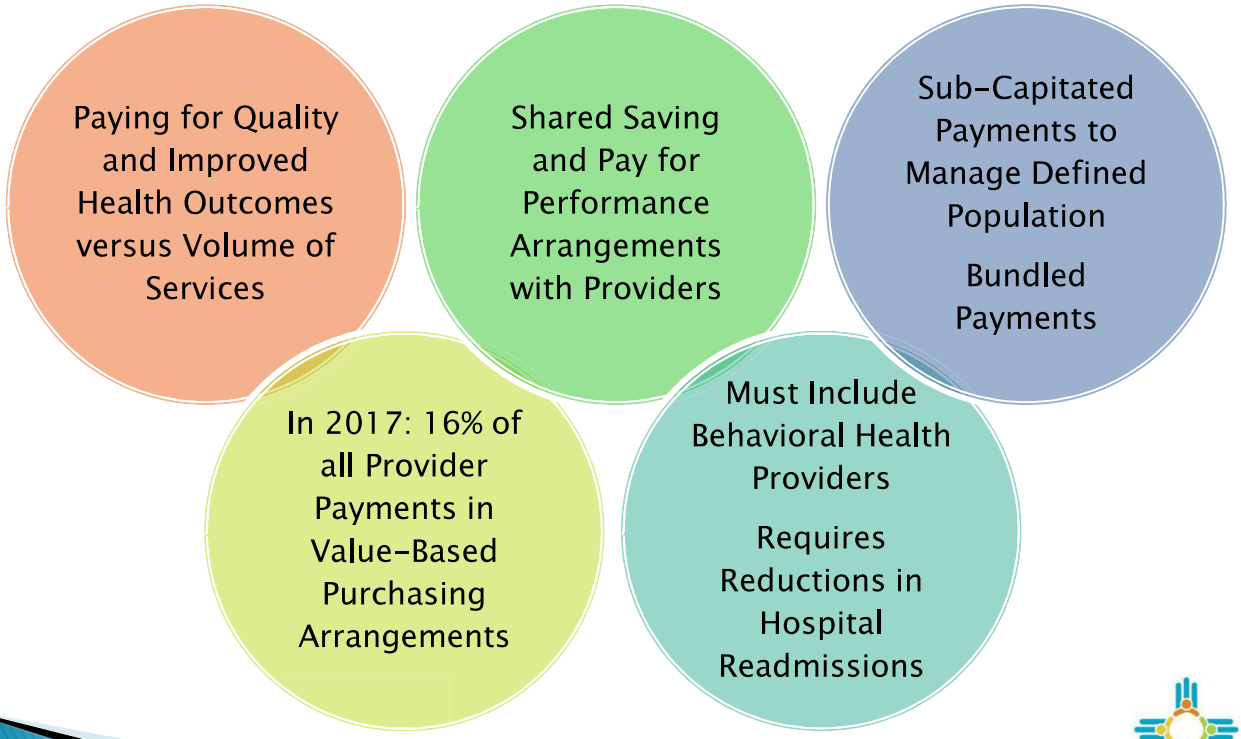
Centennial Care

Emphasize Payment Reform



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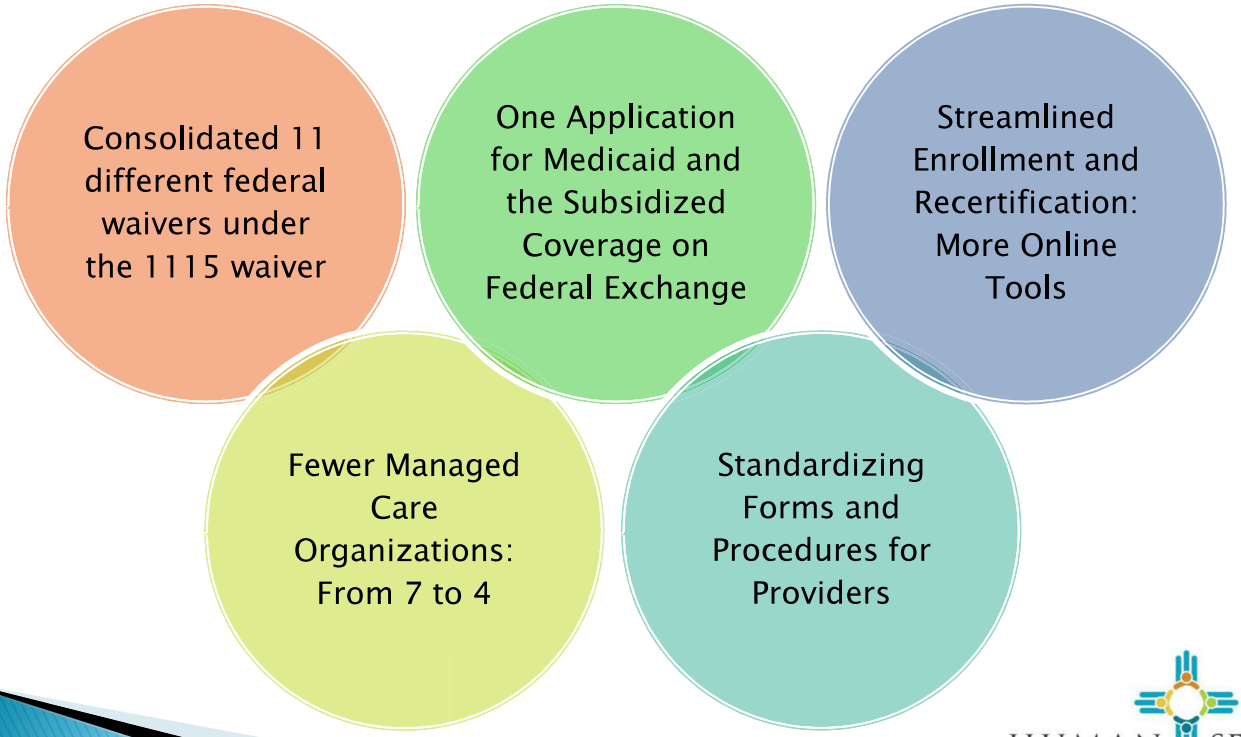
Centennial Care

Simplify Administration



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NTENNIALCARE2.0

Vision for the future of Centennial Care

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- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to benefits and eligibility

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Identified Opportunities

#1: Increase care coordination at the provider level

#2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

#3: Expand programs working with high needs populations:

- First Responders, wellness centers, personal care agencies and Project ECHO;
- Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Identified Opportunities

#4: Initiate care coordination for justice-involved prior to release from incarceration

- Allowing of delegation of care coordination to county/facility for activities that occur prior to release
- Strengthening MCO contract requirements regarding after-hour transitions and requiring a dedicated staff person at each MCO to serve as a liaison with the facilities

#5: Pilot a home-visiting program focused on pre-natal, post-partum and early childhood development

- Collaborate with the DOH and CYFD to implement a pilot in designated counties to provide Medicaid-reimbursable services to eligible pregnant women

#6: Obtain 100% federal funding for Native American members for services received through IHS/Tribal Facilities

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Behavioral Health Integration 2.0

Opportunities

#1: Expanding Health Homes (CareLink NM)

#2: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

#3: Develop Peer-Delivered, Pre-Tenancy and Tenancy Support Housing Services

- Create a supportive housing service that provides some peer-delivered tenancy support services to active participants with Serious Mental Illness (SMI)

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

#1: Allow for one-time start-up goods for transitions when a member transitions from agency-based to self-directed care

#2: Increase caregiver respite hours (from 100 to 300 hours)

#3: In order to continue to provide access to the Community Benefit services for all eligible members who meet a NF LOC, establish some limits on costs for certain services in the Self-Directed Community Benefit model

#4: Implement an automatic NF LOC approval for members whose condition is not expected to change

#5: Include nursing facilities in Value Based Purchasing (VBP) arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff

HUMAN SERVICES DEPARTMENT

Payment Reform 2.0

Opportunities

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- Expand requirements for MCOs to shift provider payments from fee-for-service to paying for quality and improved outcomes.

#2: Use Value Based Purchasing (VBP) to drive program goals, such as:

- Increasing care coordination at provider level, expanding the health home model, improving transitions of care, and improving provider shortage issues.

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Payment Reform 2.0

Opportunities

#3: Advance Safety-Net Care Pool Initiatives

- Incrementally shift the funding ratio between the Uncompensated Care Pool and the Hospital Quality Improvement Incentive Pool so that more dollars are directed toward improved hospital quality initiatives
- Expand participation to all willing hospitals and allow other providers to participate, such as nursing facilities
- Require good-faith contracting efforts between the MCOs and providers that participate to ensure a robust provider network

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Safety Net Care Pool and Hospitals

- Eliminated uncompensated care in Medicaid for 29 SNCP hospitals (2015)

Uncompensated Care Pool Requests, Payments and Capacity

($ in millions)	2014	2015	2016
Requested Uncompensated Care Payments	$176.3	$121.1	$104.4
Actual UC Payment Capacity	$107.3	$67.3	Determined in 2018
Actual UC Payments	$68.9	$67.3	$68.9

Inpatient and Selected Outpatient Hospital Payments for Services Provided to Expansion Population

Category of Service	2014	2015	2016
Inpatient Hospital – General Acute and Specialty	$193.7	$246.6	$286.3
Outpatient Hospital – Emergency Room and Urgent Care	$ 31.4	$60.2	$90.8
Total	$ 225.1	$306.8	$377.1
Note: Data from May 2017; $ in millions			

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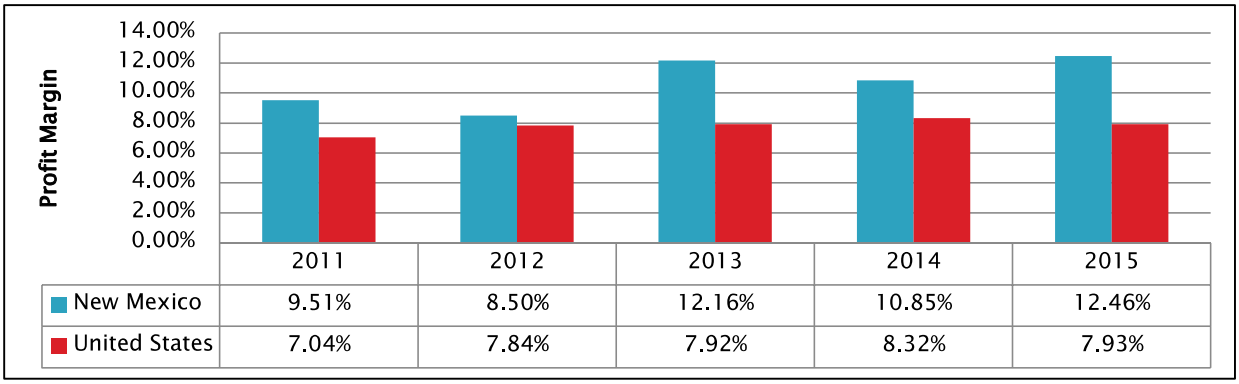
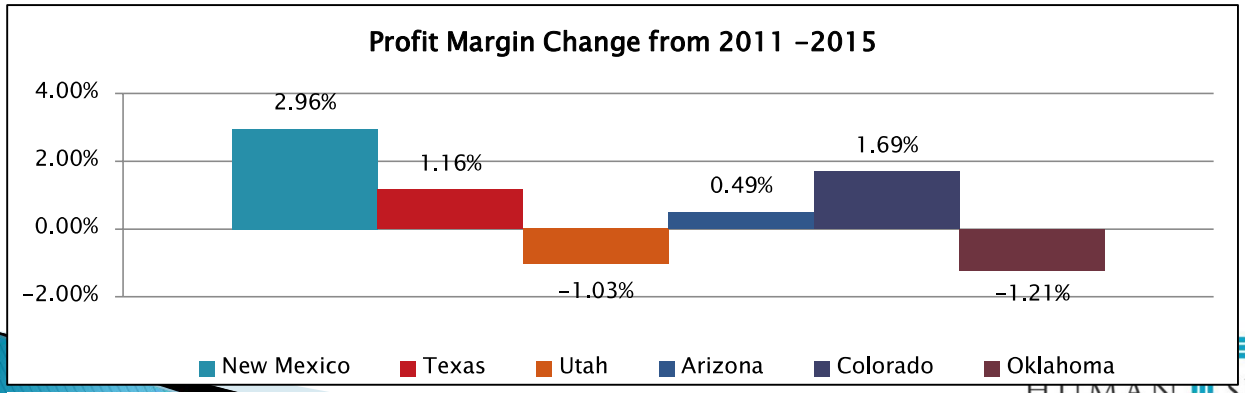
Safety Net Care Pool and Hospitals

- NM Hospitals continue to outperform hospitals in the region and nation



	2011	2012	2013	2014	2015
New Mexico	9.51%	8.50%	12.16%	10.85%	12.46%
United States	7.04%	7.84%	7.92%	8.32%	7.93%



Source: American Hospital Association

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Member Engagement and Personal Responsibility 2.0

Opportunities

#1: Advance the Centennial Rewards Program

#2: Allow providers to charge small fees for three or more missed appointments

#3: Premiums for populations with income that exceeds 100% FPL (applies only to three categories of eligibility)

- Adults in the Expansion with income greater than 100%
- CHIP program (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
- Working Disabled Individuals (WDI) Category
- Revised premium amounts to be lower in initial years (1% of household income) and higher in out-years
- Included a household rate

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Proposed Premium Structure

FPL Range	Annual Household Income (HH of 1)	Aggregate HH Maximum – 5% of Income (HH of 1)	Applicable Category of Eligibility (COE)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
101–150%	$12,060 – $18,090	$600	OAG, WDI, TMA	$10	$20	$20	$40
151–200%	$18,091 – $24,120	$900	WDI, TMA, CHIP	$15	$30	$30	$60
201–250%	$24,121 – $30,150	$1,200	WDI, TMA, CHIP	$20	$40	$40	$80
251–300%	$30,151 – $36,180	$1,500	TMA, CHIP	$25	$50	$50	$100

Member Engagement and Personal Responsibility 2.0

Opportunities

#4: Require co-payments for certain populations

- HSD currently has copayment requirements for its CHIP and WDI populations
- Seeking to streamline copayments across populations
- Add copayments for the adult expansion population with income greater than 100% FLP
- Most Centennial Care members will have copayments for non-preferred prescription drugs and for non-emergent use of the ED
- The following populations would be exempt from all copayments:
  - Native Americans
  - ICF-IDD individuals
  - QMB/SLIMB/QI1 individuals
  - Individuals on Family Planning only
  - Individuals in the PACE program
  - Individuals on the DD waivers
  - People receiving hospice care

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Proposed Co-Payment Structure

	CHIP	WDI	Expansion Adults	All Other Medicaid
Population Characteristics and Service	Age 0-5: 241-300% FPL Age 6-18: 191-240%	Up to 250% FPL	If income is greater than 100% FPL	
Outpatient office visits (non-preventive) • BH exempt	$5/visit	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	$50/stay	$50/stay	$50/stay	No co-pay
Outpatient surgeries	$50/surgery	$50/surgery	$50/surgery	No co-pay
Prescription drugs, medical equipment and supplies • Psychotropic Rx exempt • Family Planning Rx exempt • Not charged if non-preferred drug co-pay is applied	$2/prescription	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic and Family Planning Rx exempt	$8/prescription All FPLs and COEs; certain exemptions will apply			
Non-emergency ER visits	$8/visit All FPLs and COEs; certain exemptions will apply			

Member Engagement and Personal Responsibility 2.0

Opportunities

#5: Modify tracking requirements for cost sharing

- Request authority to track the out-of-pocket maximum cost sharing amounts on an annual basis rather than quarterly or monthly
- Apply an annual out-of-pocket maximum based on four FPL tiers

#6: Expand opportunities for Native American members in Centennial Care

- Requires MCOs to expand contractual or employment arrangements with CHRs throughout the state
- Work with Tribal providers to develop capacity to enroll as LTSS providers and/or health home providers
- Request authority to implement a project in collaboration with the Navajo Nation as it seeks to establish a managed care organization sponsored by the Navajo Nation

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#1: Cover most adults under one comprehensive benefit plan

- Consolidate two different adult benefit plans under a single comprehensive benefit package that more closely aligns with private insurance coverage by redesigning the Alternative Benefit Plan (ABP) for adult expansion population to also cover the Parent/Caretaker adult population
- Add a limited vision benefit to the ABP
- Waive federal EPSDT rule for 19-20 year olds in this plan
- Individuals who are determined "medically frail" may receive the standard Medicaid benefit package

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#2: Develop buy-in premiums for dental and vision services for adults (if necessary)

#3: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services
- Does not include retroactive status changes processed by SSA
- Native Americans and individuals residing in nursing facilities would be exempt from this provision

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Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#4: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that result in ineligibility per income guidelines

- The individuals previously using the category are now either transitioned to the adult expansion category or eligible to receive subsidies to purchase coverage through the federal Exchange
- Since ACA, use of the category dropped from 26,000 individuals to 2,000

#5: Incorporate eligibility requirements of the Family Planning program

- Benefits are limited to reproductive health care, contraceptives and related services—not comprehensive coverage
- 6% of population on Family Planning utilize coverage today
- HSD proposes to better target this program by designing it for men and women who are through the age of 50 who do not have other insurance(with certain exceptions)

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Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#6: Request waiver from limitations imposed on the use of Institutions of Mental Disease (IMD)

- Request expenditure authority for members in both managed care and fee-for-service to receive inpatient services in an IMD so long as the cost is the same as, or more cost effective, than a setting that is not an IMD.

#7: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

#8: Request waiver authority for enhanced administrative funding to expand availability of LARC for certain providers

- HSD has made access to LARC a high priority over past several years by unbundling LARC reimbursement from other services
- Requesting authority to receive increased administrative funding to expand availability by reimbursing DOH or other sponsoring agencies for the cost of purchasing and maintaining LARCs

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Upcoming Public Meetings

- **Las Cruces – Thursday, October 12, 2017, 1:30 pm to 3:30 pm**
  - Farm and Ranch Museum
- **Santa Fe – Monday, October 16, 2017, 1 pm to 4 pm**
  - Medicaid Advisory Committee Meeting, NM State Library
- **Las Vegas – Wednesday, October 18, 2017, 1:30 pm to 3:30 pm**
  - Highlands University – Student Union Building/Student Center
  - *Call (toll-free) 1-888-850-4523; participant code: 323 675#*
- **Tribal Consultation – Friday, October 20, 2017, 9 am**
  - Institute of American Indian Arts, Santa Fe
- Additional info: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

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Medicaid Budget Update

- FY19 Budget Request
- Enrollment
- Cost Drivers
- Federal Outlook

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Medicaid Budget Update

- The FY18 general fund (GF) need for Medicaid is **$ 938.3 million**. The Legislature appropriated **$915.6 million**, resulting in a deficit of **$22.6 million** in FY 18.
- The FY19 general fund (GF) request for Medicaid is **$ 997.2 million**. This is an increase of **$81.5 million** above the FY18 appropriation.

($ in millions)	FY14 Actual	FY15 Projection	FY16 Projection*	FY17 Projection*	FY18 Projection*	FY19 Projection*
Total Budget	$4,200.6	$5,162.3	$5,413.9	$5,558.5	$5,811.5	$5,892.2
General Fund Need	$901.9	$894.1	$912.9	$898.4	$938.3	$997.2

*Projection data as of June 2017. The projections include all push forward amounts between SFYs. FY16 general fund includes $18 million supplemental appropriation and general fund transfers from other divisions. These figures exclude Medicaid administration.

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Medicaid Budget Update

(Changes from FY18 Budget to FY19 Request)

($ in millions)	Total	General Fund
FY18 To FY19 Adjustments		
FY 19 Starting Deficit (after MCO reconciliations)	82.34	15.82
Expenditure Changes		
Price and Utilization	56.31	11.66
Enrollment	57.11	11.73
Medicare Buy Ins	5.07	2.62
Health Information Technology	(12.00)	
Revenue Changes		
Medicaid Expansion Change (94.5% to 93.5%)		14.70
CHIP FMAP Reduction (100% to 72.13%)		31.23
FMAP Change (71.90 to 72.13)		(7.18)
Added Miner's Colfax Revenue		(1.04)
Added Drug Rebates and Other Revenue		(3.34)
Less County Supported Medicaid Fund		2.34
Less Tobacco Settlement Revenue		3.00
Total:	$188.83	$81.55

FY19 – What to Watch

- Enrollment trends
- Federal action on CHIP
- Other Federal Action on the ACA and Budget
- CMS policy changes

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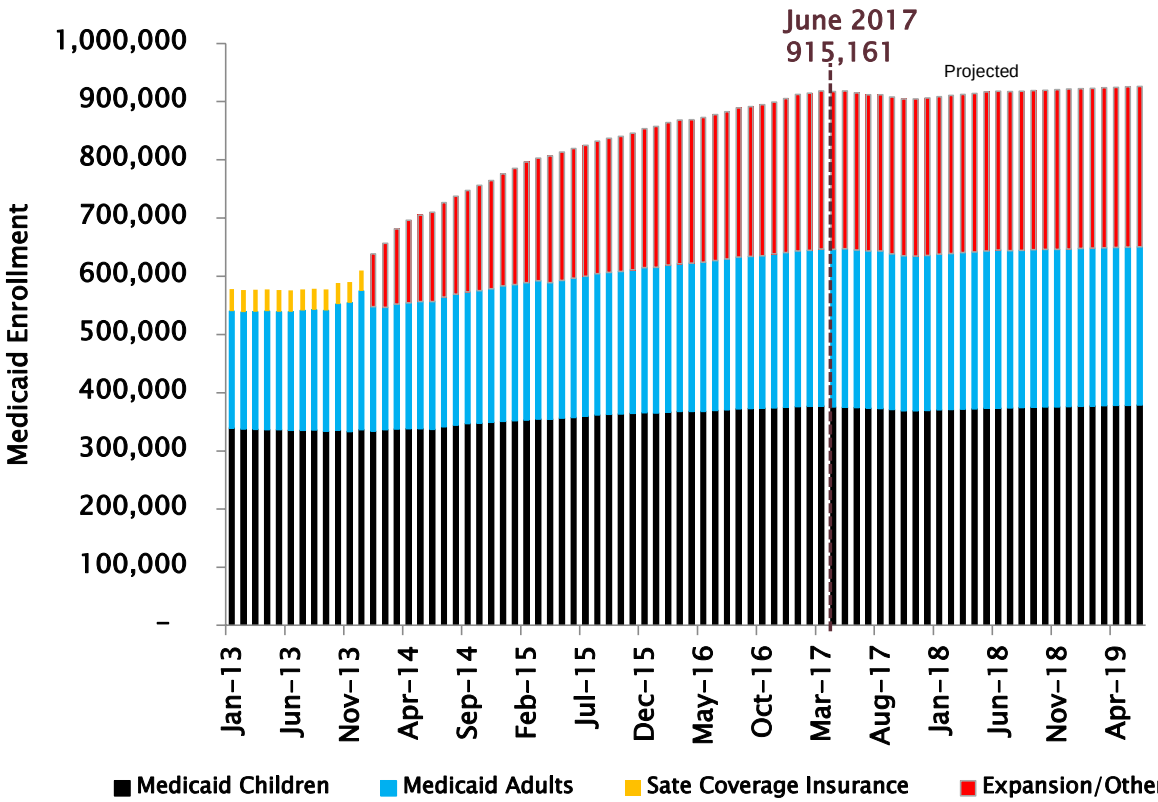
Medicaid Enrollment



June 2019 Projected Enrollment

OAG: 275,685*

Medicaid Adults: 271,512

Medicaid Children: 379,107*

*children 19-21 y.o. counted in OAG

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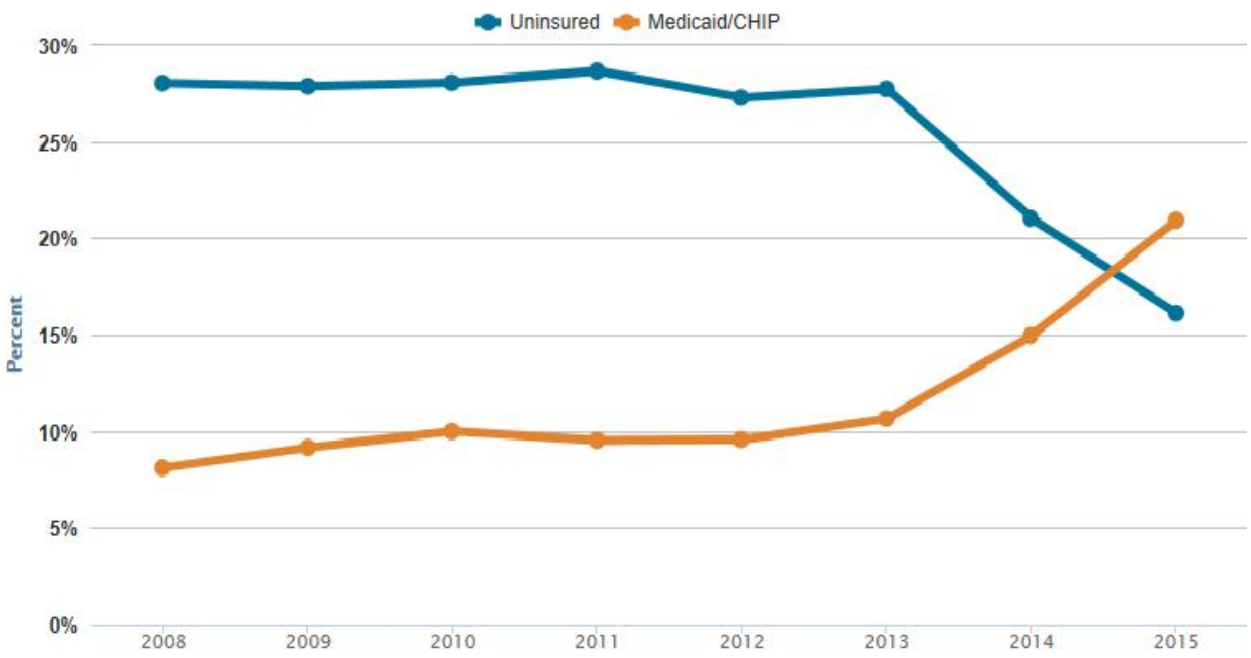
New Mexico Uninsured and Medicaid-Insured (19-64 population)



Source: SHADAC State Health Compare, University of Minnesota

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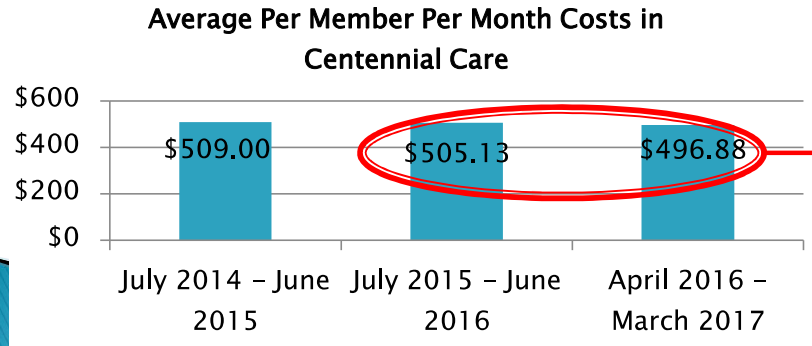
Managing Cost Growth

- Healthcare cost inflation grew an average of 2.6% in 2015 and growth averaged more than 3% in 2016
- Other national studies estimate medical cost inflation (price and utilization) at 6.5%

Centennial Care Stats

- Per capita medical services cost in Centennial Care **growing only 1.3%, driven primarily by increased enrollment and pharmacy costs**
- Managing cost through care coordination and other efforts
- Increases in preventive services and decreases in inpatient hospital costs
- Per person costs are lower in Centennial Care



Reduced spending by $68.2 million

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Section 1115 Demonstration Waiver Authority

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1115 Demonstration Authority

- Under Section 1115 of the Social Security Act, the Secretary of HHS may permit states to waive certain requirements of Medicaid and CHIP to carry out experimental, pilot or demonstration projects, which the Secretary believes are likely to promote the objectives of the Medicaid program
- Permits the HHS Secretary to allow states to use federal Medicaid funds in ways that are not otherwise allowed under the federal rules
- Permits states to make changes in Medicaid eligibility, benefits and cost-sharing.

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1115 Waivers—CMS Communication

- HHS Secretary Price and CMS Administrator sent letter to Governors in March 2017 with intent of extending greater flexibility to states, particularly through 1115 waivers.
- Key areas that the letter highlights are:
  - *Streamlined Program Management*. This involves making the State Plan Amendment process more transparent and efficient, "fast tracking" the approval of waiver and demonstration waiver extensions, and consistently evaluating waiver proposals.
  - *Alignment with Commercial Insurance*. The letter suggests that states consider aligning Medicaid design and benefit structures with those of commercial insurance. It offers specific examples of what states may do:
    - Encouraging Health Savings Accounts
    - Waiving enrollment and eligibility procedures that are inconsistent with continuous coverage
    - Reasonable, enforceable premium requirements
    - Waivers of non-emergency transportation benefits
    - Expanded options to design emergency room copayments

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1115 Demonstration Authority

Waiver of Cost Sharing Requirements:

- CMS can waive federal premium or cost-sharing statutory requirements in section 1916 of the Social Security Act (the Act) under 1115 Waiver Demonstrations.
- The authority lies in section 1902(a)(14) of the Act (42 USC 1396a), which provides that "premiums, or similar charges,. . .cost sharing, or similar charges, may be imposed only as provided in section 1916 of [the Act]." Section 1115(a) demonstration projects may waive provisions under section 1902 of the Act and grant authority for expenditures not otherwise matchable pursuant to section 1903 of the Act.
- Arizona, Arkansas, Indiana are among the states with a waiver of section 1902(a)(14) of the Act to permit collection of monthly premiums for individuals with incomes from 101% to 133% of the FPL.

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1115 Demonstration Authority

Waiver of Retroactive Coverage:

- Section 1902(a)(34) of the Act (42 USC 1396(a)(34) is the substantive requirement for retroactive eligibility under the State plan.
- CMS has issued waivers of section 1902(a)(34) of the Act to permit states to limit retroactive eligibility to the date of application for Medicaid coverage. *See, e.g.,* Delaware, Indiana, New Hampshire,
- Secretary Price's March 2017 letter to governors identified waivers of retroactive coverage as a supported state reform to "align Medicaid and private insurance policies for non-disabled adults."

Transitional Medical Assistance (TMA):

Wisconsin has existing authority to charge premiums for TMA adults above 133% FPL from the first day of enrollment as well as for TMA adults from 100%-133% FPL after 6 months of coverage. It is anticipated that additional states will request such authority.

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1115 WAIVERS IN OTHER STATES

Note: Reflects CMS-approved 1115 waivers as of June 2017. Kaiser Family Foundation – http://www.kff.org/medicaid/issue-brief/key-themes-in-section-1115-medicaid-expansion-waivers/

	AR	AZ	IA	IN	MI	MT	NH	WI	ME
Premiums for populations below 150% FPL, including Adult Expansion group and/or TMA	X	X	X	X	X	X			
Healthy behavior incentives		X	X	X	X				
Waive required benefits such as NEMT and EPSDT for 19-20 year-olds	X		X	X					
Waive retroactive eligibility	X			X			X		
Waive or reduce TMA program								X Proposed; not yet approved	X Proposed; not yet approved

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Questions?

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