

**Centennial Care 1115 Waiver Renewal Subcommittee
Long-Term Care Brief**

Background

Launched on January 1, 2014, Centennial Care provides a comprehensive delivery system for Medicaid members that integrates physical health, behavioral health and long-term services and supports; ensures cost-effective care; and focuses on quality of health care over quantity of services delivered.

Essential to the program is the Community Benefit (CB) home and community-based services (HCBS) program for members who require long-term services and supports (LTSS) to remain in the family residence, in their own home or in community residences. The CB is an alternative to placement in a Nursing Facility (NF) and is available to members who meet Nursing Facility Level of Care (NF LOC). CB services supplement a member’s natural supports but do not provide 24-hour care.

With the implementation of Centennial Care, eligibility for HCBS does not require a waiver allocation (“slot”) to access HCBS services if the member is eligible for full Medicaid. Also, personal care service (PCS) benefits were changed from being a state plan service to a component of the CB service package. Under the former Coordination of Long-Term Services (CoLTS) program, individuals who were Medicaid eligible could receive PCS under the state plan, and were required to wait for a waiver allocation in order to have access to the full array of CoLTS HCBS. Under Centennial Care, members have access to all CB services that they are assessed to need, without an allocation, upon meeting the NF LOC criteria. Individuals who do not meet full Medicaid financial eligibility requirements require an allocation or waiver “slot”. HSD increased its annual waiver enrollment limit (slots) from 3,989 to 4,289 during the 1115 Waiver period (CY 2014-2018).

The member’s managed care organization (MCO) provides the CB services as determined appropriate based on the Comprehensive Needs Assessment (CNA). Members eligible for CB services have the option of selecting the Agency-Based Community Benefit (ABCB) or the Self-Directed Community Benefit (SDCB).

Number of LTC Users

	December 2013	CY2014	CY2015	9 months of CY2016
ABCB and SDCB ¹	21,300 (Includes PCO, Mi Via and CoLTS Waiver)	24,013	27,836	27,593
Nursing Facility (long term)	3,529	3,711	3,591	3,530

1 – Includes members who are enrolled as LTSS and Medicaid Expansion.

According to a recent report by the Legislative Finance Committee (LFC) released in October 2016, *Cost, Quality and Financial Performance of Nursing Homes in New Mexico*, the number of individuals living in New Mexico nursing homes declined by 12 percent over the last five years 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.”

The report recommended that the Department consider pursuing a reimbursement system for nursing homes that takes into account additional categories of patient acuity, as well as provider quality and performance. The Department began exploration of transitioning to a case mix reimbursement structure with the New Mexico Health Care Association and its consultant. It also engaged its audit contractor to conduct an initial analysis of the impact to implement such a transition. The Association’s consultant estimated it would require significant additional funds to move to a case mix reimbursement. Considering current budgetary constraints, the Department has been unable to continue to move forward with such an implementation.

The trend of more members choosing to stay in the community rather than residing in nursing homes supports the person-centric goals of Centennial Care and improves their overall quality of life. However, it also results in reduced occupancy rates for nursing facilities and higher average costs to care for those who are residing in nursing facilities. Another recommendation in the LFC report is to pursue payment reform initiatives for nursing facilities, including value-based purchasing (VBP) arrangements that reward quality of care rather than quantity of care. This recommendation aligns with efforts in Centennial Care to advance VBP arrangements. Molina Healthcare recently informed the Department that it is implementing a Nursing Facility Quality Program that will financially reward facilities for achieving quality measures.

The program will begin on January 1, 2017. While these efforts will take time to implement and assess, they represent a movement in the right direction in terms of achieving better healthcare outcomes for members in institutional care settings.

In overall performance of its LTSS program, New Mexico ranks in the second best quartile in the 2014 National State Long-Term Care (LTC) Scorecard published by the AARP and the Commonwealth Fund. Our LTC system is especially strong in terms of:

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

Long-Term Care (LTC) Monitoring

LTC Committee

In late 2015, several LTC related issues were reported to the Human Services Department (HSD) from members and disability rights advocates. HSD created a LTC Committee that included state staff and key representation from each MCO. Meetings began in December 2015 and continue to occur at least monthly.

The LTC Committee's agenda has included:

- MCO care coordination procedures, including the comprehensive needs assessment (CNA);
- How to educate the member on the full array of CB services that may be available to him or her;
- Solutions to improve and document care coordinator discussions with members about CB services and any risks involved when a member declines certain benefits; and
- Compliance with the Federal HCBS Settings Rule by 2019.

The committee created and piloted a supplemental Community Benefit Services Questionnaire (CBSQ) with a risk agreement that is to be used along with the CNA. The risk agreement ensures that a member or his/her representative is aware of risks that may occur when he/she refuses to accept assessed services. The committee also created a CB services brochure to be given to the member during the in-home CNA that explains the services that are covered under the ABCB and the SDCB models.

Based on the results of the pilot and surveys conducted with members and care coordinators, the CBSQ was finalized in September 2016. The MCOs were directed to fully implement the CBSQ beginning in November 2016. HSD is monitoring the implementation through "ride-alongs" with care coordinators. HSD staff will attend random in-home assessments to observe the administration of the CNA and CBSQ and provide feedback to the MCOs regarding improvements as necessary.

MCO Reporting

Since the beginning of Centennial Care, HSD staff review and analyze monthly, quarterly, semi-annual and annual reports related to LTC to monitor over and under-utilization of services, gaps in care and timeliness for nursing facility level-of-care (NF LOC) determinations. Any findings are addressed with the MCOs.

Accomplishments Related to Long-Term Care

MCO Training

In 2016, HSD provided detailed direction and training to the MCOs related to NF LOC and Setting of Care (SOC) reporting timelines for NF LOC determinations, denials and closures. In March of 2016, HSD conducted training for all care coordinators on CB services to ensure that they correctly inform members about available services.

Medicare Alignment

With Centennial Care, the MCOs are required to offer Dual Eligible Special Need Plans (D-SNPs), which allow them 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 manage the members' benefits and improve customer service by having a single provider directory and member handbook, one drug plan and no copayments. In October 2016, HSD worked with the MCOs to send a letter to members who are dually eligible for Medicaid and Medicare. The letter and Frequently Asked Questions (FAQ) sheet offered information about the benefits of selecting one MCO for both Medicaid and Medicare coverage. The goal of this mailing was to align enrollment for dual eligible members to ensure better health outcomes and coordination of Medicaid and Medicare benefits. HSD will analyze data to determine the success of the mailing in January 2017 and plan for future outreach to dual-eligibles.

Allocations and Central Registry

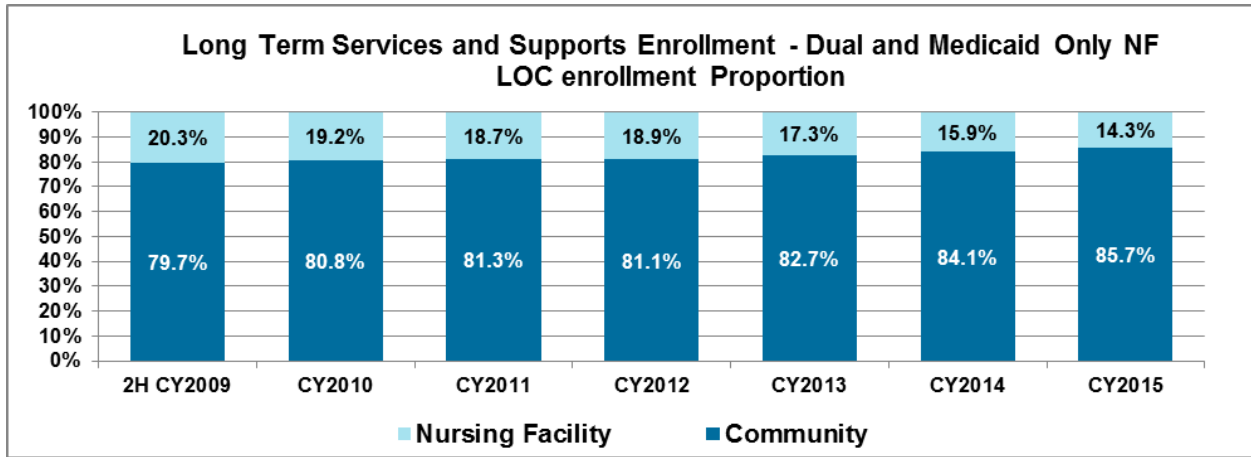
HSD has increased allocation activity throughout Centennial Care as illustrated in the chart below. As of October 2016, there are 15,288 active registrations on the central registry, and regular registrations from 2007 are currently being allocated. Community reintegration and expedited allocations are also being processed. Unfortunately, overall response rates are very low. This may be due to outdated address information in the allocation system and the complexities inherent to Medicaid enrollment.

Number of Allocations

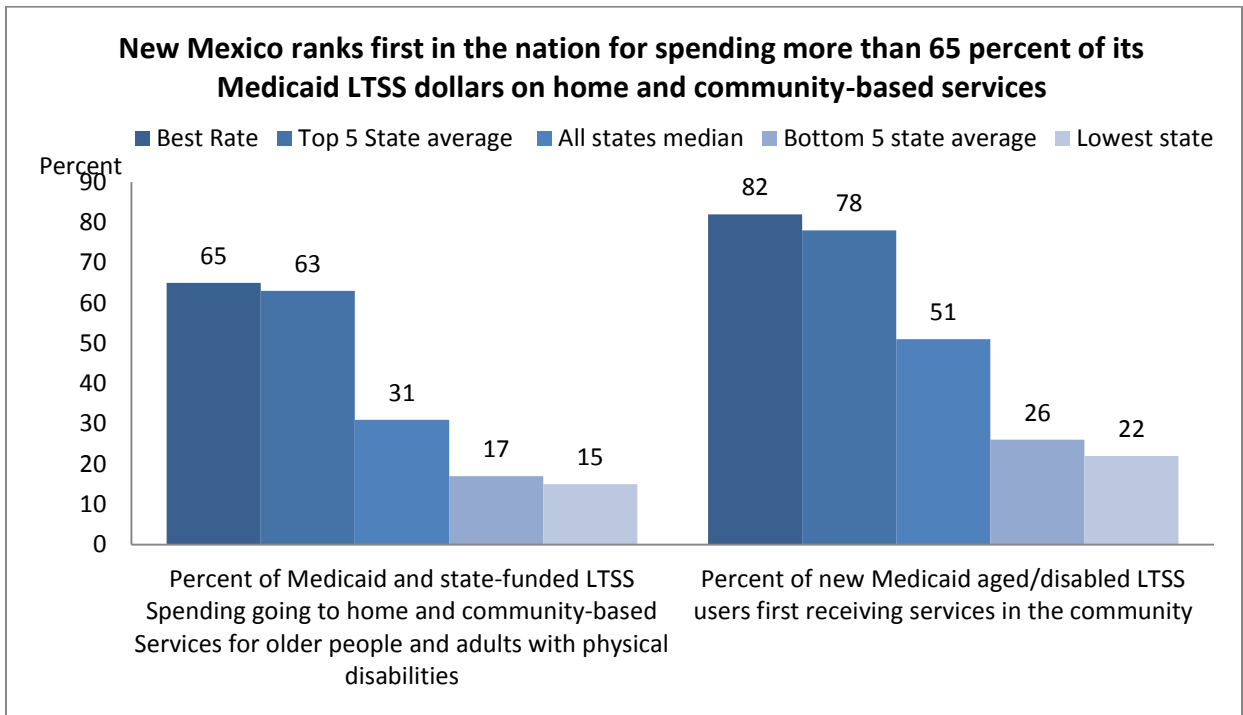
	Allocations Mailed	Responses Received	Response Rates	Eligible for Waiver
2014	1103	630	57%	168
2015	1725	786	46%	106
2016	3347	1476	44%	304

Community Reintegration/Rebalancing

Under Centennial Care, NM has continued to reintegrate members from nursing facilities into the community, with 85.7% of members in the long-term care program being served in the community in 2015.



In the AARP’s annual report for 2014, *State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*, New Mexico ranks first in the nation for spending more than 65 percent of its long-term care dollars on home and community-based services.



Top 5 states:

- 1 New Mexico**
- 2 Minnesota**
- 3 Washington**
- 4 Alaska**
- 5 Oregon**

- 1 Alaska**
- 2 Minnesota**
- 3 New Mexico**
- 4 District of Columbia**
- 5 Idaho**

Data: LTSS Spending - AARP Public Policy Institute analysis of Truven Health Analytics, Medicaid Expenditures for Long Term Services and Supports 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).

Personal Care Services

Personal Care Services (PCS) is the most utilized CB service. Total PCS expenditures have increased from \$263 Million with 19,500 users in 2013 to \$345.8 Million with 27,836 users in 2015. The state fully implemented an Electronic Verification System (EVV) in November 2016 to ensure members are receiving the approved level of PCS. Many PCS caregivers use MCO supplied tablets with location service to monitor work activities.

NM Independent Consumer Support System (NMICSS)

HSD created an independent system that links together resources throughout the state to assist Medicaid Centennial Care enrollees receiving LTSS. The NMICSS provides Centennial Care beneficiaries, their advocates and counselors with information and referral resources in the following areas:

- Centennial Care health plan choice counseling
- Grievance, appeals rights and fair hearings
- Understanding care coordination and levels of care

The NMICSS provides informational brochures to inform beneficiaries and advocates on how to access the NMICSS and which participating organizations can help with specific topics. HSD developed an NMICSS website www.nmicss.com which provides the following information:

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

HSD partners with members of the NMICSS advisory team in planning and hosting semi-annual regional roundtable discussion groups with a focus on long-term services and supports (LTSS) in Centennial Care. The purpose of these meetings is to offer an environment conducive to open discussion regarding LTSS for Centennial Care members, provider advocates, executive leadership from the four MCOs, the Director of the Medical Assistance Division (MAD) and MAD LTSS Bureau. The regional discussions are held at the San Juan Center for Independence in Farmington, the UNM Center for Development and Disability (CDD) Information Network in Albuquerque and The Ability Center in Las Cruces. These discussions have led to increased MCO trainings for care coordination; process improvements between 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.

Policy Manual Updates

HSD updates the Centennial Care MCO Policy Manual twice a year to include policy clarification for the MCOs and providers. HSD solicits public comment as part of this process. As a result of feedback from advocacy groups and stakeholders, including the NMICSS roundtable discussions, changes have included:

- Removed MCO environmental modification documentation requirement that all other viable resources must be contacted and refuse to provide the service.
- Allowed PCS agencies to create a flexible individualized schedule for members as appropriate.
- Clarified PCS agency transfer process with timeframes.
- Added the purchase of cell phone data in self-directed related goods. There is a \$100 per month limit for cell phone services.
- Increased limit from 50 miles to 75 mile radius in self-directed non-medical transportation.
- Clarified that non-medical transportation under self-direction for the purpose of picking up pharmacy prescriptions is allowed.

The CB sections of the Policy Manual will be updated again in March 2017.

LTC Challenges

CB Service Package Alignment

A major issue within the CB is the difference in the CMS approved available benefits in the self-directed and agency-based models. Several services are only available in the self-directed model such as related goods and specialized therapies. Members who struggle with the added employer related requirements of self-direction do not want to switch to ABCB because they will lose access to certain services not included in the ABCB package. HSD may more closely align the available benefits in the 1115 renewal, however, current budget constraints do not allow for an expansion of the program.

Children and Youth Appropriate Services in Centennial Care

The Community Benefit package was designed to meet the needs of the disabled and elderly population. There are many youth (under age 21) on the central registry or receiving CB services while they wait for an allocation to the Developmental Disabilities Waiver that may more appropriately meet their needs. The majority of CB services are not available to children, as they access services through the EPSDT benefit. In most instances, in the agency-based model, they are only eligible for CB respite or BH support consultation services. If a youth

switches to the self-directed model after 120 days in agency-based, he/she may be eligible for other services such as related goods or specialized therapies.

New Ideas for LTC

HSD has identified a few areas where improvement for LTC can be made in the waiver renewal if budget availability allows for such changes. These include:

- Aligning the benefits for both ABCB and SDCB models to allow for equity and smoother transitions between models.
- Explore service alternatives under both CB models that may better address members' needs.
- Implement an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change. For example, this could pertain to members with certain conditions such as: renal failure, Alzheimer's, Parkinson's, quadriplegia etc. This would reduce the burden of annual assessments for the member, increase administrative simplicity and possibly bring cost savings. MCOs would still be required to complete an annual CNA and develop an annual care plan.
- Currently, members must need assistance with two activities of daily living (ADLs) to meet NF LOC. The requirement could be changed so that members would need to meet the requirement of assistance with three ADLs to qualify for NF LOC.
- Implement a new cohort/benefit category that would include members with few PCS hours (lower ADL needs).
- Establish CB budget level ranges based on assessed need. There could be three levels: high, middle and low with corresponding dollar amount ranges that would be available to members regardless of chosen CB model.