CENTENNIAL CARE

Ensuring care for New Mexicans for the next 100 years and beyond…

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Legislative Health and Human Services Committee
Secretary Sidonie Squier
June 25, 2012

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Status of Centennial Care 1115 Waiver Submission

- The 1115 waiver application was submitted on April 25, 2012.
  - HSD will be submitting updates after further stakeholder input
- An 1115 waiver must meet a five-year budget neutrality requirement, i.e. – the cost of the program cannot exceed the projected cost of the program if nothing had changed.
- This gives the program time to bend the cost curve and "demonstrate" savings.

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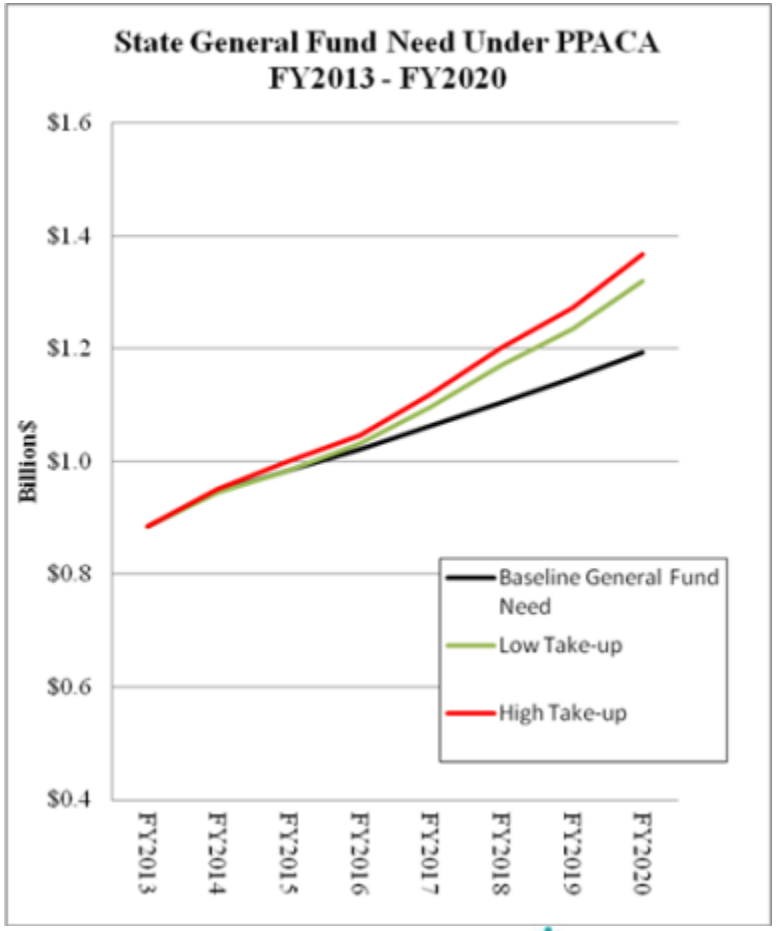
- Currently, the Medicaid program is 16% of the state budget. (Increases to 20% in State Fiscal Year 2013)
- Health care costs continue to increase.
  - 5.8% a year through 2020 according to the Centers for Medicare and Medicaid Services actuaries. This rate is faster than the economy is expected to grow this decade.
- Even with three years of 100% federal funding for newly eligible enrollees under the Federal Health Care Reform, the State's Medicaid bill will continue to rise dramatically.



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Four Principles of Centennial Care

1. Comprehensive Service Delivery System
2. Personal Responsibility
3. Payment Reform
4. Administrative Simplicity

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Care Coordination Principles

- Individualized, culturally appropriate comprehensive care management plan
  - Appropriate linkages, referrals, coordination and follow-up to needed services and supports
    - Appointment scheduling,
    - Conducting referrals and follow-up monitoring,
    - Participating in hospital discharge processes, and
    - Communicating with other providers and recipient/family members

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Care Coordination Overview

MCO

Receives Enrollment File

Completes Health Risk Assessment (HRA) (Within 10 days)

Recipient is assigned a preliminary care coordination level (Level 1, 2 or 3)

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Level 1 Care Coordination

MCO

Recipient receives information about care coordination and selects primary care provider (Within 10 days

Review Utilization data to determine if qualifying event may increase level (At least quarterly)

Completes HRA annually to determine if level change is needed

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Level 2 Care Coordination

MCO

Recipient is identified with Obesity and uncontrolled Diabetes

Conduct face-to-face Visit:
Comprehensive Assessment
Conduct level of Care Assessment (LOC)
Select Primary Care provider

Confirm care coordination level 2

Obtain information from all members of care planning team (At minimum health care providers and recipient)

Is recipient nursing facility level of care?

No

Complete care plan and review with recipient (Include Self-Direction as appropriate)

Submit care plan for any necessary authorizations

Provide Care Plan to all care plan team members and ensure initiation of services

Initiate ongoing contact, education and advocacy based on care coordination level and assessment

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Level 3 Care Coordination

MCO

Is recipient nursing facility level of care?

Yes

Determine medium or high needs for Home & Community Based Services (HCBS)

Complete care plan and review with recipient (Include Self-Direction as appropriate)

Submit care plan for any necessary authorizations

Provide Care Plan to all care plan team members and ensure initiation of services

Initiate ongoing contact, education and advocacy based on care coordination level and assessment

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Level 3 Care Coordination (Behavioral Health)

MCO

Completes Health Risk Assessment (HRA) (Within 10 days)

Recipient is identified as schizophrenic who is not receiving psychiatric care. Recipient does not have permanent housing

Is recipient a candidate for referral to Core Service Agency (CSA)/Health Home?

Yes

Refer member to CSA/Health Home (timeframe to be determined)

CSA/HH

Conduct face-to-face visit: Comprehensive Level of care Assessment (LOC) Select primary care provider (within 30 days of HRA)

Confirm care coordination level 3

Obtain information from all members of care planning team (at minimum health care providers and member)

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Level 3 Care Coordination (Behavioral Health) (Cont)

CSA/HH

Complete care plan with the recipient

Submit care plan to MCO for any necessary authorizations

Provide Care Plan to all care plan team members and ensure initiation of services

Initiate ongoing contact, education and advocacy based on care coordination level and assessment

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Behavioral Health (BH) Protections in Centennial Care

- Accountability to the BH Collaborative per current statute
- Medicaid BH decisions made jointly by Medical Assistance Division Director and the CEO of the BH Collaborative
- "Fencing the funding" – BH services will be tracked and monitored
- Core Service Agencies (CSAs) will continue as a safety net for people with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) and will be in place through the transition for recipient continuity
- BH Health Homes begin in 2013 and will be in place for the recipient through the transition for continuity
- No Carve Out to the Behavioral Health Organization (BHO)
- Sub-contracts to CSAs and CSAs/NM Provider Networks will be allowed
- Psychiatrist & leadership staff w/ BH expertise will be required in the MCO leadership structure

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Native American Participation

- Improve Health Outcomes and Promote Economic Opportunities for Native American Communities
  - Native Americans will fully participate in the Managed Care service delivery structure
  - Encourage and promote greater involvement by and with the Native American community
    - Health plans will contract with the Tribes for on-reservation case management and transportation services, where such services are available and offered by the Tribes
    - Encourage and incentivize Tribes to develop care coordination teams and health homes that meet state requirements to provide integrated care for their members with chronic medical/behavioral health conditions; and
    - Explore the concept of "mini block grants" to Tribes who are willing to provide an array of services to their members for a set amount of money.

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Protections for Indian Health Providers

- Require MCOs to offer contracts at OMB rates
- System test to assure MCOs can pay clean claims from Indian Health Providers
- Require MCOs to pay OMB rates to out of network Indian Health Providers who choose not to contract with MCOs

Protections for Native American Recipients

- Whenever possible, employ Native American care coordinators
- If a Native American care coordinator is not available, require care coordinators to work with community health representatives to schedule and sit in on appointments for face-to-face contact with Native American recipients
- Require cultural diversity training for all care coordination staff
- Require that MCOs include at least two tribal representatives in their management structure.

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Personal Responsibility

- Engage recipients in their personal health decisions
  - Reward recipients for engaging in healthy behaviors
    - Gift card to recipients who engage in quantifiable healthy behavior (e.g. well-child visits)
    - Gift card for recipients with chronic illnesses who follow a specific plan of care
    - Debit card that earns points for additional healthy behaviors
  - Targeted cost sharing strategies
    - $3.00 co-pay for any legend/brand drug dispensed when there is a generic drug available – exception of psychotropic drugs
    - Sliding scale co-payment on recipients with incomes above 100% of the Federal Poverty Level (FPL) who use emergency room for non-emergency care

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Payment Reform

- Rewarding plans and providers who practice cost-effective medicine targeted at outcomes rather than process
  - Establish pilot programs to produce the desired outcome result
    1. Chronic care pilot programs
       - Adult Diabetes
       - Pediatric Asthma
    2. Bundled payment rate for inpatient hospital care pilot programs
       - Pneumonia
       - Congestive heart failure
  - Peer-to-Peer Physician effectiveness reporting

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Administrative Simplicity

- Combine all Medicaid waivers (except for the Developmental Disabilities waiver) into a single, comprehensive 1115 waiver
- Reduce the number of managed care plans from seven to a more manageable number
  - Reduce costs
  - Focus on managing and monitoring our private contractors

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Operational/Implementation Timeline

- Currently:
  - Submit waiver to the U.S. Center for Medicare and Medicaid Services (CMS), develop Request for Proposals (RFP) for plans, finalize new contract to be used with plans
    - Waiver submitted on April 25, 2012
      - Will submit updates by August 2012
    - Procurement on the street September 1, 2012
- September 2012 – December 2012
  - Procure new plans and award contracts
- January 2013 through December 2013
  - Full year preparation for "Go Live"
  - Transition time for recipient to Centennial Care
    - To prepare recipients
    - To prepare plans

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Additional Upcoming Stakeholder Public Meetings

- Albuquerque
  - Tuesday, June 26, 2012 – 1:30 p.m. to 4:00 p.m.
  - UNM Continuing Education Building, 1634 University Blvd. NE, Auditorium
- Las Vegas
  - Wednesday, June 27, 2012 – 10:00 a.m. to 12:30 p.m.
  - Las Vegas Middle School – Lecture Hall, 947 Old National Road
- Las Cruces – Medicaid Advisory Committee (MAC) Meeting
  - Monday, July 16, 2012 – 1:00 p.m. to 5:00 p.m.
  - NM Farm & Ranch Heritage Museum, 4100 Dripping Springs Road – Ventanas Room

Access the waiver document at:
http://www.hsd.state.nm.us/Medicaid%20Modernization/index.html
Scroll down the page to the "Waiver Documents" section

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The State has several ways for people to submit suggestions and ideas for our Centennial Care waiver submission:

- Website: www.hsd.state.nm.us/medicaid.modernization
- E-mail Address: medicaid.comments@state.nm.us
- Phone: 1-855-830-5252
- Regular Mail: Centennial Care Comments – Human Services Department P.O. Box 2348, Santa Fe, New Mexico 87504

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