



**1115 WAIVER SUBCOMMITTEE - PUBLIC
COMMENTS**

February 28, 2017

CONTENTS

Care Coordination.....	1–5
Long-Term Services and Supports.....	6–10
Behavioral Health – Physical Health Integration.....	11–18
Value Based Purchasing.....	19-21
Eligibility and Benefit Alignment.....	22–25

Notes:

- *All comments provided in this document are displayed as submitted by the commenter. HSD has not made any editorial or other changes to the comments submitted.*
- *In some instances, recommendations cover multiple subjects outlined in the table of contents. Those recommendations are in one place only and not reintroduced in each section.*
- *Additional commentary is available in the subcommittee meeting minutes.*

CARE COORDINATION

Jessica Bloom

My name is Jessica Bloom. I attended the most recent meeting of this committee as an audience member. I was so incredibly impressed at the level of collaboration, cohesiveness, and general concern for the populations served within the context of reducing costs.

I recently moved to NM from Massachusetts, where I worked in the field of Behavioral Health peer support. I also have extensive lived experience receiving behavioral health services and with recovery communities.

I spoke during the public comment period at the meeting, but I wanted to reiterate a few of my statements there, and add more that have percolated since then.

Some concrete suggestions I spoke about, primarily from my experience as both consumer and provider in the BH world:

- To address hospital re-admissions within 30 days, my thoughts about the best use of limited funds are to implement (or increase) peer bridging. In a concrete way, this would look like employing a number of CPSWs to ease the transition of an inpatient psychiatric patient's return to the community. The CPSW would meet with the patient while in the hospital and then have frequent contact for (at least) the following 30 days. Since CPSWs are people who have experience navigating the system, accessing resources, and personally reintegrating into the community, these seem like perfect people to support someone to engage in their community or treatment of choice.

There was much discussion of social determinants of health, and what I have always heard is that people thrive with a combination of homes, roles, and jobs. I think CPSWs are uniquely set up to encourage folks to envision what they would really like their lives to look like, beyond stabilization or maintenance. In my experience that is truly the only path to recovery.

- I also made the recommendation to expand (and train) family peer support. There was talk about how family members who care for their struggling person often feel like the only true care coordinator. Our families are of course our most invested and consistent advocates. Because of this, there was much talk of burn out and need for respite. While this is fully real, to me one way to assist and cut down on everyone needing to reinvent the wheel is to implement family peer support programs. There are caregivers all over NM who have dedicated their lives to getting support and services for their loved ones. There are caregivers all over NM who are doing this for the first time and feeling lost, alone, intimidated. It seems to me like connecting those folks, perhaps with an option of traditional Care Coordination or Family Peer Support (different strokes for different folks) could add support and cut down on costs for coordination, respite, etc.
- In my mind, I think prevention and early intervention are our best strategies toward supporting someone before they are entrenched in our system. There was talk of the ACE study (adverse childhood experiences) and the things we know about trauma and the likelihood of developing psychiatric issues down the line. Long term psych med use wreaks havoc on the body and often contributes to chronic (and expensive) health issues, diabetes being the top one. If we can implement programs to support people to remain in their chosen communities, stay on track with their lives (homes, roles, jobs), and the focus while in crisis is on managing symptoms rather than the side effects of medication, I think we can go a long way toward both cost-saving and honestly lifesaving.

To that end, there are some innovative programs that exist and have amazing results. Often these approaches are not "evidence based," largely because they are somewhat alternative. They go a long way toward driving long term costs down, and of course increasing quality of life and investment in community.

One of the things that really struck me during the meeting was the woman who was there representing the Department of Health talking about data collection and tracking, and NM particularly excelling at that. I started to think about how to connect programs that are cutting edge but not evidence based, because they haven't been piloted in places with sufficient data collection, and our innate creativity and innovation here in NM.

Some specific programs that I have heard about or seen work include:

Open Dialogues

<http://www.dialogicpractice.net/open-dialogue/about-open-dialogue/>

Intentional Peer Support

I am an Organizational Trainer for this, and I know they are hoping to expand to NM. I also know that modified versions can be extremely valuable for all relationship building, not just CPSWs.

<http://www.intentionalpeersupport.org/>

I know that investing in building the Hearing Voices Network out here can have a huge effect on people's lives.

<http://www.hearingvoicesusa.org/>

The Soteria model is also producing powerful results internationally.

<http://www.moshersoteria.com/articles/soteria-associates/>

Anyway, these are some ideas I have had for improving people's lives, saving money long term, and increasing our reputation here as an innovative and truly recovery oriented system.

Submitted by Natalie

I am pleased to have this opportunity to comment on the importance of this program. As an RN, I have practiced in both policy/management and direct care to clients in this program, as well as the Medically Fragile Waiver, and other home health/home visiting venues. While nursing-home visits and personal care aides are contracted with the waiver, through the MCO's and their Case Management oversight, there seem to be impediments to the actual delivery of care, though the intention is a noble one.

Operationally, the direct care nursing staff, also doing a complete assessment, has to defer/refer to CM to actualize plans, and major coordination of care. The reality is, shockingly, that the CMs have a case load, often in the hundreds, or there is another level of CM that deals with the more complex cases, all this in actuality preventing the most direct care necessary, with prevention issues from being delivered in a timely fashion.

To give a personal/ professional example: I had a paraplegic client, with multiple behavioral health and many other medical diagnoses, that had skin break down in the initial stages...something common to less mobile and bed ridden patients...who needed a new shower chair due to the fact that it was contributing to his skin breakdown. By the time spent trying to get through the bureaucracy of the CM system, for this seemingly simple request, the client's ulcers had progressed to the stage where he had to be hospitalized for intensive treatment. Staff was well meaning but, as in many other cases, the system did not work as it is now structured. (If needed and according to HIPPA guidelines, these records could be used as a case study/prototype example)

It would seem that if comprehensive nursing assessment and treatment recommended and currently utilized could be "freed up" to direct implementation ability and/or if CM had increased coordination and alignment with the contracted home health agencies, there could and would be more effective outcomes. One of the benefits of the Medically Fragile Program, that I have witnessed, is that the CMs are also nurses, and these programs do always involve the body of knowledge of nursing. I do not speak of this in a hierarchical manner, rather in which discipline works most effectively within each criterion of care. It is often left to the PCA (personal care attendant) who has the most time with the patient, yet not some of the skill base or license requirements, to facilitate the outcomes and implementations necessary and needed.

What I have also seen in all of my nursing practice, most especially in the home health and waiver programs, is that the emphases is placed more on what is happening physically and not in the behavioral/mental health arenas. I have seen clients not allowed the necessary amounts of visits when the support, education and guidance, that is equally important to integrated care for positive outcomes, do not hold equal weight in assessment determinations. (this responsibility also rests with supervision of staff and the professions themselves) Knowledge based teaching and support, in all aspects of care, that is within the body of knowledge of general nursing practice is most often overlooked and underutilized in many medicaid and medicare based programs; not only are they in a prevention model, but they are also cost effective!

The DD waiver program, and its' philosophy, is essential to patient care. Perhaps, in this time of budget cuts and revisions we can continue with cost effective re looks and reorganization while in no way jeopardizing the quality of care nor the necessity of this program.

Andes Mercado

Add LEVEL 4 and LEVEL 5 care coordination for high utilizers or sub-contract it out. Level 3 is not enough. The caseload for the care coordinators is too high to manage the most complex patients.

LONG-TERM SERVICES AND SUPPORTS

SENIORLINK – Rick Henley and Jennifer Crosbie

To Whom It May Concern:

On behalf of Seniorlink, I am pleased to submit these comments to the 1115 Waiver Renewal Subcommittee.

As attendees of several Centennial Care Renewal Subcommittee (Subcommittee) meetings, we appreciate the Subcommittee's interest in obtaining diverse stakeholder input early in the process to help guide the Concept Paper for the 1115 Demonstration Waiver Renewal. Based on the thoughtful discussion at these meetings, it is clear that the Subcommittee is committed to building upon Centennial Care's successes while continuing to look for opportunities to enhance long-term services and supports.

Seniorlink has, for more than 16 years, worked with States and health plans to develop specific solutions to support family caregivers to help keep care in the community. Caregivers are the backbone of any long-term services and supports program, especially family caregivers, who often care for consumers for extended periods of time, mostly with little or no support. A recent AARP Public Policy Institute article described family caregivers as an "an invisible army ... carrying out increasingly complicated tasks and experiencing challenges and frustrations without adequate recognition, support or guidance and at great personal cost."¹ Family caregivers often feel isolated and unprepared for the tasks they are expected to perform, and caregiving—especially when it involves an intensive commitment over the long term—carries significant costs.²

Not surprisingly, the Subcommittee heard comments from family caregivers and other stakeholders about some of the challenges in keeping loved ones in the community. Recommendations to support family caregivers included:

- The need for mechanisms to engage, recognize, and pay for family caregivers as part of the care management team;
- The provision of education and training to family caregivers, including specialized support and coaching of family caregivers who need behavior intervention and management skills to care for participants with complex and evolving conditions (e.g., Alzheimer's Disease);
- The need for respite and other supports to ensure family caregivers have the support they need to continue support in the community; and
- The desire to have home and community-based services provided in a culturally-sensitive manner.

Furthermore, we heard that mechanisms needed to be in place to ensure a sufficient HCBS workforce for those who receive care in the community, especially the rural parts of the State.

¹ *Valuing the Invaluable, 2015 Update: Undeniable Progress, but Big Gaps Remain*, AARP Public Policy Institute, page 5.

² *Home Alone: Family Caregivers Providing Complex Chronic Care*, 2012.

We note that the primary guiding principles in both New Mexico's *State Plan on Alzheimer's Disease and Related Conditions* as well as the *State Plan for Family Caregivers* are that efforts should "address the rural and frontier nature of the state" and "respect and incorporate cultural and ethnic conditions."³

It is clear that the Subcommittee is charged with identifying innovative ways by which to support family caregivers and to sustain them in their caregiving roles over the long term. Based on our experience developing and delivering caregiver supports and in consideration of the expressed wishes of New Mexicans, we believe the Subcommittee should recommend the addition of consumer benefits and caregiver supports that leverage the commitment of family caregivers to keep care for their loved ones at home.

I. Add new service benefits that harness caregiver support to achieve better quality of life and longer lengths of stay in the community, while providing savings to the State.

Adding specific benefits that are designed to reinforce family caregivers – education, coaching, and professional support – will allow them to continue caring for their loved ones at home for longer periods of time and will provide considerable savings to the State. In May 2016, the National Bureau of Economic Research issued a paper that discussed the benefits of family caregiving, finding that, the engagement of a family caregiver saved Medicaid as much as \$1564 over nine months, reduced emergency room visits by 30%, and hospital admissions by 50%.⁴

States are increasingly recognizing family caregivers for the important role they play in both providing care and managing health care utilization and coordinating care, avoiding hospitalizations and other costly institutional care. One of the ways States do this is by offering Structured Family Caregiving (commonly referred to as Shared Living by CMS).⁵ Structured Family Caregiving works by combining a full-time caregiver (often a family member) who lives at home with a consumer and provides the consumer's daily care needs. Clinicians and caregiver coaches (nurses and social workers or behavioral health specialists) employed by a Structured Family Caregiving agency⁶ provide ongoing support to help caregivers manage complex cognitive and behavioral health and medical conditions and assist caregivers in communicating important information to health care providers and health plan care managers. Caregivers communicate daily with Structured Family Caregiving agency care teams relaying changes in the consumers' health status or behavioral health needs. Care teams regularly connect with and

³ See *New Mexico State Plan for Family Caregivers*, p. 7 and *New Mexico State Plan on Alzheimer's Disease and Related Conditions*, p. 7.

⁴ National Bureau of Economic Research, "What is the Marginal Benefit of Payment-Induced Family Care?" May 2016.

⁵ Seniorlink/Caregiver Homes provides Structured Family Caregiving services in LA, OH, IN, CT, RI, and MA with TX scheduled for implementation in Spring 2017

⁶ Structured Family Caregiving agencies are paid a per-diem rate. Typically, there are 2-3 levels or tiers that are based upon the consumer's acuity/needs. We note that this is consistent with one of the LTSS concepts discussed by the Subcommittee, i.e., to develop budget leveling based on need

visit consumers and caregivers to help caregivers: understand, anticipate, and prepare for changes in consumers' health conditions; develop strategies for managing challenging behaviors; recognize strains and stressors on their own health and prepare and implement plans for respite. Through frequent contacts, including home visits, Structured Family Caregiving meets important health care and quality of life outcomes for consumers, deters and delays utilization of expensive institutional services, ensures care is provided in a culturally-sensitive manner, and yields meaningful savings to States and health plans.

II. Develop high quality educational content and trainings specifically for lay caregivers that will increase their confidence and capacity to perform tasks and understand complex medical and behavioral health conditions.

Research demonstrates that education and skills training can improve caregiver confidence in managing daily care challenges; caregiver skill building and environmental modifications can improve quality of life for family caregivers and care recipients.⁷ Caregivers take on increased responsibilities over time, typically without formal training or education. It is vitally important that the State consider the supports that caregivers need as well as efficient and accessible methods of delivering such assistance.

By example, Seniorlink developed a signature clinical platform known as Vital Outcomes Inspired by Caregiver Engagement (VOICE) consisting of evidence-based programs that drive caregiver engagement and improve consumer outcomes. With VOICE, we have four core programs that focus on falls prevention, medication management, care transitions, and enhanced caregiver support for dementia management.⁸

III. Use technology to better support caregivers and allow them to provide thoughtful insight to health care providers on consumers' daily care needs and changing health conditions.

Several members of the Subcommittee noted that consumers and caregivers living in rural areas need new innovative solutions and the State has expressed interest in expanding Centennial Care Community Benefits to serve a broader base of individuals in the community through both existing and alternative programs that will help drive improved outcomes and cost savings. Caregiver-informed technology allows for the gathering of actionable information that directly improves the lives of consumers and caregivers. Technology can be used to facilitate communication and collaboration between family caregivers, case managers, health plans and providers and enable professionals to easily deliver educational content and coaching critical to lay caregivers who take on responsibility for providing and managing care for loved ones.

The Subcommittee should recommend that health plans deploy caregiver-focused technology solutions to improve the capacity and capabilities of live-in and remote caregivers, thereby

⁷ "Families Caring for an Aging America," The National Academy of Sciences, Engineering, and Medicine. 2016

⁸ An analysis of the early results of the VOICE dementia care program was recently published in the Geriatrics & Gerontology Education Journal; See <http://www.tandfonline.com/doi/full/10.1080/02701960.2016.1209419>

1115 WAIVER SUBCOMMITTEE - PUBLIC COMMENTS
LONG-TERM SERVICES AND SUPPORTS

empowering caregivers to continue their commitment to keep care at home for as long as possible.

We urge the Subcommittee to recommend the expansion of required Centennial Care Community Benefits to include the services and supports described above. We are confident that the addition of caregiver-focused services would contribute meaningfully to helping New Mexico build upon the successes of the 1115 Waiver. We would welcome the opportunity to discuss these recommendations further and thank you for the opportunity to comment.

Sincerely,

Rick Henley
Regional Director, Government and
Community Relations
Phone: 985-687-1161
Email: rhenley@seniorlink.com

Jennifer Crosbie
Director, Government Relations
Phone: 617-456-3796
Email: jcrosbie@seniorlink.com

Cc: Angela Medrano, Medicaid Deputy Director
Myles Copeland, Cabinet Secretary, New Mexico Aging and Long-Term Services
Department
Wayne Lindstrom, Director Behavioral Health Services Division and CEO, Behavioral
Health Collaborative

BEHAVIORAL HEALTH — PHYSICAL HEALTH INTEGRATION

Executive Director, Enhancement Center – Jim Shotwell, LISW

1. As an outpatient behavioral health provider I would like to see that providers are consistently paid an additional amount for Gross Receipts Tax. Currently only Molina and Presbyterian are the only two Centennial providers that do this. My discussions with BCBS and United appear to indicate that both of those Centennial MCOs currently refuse to provide this to outpatient behavioral health providers, despite the fact that they provide this for other medical providers.
2. Again for outpatient behavioral health services it should be less cumbersome for a group psychotherapy practice to work with non-independently licensed (NIL) clinicians. It would benefit some of the service areas of the state that are consistently under-served and it would facilitate professional growth for both the NIL clinicians but also for those Independently Licensed clinicians who have the desire to share their expertise with newer clinicians.

Molly Adler, LMSW, ACS

Hello,

I understand I can share feedback for Centennial Care 2.0. I am a licensed Master Social Worker and outpatient mental health provider. Last year I was disheartened to learn a client would not be covered by centennial care for a diagnosis of cyclothymia. The patient was using medication successfully and greatly benefitted from supportive counseling. The billing under that diagnosis was denied. I was shocked this significant mental illness was not considered enough to warrant outpatient mental health services on its own. Please consider including the diagnosis as covered ASAP.

Thank you for your consideration.

Al Galves

Please include the Soteria-type sanctuary house in the list of behavioral health treatment options that are eligible for reimbursement by Medicaid in the 2019 Waiver. Following is a description of the Soteria Model:

The Soteria House operated in the San Francisco Bay Area from 1971 to 1983. It was a home-like residence that treated persons who were experiencing psychiatric emergency.

- Such persons could go to Soteria House and be safe both physically and psychologically. There was no pressure on them to get better, get back on track or stop having those thoughts or hallucinations. Rather, they were told that they could stay there until they felt more stable and the staff would be with them and help them go through the experience they were having. The treatment was based on relationship and the goal was to help the person go through the experience in a safe place where they were understood and affirmed and could slowly learn whatever could be learned from the experience.
- Most of the staff were trained peers and other non-professionals who were able to relate well with the residents and help them slowly to make sense out of what was going on, understand what had triggered it and begin to feel less agitated, upset and alienated. Although some of the residents were using psychotropic medication, medication was not used as a primary modality of treatment and residents were encouraged to withdraw from medications in a careful way.
 - The Director of the House was a licensed clinician and the House had a contract with a psychiatrist who provided services as needed.
 - Residents were involved in taking care of the house and cooking. As they were able, they began to participate in community activities, education, employment-related activities, recreation and obtain other forms of help.
- The typical resident would become stabilized in about six weeks but many residents stayed at the House for three to four months. They were able to come back when they needed to and many residents kept in touch with the House and its residents after they left.

A very well-done scientific study was done to compare the outcomes of persons who were served at Soteria House with those who were treated in hospitals.^[1] When patients were compared at six weeks, there wasn't much difference but at one and two-year follow-ups the patients treated at Soteria House were doing significantly better in terms of symptoms, relapse, social functioning and employment status. And the cost of Soteria House was one-third the cost of hospitalization.

[1] Bola J & Mosher L. (2003). Treatment of acute psychosis without neuroleptics: Two-year outcomes from the Soteria project. *The Journal of Nervous and Mental Disease*. 191(4). Pp. 219 - 229

Susan Kammerer

Santa Fe County, alone, is double the National Average in substance abuse, suicide and overdoses. Sadly, this very high utilizer population lacks the determinant needed to break the cycle of addiction and all that entails. A dual diagnosis with underlying mental illness prevails in our community. The proposed determinant is for access to a safe haven for Medical Detoxification. Santa Fe has but one location, (Santa Fe Community Guidance Center), where this population can seek true help on a road toward recovery to break this unending cycle of societal dependence. Without breaking the cycle of addiction, New Mexico is not addressing the core barrier for this population to live healthy and meaningful lives. The financial impact on the state, health facilities, and emergency response facilities is enormous.

Currently, we are providing only band aides on this population. With multiple visits to hospitals when the crisis is short of death, this population is admitted to medical units for stabilization and discharged into the same environment with to tools from which to succeed. The cycle must first be broken to optimize the patient for rehabilitation. If there were access to a Federally funded medical detox center in Santa Fe, these clients could finally start at baseline, and be put on a continuum to wrap around services for follow up leading to sustainable health and mental well-being. Please, ear mark funding for a Medical Detox Center, or partner with a local hospital/clinic to intervene on behalf of this very highly neglected population and their families. If requested, data from the recent Community Needs Assessment compiled by the Care Connection can be submitted to verify the flagrant neglect of this population in our Land of Enchantment. Thank you for the opportunity to voice an idea!

Porfirio Bueno

Data clearly indicates that the State of New Mexico has a disproportionate rate of substance abuse (SA), many of the people living with SA also suffer from mental illness. The good news is that many there are lots of people who survive substance abuse and mental illness, these people are a valuable resource. People with lived experience can easily relate to people living with mental illness and addiction and can lead by example. The 12 Step approach is one a good example of how peers lead the path to recovery. New Mexico has very opportunities for peer services. Currently only CSAs can bill for peer services, the rates offered are too low and are currently limited to group work. Peers are willing to spend time in sobering centers, bus stations, soup kitchen, emergency shelters and on the streets where the homeless congregate. New Mexico needs to find ways to employ peers with a living wage. To date our state has lacked creative ways to reach the so called unreachable. We need to move away from old approaches and try new bold and compassionate avenues.

Diane Broome

Providers who are reimbursed for treating Medicaid members should meet all HEDIS requirements for their patients before receiving reimbursement.

Santa Fe Mountain Center – Tiffany Wynn

Hello,

I understand that there is a shortfall and increase requests will likely not be considered. However, here are three recommendations.

Please consider the following:

1. Pay for individual and well as group peer support services at a reimbursement rate of no less than \$12/15 minutes. With no cap per day, as there are time when people require ongoing support when they are in crisis.
2. Remove the barrier related to Non-independently licensed professions, i.e. first level license holders (with a masters), so that they can bill outpatient care and not only intensive outpatient work.
3. Allow graduate students as interns to bill for clinical services. This would help the work force and help incentivize agencies to support students and masters level programs more fully. (All under supervision of course.)

With respect for the difficult position that you are all in.

VALUE-BASED PURCHASING

Santa Fe County Community Services Department – Submitted by Rachel O’Conner

The Santa Fe County Community Services Department is comprised of four Divisions, Health Services, Community Safety, Community Operations and Senior Services. We provide services that impact health and public safety including DWI and Teen Court, the Health Care Assistance

Program (HCAP), the Mobile Health Van and Senior Services. We are actively involved in Medicaid enrollment both in the community and at the jail and fund multiple projects related to health services through both claims and value-based contracts geared at addressing specific indicators in our Santa Fe County Health Action Plan. The Santa Fe Community Services Department upholds our county’s commitment to improving the health of all residents of the county and population health indicators in Santa Fe County. Our top priorities are access to insurance to care and improvements in behavioral health.

Over the past year the Community Services Department has been working to create an Accountable Health Community (AHC) in Santa Fe County. We have devoted significant funds towards the development of an expanded system of navigation by which we can hold providers accountable through a centralized hub. Earlier this year we submitted a proposal to CMS to further our Accountable Health Community (AHC) efforts, and, with Department of Health support, have since been working to formalize a consortium for Santa Fe, Rio Arriba, Los Alamos, and Taos counties to act as a regional Accountable Health Community known as the Regional Health Alliance Northeast (RHANE).

Local government remains responsible for indigent care of our most vulnerable. We appreciate recent formalized county representation in decision-making boards, including the Long Term Solutions and the Waiver committees. We respectfully request that the New Mexico Human

Services Department follow the recommendations of the Medicaid Advisory Committee Long Term Solutions Subcommittee in fine tuning the 1115 Waiver and/or amending the state plan and considering changes to administrative policies within which flexibility currently exists.

Specifically we ask that HSD:

- Support a pilot of the Accountable Health Community in Santa Fe County whereby care coordination funds that might normally go to MCOs would flow to the county. Such a pilot would unify health and social service providers in screening for social determinants and behavioral health needs and navigating high utilizers to the resources that make a difference in health outcomes.
- Work in a mutually beneficial way with the counties to leverage federal dollars so that counties may be compensated, ideally via value-based purchasing, for the care coordination/navigation which we now directly support via contracts with local clinics and social service agencies in Santa Fe County.
- Consider structuring contracts statewide that support Regional Health Alliances or Authorities, such as those being implemented in states that have adopted a State Innovation Model. Rather than contracting with multiple health systems or even MCOs, this would allow HSD to contract with the best-resourced county in a region. With backbone support from the Department of Health and data support from HSD, that county would then convene a consortium of its neighboring counties, ensuring greater accountability and provider buy-in at the local level.

**1115 WAIVER SUBCOMMITTEE - PUBLIC COMMENTS
VALUE-BASED PURCHASING**

We are hoping that you might consider our request as a reason to present to you in more detail our current work as well as the ideas we have in improving navigation services through increased accountability, alignment and cooperation between Santa Fe County, the northern region and the State of New Mexico.

ELIGIBILITY AND BENEFIT ALIGNMENT

Waiver Recommendations from the NM Behavioral Health Provider Association

The New Mexico Behavioral Health Provider Association is a non-profit professional association of behavioral health agencies and individual practitioners providing publicly funded behavioral health care. The NMBHPA is dedicated to ensuring that behavioral health providers share a unified voice in advocating for their clients and services in New Mexico

The provider network is the backbone of the Behavioral Health system. All Medicaid policies and procedures should intentionally strengthen the provider's ability to fulfill their professional commitment to quality treatment, and to the health and well-being of consumers.

The following Medicaid Waiver recommendations are informed by :

- The collective experience of New México's behavioral health providers working with over 20 years of various managed care models,
- A 2017 survey of providers specific to their 3 year Centennial Care experience,
- Care Coordination a presentation by the state's MCOs and various Centennial Care work products

RECOMMENDATIONS

1. Management of Medicaid Funded Care
 - Develop a graduated strategic plan to transfer population health risk and management from managed care organizations to provider organizations with greater emphasis on outcomes based reimbursement.
 - Reduce number of MCOs from four to no more than two.
 - Establish Regional Health Authorities comprised of State, County, Municipality, Consumer and Provider representatives and eliminate the Medicaid MCOs with blending and braiding of all public behavioral health funding in respective regions. Administrative functions could be delegated to ASOs or developed within each Regional Authority.
2. Transfer all Care Coordination functions from the MCOs back to providers.
3. Increase parity between behavioral and physical health.
 - The burden of documenting behavioral/physical health care integration for persons with SMI/SED has been placed entirely upon behavioral health. Require these burdens to be shared more equitably between providers of physical and behavioral healthcare.
 - Review authorization requirements between behavioral and physical health in order to establish more comparable expectations.
4. Simplify and increase uniformity among MCO's and within state administration for administrative processes and standards
 - Standardize the fees for identical services. Negotiating rates with MCOs has caused a huge variance in rates. Larger agencies with negotiating clout, CSAs, Clinics and FQHCs often get fees twice as large as a specialized agency.
 - Establish more uniform service expectations and definitions All payer driven service requirements must be consistent with state statutory and policy requirements.
 - Establish more uniform and efficient auditing processes among MCOs and between MCOs and state licensing/certification authorities.
 - Establish uniform quality goals

- Payment parity among different types of Medicaid providers (eg. behavioral health agencies and private practitioners).
- Administrative requirement parity among different types of Medicaid providers.(e.g., auditing practices)

5. Expand service to fill gaps

Stimulate a dramatic increase in community based services by increasing rates, simplifying regulations and associated auditing processes, increasing flexibility and dramatically reducing administrative burden on providers with regards to reimbursement for outpatient services.

Include the following services to minimize service gaps.

- Include Infant mental health as a covered service
- Increase placement alternatives for our youth in CYFD custody - primarily via foster care, transitional living programs, crisis shelters and group homes.
- Include comprehensive substance use disorder treatment service as a Medicaid benefit
- Allow recovery services to be offered/billed as 1:1 not just group and improve rates.
- Include peer run and family run services as a covered benefit.
- Expand case management and care coordination across the board, e.g., eliminate barriers to agencies providing these services.
- Require all MCOs to take 3% of profits for Value Added Services (VAS) flexible funding, just as Optum was required to do.

6 Do not implement co-pays on Medicaid funded services

Providers oppose any requirement placed on consumers or providers that result in 1) a delay in the consumer receiving the services, and 2) increased costs. Even a marginal co-pay is believed to create a barrier to the consumer receiving services and the anticipation that they will delay getting care if they do not have the co-pay. Such delays will create the need for more costly interventions (e.g, hospitalizations). Additionally, providers will have to assume the cost of managing the co-pay process and funds and is an additional administrative burden.

Multiple Comments

Support for continuing dental coverage:

From October 2016 through February 2017, HSD received 26 public comments requesting that dental services remain covered under Centennial Care / Medicaid in New Mexico.