Centennial Care 2.0

Section 1115 Demonstration Waiver Renewal Concept Paper

New Mexico Human Services Department

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Executive Summary

Background

The New Mexico Human Services Department (HSD) implemented its new Medicaid managed care program, known as Centennial Care, through a Section 1115 Demonstration Waiver that was approved by the federal Centers for Medicare & Medicaid Services (CMS) for a five year period, beginning in January 2014 through December 2018. Centennial Care modernizes the Medicaid program by improving the efficiency and effectiveness of healthcare delivery; integrating physical, behavioral and long-term care services and supports (LTSS); advancing person-centered models of care; and slowing the rate of growth in program costs. Its guiding principles include developing a comprehensive service delivery system, increasing personal responsibility, encouraging active engagement of members in their health care, emphasizing payment reforms to incentivize quality versus quantity of services, and maximizing opportunities to achieve administrative simplification. Accomplishments for Centennial Care, now in its fourth year of operation, are listed below.

- Streamlined program administration by consolidating a myriad of federal waivers that siloed the care of populations. Today, four managed care organizations (MCOs) administer the full array of services in an integrated model of care, serving approximately 700,000 Medicaid members.
- Built a care coordination infrastructure that promotes a person-centered approach to care. Today more than 900 care coordinators ensure members receive services when they need them.
- Increased access to long-term services and supports (LTSS) for people who previously needed a waiver allocation to receive such services. Today, more than 29,750 individuals are receiving home- and community-based services (HCBS) which represents an increase of 11.4% per year between 2014 and 2016.
- Continued to be a leader in the nation in spending more of its LTSS dollars to maintain members in their homes and in community settings rather than in institutional settings.
- Advanced payment reforms in partnership with the MCOs and, in 2017, requiring value based purchasing (VBP) arrangements for at least 16% of all medical payments to providers.
- Demonstrated improved utilization of health care services and cost-effectiveness of the program despite significant enrollment growth. Total enrollment in the Medicaid program has grown 8.5% per year since 2014 while per capita costs have decreased by 1.5% between 2014 and 2016.

Building on these successes and accomplishments, HSD has identified opportunities for targeted improvements and other modifications that will continue to advance the original principles of Centennial Care through its next iteration — Centennial Care 2.0. Changes will be limited to those that are appropriate for a waiver renewal versus those that can be addressed through either policy directives or MCO contractual requirements. All of the improvements and reforms presented in the paper are intended to ensure ongoing financial viability and sustainability of the Medicaid program while preserving continued access to a comprehensive array of benefits.

Public Engagement

The concepts outlined in this paper were developed with input from a subcommittee of the Medicaid Advisory Committee (MAC), a diverse and comprehensive group of stakeholders and providers; the Native American Technical Advisory Committee (NATAC), comprised of representatives from New Mexico's tribal organizations and Indian Health Services; and comments from the general public.

HSD held a series of monthly meetings over the course of five months to solicit feedback from key stakeholders and the public to inform the development of Centennial Care 2.0. Meetings with the subcommittee of the MAC began in October of 2016 and were open to the public. Each meeting focused on one or more of the key tenets of Centennial Care: care coordination, physical and behavioral health integration, LTSS, payment reform, member responsibility and engagement, refinements to benefits and eligibility, and administrative simplification. The meetings provided ample opportunity for public comment, and HSD allowed public input through a dedicated email address and through HSD's website. In a parallel process, HSD conducted additional meetings with the NATAC with a similar structure and content to solicit recommendations specific to Native American members in Centennial Care. Final documents produced by the subcommittee of the MAC and the NATAC may be found at HSD's website at http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Summary of Improvements and Reforms for Centennial Care 2.0

A summary of the improvement and modifications by program area for Centennial Care 2.0 is outlined below.

Care Coordination

Care Coordination remains central to the effort of ensuring the right care, at the right time, and in the right place. Improvements to care coordination include targeting members with complex needs and/or higher costs through initiatives that promote integration of physical health, behavioral health, and LTSS and by leveraging partnerships with programs that are person-centered and deliver improved health outcomes.

Opportunities in care coordination for Centennial Care 2.0

- Increase care coordination at the provider level as more members are being served by patient-centered medical home (PCMH) models and as providers develop capacity to coordinate all of their members' services and willingness to accept more risk for achieving improved healthcare outcomes
- Improve transitions of care for members being discharged from inpatient and nursing homes stays or other residential and institutional facilities; children returning home from foster care placement; and members who are frequently utilizing the emergency department for non-emergent care
- Leverage partnerships to expand successful programs that target high-need populations, such as community agencies working with frequent utilizers of the emergency department; community health workers (CHWs) and community health representatives (CHRs) educating members about how best to navigate the delivery system; CareLink NM, the health home model for members with complex behavioral health needs; a new home-visiting pilot program in collaboration with the Children, Youth and Families Department (CYFD) and the Department of Health to improve early childhood outcomes; and expanding a pilot that provides intensive care coordination for youth involved with the CYFD.

Physical and Behavioral Health Integration

The goal of a fully-integrated model of care is fundamental to Centennial Care, which changed the delivery of care to members by focusing on the whole person and placing responsibility for all of a member's needs with a single MCO.

Opportunities in physical and behavioral health integration

- Expand the Health Home model that serves members with complex behavioral health needs and coordinates all of their physical, behavioral and LTSS
- Increase primary care residency training in clinic settings to promote workforce development efforts

Long-Term Services and Supports Program

Centennial Care has improved the State's performance in the management of LTSS, and New Mexico continues to lead the nation in spending more of its LTSS dollars in home and community-based settings rather than in institutional settings. By providing HCBS (referred to as community benefit (CB) services in Centennial Care) to any eligible member who meets a nursing facility level of care (NF LOC), Centennial Care has significantly increased access to LTSS.

Opportunities in long-term services and supports

- Streamline services between agency-based community benefit (ABCB) and self-directed community benefit (SDCB) models to facilitate improved transitions for members moving from one model to another
- Allowance for costs of start-up goods when members transition from ABCB to SDCB to facilitate improved transitions for members moving from one model to another
- Address the need for additional caregiver respite, specifically for caregivers of children with special health care needs by increasing the number of hours available from the current limit of 100 to 300 hours
- Establish limitations on costs for certain services in the SDCB model to ensure long-term sustainability of the program and allow HSD to continue its policy of allowing all eligible Medicaid members who meet a NF LOC to access CB services without needing a waiver allocation for such services
- Implement an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change, which reduces administrative burden for both members and the State
- Require inclusion of nursing facilities in VBP arrangements and leverage the University of New Mexico's Project Extension for Community Healthcare Outcomes (Project ECHO) to provide expert consultation to nursing home staff working with members with complex conditions to improve quality of care and healthcare outcomes for such members

Payment Reform Initiatives

Payment reform efforts in Centennial Care are achieving better value by driving improvements in quality and slowing the growth of spending in the program. Currently, the Centennial Care MCOs are required to have 16% of all provider payments in VBP arrangements.

Opportunities in payment reform

- Continue to drive reforms that pay for value versus volume by increasing the requirement of managed care provider payments that must be in VBP arrangements, including risk-based models;
- Leverage VBP arrangements that drive key program goals in the areas of care coordination, physical and behavioral health integrated models, LTSS quality initiatives and improving population health outcomes
- Advance Safety Net Care Pool (SNCP) program initiatives by updating the quality measures used to determine the Hospital Quality Incentive Initiative (HQII) pool payments, expanding the types of providers who may participate in the pool and requiring participating providers to be network providers with each Centennial Care MCO

Member Engagement and Personal Responsibility

With the goal of increasing member engagement and ensuring sustainability of the program, HSD seeks to build upon policies that enhance members' ability to make informed decisions about their health and become more active and involved participants in the healthcare system. HSD is also considering new policies to increase the financial responsibility of individuals in higher income categories and to expand opportunities for its Native American members.

Opportunities in member engagement and personal responsibility

- Advance the Centennial Rewards program that encourages healthy behaviors and promotes proactive participation of members in their health care
- Continue to require co-payments for certain populations and consider options to allow members to use healthy behavior credits earned in the rewards program to offset co-payments;
- Implement premiums for populations with higher incomes to ensure sustainability of the program, which has had significant enrollment growth since 2014
- Seek authority for providers to charge nominal fees for three or more missed appointments to address provider concerns about rising rates of missed appointments in the Medicaid program
- Expand opportunities for Native American members enrolled in Centennial Care by continuing to collaborate with the MCOs to expand contractual or employment arrangements with CHRs throughout the State; and working with tribal providers to develop their capacity to enroll as LTSS providers and/or as a Health Home provider. HSD is also interested in receiving proposals from a tribal entity partnering with a MCO to deliver Centennial Care services to Native American members

Refinements to Benefits and Eligibility

The following policies are intended to streamline aspects of the Centennial Care program and allow for innovation in program design. Streamlining eligibility processes and seeking innovation in program design will reduce administrative costs to HSD, simplify the program for beneficiaries, and ensure a viable and sustainable Medicaid program.

Opportunities in refinements to benefits and eligibility

- To ensure long-term affordability and sustainability of the adult expansion program, redesign the Alternative Benefit Plan (ABP) and provide a uniform benefit package for most Medicaid adults
- Consider developing buy-in premiums for dental and vision services for most adults
- Initiate care coordination for justice-involved individuals prior to release from incarceration to ensure continuity of care and improve their overall healthcare outcomes

- Incorporate eligibility requirements for the limited benefit "family planning" into the waiver so that appropriate changes may be made to requirements including defining the eligible population by establishing a maximum age for eligibility for the program
- Consider consolidation of multiple eligibility categories within subpopulations to simplify administration of the program as Medicaid currently has 40 different eligibility categories
- Eliminate the three month retroactive eligibility period for most Centennial Care members as more members receive an eligibility determination at the point of application through real- time capability, diminishing the need for retroactive coverage
- Accelerate transitions off of Medicaid for individuals who lose eligibility due to increased earnings by requesting a waiver of the Transitional Medical Assistance (TMA) program, which pre-dates the Patient Protection and Affordable Care Act (ACA) and served as a safety net for such members who now are eligible for federal subsidies through the federal Marketplace
- Request a waiver from limitations imposed on the use of Institutions for Mental Disease (IMD) to expand this service to more eligible members
- Request a waiver to cover former foster care individuals up to age 26 who are former residents of other states, which is a new federal waiver requirement for States
- Request waiver authority for enhanced administrative funding to expand availability of Long Acting Reversible Contraceptives (LARC) to certain providers who are having difficulty securing funding to maintain an inventory
- Explore ways to align eligibility determinations for individuals in need of long-term services to ensure parity of access to such services
- Request authority to use trusted data sources as the primary source of income verification when making an eligibility determination

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Centennial Care Overview

Medicaid System Prior to Centennial Care

Before Centennial Care, the Medicaid system in New Mexico was fragmented. In 2013, about 510,000 individuals— more than a quarter of the State's population—received health care through the Medicaid program. The challenges included:

- An expensive program, consuming about 16% of the State budget, up from 12% the previous year;
- An administratively complex program operating under 12 separate federal waivers in addition to a fee-for-service (FFS) program for those who either opted out of or were exempt from managed care;
- A fragmented program with seven different health plans administering different benefit packages for defined populations making it harder for individuals, providers, and MCOs to manage complex medical and behavioral conditions; and
- A system that paid for the quantity of services delivered without emphasis on the quality of care that is delivered.

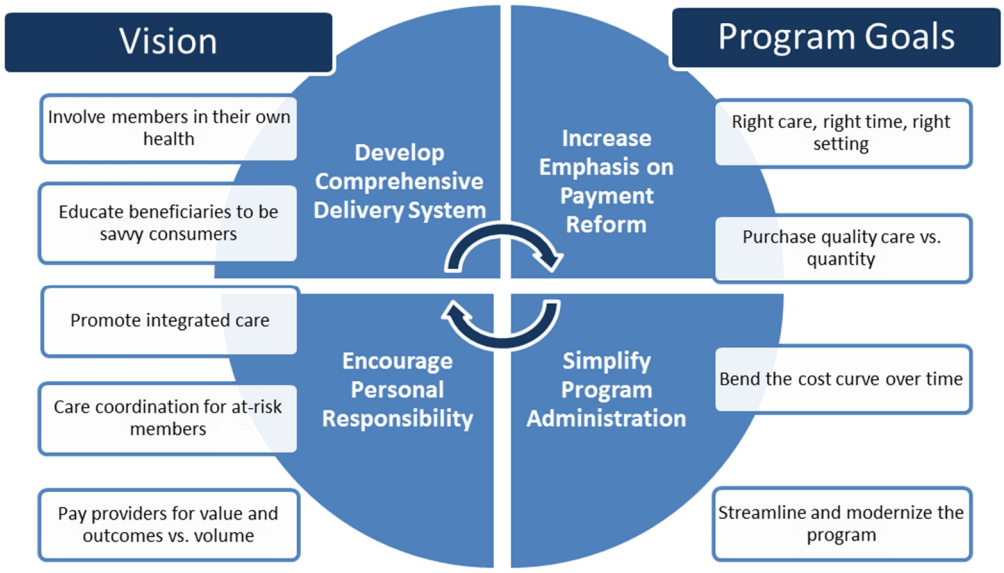
The amount of time and resources required to manage a patchwork of services with multiple MCOs and other vendors diverted HSD from focusing on providing a comprehensive system of care. Furthermore, despite the amount of time and money that flowed into the program, HSD had no clear indication whether or not it was purchasing high quality care. As it continues to advance program goals in Centennial Care 2.0, including VBP initiatives and the replacement of its Medicaid Management Information System (MMIS), HSD expects to steadily progress in its purchase of quality health care.

Centennial Care Guiding Principles

The New Mexico Medicaid system was in need of reform. The challenge was to identify the best approach to achieve this transformation, while slowing the growth rate of program costs without reducing access to necessary services and, ensuring more efficient and effective health care for Medicaid recipients. As its framework for the development of a modernized Medicaid program, New Mexico articulated the four guiding principles listed below and in Figure 1.

- Develop a comprehensive service delivery system that provides the full array of benefits and services offered through New Mexico's Medicaid program
- Encourage more personal responsibility so that beneficiaries become more active participants in their own health and more efficient users of the health care system
- Increase the emphasis on payment reforms that pay for performance rather than the quantity of services delivered
- Simplify administration of the program for the State, for providers and for beneficiaries where possible

Figure 1 —Centennial Care Guiding Principles, Vision and Goals



Today, Centennial Care is an integrated, comprehensive delivery system serving 700,000 New Mexicans. Each MCO is responsible for coordinating the full array of services for its members, including acute care (includes pharmacy), behavioral health services, institutional services and CB services.

Centennial Care Achievements
• *Streamlined administration of the program by consolidating a myriad of federal waivers that siloed care by populations. Today, four MCOs administer the full array of services in an integrated model of care.* • *Built a care coordination infrastructure that promotes a person-centered approach to care. Lower costs associated with inpatient stays and increased utilization of primary care office visits, preventive care and behavioral health services is evidence of the success.* • *Increased access to LTSS for people who previously needed a waiver slot to receive such services. Today, more than 29,750 individuals receive CB services, which is an increase of 11.4% per year between 2014 and 2016.* • *Continued to lead the nation in spending more of its LTSS dollars to keep members in their homes and in community settings rather than institutional settings* • *Demonstrated both cost-effectiveness and improved utilization of health care services. Enrollment in the Medicaid program has grown by 8.5% per year while per capita costs have decreased by 1.5% between 2014 and 2016.*

The Centennial Care 1115 Waiver renewal provides opportunities for HSD to build on the many successes and accomplishments achieved since implementation of the program. HSD has identified opportunities for continued progress in transforming its Medicaid program into an integrated, person-centered, value-based delivery system through implementation of Centennial Care 2.0. Based on

feedback received over the past three years at the annual Centennial Care public forums and through other input sessions with advocacy groups and stakeholders, HSD has identified several areas in need of refinement for the second phase of Centennial Care. The following objectives represent program modifications that leverage the existing design, expand successful 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
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health
- Enhance LTSS and maintain the progress achieved in rebalancing efforts
- Expand payment reform through VBP arrangements to achieve improved quality and better health outcomes
- Build on and incorporate policies that seek to enhance beneficiaries' ability to become more active, responsible and involved participants in their own health care
- Further simplify administrative complexities and implement innovations in program design, some of which will be achieved with the replacement of the Medicaid Management Information System. More information about this project may be found by clicking on the website link below. http://www.hsd.state.nm.us/centennial-care-2-0.aspx

In the subsequent sections of this document, HSD presents information about its proposals for Centennial Care 2.0 that will inform the development of its 1115 Waiver renewal application. The sections are organized to provide a brief background of the program area being reviewed, accomplishments achieved in each area under Centennial Care, and proposals to advance goals and enhance performance in each of the areas. HSD proposes modifications in the following core areas:

- Care Coordination;
- Behavioral Health Integration;
- LTSS;
- Payment Reform;
- Member Engagement and Personal Responsibility; and
- Refinements to Benefits and Eligibility.

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Care Coordination

The hallmark of Centennial Care, care coordination is central to the goal of ensuring that members receive the right care, at the right time, and in the right place and to advance the integration of physical health, behavioral health and long-term services. The approach to care coordination in Centennial Care includes:

- Assessing each member's physical, behavioral, functional and psychosocial needs;
- Identifying the specific medical, behavioral and LTSS and other social support services (e.g., housing, transportation or income assistance) necessary to meet a member's needs;
- Ensuring timely access and provision 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 assistance needed in order to promote each member's health, safety and welfare.

Centennial Care establishes levels of care coordination support that range from a low level of care coordination for members requiring a "light touch" (i.e., periodic service utilization monitoring) to higher levels of care coordination for members with the highest needs who require more intensive, hands on care coordination (i.e., members with chronic conditions and high utilizers). The intent is for members to receive the care coordination level of support that is most appropriate to meet their needs. In the event a member's needs should change, MCOs are required to make the corresponding change in their care coordination level of support.

Each member in Centennial Care receives a standardized health risk assessment (HRA) to determine if he or she requires a comprehensive needs assessment (CNA) and/or a higher level of care coordination. The CNA identifies members requiring level 2 or level 3 care coordination and is followed by the development of a plan of care, which establishes the necessary services based on needs identified in the CNA. Members designated to care coordination level 2 or level 3 are assigned to a care coordinator who is responsible for coordinating their total care. MCOs routinely monitor claims and utilization data for all members to identify changes in health status and high-risk members in need of a higher level of care coordination.

Centennial Care Accomplishments

Centennial Care transformed New Mexico's Medicaid managed care program with its focus on integrated, person-centered care and a robust care coordination program. HSD procured new MCOs capable of providing the entire suite of covered Medicaid services and included prescriptive contractual requirements regarding the care coordination activities to be conducted by the MCOs. The program requirements include timeframes for when the HRAs and CNAs must be completed, clear expectations of care coordination tasks for each care coordination level, required components of the plan of care, qualifications for care coordinators, frequency of touch points between care coordinator and members,

and specific care coordination requirements for members participating in a Health Home model. Furthermore, MCOs are encouraged to build care coordination systems that maximize local community supports, such as CHWs. For more information about the care coordination programs developed by the MCOs, visit HSD's website at http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Employing a workforce of more than 900 care coordinators, the MCOs have developed a care coordination infrastructure that promotes a person-centered approach to care. In the past four years, they have been increasing their use of CHWs in care coordination roles as well as using CHWs to educate members about appropriate use of the delivery system. Through these care coordination efforts and other innovations in Centennial Care, the average cost associated with inpatient hospital stays has decreased and the use of more appropriate services such as primary care office visits and preventative care services has increased between 2014 and 2016 as illustrated in Table 1.

Table 1 – Centennial Care Managed Care Medical Cost

	Per Capita Medical Cost (PMPM)			Percentage Change		
Service Categories	2014	2015	2016	2015 / 2014	2016 / 2015	2016 / 2014
Acute Inpatient	$97.54	$90.71	$91.25	-7.0%	0.6%	-3.3%
Acute Outpatient / Physician	$89.84	$92.29	$95.56	2.7%	3.5%	3.1%
Nursing Facility	$33.21	$28.40	$26.37	-14.5%	-7.1%	-10.9%
Community Benefit	$49.55	$47.85	$48.75	-3.4%	1.9%	-0.8%
Other Services	$84.55	$93.74	$91.91	10.9%	-2.0%	4.3%
Behavioral Health Services	$32.81	$32.96	$32.39	0.4%	-1.7%	-0.6%
Pharmacy	$36.84	$42.99	$49.43	16.7%	15.0%	15.8%
Total	$424.34	$428.94	$435.66	1.1%	1.6%	1.3%

Table notes:

1. *The information reflects medical services only and is based on financial and encounter data submissions by Centennial Care MCOs.*
2. *The percentage change from 2014 to 2016 is an annualized figure.*

Care Coordination Opportunities

Care coordination remains a core focus for the Centennial Care program. HSD aims to further refine care coordination to maximize resources by targeting members with high needs and members who experience transitions in settings of care. HSD will also focus on transitioning care coordination activities from the MCOs to providers with the capacity to manage subsets of the population. The proposed modifications are listed below.

- Increase care coordination at the provider level
- Strengthen transitions of care including focus on quality outcomes through arrangements with providers that incentivize improved health care outcomes in VBP models
- Expand successful programs that target high-need populations.

Care Coordination Opportunity #1: Increase care coordination at the provider level

Centennial Care continues to increase the number of members participating in PCMHs from 180,000 at the end of 2014 to 290,000 at the end of 2016. PCMH models emphasize quality, access to care,

appropriate use of health care that avoids unnecessary utilization (non-emergent emergency room visits etc.) and leads to better outcomes and cost savings. National studies suggest that patients served by PCMHs are more satisfied than those served in traditional primary care practices and that physician practice staff are happier in PCMHs. One group health study found that only 10% of staff in PCMH pilot programs felt high levels of exhaustion compared to 30% in control practices. The same study also found better retention and satisfaction among primary care physicians compared to non-PCMH practices[1]. For a state such as New Mexico with a shortage of providers, this is a particularly important outcome. PCMH providers play a critical role as they engage directly with their members and have the most frequent opportunity to build trusting relationships, which has a high impact on successful integration of physical and behavioral health. As part of the expansion of the PCMH model, the MCOs are engaging PCMH providers to conduct care coordination activities for their attributed members through VBP arrangements. Centennial Care 2.0 seeks to expand on this initiative by continuing to transition care coordination functions from the MCOs to the provider level (known as a delegated model).

As providers become more willing to accept risk for a subset of members, delegation of care coordination is critical to successful management of members. Centennial Care 2.0 seeks to leverage opportunities to continue to build on these successful models by identifying and supporting providers with the capacity to conduct care coordination activities. Formal arrangements for care coordination conducted at the provider level through a variety of models will allow HSD to ensure consistent quality measures and standards while leveraging local, community-based approaches to care.

HSD plans to revise some of its care coordination requirements to better support a delegated model, including developing a process for MCO oversight of providers with reporting requirements. As an example, the CareLink NM Health Home model features delegated care coordination arrangements with the MCOs and successfully uses a Treat First model for assessment and care planning. In New Mexico, Treat First focuses first and foremost on an individual's immediate treatment needs, then conducts the medical history and needs assessment and develops a care plan after treatment has begun (see Section 4 for details regarding the Treat First model).

In addition to allowing more opportunities for delegation, HSD, in collaboration with the MCOs, will support approaches that promote an increase in the use of local/community resources to support MCO care coordination, such as CHWs, CHRs working with tribal organizations, school-based health centers (SBHCs), paramedicine programs, community-based agencies and personal care services (PCS) agencies.

Care Coordination Opportunity #2: Improve transitions of care

Care coordination, when implemented timely and effectively, assists members through transitions of care by connecting them to local providers and stabilizing them in the new setting so that they are able to improve and thrive. Well-planned care coordination provides a variety of supports during transitions, including but not limited to: assistance with eligibility; addressing safety concerns in their home environment; and assistance with addressing housing issues. Transitional needs are identified and addressed in a transition of care plan developed by the care coordinator and the member. HSD intends

[1] Grumbach K, Grundy P. Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States. Patient Centered Primary Care Collaborative 2010 Nov

to improve transitions of care by implementing measures that enhance the MCOs' ability to identify and provide situation-specific assistance for short-term transition periods, including:

- Discharge from an inpatient or nursing home stay;
- Frequent emergency department visits in a short period of time;
- Release from incarceration or detention facilities among justice-involved individuals;
- Community placement from a residential or institutional facility; and
- Children returning home from a foster care placement.

Some of the modifications under consideration include:

- Conducting in-home assessments for members in need of CB services after transitions from facilities; and
- Strengthening requirements for care coordination of justice-involved individuals who are transitioning out of prison, jail, or juvenile detention facilities prior to release to allow for the provision of care coordination services.

In addition, HSD plans to work with MCOs to construct VBP initiatives and other member incentives that support positive outcomes of a successful discharge, such as:

- Continuing reductions in unnecessary emergency department visits post discharge for 30 days;
- Continuing reductions in preventable readmissions post discharge for 30 days;
- Ensuring timely follow-up primary care physician or behavioral health visits; and
- Encouraging timely medication reconciliation and prescription fulfillment.

Care Coordination Opportunity #3: Leverage partnerships to expand successful programs that target high-need populations

With a focus on directing resources in areas where the most potential for impact exists, Centennial Care 2.0 will continue to expand and initiate successful programs that target high-need populations. HSD proposes to advance key initiatives through supporting collaborations and expanding programs that demonstrated quality results in phase one of Centennial Care, and by leveraging successful community-based programs to initiate new opportunities in Centennial Care 2.0. These proposals are listed below.

- Continue to incentivize innovative collaborations between the MCOs and community agencies; such as: paramedicine providers, wellness centers, PCS agencies and Project ECHO
- Continue efforts to build capacity and provide flexibility for the use of Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists, to provide care coordination functions
- Continue to promote use of CHWs and CHRs as extenders of care coordination to educate members about using the health care system
- Expand the Health Home program, which serves children and adults with complex behavioral health needs, to other counties
- Pilot a wraparound approach (intensive care coordination) for youth involved with the CYFD to improve health outcomes and reduce stays in residential treatment centers
- 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 Services Program within CYFD

- Incorporate opportunities to leverage federal funding to address other social factors, such as supportive housing services, to improve health and reduce overall spending

Finally, as MCOs continue to demonstrate a thorough understanding of the requirements for basic care coordination activities, such as conducting needs assessments, face-to-face visits with members and regular updates to plans of care, HSD will shift its resources from compliance and monitoring of care coordination activities to focus on measurement of quality and healthcare outcomes. With the replacement of the MMIS underway, opportunities will develop to capture and analyze data relevant to member-specific and population health outcomes (physical, behavioral, and social), improved quality of life, total cost of care and increased social connectedness. With such capability, HSD will be able to implement continued improvements in the program that are informed by meaningful data.

4

Behavioral Health Integration

In addition to a strong care coordination model of care, Centennial Care changes how members access benefits and how these benefits are managed. Prior to Centennial Care, a member's care was managed and delivered by multiple MCOs. Members were enrolled with a physical health or LTSS MCO, as well as with the statewide behavioral health MCO for mental health and substance abuse services (MH/SA). No single MCO was responsible for all health care services for the member. This fragmentation created barriers for treating members as a whole-person. Centennial Care changed the delivery of care by focusing on the whole-person and placing the responsibility of the member's holistic care with a single MCO.

Centennial Care Accomplishments

Since the beginning of Centennial Care, HSD has explored and pursued a variety of initiatives to build provider capacity for MH/SA services. It has also implemented policies and pilot programs designed to improve integration, reduce administrative burden and expand both the services and providers available to provide services. A recent national report, *The State of Mental Health in America 2017*, shows that New Mexico improved fourteen spots, from 36 to 22, in national rankings for all areas ranked: adult, youth, need and access. Mental Health American's overall rankings are based on 15 different measures that include prevalence of behavioral health issues, access to care and mental health workforce availability. The full report may be accessed at this link: http://www.mentalhealthamerica.net/download-2017-state-mental-health-america-report.

Other accomplishments in the area of behavioral health integration in Centennial Care are outlined below.

Developed the Behavioral Health Collaborative Strategic Plan

The Behavioral Health Collaborative Strategic Plan identified several goals that have advanced Centennial Care accomplishments related to behavioral health integration.

- To promote future excellence in the behavioral health workforce and further implement integrated care, training has begun with three Federally Qualified Health Centers (FQHCs) in southern New Mexico to prepare them for intensive clinical case reviews. This methodology, called *Integrated Service Review,* connects improved clinical practice to improved member outcomes.
- Too often medically managed detoxification has not been part of regular practice among general hospitalists and nurses in New Mexico. Medically managed detoxification is a Medicaid reimbursable service in Centennial Care if provided in general hospital settings. HSD has arranged for general hospital practitioners to be trained in screening and treating patients who are at risk for complicated withdrawal and use evidence based treatment algorithms to medically manage their care.

Implemented "Treat First" Model Pilots

The Treat First model of care is an approach to clinical practice improvement, designed to improve timely and effective responses to a person's needs as a first priority. The model was structured as a way to achieve an immediate therapeutic relationship between a member and a clinician while gathering needed patient history, assessment and treatment planning information over the course of a small number of therapeutic interactions. One of the primary goals was to decrease the number of members who failed to show up ("no shows") for the next scheduled appointment because their need was not met during their initial intake. HSD implemented the pilot with six provider agencies across the State and later expanded the pilot to additional agencies including behavioral health and physical health integrated FQHCs.

After six months of implementation, close to 900 members were assigned as Treat First clients. The model has demonstrated to be effective in:

- Enhancing client engagement;
- Reducing the number of no shows;
- Increasing the quality of assessment and treatment plans; and
- In some cases, escalating the case closure rate and thus reducing the number of encounters that linger, adding cost.

Treat First providers participate in orientation, training and monthly continuing *Learning Community* meetings. Through this mechanism of teaching and learning from each other, providers are enhancing the positive outcomes listed above and strengthening engagement of members while reducing costs. Additional evaluation will take place to further evaluate impact on reducing higher level of care costs associated with hospitalization.

Increased provider capacity to deliver behavioral health services

HSD, collaborating with FQHCs and MCOs, has increased the number of providers that provide MH/SA services. FQHCs have expanded their service offering, participated in integrated quality service reviews and helped to establish Treat First protocols. MCOs have provided support to FQHCs in developing capacity to provide MH/SA services.

HSD has also expanded access to methadone and continues to approve additional methadone treatment clinics; today there are over 18 methadone clinics. Methadone clinics treat individuals who are addicted to heroin and narcotic pain medications through the administration of medicine, counseling and social support. Methadone services allow for individuals to recover from their addiction and reclaim active lives. Since 2014, six new methadone sites have been approved while the number of Medicaid members using these sites has increased from approximately 1,700 to 3,500. HSD tracks patients receiving methadone treatment to ensure that they do not receive unnecessary treatment from more than one clinic and to better serve Medicaid members during emergencies.

Implementation of Health Home Model

Beginning in 2013, HSD received a planning grant to design its first State Plan Amendment (SPA) to establish Health Homes through Section 2703 authority of the ACA. In April 2016, HSD launched CareLink NM in two counties: San Juan and Curry. CareLink NM targets individuals with one or more serious or

persistent mental health conditions, including serious mental illness and severe emotional disturbance. CareLink NM provides enhanced care coordination to members participating in two core service agencies (CSAs), coordinating both behavioral and physical health with family supports and community services such as: housing; transportation; job placement; and peer supports.

CareLink NM CSAs use electronic health records and participate in the State's Health Information Exchange to facilitate exchange of information and facilitate the transmission of health care related data, according to national standards, among facilities, health information organizations and government agencies. As of April 2016, CareLink NM was serving over 350 Centennial Care members and FFS recipients.

Developed Training and Guidance for Integrated Care

During the first three years of Centennial Care, HSD performed audits of MCO care coordination practices. The first round of audits evaluated MCO care coordination practices, while subsequent annual audits evaluated whether MCOs were improving on prior audit findings. This allowed HSD to proactively identify and address areas of concern and to ensure that course correction actions were implemented in a timely matter. As a result, HSD developed and provided additional trainings to further improve integration. These training efforts are ongoing as Centennial Care matures.

Centennial Care Behavioral Health Waiver Services

The Centennial Care Waiver included three new behavioral health services for eligible participants: family support, respite and recovery services.

- *Family Support* — This service is a community-based, face-to-face interaction with the eligible beneficiaries and family members and significant others to identify the recovery and resiliency service needs within a recovery plan to enhance their strengths, capacities, and resources so as to promote their ability to reach the recovery and resiliency behavioral health goals they consider most important.

- *Behavioral Health Respite* — This service provides supervision and/or care of children and youth (up to 21 years of age diagnosed with a serious emotional or behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) residing at home in order to provide an interval of rest and/or relief to the person and/or their primary care givers. The service may include a range of activities to meet the social, emotional and physical needs of the person during the respite period. These services may be provided on a short-term basis (i.e., few hours during the day) or for longer periods of time involving overnight stays.

- *Recovery Services* — These are peer-to-peer group instructional services that assist individuals with serious mental illness, severe emotional disturbance and substance use disorders to develop the skills they need to maximize their potential for a successful recovery.

Behavioral Health Integration Opportunities

While HSD has sufficient authority to continue advancement of physical and behavioral health integration, it has identified several strategies aimed at improving existing practices in Centennial Care that reduce the fragmentation of care through patient-centered practices. HSD may opt for waiver

authority or alternatively choose another method such as a SPA, to implement the following opportunities:

- Expanding Health Home models; and
- Establishing an alternative payment methodology to support workforce development.

Physical and Behavioral Health Integration Opportunity #1: Expanding Health Home models

CareLink NM provides a comprehensive system of care coordination for members with chronic conditions. HSD proposes expanding the program to additional providers across the State.

Physical and Behavioral Health Integration Opportunity #2: Establish an alternative payment methodology to support workforce development

To support workforce development and improve access to care, New Mexico proposes to establish an alternate payment methodology to support training for both primary care and psychiatric resident physicians deployed in community-based practices in very rural and underserved parts of New Mexico. The alternate payment will be designed to fully support resident physicians in areas of the State where it is particularly difficult to attract health care providers. Such payments are both economic and efficient because they will facilitate access to care for Medicaid recipients in the least expensive settings in their communities.

5

Long-Term Services and Supports

A central goal of the Centennial Care program is assuring that members receive the right amount of care, at the right time and in the most cost effective or "right" setting. Since 2008, HSD has administered its LTSS program through a managed care model designed to serve members in the most appropriate setting. New Mexico has been a leader in "rebalancing" long-term service delivery—serving more members in community settings than in a nursing facility. Centennial Care significantly advanced this trend. Today, more than 29,750 members receive LTSS in their homes or in the community.

Prior to Centennial Care, New Mexico's LTSS program, known as the Coordination of Long-Term Services (CoLTS) program, restricted members who met the NF LOC criteria to receiving only PCS. It required members who needed additional CB services to place their name on a central registry list and wait for a waiver allocation.

Centennial Care expanded the availability of CB services to individuals who qualify for full Medicaid coverage and who meet a NF LOC by eliminating the requirement for a waiver allocation in order to access the full suite of CB services. As part of this change, HSD removed the PCS benefit from the State plan and included it as one of many services available in the CB service array which resulted in increased access to PCS for eligible members. For those members who do not meet full Medicaid financial eligibility due to having household income that is higher than program guidelines, Centennial Care established more than 4,289 slots for allocation to the Centennial Care Waiver.

Centennial Care Accomplishments

In addition to expanding access to CB services, HSD implemented policies and other initiatives to increase person-centered care. A brief description of Centennial Care's successes in the area of LTSS is provided below.

Increased Access to the Community Benefit

As previously discussed, prior to Centennial Care, members who met NF LOC and needed CB services were limited to PCS and were required to wait for a waiver allocation to access the full suite of CB services. Centennial Care eliminated this requirement and increased the availability for more comprehensive CB services to qualifying members.

Members eligible for CB services have the option of selecting from two models of care. While each model provides similar CB services, a few differences exist. The ABCB model provides CB services through contracted managed care providers. The SDCB model allows members to direct and control how their CB services are provided and who provides them. Both models include an annualized budget that is established through a needs based assessment.

As a result of Centennial Care's policy change to increase access to CB services, the number of members accessing CB services has increased, as illustrated in Table 2.

Table 2 – CB Services Users by Calendar Year

Calendar Year	Unique count of users	Annual Growth Rate (Year over year)
2014	24,016	N/A
2015	27,860	16.0%
2016	29,799	7.0%

Table note: The data presented are based on encounter data submitted through March 31, 2017 for LTSS and adult expansion members for each calendar year period.

Allocations and the Central Registry

As part of Centennial Care, HSD focused on increasing the number of individuals receiving waiver allocations from the central registry. HSD's progress in allocating members from the central registry is provided in below Table 3. For the first time in many years, all placements on the central registry that are categorized as "expedited" have been allocated.

Table 3 – Waiver Allocation Statistics

Calendar Year	Allocations Mailed	Responses Received	Response Rate	Eligible for Waiver
2014	1,103	630	57%	168
2015	1,725	786	46%	106
2016	3,788	1,703	48%	221

As of January 2017, the central registry had 14,691 active registrations. While this number may appear high, a financial or medical eligibility assessment is not required for placement on the registry; therefore, any resident of New Mexico may have his or her name added to the list at any point in time. The waiver allocation process has contributed to the increase in Centennial Care members receiving CB services.

Community Based Transitions, Rebalancing and Long-Term Care Program Performance

Centennial Care and its predecessor program, CoLTS, have increased the proportion of members receiving LTSS in the community versus a nursing facility. New Mexico continues to lead the nation in spending more of its LTSS dollars to keep members residing in their homes and in community settings rather than institutional settings. The American Association of Retired Persons (AARP) annual report for 2014, *State Scorecard on LTSS for Older Adults, People with Physical Disabilities and Family Caregivers*, ranked New Mexico first in the nation for spending more than 65% of its LTSS dollars on CB services and has successfully decreased the rate of LTSS members in nursing home placements from 20.3% in 2009 to 13.6% in 2016.

In overall performance of its LTSS program, New Mexico ranks in the second best quartile in the 2014 National State LTSS Scorecard published by the AARP and the Commonwealth Fund[2]. Our LTSS system is especially strong in terms of:

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

Table 4 illustrates HSD's success over the past eight years with reducing the number of members in nursing facilities and increasing the number of members in community-settings.

Table 4 – Proportion of Members in a Nursing Facility and Community

Setting of care	2009	2010	2011	2012	2013	2014	2015	2016
Nursing Facility	20.3%	19.2%	18.7%	18.9%	17.3%	14.7%	13.5%	13.6%
Community Benefit	79.7%	80.8%	81.3%	81.1%	82.7%	85.3%	86.4%	87.3%

Table note: The data presented is based on LTSS setting of care information for each calendar year period.

While these efforts result in improved outcomes, they have also resulted in reduced occupancy rates for nursing facilities and higher average costs to care for those who are residing in nursing facilities. According to a report by the New Mexico Legislative Finance Committee released in October 2016[3], *Cost, Quality and Financial Performance of Nursing Homes in New Mexico (report #16-10)*, the number of individuals living in New Mexico nursing homes declined by 12% between 2011 and 2015 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."

HSD will continue to work with the New Mexico Health Care Association—representing the nursing home industry in New Mexico—as available funding allows the exploration of the transition to a reimbursement system for nursing facilities that takes into account additional categories of patient acuity, as well as quality and performance. As part of its commitment to pursuing payment reform initiatives for nursing facilities, HSD is advancing VBP arrangements and plans to include requirements in Centennial Care 2.0 that mandate the inclusion of nursing facilities in VBP arrangements. Additionally, HSD intends to explore a program through its affiliation with Project ECHO that will support consultation services and training for nursing facility staff to improve the care of members with complex conditions and to improve transitions of care.

Other Long-Term Services and Supports Based Initiatives

Advancements in the LTSS program have been achieved through HSD's focused and comprehensive oversight of the program. Because LTSS represents a high per capita cost, continued oversight and

[2] Data: LTSS Spending - AARP Public Policy Institute analysis of Truven Health Analytics, Medicaid Expenditures for LTSS 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 LTSS Scorecard, 2014

[3] New Mexico Legislative Finance Committee Program Evaluation Unit – Cost, Quality, and Financial Performance of Nursing Homes in New Mexico (Report #16-10) October 2016

improvement opportunities remain at the forefront of HSD's day-to-day activities. Additional LTSS-specific initiatives implemented by HSD are below.

Electronic Visit Verification System

PCS is the most utilized CB service and represents a significant portion of overall LTSS expenditures. Annual PCS expenditures have increased from $263 million in 2013 to over $344 million in 2016. The number of users has also increased from approximately 19,500 in 2013 to 29,750 users in 2016. MCOs completed implementation of an Electronic Visit Verification system in November 2016 to ensure that care is being delivered as authorized. PCS caregivers use tablets supplied by the MCOs with location service technology to record and track PCS hours provided to members and to ensure that the hours provided align with the members' assessed need and the approved PCS hours.

New Mexico Independent Consumer Support System

HSD created an independent system that links resources throughout the State to assist newly-eligible individuals and those currently receiving LTSS in Centennial Care. The New Mexico Independent Consumer Support System (NMICSS) provides Centennial Care beneficiaries, their advocates and counselors with information and referral resources in the following areas:

- Centennial Care health plan choice counseling;
- Member grievance, appeals and rights to fair hearings; and
- Understanding care coordination and levels of care.

The NMICSS provides informational brochures to beneficiaries and advocates that outline how to access the NMICSS and identify participating organizations that can help with specific topics. Additionally, HSD developed an NMICSS website (www.nmicss.com) which offers the following:

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

HSD partners with members of the NMICSS advisory team to plan and host semi-annual regional roundtable discussion groups with a focus on LTSS in Centennial Care. The composition of the NMICSS advisory team includes:

- Centennial Care members;
- Provider advocates;
- Executive leadership from the four MCOs;
- Director of the Medical Assistance Division; and
- Medicaid staff with the LTSS Bureau.

The purpose of these roundtable discussions is to offer an environment conducive to open discussion regarding LTSS. The regional discussions were held at the San Juan Center for Independence in Farmington, New Mexico; the UNM Center for Development and Disability Information Network in Albuquerque; and The Ability Center in Las Cruces, New Mexico. These discussions have led to increased MCO trainings for care coordinators; process improvements among 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.

Medicare Advantage Dual Special Needs Plans

With Centennial Care, the MCOs are required to offer dual special needs plans (D-SNPs), which allow each MCO 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 coordinate and align the member's benefits and improve customer service by having a single provider directory and member handbook, one drug plan and elimination of co-payments. In October 2016, HSD collaborated with the MCOs to develop a communication plan for members who are dually eligible for Medicaid and Medicare about the benefits of selecting the same MCO for both Medicaid and Medicare coverage. HSD plans to continue working with the MCOs to promote the benefits for dually eligible members to enroll in D-SNPs.

Other Improvements to Long-Term Services and Supports

As a result of feedback from advocacy groups and stakeholders, including the NMICSS roundtable discussions, HSD and the MCOs collaborated to implement the following policy modifications:

- Streamlined the approval process for environmental modifications;
- Allowed PCS agencies to create a flexible individualized schedule for members;
- Clarified PCS agency transfer process;
- Added the purchase of cell phone data as an allowable expense in SDCB related goods; and
- Increased non-medical transportation mileage limit from 50 to 75 mile radius in SDCB.

Long-Term Services and Supports Opportunities

Essential to Centennial Care is the availability of CB services for members who require LTSS and wish to remain in the community or in their own home. As program utilization continues to increase, HSD's proposal for modifications to the CB services are focused on the long-term sustainability of the program without jeopardizing the gains in improved access to care and health care outcomes derived from the innovative policy change. HSD proposes the following modifications to the program in the Centennial Care Waiver renewal:

- Streamline services across the ABCB and SDCB options;
- Establish a one-time allowance for the cost of start-up goods when a member transitions from ABCB to SDCB;
- Address the need for additional caregiver respite, specifically for caregivers of children with special health care needs by increasing the number of hours available; and
- Establish limitations on costs for certain services in the SDCB model
- Implement an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change
- Require inclusion of nursing facilities in VBP arrangements and leverage Project ECHO to provide expert consultation to nursing home staff working with members with complex conditions.

LTSS Opportunity #1: Streamline Services between ABCB and SDCB Models

HSD proposes to streamline the CB service package as outlined in Table 5. HSD proposes adding nutritional counseling under the ABCB service model and aligning SDCB homemaker service with PCS. These changes will facilitate improved transitions for members moving from one model to another.

Table 5 – ABCB and SDCB Community Benefits in Centennial Care 2.0

Service Description	ABCB	SDCB
Adult Day Health	X	X
Assisted Living	X	
Behavioral Support Consultation	X	X
Community Transition *(community reintegration members only)*	X	X
Customized Community Supports		X
Emergency Response	X	X
Employment Supports	X	X
Environmental Modifications *($5,000 every 5 years)*	X	X
Home Health Aide	X	
Job Developer		X
Nutritional Counseling	X	X
Personal Care Services *(Consumer Directed, Consumer Delegated and Self-Directed)*	X	X
Private Duty Nursing Services for Adults (RN or LPN)	X	X
Home Health Aide	X	X
Related Goods *(phone, internet, printer etc…)*		X
Respite (registered nurse or limited practice nurse)	X	X
Skilled Maintenance Therapy Services *(occupational, physical and speech therapy)*	X	X
Specialized Therapies *(acupuncture, biofeedback, chiropractic, cognitive rehabilitation therapy, Hippotherapy, massage therapy, Naprapathy, Native American Healers)*		X
Non-Medical Transportation *(carrier pass and mileage only)*		X

LTSS Opportunity #2: Allow for one-time start-up goods when a member transitions from ABCB to SDCB

HSD proposes establishing a one-time amount of $2,000 that will be added to members' SDCB annual budgets to provide for needed items (such as a computer and printer) when they transition from ABCB to SDCB. This change will result in maintaining the member in the community by accommodating for a one-time cost of goods and services necessary to successfully self-direct. For periods after transition, the

annual budget will be reduced for the one-time costs and an annual limit established for continued purchase of goods and services as described in LTSS opportunity #4.

LTSS Opportunity #3: Address the need for additional caregiver respite

Currently, respite services available under the CB services are limited to 100 hours in most circumstances; HSD is proposing to increase the limit from 100 to 300 hours. This increase will allow members to access over 30 days of respite per annual period.

LTSS Opportunity #4: Establish cost limitations for certain services in the SDCB model

HSD proposes establishing annual budget limitations for the following services for members in the SDCB model (see Table 6 below): related goods and services, non-medical transportation and specialized therapies. As this 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.

Table 6 – SDCB Annual Service Limitations

SDCB Service Description	Description	Annual Limit
Related goods and services	Separate from the one-time funding for start-up goods and for members who transition from ABCB to SDCB. HSD proposes that for periods after transition an annual limit be established for continued purchase of goods and services.	$2,000
Non-medical transportation	HSD proposes an annual limit for non-medical transportation (carrier passes and/or mileage).	$1,000
Specialized therapies	HSD proposes to include an overall annual limit for the following specialized therapies such as: • Acupuncture • Chiropractic • Hippotherapy • Massage therapy	$2,000

LTSS Opportunity #5: Implement an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change

This proposed change would result in reducing annual assessments for certain members, increasing administrative simplification and possibly achieve cost savings. Under this approach MCOs would still be required to complete an annual CNA and develop an annual plan of care. Individuals must meet all financial eligibility criteria to qualify for ongoing coverage. This policy change is particularly relevant for members with certain conditions such as renal failure, quadriplegia, etc.

LTSS Opportunity #6: Require inclusion of nursing facilities in VBP arrangements and leverage Project ECHO to provide expert consultation to nursing home staff working with members with complex conditions

As New Mexico continues to increase the number of members receiving LTSS in home and community settings, nursing facility occupancy rates continue to decline resulting in higher average costs to care for those who are residing in nursing facilities. HSD proposes, as funding permits, to continue to work with the New Mexico Health Care Association to explore a different reimbursement methodology and to mandate inclusion of nursing homes in MCO VBP arrangements. Additionally, HSD will explore the possibility of leveraging the University of New Mexico's Project ECHO program to provide consultation services to nursing facility staff working with members with complex conditions.

6

Payment Reform

A key program goal of Centennial Care has been to pay for value and not solely for volume of services rendered by rewarding providers' achievement in quality of care and member health outcomes.

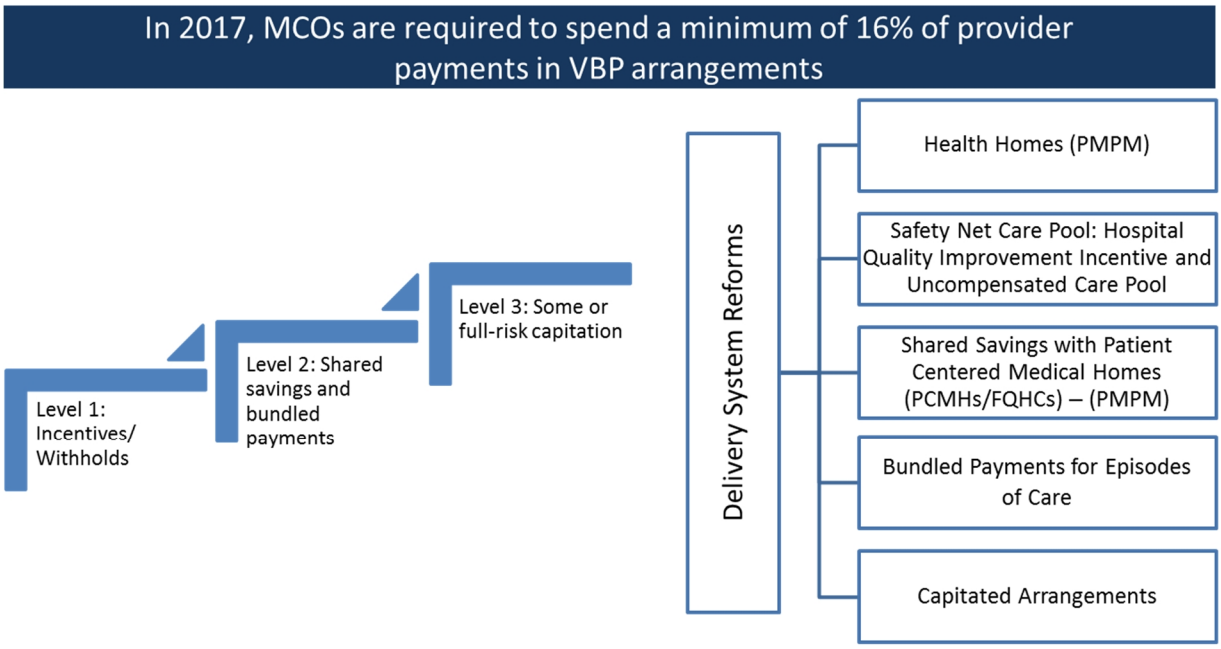
Centennial Care Accomplishments

In 2015, HSD implemented payment reforms through a variety of pilot projects to test their effectiveness and to begin to engage providers' in changing reimbursement methodologies to more effectively align with quality outcomes.

Value Based Purchasing

HSD has implemented payment reforms through multiple pilot projects to test effectiveness and more recently through contractual requirements for MCOs. In calendar year 2017, the MCOs are required to have a prescribed percentage of all provider payments in one of three levels of VBP payment arrangements. HSD intends to continue to increase the overall percentage of provider payments covered under a VBP arrangement in various models. Currently, MCOs must have 16% of provider payments across three levels with level one at the lower end of the risk continuum and level three at the higher end as illustrated in Figure 2.

Figure 2 – Value Based Purchasing



MCOs are permitted to tailor their program to their covered population and submit proposals for HSD's approval.

As part of its delivery system reform initiatives, HSD has implemented other payment reforms through Health Homes, the SNCP HQII pool, and required the MCOs to increase the number of PCMHs serving Centennial Care members.

Safety Net Care Pool

The SNCP is comprised of two programs: the Uncompensated Care (UC) pool and the HQII pool. Today the UC pool provides funding to 29 eligible hospitals (formerly known as sole community provider program hospitals) for their UC with a hierarchical payment structure that provides funding to the smallest hospitals first, and then to medium-sized and to largest hospitals, based on available funding.

The HQII Program incentivizes participating hospitals to meaningfully improve the health and quality of care of the individuals they serve who are on Medicaid or are uninsured. Beginning in 2015, the HQII Program evaluated improvement and rewarded hospitals in essential quality measures for urgent improvements in care, including:

- All cause readmissions;
- Obstetrical adverse events (without instrument);
- Postoperative deep vein-thrombosis or pulmonary embolism;
- Surgical site infections;
- Ventilator associated events;
- Adverse drug events;
- Catheter-associated urinary tract infections;
- Central line associated blood stream infections;
- Injury from falls and immobility; and
- Obstetrical adverse events (with instrument) and pressure ulcers.

Each hospital's HQII activities are consistent with the State's quality goals, as well as CMS' overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population and lower cost through improvement (without any harm whatsoever to individuals, families or communities).

As HQII advances into the final years of the current Centennial Care waiver, measures are evolving toward population-focused improvements including diabetes short-term and long-term complication rate, adults with asthma admission rate, heart failure admission rate and bacterial pneumonia admission rate.

In 2018, the percentage of funding available to the UC pool is 85%, or $68.9 million of the total available funding of $80.9 million. That leaves $12.0 million or 15% available for HQII pool.

- From 2014 to 2016 there was a 41% decrease in requests for UC funding by the 29 SNCP hospitals participating in the UC program
- For 2015, the defined need for UC funding was fulfilled with $1.6 million subsequently flowing from the UC pool to the HQII pool.

Payment Reform Opportunities

As previously discussed, HSD has implemented requirements for MCOs to increase the portion of provider payments in VBP arrangements. HSD will expand its current payment reform requirements and incrementally increase the percentage of provider payments that operate under a VBP arrangement that are risk-based. For Centennial Care 2.0, HSD proposes the following initiatives related to payment reform:

- Continue to drive value by improving provider readiness to participate in risk-based payment arrangements and increasing the percentage requirement of managed care provider payments that are risk-based;
- Leverage VBP arrangements that drive key program goals in the areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes; and
- Advance the SNCP program to additional providers with the goal of improving quality outcomes and include requirements for providers that participate in SNCP initiatives to be contracted network providers with each Centennial Care MCO.

Payment Reform Opportunity #1: Pay for value versus volume and increase the percentage of provider payment arrangements that are risk-based

As HSD continues to expand requirements for MCOs to shift payments from volume of services to paying for quality and improved outcomes, HSD recognizes that it must continue to develop requirements for the MCOs, identify areas for providing technical assistance to interested health care providers and promote aligned quality metrics. As part of this opportunity, HSD intends to:

- Increase the total percentage of MCO provider payments that are in VBP level 2 (shared savings and bundled payments) and level 3 (partial or full risk) arrangements;
- Improve provider readiness to participate in risk-based payment arrangements;
- Identify achievable VBP models for behavioral health providers, LTSS providers and smaller volume providers, including options for small providers to build collaborative partnerships;
- Reduce administrative burden and complexity wherever possible;
- Eliminate barriers to data sharing and improve the availability of actionable and reliable data for providers participating in VBP strategies;
- Align quality metrics and technical specifications across MCOs and health care payers (noting that in many instances Medicare and commercial insurance quality measures do not necessarily align with Medicaid populations); and
- Identify best practices to evaluate and quantify the success of VBP strategies.

Payment Reform Opportunity #2: 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

Many of the concepts in payment reform cross over other opportunities and areas included in this concept paper including:

- Expand the CareLink NM Health Home model to additional counties and evaluate other types of Health Homes for different health conditions;
- Research options to potentially expand Health Homes to Indian Health Services (IHS) and tribal organizations through VBP strategies that support their ability to provide enhanced care coordination interventions;
- Broaden MCO VBP programs to test strategies that target key program goal areas; and
- Explore VBP strategies to improve provider shortage issues, particularly within primary care.

Payment Reform Opportunity #3: Advance SNCP Initiatives

In the 1115 Waiver renewal, HSD proposes funding in future periods to equal the last year of the current 1115 Waiver (CY2018 level) and an incremental change to shift the funding ratio between the two pools so that 43% of the funding is allocated for the UC pool and 57% to HQII. This ratio fits with the goal of the program to pursue arrangements that prioritize quality versus volume. The HQII Program will continue to evaluate urgent improvements in care and continue to evolve toward the evaluation of population focused improvements. Areas of increasing importance are obstetrical adverse events, all cause readmissions and uncontrolled diabetes admission rates.

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

- Flexibility to modify or update measures that factor into determining the HQII pool and to also include other providers such as nursing facilities in the HQII pool; and
- Include the requirement for providers that participate in SNCP initiatives to be network providers with each Centennial Care MCO.

7

Member Engagement and Personal Responsibility

One of the core principles of the New Mexico Centennial Care program is to encourage greater member personal responsibility of their care so members become more efficient users of the health care system. As HSD seeks to renew the Centennial Care Waiver, it plans to build on existing policies and incorporate new policies that enhance beneficiaries' ability to make informed decisions about their health and health care to become more active, responsible and involved participants in the health care system.

Centennial Care Accomplishments

Centennial Care required a member rewards program that provides incentives for members to become more active in managing their health as well as relying on MCOs' efforts to design and implement programs that increase member engagement. In addition, HSD engaged more frequently with IHS and tribes through standing quarterly meetings to collect input and discuss potential solutions for improvements to the program.

Centennial Rewards

Centennial Care established a member-based rewards program known as Centennial Rewards. Centennial Rewards was designed to encourage members to actively participate in their health care and drive improvements in health outcomes. It required the MCOs to collaborate and procure a vendor to implement a member rewards program. The MCOs selected the company Finity to administer the program, which was launched in the spring of 2014.

All Centennial Care members enrolled in a MCO may participate in the Centennial Rewards program and receive points for engaging in and completing healthy activities and behaviors, including:

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

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

In 2016, approximately 70% of Centennial Care members participated in the Centennial Rewards program. Some of the demonstrated health outcomes for these members are listed below.

- Inpatient admissions have decreased among participants in the program, resulting in a cost-savings of approximately $23 million in 2015
- The average redemption rate of earned rewards is 24%, with the notable exception of the Step-Up Challenge, which has a redemption rate of 85%. 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
- Participants across all conditions had higher compliance with Healthcare Effectiveness Data and Information Set 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' refills. Medication adherence for schizophrenia and bipolar disorder have both increased substantially year-over-year and were above 90% for participants in 2015
- Hemoglobin A1c (HbA1c) test compliance for participants increased substantially — nearly 20% from 2014 to 2015 — while the year-over-year increase for nonparticipants was only 1%.

Member Engagement

In addition to Centennial Rewards, the MCOs continue to increase member engagement through implementation of the care coordination program, disease management programs, member advisory committees and Ombudsman programs that assist members with understanding MCO processes and address concerns not resolved through appeals and grievance procedures. MCO care coordinators remain critical in educating members about appropriate use of the delivery system and helping them to navigate the system. For example, CHWs employed by the MCOs engage members who frequently use the emergency department to connect them with primary care physicians. In addition, members in need of LTSS are able to review and discuss available CB services together with their care coordinator to determine which services they are interested in receiving through the Community Benefit Services Questionnaire. Members who receive the SDCB are also actively engaged in developing their plans of care, hiring their own caregivers and developing their hourly payment rates. These members are responsible for completing employer-related tasks, such as approving and submitting employee timesheets to the fiscal management agency for payment.

In addition, the MCOs continue to develop strategies that promote member engagement through:

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

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

Native American Participation in Centennial Care

New Mexico is home to 23 different tribes, nations and pueblos. While not all Native Americans who are eligible for Medicaid are required to enroll in Centennial Care, those in need of LTSS are required to participate in the managed care program. Native American members are able to continue to seek care from IHS and/or tribal providers regardless of whether those providers are contracted with a MCO. A few key points are listed below.

- As of April 2017, there are 44,426 Native American enrolled in Centennial Care, including more than 6,000 members receiving LTSS. Consistent with the non-Native American Medicaid population, PCS continues to be the most utilized CB service by Native Americans
- Approximately 12,000 Native American members are enrolled in the Medicaid expansion for adults
- In 2016, the State experienced a significant decrease in the non-emergent use of emergency department services by Native Americans
- The MCOs have implemented a variety of programs in Native American communities throughout New Mexico including:
  - A resource center in Shiprock, New Mexico; and
  - Tribal employment initiatives to perform specified care coordination activities.
    - Attached is a link to a MCO video related to these initiatives: http://www.unitedhealthgroup.com/Newsroom/Articles/Feed/UnitedHealth%20Group/2016/0719HealthEquityNavajo.aspx?r=2

The State seeks ongoing input from two Native American advisory committees: the MCOs' Native American Advisory Boards (NAAB) and the State's NATAC. The NAAB meets quarterly in tribal communities that have high enrollment in Centennial Care to discuss issues related to service delivery and operations. HSD works directly with the NATAC, which advises the State on issues pertaining to Native Americans, IHS, tribal health providers and urban providers (I/T/Us), including but not limited to policy and notice review, resolution of payment issues and quality improvement initiatives. Each of the MCOs has a Native American liaison who collaborates with IHS, tribal 638 providers and HSD's Native American liaison.

Native American Protections

Several protections were implemented in Centennial Care to ensure that Native Americans continued to have access to I/T/Us and to facilitate access to timely, quality care. The protections, several of which are listed below, fall into the following areas: MCO staff requirements, care coordination, claims management/claims processing, reporting and providers.

- Each MCO must have a full-time staff person to work directly with I/T/Us and be proficient in at least one New Mexican Native American/pueblo language
- The MCOs must use local resources, such as I/T/Us, PCMHs, Health Homes, CSAs and tribal services to perform the care coordination functions
- The MCO cannot impose co-payments on Native Americans
- Members can chose I/T/Us to serve as their primary care provider

- At least one FQHC shall be an Urban Indian FQHC in Bernalillo County
- A MCO must allow members to seek care from any I/T/U whether or not the I/T/U is a contract provider
- MCOs must track and report quarterly reimbursement and utilization data related to I/T/Us
- MCOs must reimburse I/T/Us at least 100% of the rate currently established for IHS facilities (with a few exceptions)
- Services provided within I/T/Us are not subject to prior authorization requirements;
- Native American members accessing the pharmacy benefit at I/T/Us are exempt from the MCO's preferred drug list
- Native Americans may self-refer to an I/T/U for services.

HSD plans to maintain all of the established protection for Native Americans in Centennial Care 2.0.

Opportunities to Advance Member Engagement and Personal Responsibility

For the Centennial Care Waiver renewal, HSD is looking to build on and incorporate policies that seek to enhance members' 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. In addition, HSD is considering initiatives to increase the financial responsibility of individuals in higher-income Medicaid categories, including the Adult Expansion, Children's Health Insurance Program (CHIP) and Working Disabled Individuals (WDI). Please note that Native Americans would be exempt from any cost-sharing proposals. Ideas under consideration include:

- Advancing the Centennial Rewards Program;
- Continuing to require co-payments for certain populations;
- Implementing premiums for populations with income that exceeds 100% of the federal poverty level (FPL); and
- Allowing providers to charge nominal fees for three or more missed appointments.

Member Engagement and Personal Responsibility Opportunity #1: Advance the Centennial Rewards Program

To advance Centennial Rewards, HSD is considering restructuring rewards to focus on new conditions and to promote more proactive engagement. HSD is considering modifications that may include:

- Designing rewards bonus criteria that promote proactive participation, such as lowering blood pressure, meeting weight loss goals or smoking cessation;
- Lowering age threshold to 15 years old so that adolescents can earn rewards and bonuses;
- Tying reward values to exemptions from potential premiums/co-payments;
- Making it easier for Native American members to accumulate rewards by addressing barriers related to billing the all-inclusive rate known as Office of Management and Budget rate; and
- Improving the promotion of Centennial Rewards by requiring mobile app technology to expand member engagement and participation.

Member Engagement and Personal Responsibility Opportunity #2: Continue Requiring Co-payments for certain populations

Changes to the Centennial Care program will require modifications to the waiver, as well as changes to supporting policies and regulations. HSD intends to implement the following policies, outside of the waiver renewal.

- HSD drafted a SPA to charge co-payments for non-preventive outpatient office visits, inpatient hospital stays, outpatient surgeries, prescription drugs and non-emergent use of the hospital emergency department for certain members (Expansion Adults, WDI, and CHIP)
- Native Americans and individuals receiving services through the DD waiver are exempted from co-payments
- Co-payment requirements will continue under Centennial Care 2.0; however, under the waiver renewal HSD is considering options to allow members to use healthy behavior credits earned in the Centennial Rewards program to offset co-payments.

As part of the waiver renewal, HSD proposes a change to how member co-payments are tracked from a quarterly basis to an annual basis.

Member Engagement and Personal Responsibility Opportunity #3: Implement premiums for populations with income that exceeds 100% FPL

The ACA expanded Medicaid eligibility to adults with income up to 138% 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 the newly eligible resulted in significant enrollment growth compared to enrollment of low-income adults before the Adult Expansion. Additionally, since early 2014, enrollment in CHIP increased by 85%. Compared to other states, New Mexico has generous eligibility thresholds for both children and adults, with the CHIP program extending to 300% 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-payments for CHIP recipients are minimal. In New Mexico, there are also minimal co-payments for WDI, which provides coverage for individuals up to 250% FPL. HSD has notified the public of its intent to submit a SPA to CMS to revise co-payment requirements for CHIP and WDI, and to implement new co-payments for Medicaid Expansion Adults, beginning in 2017.

For the Centennial Care Waiver renewal, HSD proposes policies to encourage greater personal responsibility and financial responsibility for individuals in higher-income Medicaid categories, including the Adult Expansion, CHIP and WDI. This includes assessing premiums for populations above 100% FPL. Premiums are the norm for private insurance and coverage obtained through the Health Insurance Marketplace. Proposed premiums would offset some costs of health care expenditures. The proposed mandatory monthly premiums for individuals with income above 100% FPL are outlined in Table 7.

Table 7 – Proposed Monthly Premiums for Incomes above 100% FPL

FPL Range	Annual Household Income (Household of 1)	Approximate Monthly Premium
101–150% FPL	$11,881–$16,404	$20
151–200% FPL	$16,405–$23-760	$30
201–250% FPL	$23,761–$29,700	$40

- Native American members will be exempt from premiums
- HSD is exploring ways to enforce payment of premiums HSD and will develop criteria for a hardship waiver for circumstances such as homelessness or difficulty paying bills
- Premiums may be waived if members engage in certain healthy behaviors.

Member Engagement and Personal Responsibility Opportunity #4: Seek authority for providers to charge nominal fees for three or more missed appointments

With the Adult Expansion of Medicaid, providers have expressed concerns 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 will include a proposal under the waiver to allow providers to charge nominal fees for missed appointments.

Member Engagement and Personal Responsibility Opportunity #5: Expand opportunities for Native Americans enrolled in Centennial Care

- HSD is interested in receiving proposals from a tribal entity partnering with a MCO to deliver Centennial Care services to Native American members
- HSD will continue to work with the MCOs to expand contractual or employment arrangements with CHRs throughout the State
- HSD will work with tribal providers to develop their capacity to enroll as LTSS providers and/or as a Health Home provider

8

Administrative Simplification through Refinements to Benefits and Eligibility

Centennial Care made significant progress towards modernizing New Mexico's Medicaid program and preparing the system for Medicaid expansion. At the end of 2016, New Mexico's Medicaid program covered approximately 900,000 individuals. Since the end of 2013, HSD has enrolled over 390,000 individuals with the largest growth attributed to the Medicaid expansion program.

Centennial Care Accomplishments

Centennial Care accomplishments regarding streamlining benefits and eligibility are significant and include administrative cost efficiencies such as consolidating multiple waiver programs and the number of managed care organizations administering different aspects of the Medicaid program. When the State elected to opt-in to the Medicaid expansion, it added over 234,000 individuals since 2014, many of whom were previously uninsured. Since the implementation of Centennial Care, HSD has observed lower per capita cost growth than previously experienced, indicating that Centennial Care has had the desired impact of bending the cost curve.

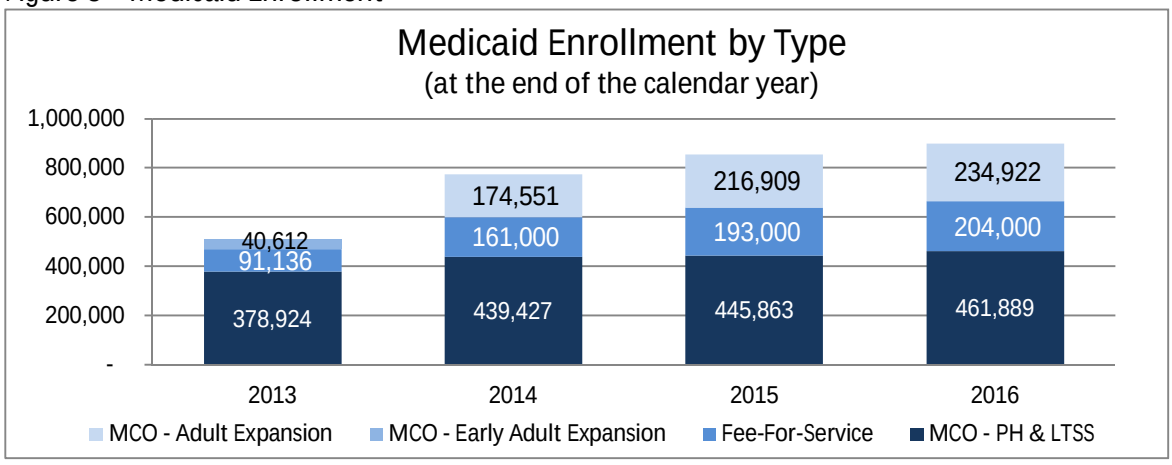
Consolidating a Number of Waiver Programs and Managed Care Organizations

HSD successfully consolidated nine individual waivers into a single waiver authority including a 1915(b) Waiver for SALUD, a 1915 (b)/(c) concurrent Waiver for CoLTS, two 1115 Waivers for the State Coverage Insurance program, an 1115 Waiver to allow co-payment and waiting period for CHIP, multiple 1915(c) Waivers to provide HCBS, and a 1915(b) Waiver to manage behavioral health.

Enrolling a Significant Number of Individuals

As illustrated in Figure 3, HSD experienced significant enrollment growth as a result of the combination of Centennial Care implementation, ACA implementation and Medicaid expansion.

Figure 3 – Medicaid Enrollment



Additional Administrative Simplification Proposals

One of the core principles of the 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 multiple benefit packages for both children and adults.

As HSD moves toward developing Centennial Care 2.0, it is considering opportunities to streamline some of these administrative complexities and examining innovations in program design aimed at addressing and resolving certain specific issues and concerns. Addressing these issues will reduce Medicaid administrative costs, reduce health care expenses and help the State maintain a financially viable and sustainable program.

Administrative refinements under consideration include:

- Developing a uniform benefit package for most Medicaid adults;
- Developing a buy-in program for dental and vision services for adults;
- Initiating care coordination for justice-involved individuals prior to their release from incarceration;
- Eliminating the three month retroactive eligibility period for most (non-SSI) Centennial Care members;
- Consider consolidation of multiple eligibility categories within subpopulations to simplify administration of the program as Medicaid currently has 40 different eligibility categories;
- Accelerating the transition off Medicaid for individuals who lose eligibility due to increased earnings by requesting a waiver of the TMA program;
- Waiving limitations on the use of IMDs;
- Covering former foster care individuals up to age 26 who aged out of foster care in another state;
- Including enhanced administrative funding to maintain an inventory of LARC for certain providers;
- Ensuring parity for individuals to access LTSS by aligning eligibility requirements between Institutional Care determinations and MAGI determinations for individuals needing these services;
- Incorporating eligibility for Family Planning into the waiver so that it covers men and women up to age 45 who do not have other insurance coverage; and
- Using trusted data sources as the primary source of income verification when making an eligibility determination.

Benefits and Eligibility Opportunity #1: Redesign the Alternative Benefit Plan and provide a uniform benefit package for most Medicaid-covered Adults

Most adults who are enrolled in the Medicaid Expansion Category receive services under the ABP. The ABP is a comprehensive benefit package that covers all services that are defined under the ACA as "essential health benefits" and includes Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for individuals who are age 19 and 20. The ABP is closely aligned with the types of benefit packages that are available on the commercial market, meaning that there are limitations on certain services, such as: physical, occupational and speech therapy and home health services; and that some services are not covered, such as routine vision services and hearing aids. Although most adults in the Medicaid Expansion receive the ABP, individuals who are considered "medically frail" are exempt from the ABP and may receive the standard Medicaid benefit package. This includes access to CB services and nursing facility care for individuals who meet the NF LOC criteria.

Non-expansion Medicaid adults (Parent/Caretaker category) receive the standard Medicaid benefit package, which does not have coverage limits like the ABP. To ensure the Medicaid program's long-term affordability and sustainability, HSD will request waiver authority to cover adults in the Parent/Caretaker category under the ABP, essentially providing one benefit package to most Medicaid-covered adults. Individuals who are determined "medically frail" are able to receive the standard Medicaid benefit package. In addition, HSD proposes the following:

- Redesign the ABP as "Secretary-approved" coverage, providing HSD with the flexibility to offer a comprehensive benefit package with limitations on certain services and elimination of other services that are not widely used such as habilitation services;
- Waive the federal EPSDT rule for adults in the Expansion Adult and Parent/Caretaker categories who are 19–20 years-old. Again, any adult that meets the medically-frail criteria is able to receive the standard Medicaid benefit package; and
- Depending on future changes to federal financing to ensure sustainability of the CHIP program, HSD may also consider covering children in families with higher income who are enrolled in the CHIP under the ABP.

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

As a result of a budgetary shortfall, HSD may need to scale back benefit design for adults to ensure the ongoing sustainability of the Medicaid program. Should HSD need to eliminate or reduce optional dental and/or vision services for adults, HSD is considering the development of dental or vision riders that individuals could purchase at an affordable premium under Centennial Care.

Benefits and Eligibility Opportunity #3: Initiate care coordination for justice-involved individuals prior to their release from incarceration

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. New Mexico seeks to expand its efforts to engage individuals being released from correctional facilities to improve health care outcomes and, potentially, reduce recidivism. Beginning with a pilot in two county jail facilities, HSD will seek approval to allow MCO care coordinators to work with justice-involved individuals to establish appointments, referrals and pharmacy services before these individuals are released to ensure continuity of care. Implementing the pilot may also include:

- Allowing for MCO delegation of care coordination to the county or facility for activities that occur in the 30 days prior to release; and
- Strengthening MCO contract requirements regarding after-hour transitions to address spontaneous or unplanned discharge from custody, often occurring during evening or weekend hours.

Benefits and Eligibility Opportunity #4: Incorporate eligibility requirements of the Family Planning program

HSD proposes to better target the Family Planning program to those individuals who are accessing these services by designing it for men and women up to age 45 who do not have other health insurance

coverage since family planning services are included in the benefit packages of full Medicaid and Medicare coverage and other commercial insurance. Streamlining the Family Planning program to apply to the appropriate population will preserve the program for those who use it while saving administrative dollars and resources spent on renewal processes.

Currently, the Family Planning Category serves as a catchall for individuals who apply for Medicaid, but who do not meet the financial eligibility standards to qualify for full coverage. This results in approximately 72,000 individuals enrolled in the program, including many who have existing insurance (such as Medicare) or who are outside of the average Family Planning age standards. Based on an analysis of this population, only 9% use Family Planning services. This is because the benefit package is limited to reproductive health services and contraceptives, and most individuals find that it does not meet their health care needs. In addition, the program is administratively burdensome for HSD because all covered individuals must be renewed yearly, at a rate of approximately 6,000 renewals per month.

Benefits and Eligibility Opportunity #5: Eliminate the three month retroactive eligibility period for most Centennial Care members

HSD is moving toward a streamlined environment for Medicaid eligibility, both initial determinations and renewals. Implementation of Real-Time eligibility is scheduled for 2017, meaning that many individuals will receive an eligibility determination at the point of application. This change provides an opportunity to eliminate the administratively complex reconciliation process with the MCOs for retroactive eligibility periods. Key proposals are below.

- Eliminate the three month retroactive eligibility period which is accompanied with an intensive reconciliation process and substantial administrative burden. As more members receive an eligibility determination at the point of application through Real-Time eligibility capability, the need for retroactive coverage is diminished. Populations covered under FFS would be exempt from this change.
- The retroactive period elimination does not include retroactive status changes processed by the Social Security Administration.

Benefits and Eligibility Opportunity #6: Accelerate transitions off Medicaid for individuals who lose eligibility due to increased earnings by requesting a waiver of the TMA program

TMA is a concept that predates the ACA and was intended to provide coverage for 12 months to Parent/Caretaker adults whose income increases above the eligibility standards for full coverage and renders them ineligible for Medicaid.

- With availability of individual insurance through the federal Marketplace this coverage category is unnecessary
- HSD may also request waiver authority to check earned income through trusted data sources quarterly or every six months to ensure that individuals who are no longer eligible do not remain on the program.

Benefits and Eligibility Opportunity #7: Request waiver from limitations imposed on the use of Institutions for Mental Disease

HSD will request expenditure authority for members in managed care and FFS to receive inpatient services in an IMD so long as the cost of care is the same as, or more cost effective, than a setting that is not an IMD. Currently, federal financial participation is limited for when individuals between the ages of 21 and 64 are institutionalized in an IMD. This proposal will improve the availability of residential inpatient treatment services and ensure federal financial participation and simplify the administration of the program for both HSD and the MCOs.

Benefits and Eligibility Opportunity #8: Request waiver to cover former foster care individuals up to age 26 who are former residents of other states

Under the Waiver, HSD proposes to cover former foster care individuals up to age 26 who aged out of foster care in another state. While New Mexico currently has State Plan authority for this population, CMS recently finalized a regulation revoking states' authority to receive federal Medicaid matching funds to cover this population without a waiver.

Benefits and Eligibility Opportunity #9: 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 the past several years, successfully "unbundling" LARC reimbursement from other services in FQHCs, Rural Health Clinics (RHCs), 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 will propose authority to obtain increased administrative funding (90%, in line with the federal matching rate for Family Planning services and contraceptives) to expand availability of LARC for certain providers, such as FQHCs, RHCs, and SBHCs. Under this proposal, the State would reimburse eligible providers for the cost of purchasing and maintaining LARCs to use for Medicaid beneficiaries.

Benefits and Eligibility Opportunity #10: Request authority to use trusted data sources as the primary source of income verification when making an eligibility determination, when those sources are current

HSD will seek a waiver of federal rules requiring states to use self-attested income amounts in lieu of trusted data sources, when the self-attested amount and trusted data are both below the eligibility threshold for full coverage. New Mexico believes that this provision in federal rule is inconsistent with the requirement to use trusted data sources at renewal, and that it impedes New Mexico's ability to assure program integrity in the income verification process. The State believes that trusted data sources can and should be used as a correct source of income not only at renewal, but also at initial application.

9

1115 Waiver Renewal Process and Timeframes

Stakeholder Engagement

Stakeholder engagement is a critical component of any program initiative. HSD is committed to implementing an extensive stakeholder engagement process as it moves forward to renew Centennial Care. HSD is defining an extensive stakeholder engagement process as one that:

- Seeks feedback from a broad and diverse range of stakeholders that include members, advocates, providers and other impacted parties;
- Provides multiple opportunities, locations and venues for stakeholders to provide input and feedback;
- Tailors the messaging to the target audience; and
- Allows stakeholders sufficient time to review the concepts, attend public input meetings and provide feedback to HSD.

The following sections outline HSD's stakeholder engagement process for the renewal of the Centennial Care Waiver.

MAC Subcommittee

As previously discussed, HSD sought stakeholder input and recommendations for Centennial Care 2.0 beginning in October 2016. HSD convened a subcommittee of the MAC between October 2016 and February 2017. The subcommittee of the MAC was comprised of 21 members representing members, advocates, providers, tribal liaisons, other State agencies and was also open to the public. In addition to facilitated discussions during each meeting, individual subcommittee members and the public were asked to submit their recommendations to HSD in writing.

Native American/Tribal Meetings

During the same time HSD was meeting with the subcommittee of the MAC, HSD utilized monthly NATAC meetings to present the same materials and concepts provided at the MAC subcommittee meetings and facilitated discussion to obtain input and feedback about the renewal process similar to the MAC subcommittee meetings. While these meetings do not meet the federal definition of a formal tribal consultation, they did provide an opportunity for HSD to present concepts and solicit feedback both verbally and written from the Native American Tribal and IHS representatives.

Additional Public Meetings

This concept paper presents policy changes HSD may include in the Centennial Care 2.0 Waiver renewal application. HSD will solicit feedback through concept paper public input sessions, tentatively planned for June 2017, to be held with the general public. HSD will consider the input and information gathered from these public input meetings as HSD develops the Waiver renewal application. HSD will also conduct a Native American Tribal consultation regarding this concept paper in June.

HSD's goal is to provide for a transparent Centennial Care Waiver renewal process and to clearly convey expectations. As such, HSD welcomes feedback from stakeholders, although it is important to note that not all feedback will be incorporated in the Centennial Care renewal application. Please refer to section 2 for the criteria for renewal considerations; however, HSD ensures that all voices will be heard in the process and all recommendations will be considered.

Final documents produced by the subcommittee of the MAC and the NATAC may be found at HSD's website at http://www.hsd.state.nm.us/centennial-care-2-0.aspx. The website also provides information about scheduled public input sessions including meeting dates, times and locations. Public comments related to the concept paper continue to be accepted by HSD via the same website.

HSD will publish the draft waiver application by September 1, 2017, then conduct public hearings and Native American Tribal consultation. HSD intends to submit the final Waiver renewal application to CMS in November 2017. Table 8 outlines HSD's timeline; however readers should note that the dates outlined below are subject to change depending on priorities, available resources or other unforeseen events that may occur.

Table 8 – Concept Paper and 1115 Waiver Timeline

Event	Dates
Planning and Design Meetings:	
Subcommittee of the MAC	October 14, 2016 November 18, 2016 December 16, 2016 January 13, 2017 February 10, 2017
NATAC 1115 Waiver design	December 5, 2016 January 20, 2017 February 10, 2017
Publish Date: Concept Paper	May 19, 2017
Gather Feedback: Concept Paper Statewide Presentations & Tribal Consultation. *Meeting sites: Albuquerque, Farmington, Roswell, and Silver City*	Between June 12, 2017 and June 30, 2017
Notice Period: 60-day advanced notification to Native American / Tribal stakeholders regarding 1115 waiver renewal application	August 31, 2017
Publish Date: Draft 1115 Waiver Application	September 1, 2017
Gather Feedback: Draft Waiver Application Public Hearings & Tribal Consultation. *Meeting sites: Las Cruces and Santa Fe*	Between September 18, 2017 and October 19, 2017
Final Waiver Application Submission	November 2017

Waiver Renewal Application

The Waiver renewal application is the culmination of the Centennial Care renewal process. CMS has prescriptive requirements for public input regarding Waiver applications, which are listed below.

- 30 day public comment period on the waiver application and notice which includes:
  - Location and internet address where copies of the application are available for public review and the 30 day comment period; and
  - Postal and internet email addresses where written comments may be sent and reviewed by the public and the 30 day comment period
- 20 days prior to submission to CMS, the State must have conducted at least two public hearings, on separate dates at separate locations at which members of the public throughout the State have an opportunity to provide comments
- Link to a page on the CMS website in a prominent location on either the main page or on a demo-specific web page that is linked in a readily identifiable way to the main page of the State's website
- Maintain and keep current the public website throughout the entire public comment and review process;
- Publish abbreviated notice, which includes a summary description of the program, the location and times of the two or more hearings, and an active link to the full public notice on the State's website in: (1) the State's administrative record 30 days prior to submission OR (2) in the newspapers of widest circulation in each city with a population of 100,000 or more 30 days prior to submission of waiver to CMS
- Consultation with Federally-recognized Indian tribes and solicitation of advice from affected Indian health providers and urban Indian organizations.

HSD will adhere to all requirements for public notification and comments.

Submission to CMS and Negotiation Process

New Mexico must submit the Centennial Care renewal application to CMS by no later than December 31, 2017. Per CMS requirements, this timeframe allows for a year of negotiation with CMS on the program details prior to a January 1, 2019 start date of the Waiver renewal.

HSD is well positioned to respond to identified issues given previous experience with the initial Centennial Care submission. HSD has been through the CMS review and approval process before, has a good sense of what to expect, and has the resources to appropriately respond to identified issues; however; HSD cannot account for any change in priorities and expectations regarding 1115 Waiver programs at the federal level. Nevertheless, HSD will move forward with due diligence to ensure timely submission of the Waiver renewal application for Centennial Care 2.0 and obtain timely CMS approval.