Medicaid 1115 Wavier Renewal Subcommittee Meeting

Meeting Minutes

February 10, 2017 — 8:30am – 11:30am

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

Subcommittee Members:

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

Absent Members:

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

Staff and Visitors Attending:

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

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

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

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

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

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

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

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

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

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

Acronym Guide for MAD / HSD 1115 Waiver Renewal Process

ABCB – Agency-Based Community Benefit
ACEs – Adverse Childhood Experiences
ACO – Accountable Care Organization
ADL – Activity of Daily Living
ALTSD – NM Aging and Long Term Services Department
BCBSNM – Blue Cross Blue Shield of NM
BH – Behavioral Health
BHSD – Behavioral Health Services Division of the HSD
CB – Community Benefit
CBSQ - Community Benefit Services Questionnaire
CCBHCs - Certified Community Behavioral Health Clinic
CC – Care Coordination
CCP – Comprehensive Care Plan
CCS – Comprehensive Community Support
CHIP – Children's Health Insurance Program
CHR – Community Health Resources
CMS – Centers for Medicaid and Medicaid Services, division of the HHS
CNA – Comprehensive Needs Assessment
CPSW – Certified Peer Support Worker
CSA – Core Service Agency
CYFD – NM Children, Families and Youth Department
DD – Developmental Disability and Developmentally Disabled
D&E – Disabled and Elderly
DOH – NM Department of Health
DHI – Division of Health Improvement
D-SNP – Dual Eligible Special Need Plan
ED – Emergency Department
EDIE – Emergency Department Information Exchange
EPSDT – Early and Periodic Screening, Diagnostic, and Treatment
EVV – Electronic Visit Verification
FAQ – Frequently Asked Questions
FF – Face to Face
FFS – Fee for Service
FIT – Family Infant Toddler Program
FQHC – Federally Qualified Health Center
HCBS – Home and Community-Based Services
HH – Health Home
HHS – US Health and Human Service Department
HRA – Health Risk Assessment
HSD – NM Human Services Department
IBAC – Interagency Benefits Advisory Committee
I/DD – Intellectual and Developmental Disabilities
IHS – Indian Health Service
IP – In-patient
LEAD – Law Enforcement Assisted Diversion
LFC – Legislative Finance Committee
LOC – Level of Care
LTC – Long Term Care
LTSS – Long-Term Services and Supports

MACRA – Medicare Access and CHIP Reauthorization Act of 2015
MAD – Medical Assistance Division of the HSD
MC – Managed Care
MCO – Managed Care Organization
MH – Mental Health
MMIS – Medicaid Management Information System
MMISR – Medicaid Management Information System Replacement
NATAC – Native American Technical Advisory Committee
NF – Nursing Facility
NF LOC – Nursing Facility Level of Care
NMICSS – NM Independent Consumer Support System
PCMH – Patient-Centered Medical Home
PCP – Primary Care Physician
PCS – Personal Care Services
PH – Physical Health
PH-BH – Physical Health – Behavioral Health
PHP – Presbyterian Health Plan
PMPM – per member per month
PMS – Presbyterian Medical Services (FQHC)
PQRS – Physician Quality Reporting System
SA – Substance Abuse
SAMHSA – Substance Abuse and Mental Health Services Administration, an agency within the US Department of Health and Human Services
SBHC – School-Based Health Center
SBIRT – Screening, Brief Intervention and Referral to Treatment
SDCB – Self-Directed Community Benefit
SED – Severe Emotional Disturbance
SMI – Serious Mental Illness
SOC – Setting of Care
SUD – Substance Use Disorder
UHC – United Health Care
VBP – Value-Based Purchasing