

# Public Comment Summary for the Draft 1115 Waiver Renewal Application

## Comment Overview

The Human Services Department (HSD) received comments from 255 people related to its Draft 1115 Demonstration Waiver renewal application (released on September 5, 2017 and revised and re-released on October 6, 2017) through multiple public comment opportunities that included four public hearings, a Tribal Consultation, email submissions and voicemail comments. Comments were submitted from Centennial Care members, the general public, Tribal representatives, Centennial Care providers, provider organizations, legal advocates, advocacy groups, non-profit organizations, religious organizations, and healthcare management entities. The majority of commenters expressed opposition to several proposals in the waiver that advance member engagement and personal responsibility, in particular about proposed cost-sharing for Medicaid participants. More than a third of commenters provided feedback opposing specific proposals in benefit design and eligibility refinements, viewing those as reductions to services and an attempt to decrease enrollment.

Two letters with comments were submitted on behalf of organizations and individuals expressing strong opposition to Medicaid benefits and coverage reductions. One of the letters submitted on behalf of and signed by 24 organizations and 19 individuals stated that proposals in the draft waiver are cuts to the program that will leave thousands without healthcare coverage, create health and financial hardships for families and drive-up long-term costs for the state's healthcare system. The second letter, submitted on behalf of 58 organizations and 271 individuals also strongly opposed proposals in the waiver that they perceived as reductions to health coverage and services that will result in medical debt for families, deter patients from seeking care, and shift costs to healthcare providers. A number of comments received expressed support for the state's effort to improve the Centennial Care program with a strong emphasis on improving care coordination, behavioral health services and provider network adequacy even if they shared opposition to other sections of the waiver proposal.

*Response: Many dedicated organizations, advocates, stakeholders and community members have expended significant effort to review and comment on various draft proposals that ultimately informed the final waiver application. HSD appreciates and acknowledges those efforts and the valuable input it received throughout the year-long process. This feedback has been incorporated throughout the process—from discussions during the early subcommittee meetings, to comments received on the draft concept paper and most recently, for the draft waiver renewal application. HSD developed many of its initial proposals based on public feedback and has since modified them in response to the comments received. For example, it reduced premium amounts that were initially set at two percent of income in the concept paper to one percent in the draft waiver renewal application. It also removed the CHIP and WDI programs from premium requirements in the final waiver renewal application. Additionally, the six copayment requirements in the draft waiver renewal were reduced to only two copayments in the final waiver application. HSD is also eliminating the copayments that exist today in the CHIP and WDI programs in order to align incentives across the system for the most appropriate care, in the most appropriate setting. It is also continuing to provide retroactive eligibility for one month during the first year of the renewal in response to concerns about members in crisis who should receive presumptive eligibility at the point of service but are not completing the process. This will provide additional time for HSD to retrain hospital staff and other safety net providers in the presumptive eligibility process.*

## Summary of Comments by Waiver Proposal Subject

The summary of comments that follows is organized by subject area. Throughout the public input process, HSD has presented the proposed waiver modifications by subject, including: care coordination, benefit and delivery system (including long term supports and services and physical and behavioral health integration), payment reform, member engagement and personal responsibility, and administrative simplification through eligibility modifications.

### 1. Care Coordination

#### 1. a. Increase care coordination at the provider level *(13 comments)*

Many commenters expressed support for increasing care coordination activities at the provider level as part of Value Based Purchasing (VPB). Providers and advocates speaking in support of care coordination expressed concern that appropriate oversight and quality measures are needed and should be imposed on MCOs and providers as part of VBP arrangements. Providers suggested that funding flow from MCOs to providers as part of VBP arrangements to allow for infrastructure development. Commenters encouraged expansion of Patient-Centered Medical Homes (PCMHs) and more inclusive care coordination for behavioral health needs. Pediatric provider groups expressed concerns with PCMHs and said reimbursement rates are inadequate and achieving National Committee for Quality Assurance (NCQA) certification is burdensome. One commenter representing hospitals expressed support for the opportunity for more hospitals to participate but providers will need technical assistance and infrastructure support. A commenter asked the state to require MCOs to assist. One commenter recommended the state provide Medicaid claims data and other data which will enable providers to plan interventions and track progress.

Some advocacy organizations believe care coordination has not met the goals promoted in Centennial Care and is in need of improvement. Advocates from the disability and aging community recommended including information on community supports, reasonable ratio of care coordinators to members, and adequate reimbursement. Commenters asked the state to make care coordination a priority for the dually-eligible population and individuals using long-term services and supports (LTSS) adding that these individuals can benefit from targeted interventions to improve health and bring costs down.

Comments from Tribal organizations were supportive of increasing care coordination at the provider level, but concerns were expressed regarding the reimbursement process and recommendations were made for contracts between Tribes and the state.

*Response: In response to comments about care coordination during the year-long public input process, HSD developed the proposal to target care coordination efforts to high-need, high-cost members and improve transitions of care. Efforts in these areas are being implemented today, through strengthening requirements in the managed care organizations' contracts rather than through changes via the waiver renewal. HSD has also responded to providers who requested increased delegation of care coordination at the provider level by developing a comprehensive plan to implement VBP goals over four years and include requirements for a full delegation model and a shared functions model of care coordination activities. The plan offers flexibility within the VBP arrangements and the delegated structure for both providers and the MCOs. Additionally, HSD has added contractual requirements that will increase the use of Community Health Representatives working with Tribal organizations to conduct care coordination activities, which was in response to comments received through the NATAC. HSD continues to work with the NATAC and meet on a quarterly basis to discuss areas in need of improvement, including care coordination.*

1. b. Improve transitions of care (8 comments)

Commenters expressed support to improve transitions of care and target care coordination. One commenter expressed support of in-home assessments for members in need of Community Benefit (CB) services when transitioning from a facility. One commenter recommended transitions of care could be improved by using VPB initiatives. Advocates warned that MCOs may be incentivized to deny access to subsequent treatments that impacted their VBP revenue. The state was asked by one commenter to include family caregivers in the discharge process from inpatient and nursing homes stays. One commenter stated the Lay Caregiver Act of 2015 requires hospitals to record designated caregiver information, and a commenter suggested that the MCOs train care coordinators about the law.

*Response: In response to comments about improving transitions of care, HSD included clarifying language in the sample MCO contract for Centennial Care 2.0 to include a variety of transitions that the MCOs will be required to address such as members transitioning from a nursing facility to the community or from an inpatient-hospital stay to home. Care coordinators must address the member's service needs such as Home and Community Based Services, follow-up appointments, treatments, medications and durable medical equipment. The contract also requires the MCOs to perform an in-home assessment within three calendar days of discharge followed by three monthly contacts after a transition from inpatient hospital or nursing facility stay to assess the member's needs and ensure the needs are being met. HSD will review its training requirements for care coordinators and identify additional educational opportunities about family caregivers.*

1. c. Leverage partnerships to expand successful programs that target high-needs populations (7 comments)

Commenters expressed support for efforts to leverage partnerships to expand successful programs targeting high-needs populations. Support was expressed for increased utilization of community health workers (CHW) with requirements that contractors describe sustainable funding streams for CHW. One commenter expressed concern for inadequate funding and resources that are needed to have successful programs. Organizations and individuals expressed support of the wraparound approach for youth involved with the Children, Youth, and Families Department (CYFD). A few commenters suggested collaboration with providers at the community level. One advocacy group supportive of wraparound approaches had a concern that this could be used to deny services to children in need of residential treatment center (RTC) placement.

*Response: In response to comments about targeting high-need populations, HSD developed a new section in the sample MCO contract for Centennial Care 2.0 to address this population. The MCOs are required to employ or contract with dedicated care coordinators to meet the needs of individuals with intellectual disabilities, special health care needs, housing insecurity, and/or complex behavioral health needs and individuals that are considered medically-fragile and/or justice-involved individuals. Specialized care coordinators are required to pursue training specific to the particular population's needs and be familiar with available services. In addition, HSD added requirements for the MCOs to include Community Health Workers (CHWs) and Community Health Representatives (CHRs) as part of their delivery system and included goals specific to CHWs and CHRs within a Delivery System Improvement Performance Target.*

1. d. Initiate care coordination for justice-involved individuals prior to their release from incarceration (9 comments)

Providers and individuals support care coordination for justice-involved individuals prior to their release from incarceration. One organization recommended MCOs collaborate with community organizations to identify best practices to effectively coordinate healthcare needs for this population. One commenter expressed support stating individuals in the facilities are often in need of community supports and do not know how to access them.

*Response: In response to comments regarding care coordination for justice-involved individuals, HSD added language to the sample MCO contract for Centennial Care 2.0 that requires the MCOs to participate in care coordination efforts for justice-involved individuals to facilitate the transition of members from prisons, jails and detention facilities into the community. Care coordination for the justice involved will require the MCOs to collaborate with criminal justice partners to identify members with physical and behavioral health chronic/complex care needs prior to release. The MCOs will also be required to designate a justice-involved liaison to be the point of contact for the prisons, jails, and detention facilities and ensure appropriate transition of care prior to release.*

1. e. Pilot a home visiting program that focuses on pre-natal care, post-partum care and early childhood development with the Department of Health and the early Childhood Service Program within CYFD (9)

Commenters expressed support for piloting an evidence-based home visiting project and improving birth outcomes. Legal advocates commented this proposal will encourage state agencies to work together which could lead to reducing administrative waste and duplication of services. One commenter believes home visiting programs are needed to improve better health outcomes.

*Response: HSD added language in this section to further clarify the home visiting models, services and provider qualifications for the pilot.*

1. f. Obtain 100% Federal Funding for covered services delivered to Native American members in Centennial Care that are received through Indian Health Services (IHS) or Tribal Facilities (4)  
Support was expressed for efforts to obtain 100% federal funding for covered services delivered to Native American members in Centennial Care that are received through IHS or Tribal Facilities. Native American providers clarified their interpretation for the referral process to come from IHS or Tribal site and that the MCOs are not allowed to require prior authorization. One commenter stated that collecting more federal dollars to help Native Americans would benefit the state.

*Response: HSD included this proposal in the waiver to primarily address long-term care services. Since Native American members in need of long term care services are required to enroll in Centennial Care, the MCOs have contractual relationships with long-term care providers, including nursing facilities and personal care service agencies, while IHS does not typically have such contractual relationships nor traditionally refer for such services. Additionally, the MCOs are responsible for developing and maintaining the care plans of those members, and so having them serve as the responsible party for record custody but share the records with IHS/ITUs will reduce administrative burden and barriers to care in such circumstances.*

## 2. Long-Term Services and Supports (LTSS)

### 2. a. Align Services between ABCB and SDCB models (8 comments)

Strong support was expressed by commenters for an aligned process between ABCB and SDCB models. Some advocates believe all Community Benefits (CB) should be available to both models which would equalize the service array options. One organization expressed gratitude for the development of the Community Benefit Service Questionnaire (CBSQ) but wanted more focus on ensuring CB participants are properly assessed.

*Response: Several Self-Directed services such as related goods and specialized therapies were added to the Self-Directed benefit package under the previous Mi Via Waiver prior to Centennial Care and were never intended to be managed or provided by an MCO in the agency-based model. The MCOs are implementing the CBSQ with members as required by HSD. As of September 30, 2017, and 11 months with full implementation of the CBSQ, over 19,000 CBSQs have been completed with members in the long-term care program. HSD also monitors CB assessments through ride-alongs with care coordinators and quality audits. It also has its External Quality Review Organization conduct reviews.*

### 2. b. Allow for one-time start-up goods when a member transitions from ABCB to SDCB (3 comments)

Commenters support the allowance for one-time start-up goods when a member transitions from ABCB to SDCB. One commenter asked that allowance for rare exceptions to limits for unusual cases be considered for additional resources for the transition to be successful.

*Response: This a new benefit added to the list of self-direction services. Prior to recommending a \$2000 cap for start-up goods, HSD researched the average cost of items that are beneficial for individuals who are self-directing services, such as computers, printers and fax machines. All of these items may be purchased within the \$2000 cap.*

### 2. c. Address the need for additional caregiver respite (6 comments)

Commenters support adding additional hours to address the need for additional caregiver respite. One commenter stated that any proposed limit to the use of respite must be sufficiently flexible to allow for exceptions to avoid violating the Americans with Disabilities Act (ADA). Commenters expressed appreciation for needed respite hours to help relieve caregivers. Advocates from the aging community expressed support for the additional respite hours to support people using LTSS. One commenter asked the state to not impose a program cap on the hours and suggested using a sliding scale.

*Response: HSD has had an exception process in Centennial Care to allow additional respite over the 100 hour limit when a member's health and safety needs exceed the limit and will preserve this policy under Centennial Care 2.0. See 8.308.12.13.K.(4) NMAC.*

### 2. d. Establish limitations on costs for certain services in the SDCB model (6 comments)

Advocacy organizations believe establishing limitations on costs for certain services in the SDCB model violates the ADA. Providers expressed support for hippotherapy, biofeedback and cognitive rehabilitation specialty services and are concerned about caps. One commenter stated that the cap is arbitrary and will ensure a lack of supportive therapies that maintain or improve health. One commenter stated caps will result in a lack of continuity of care and poorer health outcomes. A few commenters asked the state to allow individuals in SDCB to make their own decisions on how much to spend depending on their needs and not target certain services. One commenter stated limiting non-

emergency transportation will negatively impact older adults in rural areas with limited access to public transportation.

*Response: As the SDCB program continues to experience increased enrollment, the limitations will help to ensure long-term sustainability of the program and continue to allow HSD to offer access to the community benefit to all eligible Medicaid members who meet a NF LOC without needing a waiver allocation for such services. HSD will “grandfather” budgets that exceed the limits for existing SDCB members, and their approved amounts over the proposed cost limits will become their on-going cost limit for as long as they remain in the SDCB model. To clarify, the MCOs are responsible for providing non-emergency medical transportation to all members and there is not a limit or cap for this service. The SDCB transportation benefit that will be subject to the limit provides non-medical transportation to social activities including community events, libraries, museums etc.*

2. e. Implement an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change (3 comments)

Commenters strongly support implementing an ongoing automatic NF LOC approval with specific members whose condition is not expected to change. One commenter stated this policy will help alleviate stressors for members and preserve access to services.

*Response: HSD has not made any additional changes to this proposal in the final waiver application.*

2. f. Require inclusion of nursing facilities in VBP arrangements and leverage Project ECHO and the UNM Section of Geriatrics to provide expert consultation to nursing home staff working with members with complex conditions, systemic improvements in nursing home quality of care, and reductions in avoidable readmissions from nursing facilities to hospitals (2 comments)

Two comments were offered in support of VBP arrangements with nursing facilities and working with Project ECHO. One commenter would like to see more information that supports using an alternative reimbursement method through VBP and allocate more LTSS funding for HCBS.

*Response: HSD’s collaborative work with Project ECHO and UNM Section of Geriatrics will begin in 2018 and include the New Mexico Health Care Association in the development of the VBP plan for nursing facilities in 2019. New Mexico continues to be a national leader in spending more of its long-term care program dollars in home and community-based settings rather than institutional settings.*

### 3. Physical Health and Behavioral Health Integration

3. a. Expand the Health Home model (5 comments)

Comments were expressed in favor of expanding Health Home models to better integrate physical and behavioral health with one commenter asking for more data demonstrating successful models. Support was provided for expansion of the CareLink NM model to additional sites, including a Native American Health Home provider site. One commenter suggested the state provide explicit expectations with respect to behavioral health network adequacy, and evaluate and enforce network adequacy when the MCOs are operational. One commenter expressed concern that it is not clear what services Health Home members receive compared to other Medicaid members.

*Response: The purpose of the Health Home model is to provide more comprehensive care coordination and whole-person chronic condition care management to groups of Medicaid beneficiaries with complex health care needs. The goals of the CareLink NM are to 1) Promote acute and long term health; 2)*

*Prevent risk behaviors; 3) Enhance member engagement and self-efficacy; 4) Improve quality of life for individuals with SMI/SED; and 5) Reduce avoidable utilization of emergency department, inpatient and residential services. Early quality evaluations of CareLink NM are very positive and member satisfaction is reported as high.*

3. b. Establish an alternative payment methodology to support workforce development (10 comments)

Commenters expressed support for an alternative payment methodology to support workforce development to improve access to care. One legal advocacy organization referenced New Mexico's designation as a "Health Professional Shortage Area" and although is supportive of funding that is dedicated to increasing provider access believes it is not enough. One commenter stated the proposal does not address the insufficiencies in the state's behavioral health system. One commenter asked for clarification from the state, on behalf of primary care providers, of the difference between funding Graduate Medical Education (GME) for Family Medicine and Psychiatry as opposed to Primary Care. One commenter is concerned the state intends to require training for family physicians in an integrated Primary Care and Behavioral Health services setting. Two commenters recommended that Accreditation Council of Graduate Medical Education (ACGME) be the standard for clinic eligibility to participate in the alternative payment methodology program, and requested that the state provide Indirect Graduate Medical Education (IME) support for the hospital's portion of the training costs. These commenters also requested clarifying language on an existing State Plan Amendment and state regulations for IME and GME. A commenter from the Native American community suggested funding increases for Primary Care Physicians, Psych Nurses, Nurse Practitioners and Physician Assistants. A hospital provider expressed concerns with moving residency resources from hospital settings and recommends a comprehensive approach to enhance reimbursement across the system. One commenter expressed concerns with moving residency resources from hospital settings to community clinics, which could reduce resources that will contribute to workforce shortages that already exist. Commenter speaking on behalf of hospitals expressed opposition to shifting dollars when GME funding should be maintained for existing GME slots and enhanced for expanded opportunities and new hospital slots.

*Response: HSD's proposed alternative payment methodology is designed to support primary care, family medicine, and psychiatric resident physicians. The state's proposal seeks flexibility to choose clinics that are located in primarily rural, frontier or tribal communities to maximize the state's ability to address workforce shortages within the constraints of available funding. The state does not intend to impose additional training requirements for family physicians. Waiver language was revised to clarify that HSD is not moving residents out of hospital-based settings. HSD disagrees that ACGME accreditation should be the standard for clinic eligibility to receive alternative payments under this program, as this would greatly reduce the likelihood that clinics can participate across different regions of the state. As proposed in the final waiver, HSD is seeking to support the full cost of the resident, which may include the hospital's portion of training costs. HSD will consider comments relating the state's SPA and IME/GME regulations separately.*

3. c. Develop Peer-Delivered Pre-Tenancy and Tenancy Support (7 comments)

Commenters expressed support in developing peer-delivered pre-tenancy and tenancy support to participants with Serious Mental Illness (SMI). Advocates view this approach as an addition to other fully integrated behavioral health treatments. One commenter in expressing support said he/she believes it will help people with SMI. One health plan commented that this expansion will have a beneficial impact for members and reduce unnecessary hospitalizations and emergency department use.

*Response: HSD added language in the final waiver application to further describe this benefit.*

#### 4. Payment Reform

4. a. Pay for value versus volume and increase the share of provider payment arrangements that are risk-based (6 comments)

Commenters expressed support for pay for value versus volume and increase the share of provider payment arrangement that is risk-based. One health plan suggested a flexible range of models including shared savings, shared risk, and partial and full capitation payment. Advocates support efforts to improve outcomes but asked the state to monitor MCOs possible denial or reduction of services to meet VBP goals.

*Response: HSD has been incrementally increasing the amount of provider payments that are in value-based purchasing arrangements since 2015. For CY 18, 20 percent of provider payments must be in VBP arrangements. The ultimate goal of VBP arrangements is to improve healthcare outcomes for members and ensure that members are receiving high-quality care. These arrangements are not designed to reduce or deny services, but rather to incentivize providers to achieve improved rates for routine and preventive care services while reducing rates for potentially preventable services such as emergency room visits and readmissions to hospitals. The Centennial Care 2.0 MCO sample contract requirements outline a four-year plan to continue to drive VBP goals with annual increases in the percentage of provider payments in VBP arrangements, including requirements to include nursing facilities, rural providers and behavioral health providers.*

4.b. Leverage VBP to incentivize and drive key program goals in areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes, including avoidable emergency department utilization (7 comments)

Comments were offered in support of leveraging VBP to incentivize and drive key program goals in areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes, including avoidable emergency department utilization. One commenter recommended including MCOs in developing solutions and evaluating performance against goals. Advocates expressed concerns that VBP could translate into MCO cost savings instead of health outcomes. One commenter expressed concern the MCOs will take away services to meet their VBP goals. One commenter asked the state to include hospital associations and hospitals in efforts to improve readiness to participate in risk-based payment arrangements and to leverage VBP arrangements that drive key program goals. Commenter stated that VBP arrangements should be consistent across MCOs and enable achievement of mutually-agreed upon goals based on hospital capacity and performance.

*Response: As stated in response above, HSD has outlined a detailed plan for its VBP program in its Centennial Care 2.0 MCO contracts, with specific targets and provider payment thresholds in three different VBP levels over four years. The plan includes requirements for inclusion of rural, behavioral health and nursing facility providers, data reporting requirements and specific targets for achieving certain quality metrics. The 2.0 sample contract may be found at this website:*

[http://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/Amended\\_Versi on\\_RFP\\_A2\\_RFP\\_Sample\\_Contract.pdf](http://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/Amended_Versi on_RFP_A2_RFP_Sample_Contract.pdf)



#### 4. c. Advance Safety Net Care Pool (SNCP) Initiatives (5 comments)

Commenters support advancing SNCP initiatives to expand participation to all willing hospitals. Support was expressed for initiatives that are data-informed and focus on health outcomes. One hospital provider expressed concerns with MCO contractual requirements and adding stress on safety net hospitals. One commenter stated that under federal law, states must assure Medicaid payments are sufficient to enlist healthcare providers to the same extent they are available to the general population in the same geographic area. One commenter representing hospitals stated that Medicaid payments to all New Mexico hospitals in aggregate are approximately 85 percent of actual costs for delivering services. Hospital representatives believe the “enhanced rate” does not fully cover their shortfall and is unsustainable. Commenter cited a report that was commissioned by Manatt to provide an analysis with examples from other states to illustrate the rationale for not reducing the uncompensated care (UC) pool and recommended that the state maintain the UC pool at \$68.8 million, or expand it.

One commenter expressed concern with the proposal to expand the range of provider groups participating in SNCP, specifically the inclusion of nursing homes. Commenter explained the SNCP program aligns with county funding and state law, and is applicable only to hospitals. One commenter recommended creating a related program specific to nursing homes and funded separately from hospitals as a more logical approach. Commenter asked the state to consider removing any suggestion about “requiring participating providers to be network providers with each Centennial Care MCO”. Hospital providers expressed concern with the requirement that hospitals must contract with all Medicaid health plans to receive funds from the safety net care pool and that it unreasonably interferes with the free market by mandating that hospitals enter into certain business arrangements.

*Response: HSD seeks authority to retain the Safety Net Care Pool funding. It proposes to incrementally shift the funding ratio between the Uncompensated Care Pool and Hospital Quality Improvement Incentive Pool (HQII) so that 43% of the funding is allocated for the UC pool and 57% for the HQII. This ratio aligns with Centennial Care’s goal to prioritize paying for quality versus volume.*

*In addition to the revised allocation of funding, HSD proposes:*

- *Expanded flexibility to modify or update measures that factor into funding of the HQII pool;*
- *Continue increases to the enhanced inpatient rates and increase outpatient rates; and*
- *Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network for the Centennial Care MCOs.*

*HSD did remove language that included nursing facilities in this section as it has advanced other proposals in the final waiver application specific to nursing facilities and removed the expansion to all willing hospitals.*

#### 5. Advance Member Engagement and Personal Responsibility

##### 5. a. Advance Centennial Rewards Program (5 comments)

Support was expressed for Centennial Rewards Program and suggestions were made to better educate members about how the rewards program works. Support for utilizing rewards towards premiums was expressed and one health plan recommended a 90-day buffer for processing. Advocates and individual commenters expressed support for rewards improving health outcomes. One commenter stated support for the rewards program but thinks people don’t know about it or how to use it.

*Response: HSD did not modify this section in the final waiver.*

5. b. Implement premiums for populations with income that exceeds 100% FPL (141 comments plus joint organizational sign-on letters)

The majority of the comments received explicitly oppose the implementation of premiums for populations with income that exceeds 100% FPL. Many of the comments in opposition to premiums were submitted as form letters or as part of a joint organizational and individual letter. Commenters consistently argued against imposing premiums and offered examples of research that discourages the use of premiums. Commenters suggested the Medicaid program would see enrollment decline and people would lose coverage. One commenter expressed concern that adding more expenses for Medicaid individuals, such as premiums, will directly impact their health. Individuals expressed fear and worry about their ability to afford other expenses like housing, food and transportation. One commenter expressed concern for families living on the edge of poverty, children in CHIP and working disabled individuals. One commenter expressed worry about having to pay both premiums and co-payments. A broad range of providers including family physicians, pediatricians, nurses, social workers, behavioral health providers and others strongly oppose premiums and other forms of cost sharing and believe it will lead to a reluctance to seek care and result in chronic diseases leading to higher emergency care utilization and hospitalizations. Hospital providers expressed concern that premiums will have an effect on enrollment and impact members' ability to stay consistently connected to the Medicaid program. Some commenters suggested the state look for new revenue streams for New Mexico that could benefit the Medicaid program. Some cited an increased administrative burden on the state to collect premiums, which would outweigh any potential savings from cost sharing.

A few commenters expressed support for cost sharing in Medicaid and were in support of premiums.

*Response: HSD carefully considered the comments related to premiums and made the decision to restrict premiums to only one category of eligibility—the Expansion Adult population with income greater than 100% of the FPL. It removed premium requirements for the CHIP and WDI programs in the final application. With this change, the premium structure is simplified, consisting of one income tier for adults with income between 101 and 138% FPL, so that the monthly premium amount is the same for all adults in this category (\$10). The annual premium amount is calculated at one percent of the lowest annual income in the tier, which is \$12,060. At its discretion, HSD is requesting authority to increase the premium amount to two percent of annual income in future years of the Demonstration. HSD does not consider this policy as a reduction to eligibility or services—eligible individuals have the ability to retain coverage and continue accessing all covered services by complying with the premium requirements. Additionally, the premium requirement for this subgroup of the Adult Expansion population with higher income lessens the impact of the cost sharing cliff that is experienced when individuals transition from Medicaid coverage to coverage through the federal Marketplace or commercial market where cost sharing responsibilities are much higher.*

5. c. Require co-payments for certain populations (136 comments plus joint organization sign-on letters)

The majority of the comments received explicitly oppose requiring co-payments for certain populations. Most of the comments in opposition to co-payments were submitted as form letters or as part of a joint organizational and individual letter. Commenters consistently argued against and offered examples of research that discourages imposing co-payments. Commenters suggested the Medicaid program would see enrollment decline and people would lose coverage leading to poor health outcomes. Individuals

expressed fear and worry about their ability to afford other expenses like housing, food and transportation. One commenter stated that the department is applying moral judgement that people need to have more “skin in the game”. One commenter stated that research should be used to prove co-payments work. Families and individuals with chronic health conditions worry about out of pocket cost becoming unaffordable. Concern was expressed for families living on the edge of poverty, children in CHIP and working disabled individuals. A broad range of providers including family physicians, pediatricians, nurses, social workers, behavioral health and others strongly oppose co-pays and other forms of cost sharing and believe it will lead to a reluctance to seek care and result in chronic diseases leading to higher emergency care utilization and hospitalizations.

Hospital providers commented that requirements around co-payments and cost sharing for Medicaid members create increasing administrative burdens for healthcare providers and could impact a rate reduction for services requiring co-payments. They also suggested the administrative burden will offset system savings for Medicaid by increasing costs for providers.

A few commenters expressed support for cost sharing in Medicaid and co-payments.

*Response: HSD carefully considered the comments related to copayment requirements and made the decision to remove most copayments from the final waiver application. Furthermore, it is removing copayments that exist today in the CHIP and WDI programs with the commencement of the waiver renewal. HSD is requesting authority to apply only two copayments in the final waiver, which are consistent with policy priorities to reduce unnecessary use in the delivery system and to incentivize preventive and routine care. HSD's decision to reduce the number of copayments addresses concerns raised about the complexity of the former copayment structure and increasing the administrative burden for providers.*

#### 5. d. Seek authority to modify the tracking requirements for cost sharing (2 comments)

Commenters oppose efforts by the state to seek authority to modify the tracking requirements for cost sharing.

*Response: Since HSD has made decisions to restrict the premium payment requirements and to reduce the copayment requirements, tracking the five percent out of pocket maximum is simplified. HSD is requesting authority to waive federal tracking requirements for the two copayments since the members are choosing those service options rather than alternative options that do not require copayments. Because the premium amount is calculated at one percent of annual household income it should not exceed any member's out of pocket maximum, which is calculated at five percent of annual household income. This simplified cost sharing structure reduces any potential administrative costs that may have been incurred to track member cost sharing.*

#### 5. e. Seek authority for providers to charge nominal fees for three or more missed appointments (62 comments plus joint organization sign-on letters)

The majority of commenters expressed opposition to fees for missed appointments and pointed to obstacles some members face, for example, with access to reliable transportation, health issues that affect their ability to keep appointments, or cognitive issues related to a disability. One commenter expressed concerns for people with behavioral health issues being penalized. One commenter stated that transportation is limited in rural areas. Commenters stated that transportation is not reliable and people sometimes miss appointments. Some providers expressed concerns with administrative burdens they would face in collecting fees. One provider association expressed support for fees as a way to

reduce missed appointments. One commenter suggested using a multiple reminder approach. Some commenters who oppose co-pays and premiums support a small fee for missed appointments but suggested lowering the amount.

*Response: HSD appreciates the feedback received related to this proposal. It is at the provider's discretion to charge the nominal fee after three missed appointments without notification to the provider in a calendar year. HSD has not made any additional changes in the final waiver as a result of these comments.*

5. f. Expand opportunities for Native American members enrolled in Centennial Care (8 comments)  
Commenters were supportive of expanding opportunities for Native Americans enrolled in Centennial Care. Native American providers and tribes expressed support for the state's effort to seek authority to collaborate with Indian Managed Care Entities (IMCE). One commenter emphasized that this effort would not negate the need for fee-for-service (FFS) in New Mexico. Commenter believes the language in the draft waiver does not include a mandate for Native Americans to join an ICME. Most of the commenters reminded the state that they are sovereign. Some Tribal organizations expressed interest in becoming an IMCE as well as becoming other types of Medicaid providers. One commenter stated that because tribes are sovereign, agreements should be between the state and Tribal governments. All of the commenters encouraged the state to work directly with the Tribal community.

*Response: HSD continues to collaborate with the Navajo Nation as it seeks to establish an IMCE. It will also work with other interested Tribal organizations at their request. HSD is not requesting mandatory enrollment for Native American members as part of this proposal to expand opportunities for Native American members. HSD expanded the language in this section of the draft waiver application to clarify expectations for establishment of IMCEs, including the requirement 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 and to demonstrate compliance with the requirements in the Centennial Care Managed Care Professional Services Agreement, including delivery of all Medicaid services as listed.*

## 6. Administrative Simplification through Eligibility Modifications

6. a. Redesign the Alternative Benefit Plan and provide a uniform benefit package for most Medicaid-covered adults (85 comments plus joint organization sign-on letters)

The majority of the comments received explicitly opposes redesigning the Alternative Benefit Plan (ABP) and provide a uniform benefit package for most Medicaid-covered adults. Most of the comments in opposition to redesigning the ABP were submitted as form letters or as part of a joint organizational and individual letter. Many individual commenters expressed concern with cutting essential benefit and EPSDT for 19-20-year-olds and believe it will have a negative effect. One commenter believes elimination of EPSTD in the ABP will impact families. Physical, Occupational and Speech-Language therapy providers strongly oppose changes that would reduce or eliminate therapy services. Providers, advocacy organizations and individuals commented changes would create higher costs for members and shift costs to healthcare providers.

*Response: HSD carefully considered the comments related to this proposal and made the following change to the benefit design—it removed the proposed elimination of habilitative services. However, HSD is seeking a waiver of federal EPSDT requirements for 19 and 20 year olds in the ABP to streamline the adult benefit package and since individuals who qualify for a medically-frail exemption in the ABP*

*have access to the traditional Medicaid benefits that includes EPSDT services. The medically frail exemption criteria includes a list of specific conditions as well as the condition of needing assistance with one activity of daily living. HSD is proposing to add a limited vision benefit to the ABP which will provide access to this service to more than 240,000 adults who previously did not have this benefit. The ABP will continue to offer comprehensive benefits, including routine and preventive services, inpatient and outpatient services, pharmacy, non-emergency medical transportation, physical, occupational and speech therapy services and a dental benefit.*

6. b. Develop buy in premiums for dental and vision services for adults, if needed (33 comments)

The majority of commenters oppose buy-in premiums for dental and vision services for adults and any cuts to services that exist. One commenter expressed opposition to another cost to people who have limited income or lack coverage from their employer. Opposition to changes to adult dental services was received from the oral health coalition and hygienists expressing concern for increased disease risk like heart disease, diabetes and prenatal complications if dental services are reduced. Providers in ophthalmology and optometry also expressed opposition to premiums and changes to vision services stating that it would lead to reductions in thousands of eye exams and contribute to health risks and conditions.

A few commenters expressed support for buy-in premiums for dental and vision services. One commenter stated that the state does not have the money to pay for everything.

*Response: HSD appreciates the comments it received related to this proposal and did not make any changes to this proposal in the final waiver application. This proposal remains to allow flexibility in future years to address potential federal financing policy changes and/or state general fund budgetary deficits.*

6. c. Incorporate eligibility requirements of the Family Planning program (10 comments)

Commenters oppose incorporating eligibility requirements of the Family Planning program. One commenter expressed concerns that limits on the age of recipients would deny access for treatments available through the family planning program. One commenter specifically opposes the age cap of 50 for family planning. Advocates raised concerns that people with disabilities will lack reproductive health coverage and recipients will face co-payments for family planning services in Medicaid and the ABP. Individuals commented that New Mexico already has a high unintended pregnancy rate that leads to cycles of poverty and the state should not reduce access. One commenter stated that risks for sexually transmitted infections with older adults are growing and they need to have access to these services.

*Response: HSD appreciates the comments it received related to this proposal and did not make any changes to this proposal in the final waiver. HSD's policy to target the family planning to those who are accessing the services aligns with the age limitation of up to 50 years old. There are no proposed copayments for family planning services in the Medicaid program.*

6. d. Eliminate the three-month retroactive eligibility period for most Centennial Care members (86 comments plus joint organization sign-on letters)

The majority of commenters expressed strong opposition to eliminating the three-month retroactive eligibility period for most Centennial Care members. Most of the comments in opposition were submitted as form letters or as part of a joint organizational and individual letter. One commenter stated opposition to eliminating the retroactive coverage and that it will leave families exposed to massive financial debt. Advocates and individuals believe ending coverage would take away important

protections that protect people from medical debt. UNMH specifically asks the state to remove this provision from the Waiver proposal. They state that the elimination retroactive cases would have a disproportionate impact on hospitals and other safety net providers. One hospital association commenter stated that the limitation of retroactive eligibility cases would have a disproportionate impact on hospitals and other safety net providers.

*Response: In consideration to the comments received to this proposal, HSD has modified the proposal. The final policy decision is to phase out the retroactive period of eligibility by reducing it to one month in 2019, then eliminating it with the start of the second year of the demonstration (2020). Providing one month of retroactive eligibility to new recipients during the first year of the waiver renewal allows ample time for the delivery system to develop the necessary processes to secure coverage at point of service and provides additional time for HSD to retrain hospitals and other safety net providers in presumptive eligibility determinations. Additionally, HSD is moving toward an environment in which Medicaid eligibility, both initial determinations and renewals, is streamlined where possible. Real-Time eligibility is scheduled to roll-out by the end of 2018, meaning that many individuals will receive an eligibility determination at the point of application. Additionally, the ACA and expansion of Medicaid to adults who were previously uninsured have dramatically changed the landscape of coverage options. New Mexico hospitals have substantially reduced their uncompensated care needs and are able to make individuals presumptively eligible for Medicaid at the time of service. In calendar year 2016, only one percent of the Medicaid population requested retroactive coverage (10,000 individuals). Safety Net Clinics are also able to immediately enroll individuals at point of service through the Presumptive Eligibility program and receive payment for services. These changes provide an opportunity to reduce the administratively complex reconciliation process with the MCOs for retroactive eligibility periods.*

6.e. Accelerate the transition off of Medicaid for individuals who are eligible for the Transitional Medical Assistance (TMA) program due to increase income (73 comments plus joint organization sign-on letters)

The majority of commenters expressed strong opposition to accelerating the transition off of Medicaid for individuals who are eligible for the Transitional Medical Assistance (TMA) program due to increased income. Most of the comments in opposition were submitted as form letters or as part of a joint organizational and individual letter. Many individuals expressed opposition and are concerned this will cause financial problems for families changing jobs or accepting raises.

One commenter stated that ending transitional Medicaid would result in coverage loss for the lowest income families. One commenter expressed concern the proposal will penalize people for working and earning more money. Legal advocates stated that TMA cannot be waived under Section 1115 authority and cautioned the state. One legal advocate commented that ending transitional Medicaid will make it difficult for families to gain economic security and will disrupt healthcare coverage.

*Response: HSD appreciates the comments it received for this proposal. No changes were made as a result of the comments. As an expansion state, New Mexico has an option available to individuals in the Parent/Caretaker category when their earnings increase and make them ineligible for the Parent/Caregiver category, which it did not have prior to the passage of the Affordable Care Act (ACA). As stated in the final waiver application:*

- *TMA is a concept that predates the ACA and was intended to provide coverage to Parent/Caretaker adults whose income increases above the eligibility standard for full coverage. Most of these individuals are transitioned to the adult expansion category, which has resulted in diminishing enrollment in TMA;*

- *In 2013, 26,000 individuals were enrolled in the TMA category; today, fewer than 2,000 individuals are enrolled; and*
- *Parent/Caretakers that have increased earnings above the income threshold for the adult expansion category (138% of the FPL) are eligible to receive subsidies to purchase coverage through the federal Marketplace.*

6. f. Request waiver from limitations imposed on the use of Institutions for Mental Disease (3 comments)

One commenter expressed support in waiving limitations imposed on the use of institutions for mental disease. Disability advocates do not support incentivizing the use of institutional care and asked the state to focus on funding community-based services reducing the need for hospitalization. One commenter representing hospitals commended the state for requesting a waiver of the IMD exclusion and stated it would greatly expand access to inpatient psychiatric care and reduce the administrative burden on MCOs.

*Response: HSD appreciates the comments submitted for this proposal. Other proposals in the final waiver application support use of community-based services rather than institutional settings of care; however, when necessary and in certain circumstances, individuals may require services in an IMD and the State seeks authority to utilize IMDs in those instances without exclusions. Additionally, HSD has added new language to this section of the final application to add several behavioral health services to the benefit package that are needed to fill gaps in care, including expanding use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services through primary care settings, community health centers, and urgent care facilities; and including residential treatment for adults with substance use disorder (ASAM Level 3).*

6. g. Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states (2 comments)

Commenters expressed support for requesting waiver authority to cover former foster care individuals up to age 26. One advocate believes foster care is overrepresented by people with disabilities and behavioral health needs.

*Response: HSD did not modify this proposal in the final waiver application.*

6. h. Request waiver authority for enhanced administrative funding to expand availability of LARC for certain providers (5 comments)

Commenters expressed support for enhanced administrative funding to expand availability of LARC for certain providers. One commenter raised concerns for people with disabilities covered by Medicare and do not have access to LARC would need the Family Planning program for services not available to them.

*Response: HSD did not modify this proposal in the final waiver application.*

6. i. Continue to provide access to Community Interveners (3 comments)

Commenter expressed support for continuing to provide access to Community Interveners. Disability advocates think this opportunity has been underutilized. One commenter expressed support for expanding use of Community Interveners.

*Response: HSD did not modify this proposal in the final waiver application.*

## 7. Comments for related to Multiple or Not Specific Wavier Proposals

### 7. a. Miscellaneous Comments (6 comments)

Comments were received from independent pharmacists and pharmacies offering recommendations for the state to consider. One commenter asked that the state require all pharmacy reimbursement through Centennial Care be in compliance with NADAC pricing. One commenter asked the state to clarify the prior-authorization process for pharmacy and expressed concern that MCOs are using prior-authorization as a way to deny access to prescription drugs. One commenter asked the state to raise reimbursement rates and expressed concerns with contracting with the MCOs. One commenter expressed concerns with the lack of enforcement regarding use of tamper-resistant prescription pads.

One commenter representing hospitals expressed concerns with current infrastructure for oversight of the MCOs and believes it is significantly under-resourced. Commenter stated providers do not have a formal appeal process with the Department and asked the state for a complete restructuring of the fair hearing process.

One commenter expressed frustration with the state's lack of creating new revenue that could help the Medicaid program. One commenter suggested that the state create a tax on New Mexico corporations.

*Response: HSD appreciates these comments; however, the comments are best addressed through review of contractual requirements with and monitoring of the MCOs and review of the agency's internal procedures and processes. Revenue enhancement and modifications to the tax structure are not within the scope of the Medicaid agency's authority.*