Update to the Medicaid Advisory Committee

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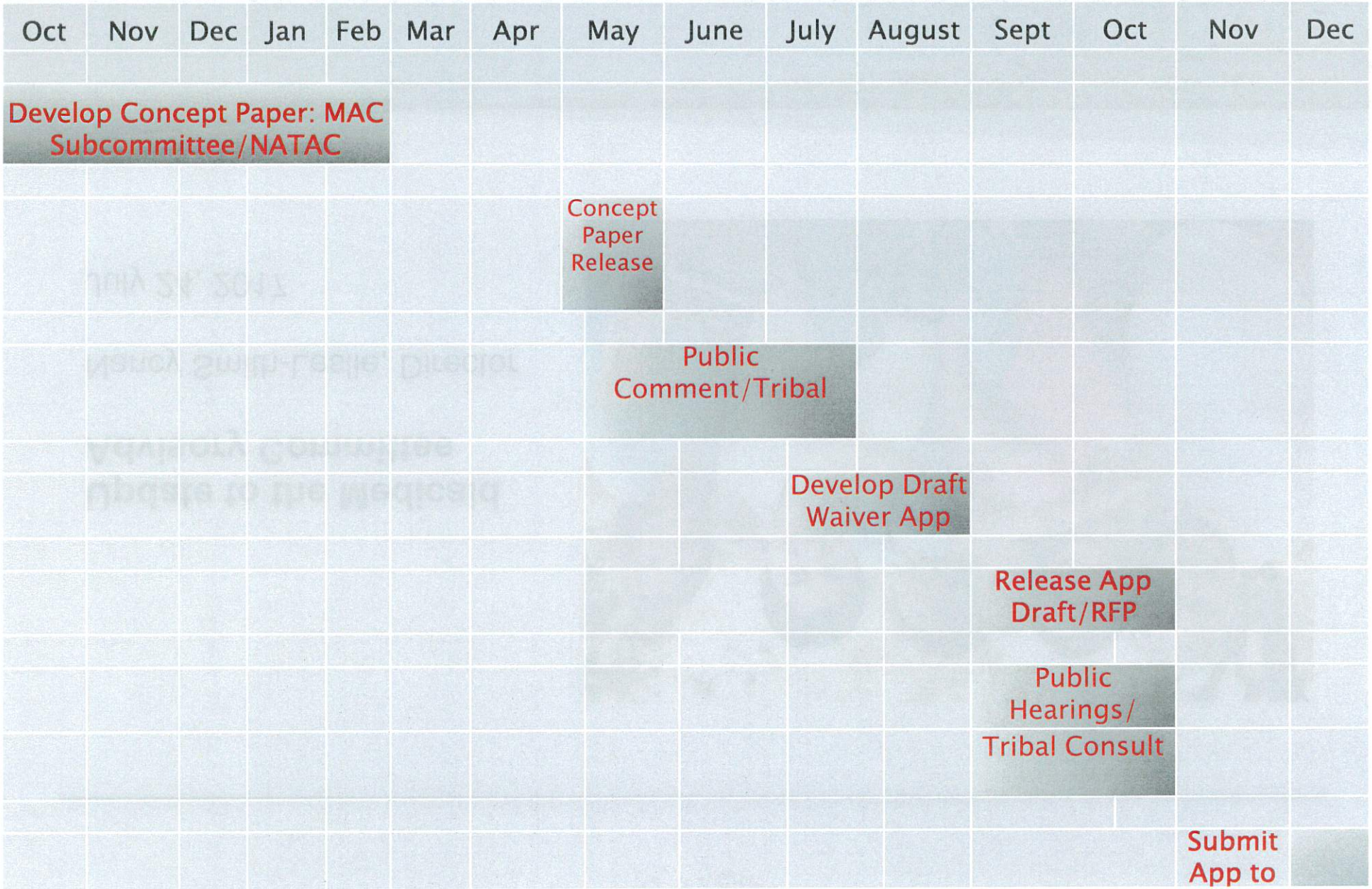
July 24, 2017

Centennial Care 2.0 Waiver Renewal



Centennial Care 2.0 Waiver Renewal

- Conducted public comment sessions around the state in June 2017—Roswell, Silver City, Albuquerque, Farmington and Tribal Consultation in Albuquerque
- Review of the public comments in process
- Plan to release the draft waiver application on September 1, 2017
- Will hold 2 public hearings on the draft waiver application (Santa Fe and Las Cruces) in October
- Submit final application to CMS in November 2017
- CC 2.0 begins January 1, 2019

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Public Comment Opportunities

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
MAC Subcommittee: October 14, 2016 – 29 attendees November 18, 2016 – 34 attendees December 16, 2016 – 62 attendees January 13, 2017 – 55 attendees February 10, 2017 – 50 attendees *Public Comment at end of meetings*	**Statewide Public Input Sessions & Attendees:** 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	**Written Comments:** May – July 2017 – 21 letters received
Native American Technical Advisory Committee: December 5, 2016 – NATAC Membership January 20, 2017 – NATAC Membership February 10, 2017 – NATAC Membership April 10, 2017 – NATAC Membership	**Native American Technical Advisory Committee:** July 10, 2017 – NATAC Membership	**HSD Email Address Established:** Ongoing from October 2016– July 2017 137 emails received
MAC Meetings with Public Input: November 2016 – 77 attendees April 2017 – 55 attendees	**Formal Tribal Consultation** June 23, 2017 – 12 tribal officials/reps & 85 attendees	

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Section 1115 Demonstration Waiver Authority

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1115 Demonstration Authority

- Under Section 1115 of the Social Security Act, the Secretary of HHS can waive specific provisions of major health programs, including certain requirements of Medicaid and CHIP.
- This authority permits the Secretary to allow states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under the federal rules
- Permits states to make broad changes in Medicaid eligibility, benefits and cost-sharing.

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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

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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.

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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.

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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-medicaid-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

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Health Home Update

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Carelink New Mexico (CLNM)

- Coordinated care for the populations with a serious mental illness or severe emotional disturbance and all co-occurring conditions
  - Behavioral health
  - Physical health
  - Social health

- Integration and support for
  - Primary care
  - Acute care
  - Behavioral health
  - Long term care
  - Prevention of high risk & associated health issues
  - Maintenance of chronic illnesses
  - Wellness and self actualization

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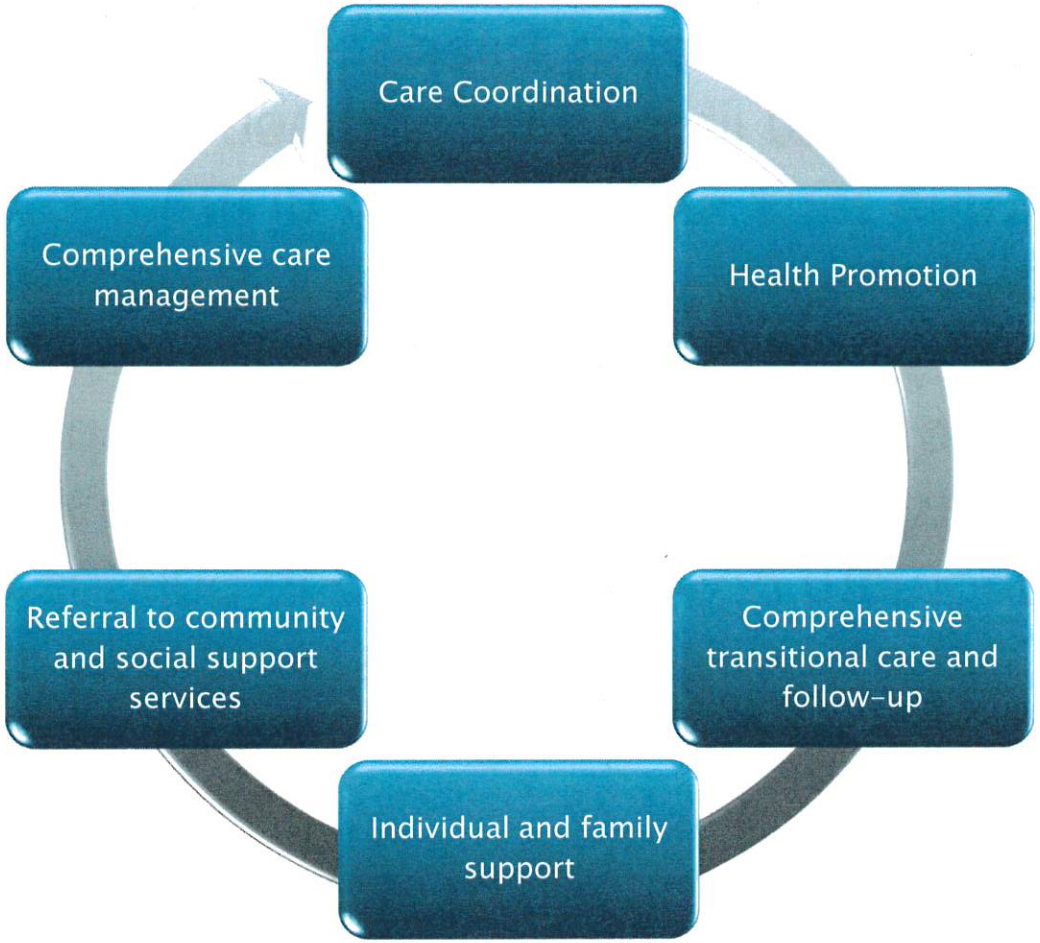
CLNM Six Core Services



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Health Home Implementation

- CMS approval of State Plan Amendment – March 2016
- Implemented April 1, 2016
- 2 Sites/2 Counties:
  - Presbyterian Medical Services-San Juan; and
  - Mental Health Resource Center – Curry
- Currently serving approximately 400 members
- Preliminary evaluation conducted by UNM indicates cost savings and improved quality outcomes for participants
  - Comparison of utilization/costs for HH participants
    - Compared member costs--2 years prior to enrollment in HH with costs after enrollment
      - Demonstrated an overall reduction in costs
    - Analysis of 12 quality measures exceeded national and state HEDIS benchmarks

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Planned Expansion for CY 18

- 9 additional counties and 11 new agencies

Northwest

San Juan*

West Central

Sandoval
Bernalillo

Southwest

Grant
Hidalgo
Dona Ana

Eastern

Quay
Curry*
Roosevelt
De Baca
Lea

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Proposed Copayments Update

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CURRENT MEDICAID CO-PAYS

Note: New co-pay structure will include new charge for outpatient surgery of $50/procedure, as well as $8 for non-emergency use of the hospital Emergency Department.

	CHIP Age 0-5: 241-300% FPL Age 6-18: 191-240% FPL	WDI Up to 250% FPL
Outpatient office visits • Includes dental visits • BH visits not currently exempt (but will be exempt under new co-pay structure)	$5/visit *(stays same under new co-pay structure)*	$7/visit *(decreases to $5 under new co-pay structure)*
Inpatient hospital stays	$25/stay *(increases to $50 under new co-pay structure)*	$30/stay *(increases to $50 under new co-pay structure)*
Prescription drugs, medical equipment and supplies • Psychotropic drugs and family planning drugs/supplies exempt	$2/preferred prescription $3/non-preferred prescription *(co-pay for preferred drugs stays same under new co-pay structure; non-preferred increases to $8)*	$3/any prescription *(co-pay for preferred drugs decreases to $2 under new co-pay structure; new co-pay of $8 for non-preferred drugs)*

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CO-PAYS FOR CY18

Note: Native Americans exempt from all co-pays. Notice of Proposed Rulemaking published on 6/13/17; public hearing held on 7/14/17. Proposed rules are posted at www.hsd.state.nm.us/LookingforInformation/registers.aspx. Effective date 10/1/17.

	CHIP Age 0-5: 241-300% FPL Age 6-18: 191-240% FPL	WDI Up to 250% FPL	Expansion Adults Co-pays only for individuals with income greater than 100% FPL	Other Medicaid
Outpatient office visits • Preventive visits exempt • BH outpatient 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/procedure**	**$50/procedure**	**$50/procedure**	**No co-pay**
Prescription drugs, medical equipment and supplies • Psychotropic drugs and family planning drugs/supplies 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 drugs and family planning drugs/supplies 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**			

Proposed Copays: Exemptions

The following populations are exempt from all copayments:

- Native Americans
- ICF-IID individuals
- QMB/SLIMB/QI1 individuals
- Individuals on Family Planning-Only
- Individuals in PACE program
- Individuals on the DD waiver
- People receiving hospice care

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Outpatient office visits – $5/visit	Exempt Services • Community benefits and waiver services • Family planning visits/procedures • Preventive visits (ie, Well Child and immunizations) • Preventive dental • BH outpatient • Maternity, prenatal, postnatal care • Diagnostic lab/x-ray • **Treatment related to Diabetes**
Inpatient hospital stays – $50/stay	Exempt Services • BH inpatient • NF stays • Labor and delivery; pregnancy-related care
Outpatient surgeries – $50/procedure	Exempt Services • Family planning procedures • Pregnancy-related care
Prescription drugs, medical equipment and supplies – $2/prescription	Exempt Items • Psychotropic drugs • Pregnancy-related drug items, including tobacco cessation and prenatal drug items • Family planning items/contraceptives • Not charged if non-preferred co-pay is applied
Non-preferred prescription drugs – $8/prescription	Exempt Items • Psychotropic drugs (legend drugs that are classified as psychotropic drugs to treat BH conditions) • Pregnancy-related/prenatal drug items • Family planning items/contraceptives • Drugs that are determined by the provider as medically necessary
Non-emergency use of the ER – $8/visit	Exempt Services • Emergency services

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

Dear Governor:

We write to you to affirm our partnership in improving Medicaid and the lives of those it serves. Medicaid is a safety net program that provides life-saving medical care to millions of Americans facing some of the most challenging health circumstances. In addressing the diversity and complexity of Medicaid recipients, we have a duty to ensure the highest level of quality, accessibility, and choices for Americans who rely on the program. We also have an obligation to taxpayers to make sure Medicaid operates in a way that best serves the most vulnerable populations.

Today, there are significant impediments that stand in the way of achieving these goals. Rigid and outdated implementation and interpretation of federal rules and requirements hinder states from focusing on their most important job: ensuring Medicaid achieves positive health outcomes for vulnerable individuals and families. The federal framework for Medicaid has not kept pace with emerging evidence around the factors that drive improvements in health outcomes. It often fails to properly account for demographic and geographic considerations, as well as health system variables, which vary in degree from one state to the next. Despite the significant investment by states and the federal government, the results should be better.

The expansion of Medicaid through the Affordable Care Act (ACA) to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program. Moreover, by providing a much higher federal reimbursement rate for the expansion population, the ACA provided states with an incentive to deprioritize the most vulnerable populations. The enhanced rate also puts upward pressure on both state and federal spending. We are going to work with both expansion and non-expansion states on a solution that best uses taxpayer dollars to serve the truly vulnerable.

Today, we commit to ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population. We wish to empower all states to advance the next wave of innovative solutions to Medicaid's challenges—solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner. States, as administrators of the program, are in the best position to assess the unique needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes.

As we break down the barriers to support state initiatives aimed at continuously improving the health outcomes for their Medicaid population, we remain committed to certain mechanisms, which ensure state accountability for the outcomes produced by the Medicaid program. For example, budget neutrality for waivers and demonstration projects remains an important policy for protecting the long-term sustainability of the program for states and the federal government,

and state waiver and demonstration requests will continue to be reviewed on a case-by-case basis. Similarly, reasonable public input processes and transparency guidelines provide states an opportunity to consider the views of Medicaid enrollees and stakeholders and gather input that may support continuous improvement of the program.

Some of the key areas where we will improve collaboration with states and move towards more effective program management are described below.

Improve Federal and State Program Management
The Centers for Medicare & Medicaid Services (CMS) is committed to engaging with states in a bilateral process to make the State Plan Amendment approval process more transparent, efficient, and less burdensome. Additionally, we aim to improve the process and speed to facilitate expedited—or "fast-track"—approval of waiver and demonstration project extensions. We also endeavor to be more consistent in evaluating and incorporating state requests for specific waivers and demonstration project approaches that have already received approval in another state. Finally, we plan to conduct a full review of managed care regulations in order to prioritize beneficiary outcomes and state priorities.

Support Innovative Approaches to Increase Employment and Community Engagement
Today, we reaffirm the agency's commitment to support and complement the various federal, state, and local programs that have demonstrated success in assisting eligible low-income adult beneficiaries to improve their economic standing and materially advance in an effort to rise out of poverty. The best way to improve the long-term health of low-income Americans is to empower them with skills and employment. It is our intent to use existing Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment and independence.

Align Medicaid and Private Insurance Policies for Non-Disabled Adults
States may also consider creating greater alignment between Medicaid's design and benefit structure with common features of commercial health insurance, to help working age, non-pregnant, non-disabled adults prepare for private coverage. These state-led reforms could include, as allowed by law:

- Alternative benefit plan designs and cost-sharing models, including consumer-directed health care with Health Savings Account-like features, for individuals at all income levels;
- Facilitating enrollment in affordable employer-sponsored health insurance options;
- Reasonable, enforceable premium or contribution requirements, with appropriate protections for high-risk populations;
- Initiatives designed to break down the barriers that prevent families from being together on the same plan;
- Waivers of non-emergency transportation benefit requirements;
- Expanded options to design emergency room copayments to encourage the use of primary and other non-emergency providers for non-emergency medical care; and
- Waivers of enrollment and eligibility procedures that do not promote continuous coverage, such as presumptive eligibility and retroactive coverage.

Provide Reasonable Timelines and Processes for Home and Community-Based Services Transformation

CMS has worked with our state partners and other stakeholders to implement provisions of the final regulation defining a home and community-based setting. In recognition of the significance of the reform efforts underway, CMS will work toward providing additional time for states to comply with the January 16, 2014, Home and Community-Based Services (HCBS) rule. Additionally, we will be examining ways in which we can improve our engagement with states on the implementation of the HCBS rule, including greater state involvement in the process of assessing compliance of specific settings.

Provide States with More Tools to Address the Opioid Epidemic

We are committed to ensuring that states have the tools they need to combat the growing opioid epidemic that is devastating families and communities. In recognition of the urgent need to improve access to comprehensive substance abuse treatment, we will continue to work with states to improve care for individuals struggling with addiction under their Medicaid state plans and through the Medicaid Innovation Accelerator Program to improve their substance abuse treatment delivery systems. In addition, under recent regulatory changes, states may now make managed care capitation payments for individuals with Institutions for Mental Disease stays of 15 days or less within a month. We will continue to explore additional opportunities for states to provide a full continuum of care for people struggling with addiction and develop a more streamlined approach for Section 1115 substance abuse treatment demonstration opportunities. We look forward to building upon initial efforts, including previous collaborations amongst the states.

We intend for this to be the beginning of a discussion on how we can revamp the federal and state Medicaid partnership to effectively and efficiently improve health outcomes. We look forward to partnering with you in the years ahead to deliver on our shared goals of providing high quality, sustainable, health care to those who need it most.

Yours truly,

/Thomas E. Price, M.D./

Thomas E. Price, M.D.
Secretary

/Seema Verma, MPH/

Seema Verma, MPH
CMS Administrator