



HUMAN SERVICES
DEPARTMENT

Centennial Care 2.0 Update
Legislative Health and Human Services Committee

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Nancy Smith-Leslie, Director, Medical Assistance Division
September 20, 2017

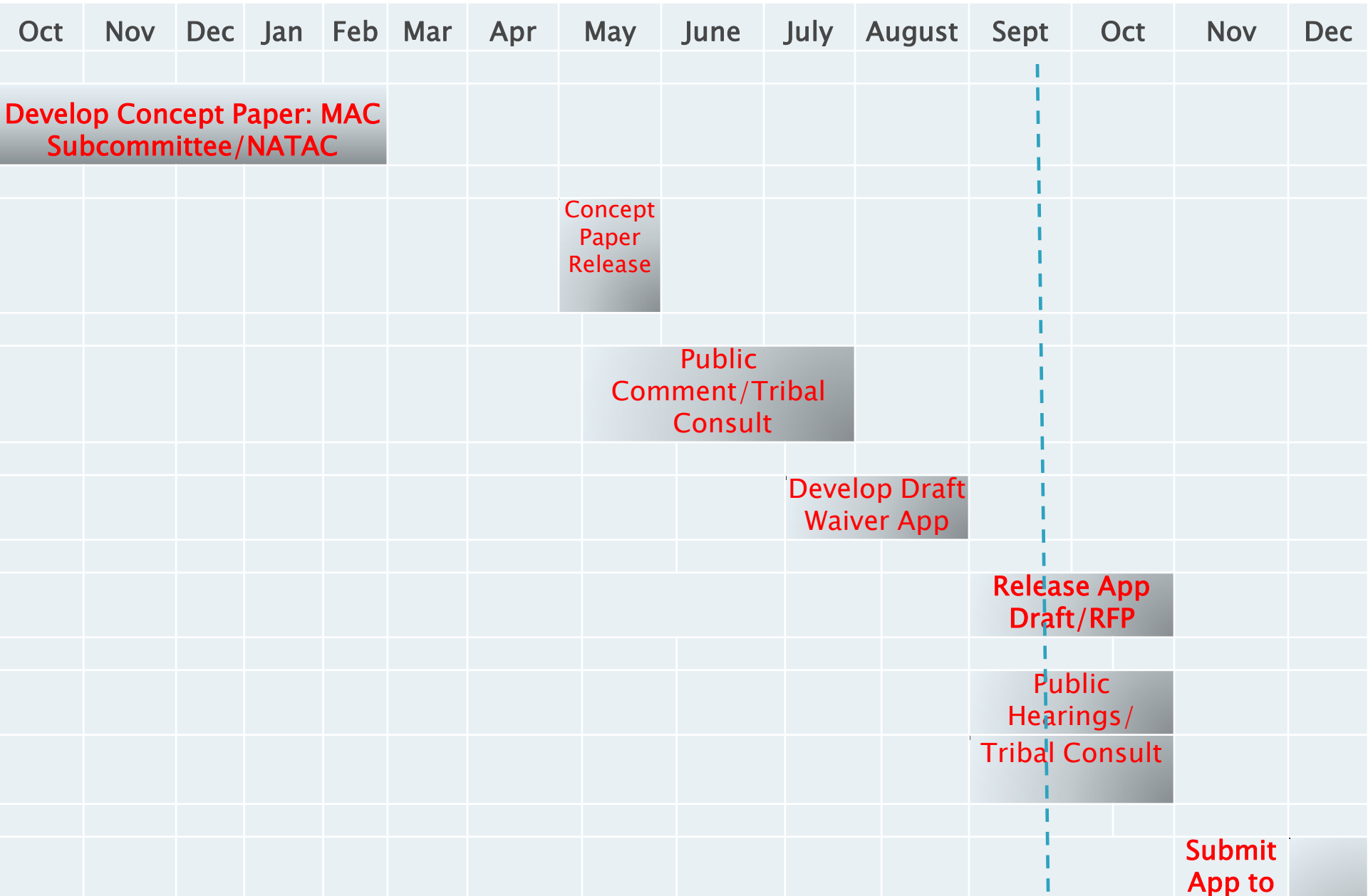


HUMAN SERVICES
DEPARTMENT

Today's Topics

- ▶ Update on 1115 Waiver Renewal
 - Renewal process
 - Centennial Care—first 4 years
 - Centennial Care 2.0
- ▶ Medicaid Budget Update
 - FY19 Appropriation Request
 - Federal update
- ▶ Overview of 1115 Waiver Authority

Centennial Care 2.0 Waiver Renewal



Waiver Renewal Public Input Meetings

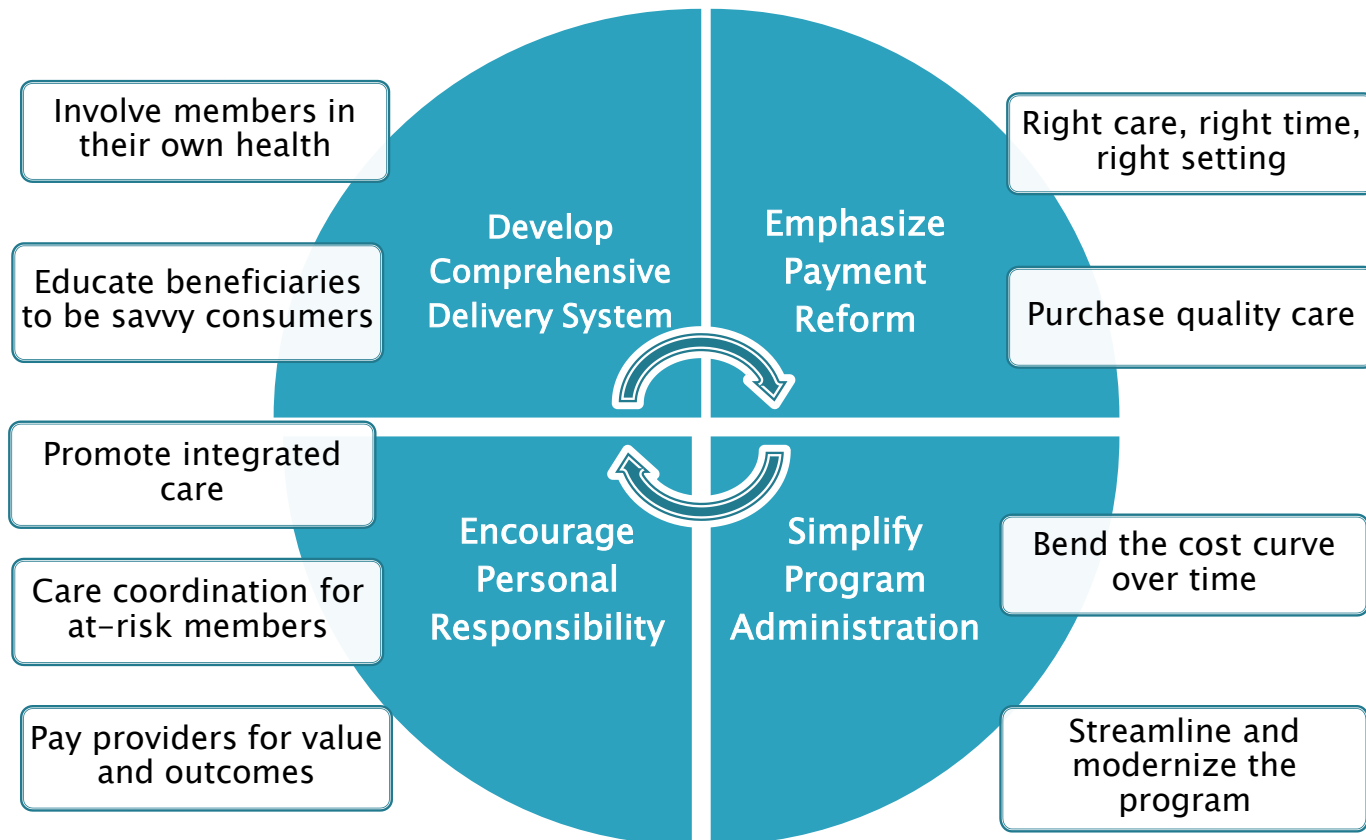
Public Input Opportunities Prior to Development of Concept Paper (before May 2017)	Public Input Meetings on Draft Concept Paper (after May 2017)	Other Input Opportunities
<p><u>Medicaid Advisory Subcommittee:</u> October 14, 2016 – 29 attendees (Santa Fe) November 18, 2016 – 34 attendees (ABQ) December 16, 2016 – 62 attendees (Santa Fe) January 13, 2017 – 55 attendees (ABQ) February 10, 2017 – 50 attendees (Santa Fe)</p> <p><i>Public Comment at end of each meeting</i></p>	<p><u>Statewide Public Input Sessions & Attendees:</u></p> <p>Albuquerque – June 14, 2017 – 160 attendees Silver City – June 19, 2017 – 22 attendees Farmington – June 21, 2017 – 41 attendees Roswell – June 26, 2017 – 30 attendees</p>	<p><u>Written Comments:</u> May – July 2017 –</p> <p>21 letters received</p>
<p><u>Native American Technical Advisory Committee:</u> December 5, 2016 – NATAC Membership (Santa Fe) January 20, 2017 – NATAC Membership (ABQ) February 10, 2017 – NATAC Membership (Santa Fe) April 10, 2017 – NATAC Membership (ABQ)</p>	<p><u>Formal Tribal Consultation</u> June 23, 2017 – 12 tribal officials/ reps & 85 attendees – Albuquerque</p> <p><u>Native American Technical Advisory Committee:</u> July 10, 2017 – NATAC Membership</p>	<p><u>HSD Email Address Established:</u> Ongoing from October 2016– July 2017</p> <p>137 emails received</p>
<p><u>MAC Meetings with Public Input:</u> November 2016 – 77 attendees (Santa Fe) April 2017 – 55 attendees (Santa Fe)</p>	<p><u>MAC Meetings with Public Input:</u> July 24, 2017 – (Santa Fe)</p>	<p><u>Public Hearings to be held in October 2017:</u></p> <ul style="list-style-type: none"> • Las Cruces • Las Vegas • Santa Fe

Centennial Care:
CY 2014 - 2017



Centennial Care

Guiding Principles for Medicaid Reform



Centennial Care

Create a Comprehensive Delivery System

Built Care
Coordination
Infrastructure
(950 Care
Coordinators)

Increased Use of
Community
Health Workers
(100 employed/
contracted)

Expanded
Patient-Centered
Medical Homes
(334,000
Members Served)

Implemented
Health Homes for
Members with
Complex
Behavioral Health
Conditions

Expanded Access
to Home and
Community-Based
Services

Centennial Care

Encourage Personal Responsibility

Implemented a Member Rewards Program:
Centennial Rewards

70% of Members Participating in Healthy Behaviors and Earning Rewards

Estimated Cost Savings in 2015:
\$23 Million

Reduced Hospital Admissions
43% Higher Asthma Controller Refills
40% Higher Test Compliance for Diabetes

70,000 Members Participating in the Walking Step-Up Challenge

Centennial Care

Emphasize Payment Reform

Paying for Quality and Improved Health Outcomes versus Volume of Services

Shared Saving and Pay for Performance Arrangements with Providers

Sub-Capitated Payments to Manage Defined Population
Bundled Payments

In 2017: 16% of all Provider Payments in Value-Based Purchasing Arrangements

Must Include Behavioral Health Providers
Requires Reductions in Hospital Readmissions

Centennial Care

Simplify Administration

Consolidated 11 different federal waivers under the 1115 waiver

One Application for Medicaid and the Subsidized Coverage on Federal Exchange

Streamlined Enrollment and Recertification: More Online Tools

Fewer Managed Care Organizations: From 7 to 4

Standardizing Forms and Procedures for Providers





Vision for the future of Centennial Care

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

Areas of focus

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

Care Coordination 2.0

Identified Opportunities

#1: Increase care coordination at the provider level

#2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

#3: Expand programs working with high needs populations:

- First Responders, wellness centers, personal care agencies and Project ECHO;
- Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists

Care Coordination 2.0

Identified Opportunities

#4: Initiate care coordination for justice-involved prior to release from incarceration

- Allowing of delegation of care coordination to county/facility for activities that occur prior to release
- Strengthening MCO contract requirements regarding after-hour transitions and requiring a dedicated staff person at each MCO to serve as a liaison with the facilities

#5: Pilot a home-visiting program focused on pre-natal, post-partum and early childhood development

- Collaborate with the DOH and CYFD to implement a pilot in designated counties to provide Medicaid-reimbursable services to eligible pregnant women

#6: Obtain 100% federal funding for Native American members for services received through IHS/Tribal Facilities

Behavioral Health Integration 2.0

Opportunities

#1: Expanding Health Homes (CareLink NM)

#2: Support workforce development

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

#3: Develop Peer-Delivered, Pre-Tenancy and Tenancy Support Housing Services

- Create a supportive housing service that provides some peer-delivered tenancy support services to active participants with Serious Mental Illness (SMI)

Long-Term Services and Supports 2.0

Opportunities

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

#2: Increase caregiver respite hours (from 100 to 300 hours)

#3: In order to continue to provide access to the Community Benefit services for all eligible members who meet a NF LOC, establish some limits on costs for certain services in the Self-Directed Community Benefit model

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

#5: Include nursing facilities in Value Based Purchasing (VBP) arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff

Payment Reform 2.0

Opportunities

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

- Expand requirements for MCOs to shift provider payments from fee-for-service to paying for quality and improved outcomes.

#2: Use Value Based Purchasing (VBP) to drive program goals, such as:

- Increasing care coordination at provider level, expanding the health home model, improving transitions of care, and improving provider shortage issues.



Payment Reform 2.0

Opportunities

#3: Advance Safety-Net Care Pool Initiatives

- Incrementally shift the funding ratio between the Uncompensated Care Pool and the Hospital Quality Improvement Incentive Pool so that more dollars are directed toward improved hospital quality initiatives
- Expand participation to all willing hospitals and allow other providers to participate, such as nursing facilities
- Require good-faith contracting efforts between the MCOs and providers that participate to ensure a robust provider network



Safety Net Care Pool and Hospitals

- Eliminated uncompensated care in Medicaid for 29 SNCP hospitals (2015)

Uncompensated Care Pool Requests, Payments and Capacity

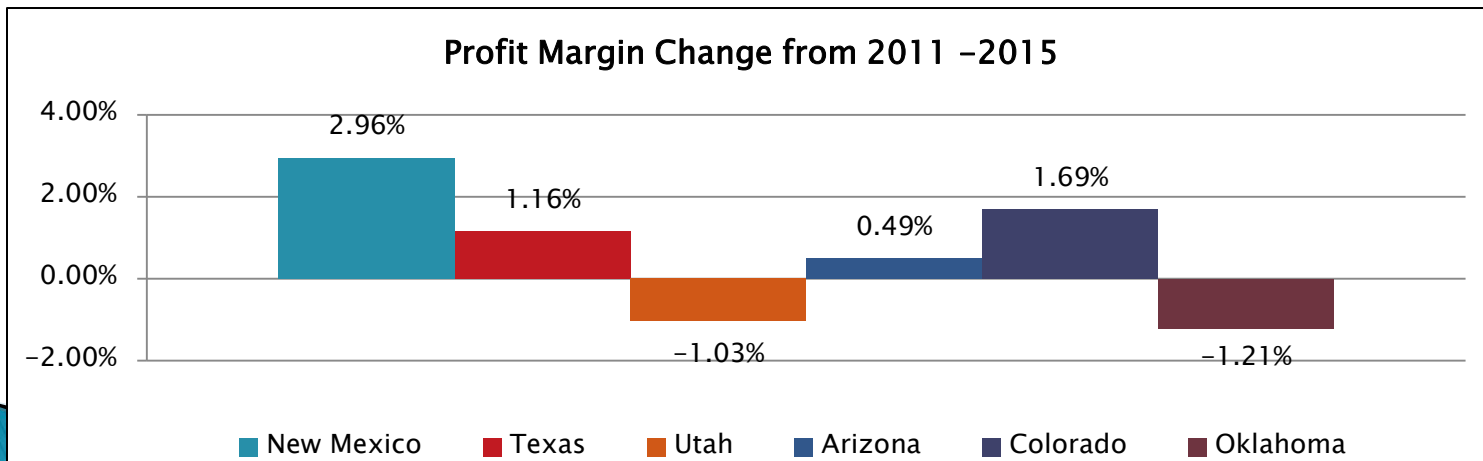
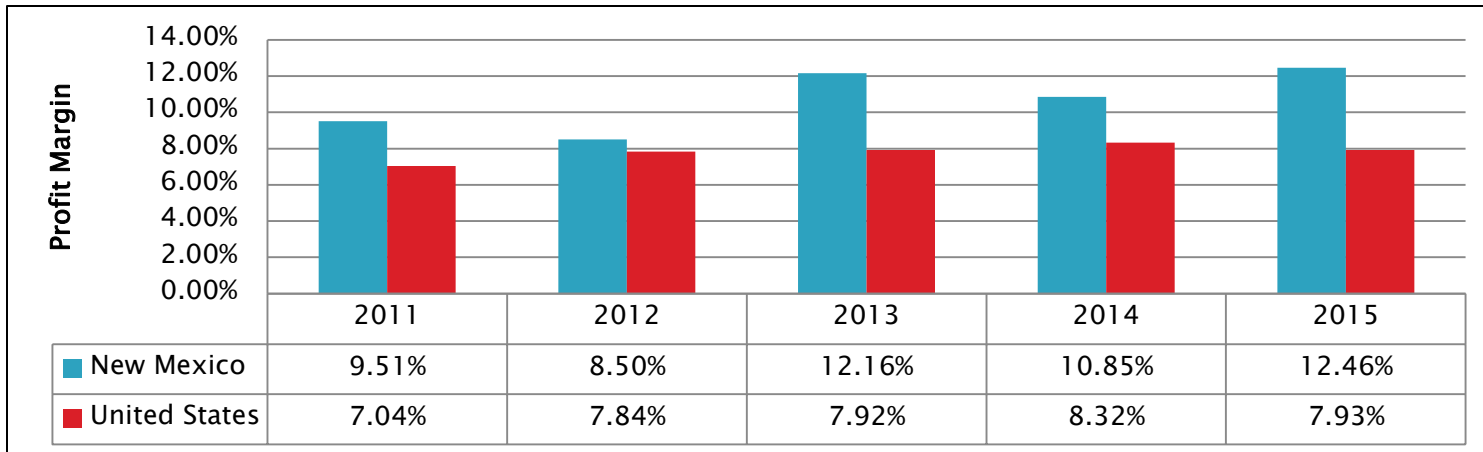
(\$ in millions)	2014	2015	2016
Requested Uncompensated Care Payments	\$176.3	\$121.1	\$104.4
Actual UC Payment Capacity	\$107.3	\$67.3	Determined in 2018
Actual UC Payments	\$68.9	\$67.3	\$68.9

Inpatient and Selected Outpatient Hospital Payments for Services Provided to Expansion Population

Category of Service	2014	2015	2016
Inpatient Hospital – General Acute and Specialty	\$193.7	\$246.6	\$286.3
Outpatient Hospital – Emergency Room and Urgent Care	\$ 31.4	\$60.2	\$90.8
Total	\$ 225.1	\$306.8	\$377.1
Note: Data from May 2017; \$ in millions			

Safety Net Care Pool and Hospitals

- ▶ NM Hospitals continue to outperform hospitals in the region and nation



Source: American Hospital Association

Member Engagement and Personal Responsibility 2.0

Opportunities

#1: Advance the Centennial Rewards Program

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

#3: Premiums for populations with income that exceeds 100% FPL (applies only to three categories of eligibility)

- Adults in the Expansion with income greater than 100%
- CHIP program (income guideline extends to 300% FPL for children age 0–5 and to 240% FPL for children age 6–18)
- Working Disabled Individuals (WDI) Category
- Revised premium amounts to be lower in initial years (1% of household income) and higher in out-years
- Included a household rate

Proposed Premium Structure

FPL Range	Annual Household Income (HH of 1)	Aggregate HH Maximum – 5% of Income (HH of 1)	Applicable Category of Eligibility (COE)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
101–150%	\$12,060 – \$18,090	\$600	OAG, WDI, TMA	\$10	\$20	\$20	\$40
151–200%	\$18,091 – \$24,120	\$900	WDI, TMA, CHIP	\$15	\$30	\$30	\$60
201–250%	\$24,121 – \$30,150	\$1,200	WDI, TMA, CHIP	\$20	\$40	\$40	\$80
251–300%	\$30,151 – \$36,180	\$1,500	TMA, CHIP	\$25	\$50	\$50	\$100

Member Engagement and Personal Responsibility 2.0

Opportunities

#4: Require co-payments for certain populations

- HSD currently has copayment requirements for its CHIP and WDI populations
- Seeking to streamline copayments across populations
- Add copayments for the adult expansion population with income greater than 100% FLP
- Most Centennial Care members will have copayments for non-preferred prescription drugs and for non-emergent use of the ED
- The following populations would be exempt from all copayments:
 - Native Americans
 - ICF-IDD individuals
 - QMB/SLIMB/QI1 individuals
 - Individuals on Family Planning only
 - Individuals in the PACE program
 - Individuals on the DD waivers
 - People receiving hospice care



Proposed Co-Payment Structure

	CHIP	WDI	Expansion Adults	All Other Medicaid
Population Characteristics and Service	<u>Age 0-5:</u> 241-300% FPL <u>Age 6-18:</u> 191-240%	Up to 250% FPL	If income is greater than 100% FPL	
Outpatient office visits (non-preventive) • BH exempt	\$5/visit	\$5/visit	\$5/visit	No co-pay
Inpatient hospital stays	\$50/stay	\$50/stay	\$50/stay	No co-pay
Outpatient surgeries	\$50/surgery	\$50/surgery	\$50/surgery	No co-pay
Prescription drugs, medical equipment and supplies • Psychotropic Rx exempt • Family Planning Rx exempt • Not charged if non-preferred drug co-pay is applied	\$2/prescription	\$2/prescription	\$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic and Family Planning Rx exempt	\$8/prescription All FPLs and COEs; certain exemptions will apply			
Non-emergency ER visits	\$8/visit All FPLs and COEs; certain exemptions will apply			

Member Engagement and Personal Responsibility 2.0

Opportunities

#5: Modify tracking requirements for cost sharing

- Request authority to track the out-of-pocket maximum cost sharing amounts on an annual basis rather than quarterly or monthly
- Apply an annual out-of-pocket maximum based on four FPL tiers

#6: Expand opportunities for Native American members in Centennial Care

- Requires MCOs to expand contractual or employment arrangements with CHRs throughout the state
- Work with Tribal providers to develop capacity to enroll as LTSS providers and/or health home providers
- Request authority to implement a project in collaboration with the Navajo Nation as it seeks to establish a managed care organization sponsored by the Navajo Nation

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#1: Cover most adults under one comprehensive benefit plan

- Consolidate two different adult benefit plans under a single comprehensive benefit package that more closely aligns with private insurance coverage by redesigning the Alternative Benefit Plan (ABP) for adult expansion population to also cover the Parent/Caretaker adult population
- Add a limited vision benefit to the ABP
- Waive federal EPSDT rule for 19–20 year olds in this plan
- Individuals who are determined “medically frail” may receive the standard Medicaid benefit package

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#2: Develop buy-in premiums for dental and vision services for adults (if necessary)

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

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services
- Does not include retroactive status changes processed by SSA
- Native Americans and individuals residing in nursing facilities would be exempt from this provision

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#4: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that result in ineligibility per income guidelines

- The individuals previously using the category are now either transitioned to the adult expansion category or eligible to receive subsidies to purchase coverage through the federal Exchange
- Since ACA, use of the category dropped from 26,000 individuals to 2,000

#5: Incorporate eligibility requirements of the Family Planning program

- Benefits are limited to reproductive health care, contraceptives and related services—not comprehensive coverage
- 6% of population on Family Planning utilize coverage today
- HSD proposes to better target this program by designing it for men and women who are through the age of 50 who do not have other insurance (with certain exceptions)

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#6: Request waiver from limitations imposed on the use of Institutions of Mental Disease (IMD)

- Request expenditure authority for members in both managed care and fee-for-service to receive inpatient services in an IMD so long as the cost is the same as, or more cost effective, than a setting that is not an IMD.

#7: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

#8: Request waiver authority for enhanced administrative funding to expand availability of LARC for certain providers

- HSD has made access to LARC a high priority over past several years by unbundling LARC reimbursement from other services
- Requesting authority to receive increased administrative funding to expand availability by reimbursing DOH or other sponsoring agencies for the cost of purchasing and maintaining LARCs

Upcoming Public Meetings

- ▶ **Las Cruces – Thursday, October 12, 2017, 1:30 pm to 3:30 pm**
 - Farm and Ranch Museum
- ▶ **Santa Fe – Monday, October 16, 2017, 1 pm to 4 pm**
 - Medicaid Advisory Committee Meeting, NM State Library
- ▶ **Las Vegas – Wednesday, October 18, 2017, 1:30 pm to 3:30 pm**
 - Highlands University – Student Union Building/Student Center
 - *Call (toll-free) 1-888-850-4523; participant code: 323 675#*
- ▶ **Tribal Consultation – Friday, October 20, 2017, 9 am**
 - Institute of American Indian Arts, Santa Fe
- ▶ Additional info: <http://www.hsd.state.nm.us/centennial-care-2-0.aspx>

Medicaid Budget Update

- ▶ FY19 Budget Request
- ▶ Enrollment
- ▶ Cost Drivers
- ▶ Federal Outlook

Medicaid Budget Update

- ▶ The FY18 general fund (GF) need for Medicaid is **\$ 938.3 million**. The Legislature appropriated **\$915.6 million**, resulting in a deficit of **\$22.6 million** in FY 18.
- ▶ The FY19 general fund (GF) request for Medicaid is **\$ 997.2 million**. This is an increase of **\$81.5 million** above the FY18 appropriation.

(\$ in millions)	FY14 Actual	FY15 Projection	FY16 Projection*	FY17 Projection*	FY18 Projection*	FY19 Projection*
Total Budget	\$4,200.6	\$5,162.3	\$5,413.9	\$5,558.5	\$5,811.5	\$5,892.2
General Fund Need	\$901.9	\$894.1	\$912.9	\$898.4	\$938.3	\$997.2

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

Medicaid Budget Update

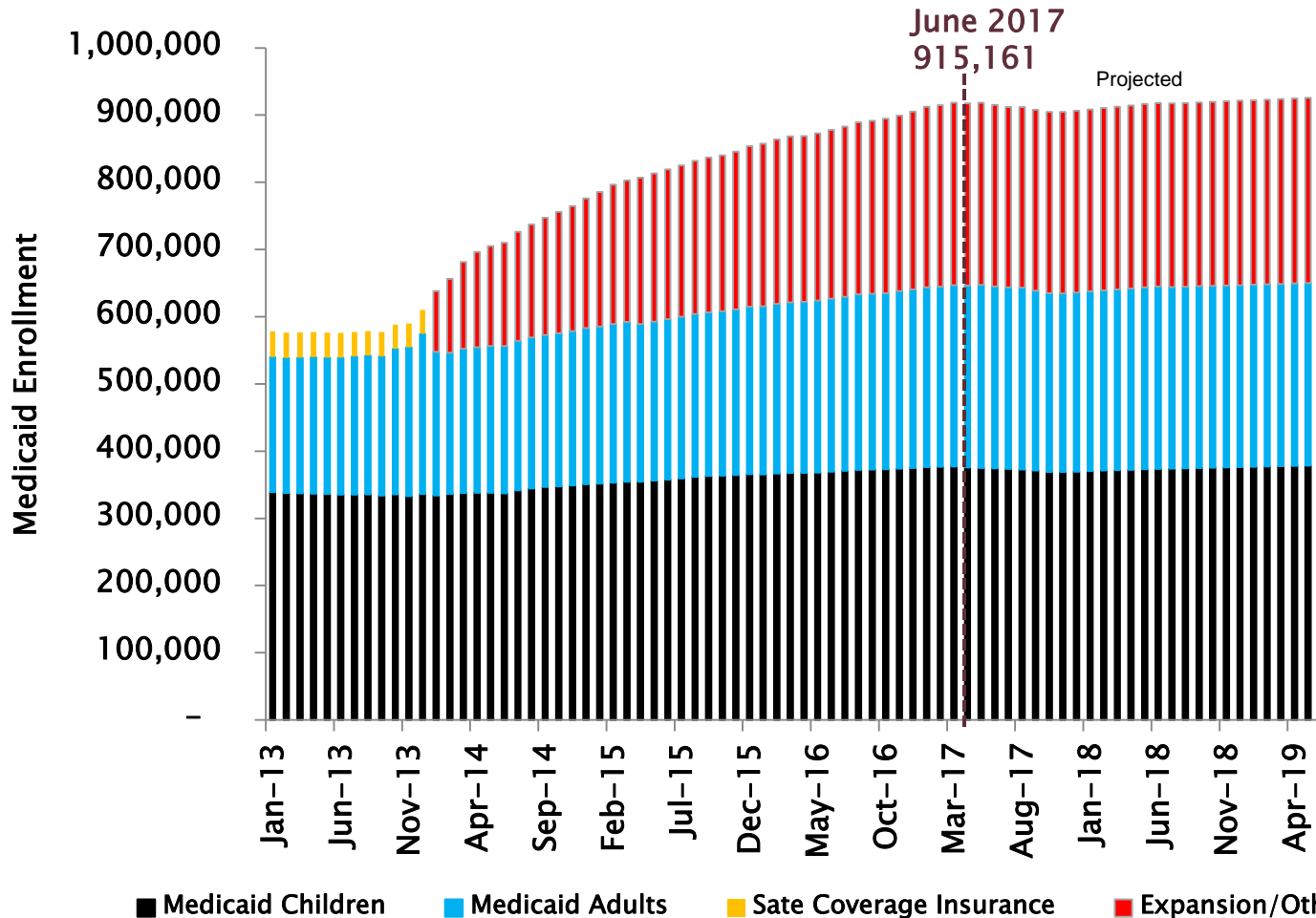
(Changes from FY18 Budget to FY19 Request)

(\$ in millions)	Total	General Fund
<u>FY18 To FY19 Adjustments</u>		
FY 19 Starting Deficit (after MCO reconciliations)	82.34	15.82
<u>Expenditure Changes</u>		
Price and Utilization	56.31	11.66
Enrollment	57.11	11.73
Medicare Buy Ins	5.07	2.62
Health Information Technology	(12.00)	
<u>Revenue Changes</u>		
Medicaid Expansion Change (94.5% to 93.5%)		14.70
CHIP FMAP Reduction (100% to 72.13%)		31.23
FMAP Change (71.90 to 72.13)		(7.18)
Added Miner's Colfax Revenue		(1.04)
Added Drug Rebates and Other Revenue		(3.34)
Less County Supported Medicaid Fund		2.34
Less Tobacco Settlement Revenue		3.00
Total:	\$188.83	\$81.55

FY19 – What to Watch

- Enrollment trends
- Federal action on CHIP
- Other Federal Action on the ACA and Budget
- CMS policy changes

Medicaid Enrollment



June 2019
Projected Enrollment

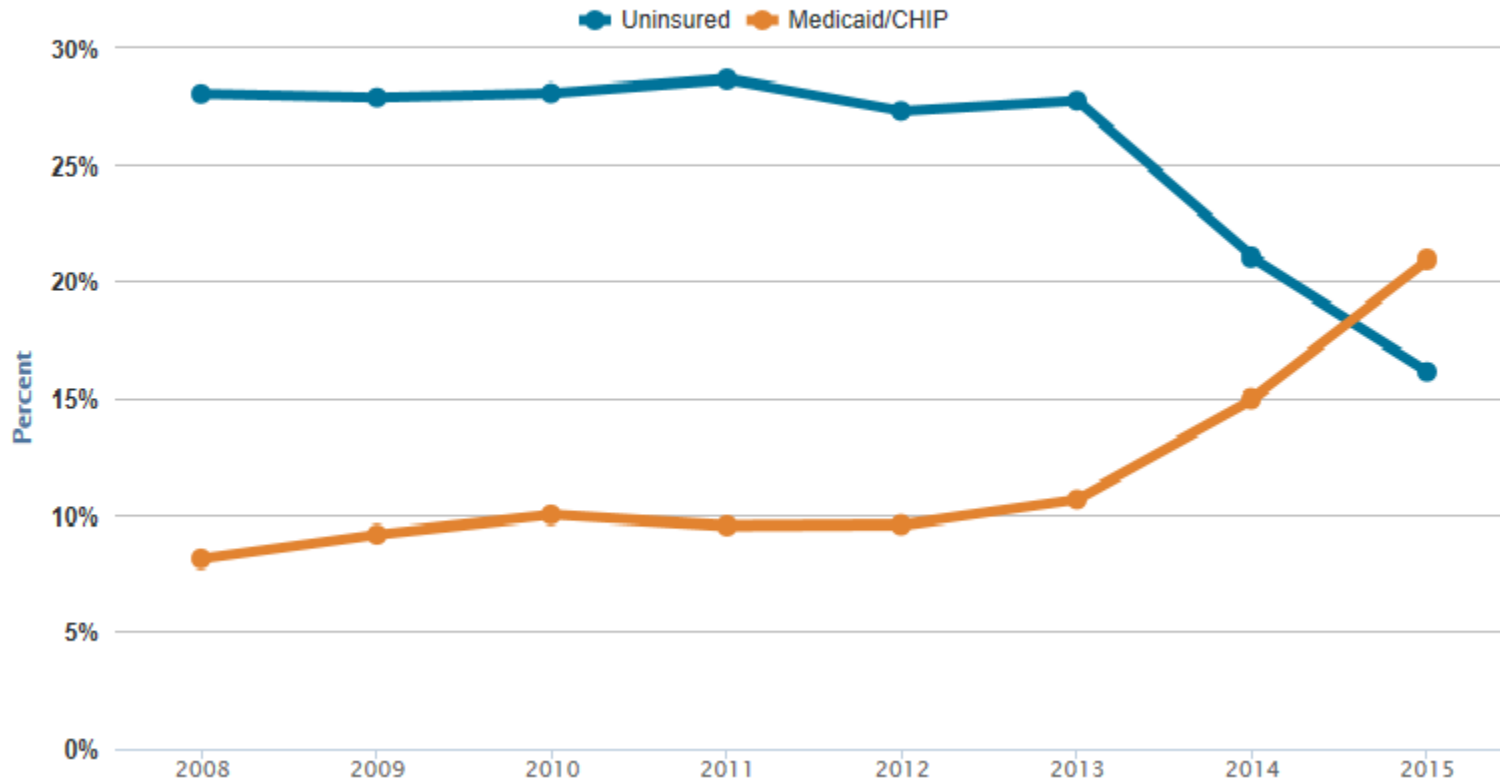
OAG:
275,685*

Medicaid Adults:
271,512

Medicaid Children:
379,107*

*children 19-21
y.o. counted in
OAG

New Mexico Uninsured and Medicaid–Insured (19–64 population)



Source: SHADAC State Health Compare, University of Minnesota

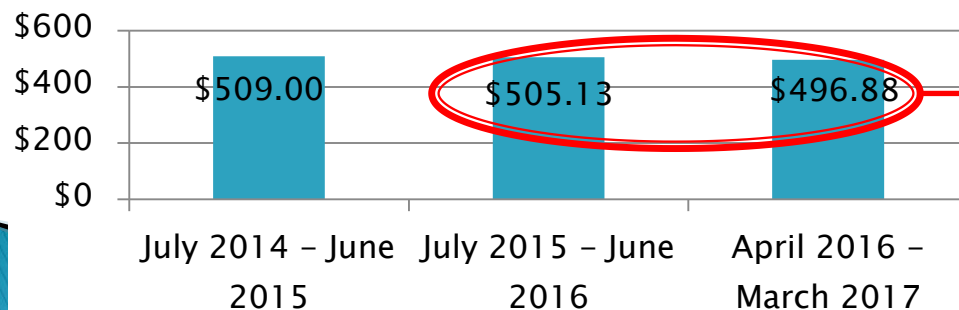
Managing Cost Growth

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

Centennial Care Stats

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

Average Per Member Per Month Costs in Centennial Care



Reduced spending by \$68.2 million

Section 1115 Demonstration Waiver Authority

1115 Demonstration Authority

- ▶ Under Section 1115 of the Social Security Act, the Secretary of HHS may permit states to waive certain requirements of Medicaid and CHIP to carry out experimental, pilot or demonstration projects, which the Secretary believes are likely to promote the objectives of the Medicaid program
- ▶ Permits the HHS Secretary to allow states to use federal Medicaid funds in ways that are not otherwise allowed under the federal rules
- ▶ Permits states to make changes in Medicaid eligibility, benefits and cost-sharing.

1115 Waivers—CMS Communication

- ▶ HHS Secretary Price and CMS Administrator sent letter to Governors in March 2017 with intent of extending greater flexibility to states, particularly through 1115 waivers.
- ▶ Key areas that the letter highlights are:
 - *Streamlined Program Management.* This involves making the State Plan Amendment process more transparent and efficient, “fast tracking” the approval of waiver and demonstration waiver extensions, and consistently evaluating waiver proposals.
 - *Alignment with Commercial Insurance.* The letter suggests that states consider aligning Medicaid design and benefit structures with those of commercial insurance. It offers specific examples of what states may do:
 - Encouraging Health Savings Accounts
 - Waiving enrollment and eligibility procedures that are inconsistent with continuous coverage
 - Reasonable, enforceable premium requirements
 - Waivers of non-emergency transportation benefits
 - Expanded options to design emergency room copayments

1115 Demonstration Authority

Waiver of Cost Sharing Requirements:

- CMS can waive federal premium or cost-sharing statutory requirements in section 1916 of the Social Security Act (the Act) under 1115 Waiver Demonstrations.
- The authority lies in section 1902(a)(14) of the Act (42 USC 1396a), which provides that “premiums, or similar charges, . . . cost sharing, or similar charges, may be imposed only as provided in section 1916 of [the Act].” Section 1115(a) demonstration projects may waive provisions under section 1902 of the Act and grant authority for expenditures not otherwise matchable pursuant to section 1903 of the Act.
- [Arizona](#), [Arkansas](#), [Indiana](#) are among the states with a waiver of section 1902(a)(14) of the Act to permit collection of monthly premiums for individuals with incomes from 101% to 133% of the FPL.

1115 Demonstration Authority

Waiver of Retroactive Coverage:

- Section 1902(a)(34) of the Act (42 USC 1396(a)(34)) is the substantive requirement for retroactive eligibility under the State plan.
- CMS has issued waivers of section 1902(a)(34) of the Act to permit states to limit retroactive eligibility to the date of application for Medicaid coverage. *See, e.g., [Delaware](#), [Indiana](#), [New Hampshire](#),*
- Secretary Price's March 2017 letter to governors identified waivers of retroactive coverage as a supported state reform to "align Medicaid and private insurance policies for non-disabled adults."

Transitional Medical Assistance (TMA):

[Wisconsin](#) has existing authority to charge premiums for TMA adults above 133% FPL from the first day of enrollment as well as for TMA adults from 100%–133% FPL after 6 months of coverage. It is anticipated that additional states will request such authority.

1115 WAIVERS IN OTHER STATES

Note: Reflects CMS-approved 1115 waivers as of June 2017. Kaiser Family Foundation – <http://www.kff.org/medicaid/issue-brief/key-themes-in-section-1115-medicare-expansion-waivers/>

	AR	AZ	IA	IN	MI	MT	NH	WI	ME
Premiums for populations below 150% FPL, including Adult Expansion group and/or TMA	X	X	X	X	X	X			
Healthy behavior incentives		X	X	X	X				
Waive required benefits such as NEMT and EPSDT for 19-20 year-olds	X		X	X					
Waive retroactive eligibility	X			X			X		
Waive or reduce TMA program								X Proposed; not yet approved	X Proposed; not yet approved

Questions?