



Individual Recommendations  
Submitted by Members of the  
1115 Waiver Renewal Subcommittee

Feb 28, 2017

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Note:

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.

# CARE COORDINATION

## **Centennial Care MCOs – Submitted by Mary Eden – Presbyterian Health Plan with input from all Centennial Care MCOs Proposed Care Coordination Enhancements**

As a member of 1115 Waiver Renewal Subcommittee, Presbyterian has initiated this proposal with valuable input from each of the four Centennial Care MCOs. This information is a compilation of recommendations for enhancements to the current care coordination model under the Centennial Care contract with HSD, based on working knowledge of our respective populations and trends and almost 3 years of experience in the program. The proposed enhancements will be used to inform the 1115 Waiver Renewal Subcommittee to the Medicaid Advisory Committee.

### **Principles:**

- **Increase care coordination at the point of service by providers.** By engaging in further development with HSD and our provider network, delegation of care coordination can occur as part of value-based purchasing and partnerships.
- **Access to and improved use of real-time data** analytics, predictive modeling, and real-time data exchange will better inform member stratification and the need for effective care coordination leveling with increased reliance on key indicators.
- **Focus on member impactability specific to actionable clinical and social needs and outcomes.** Indicators such as risk scores for readmission, probability of episodes, readiness to change, and other predictors are used to identify clinical situations and profiles where care coordination can impact care, cost and health outcomes. And, an individualized care plan that is the focal point of care coordination activities rather than care coordination activities driving interactions with members without relevance or connection to a member's needs.
- **Care coordination effectiveness.** Dynamic actions are decided on by a member and care coordinator as a partnership which are synchronized and connected directly to a well thought-out care plan and drive meaningful and lasting positive change in health outcomes and quality of life.

### **Opportunities**

Opportunities exist to build upon the great work that has been done thus far in Centennial Care. More specifically, there is further enhancement the MCOs have identified to care coordination that can occur to advance the state's focus on bending the cost curve and improving the quality and outcomes of those we serve.

Care coordination is evolving nationally as systems gain experience and make various adjustments to first generation models. The opportunities for improvement listed below were developed based on a combination of experience from nearly three years of care coordination operations under Centennial Care, and by reviewing features of effective or evidence-based models and approaches from other parts of the country.

### **Learning More from Other Approaches**

**Denver Health** — Using funding from the Centers for Medicare and Medicaid Innovation, Denver Health (DH) implemented a “population health” approach to delivery of primary care in

its integrated, safety net health system. The approach includes predictive modeling in combination with front-line clinical judgment to achieve a clinically actionable, risk stratification of patients. Recognizing that not all high cost situations can be impacted, the resulting tiers were designed to identify “avoidable utilization”, particularly avoidably hospitalizations, and not just high utilization in general. The algorithms were refined over approximately four years, and the resulting tiers were used to direct varying levels of care coordination and service delivery methods to impact both the quality and cost of care. DH used chart reviews to identify algorithm elements to differentiate utilization patterns that are insensitive to change and to augment risk scores with data known to the provider but unlikely to impact the automated score. During the course of the project, DH transitioned from a financially oriented risk-adjustment tool used to adjust capitated Medicaid payments to a predictive modeling tool with diagnostic groupings — Clinical Risk Groups (CRGs) from 3M. Using CRG, DH attempted to predict which patients are likely to experience outlier utilization before it occurs and use care coordination and direct clinical care interventions to impact that path favorably for care and costs. The DH model with the CRG tool is being considered by several states with 1115 waivers as part of their DSRIP initiatives to better target care coordination resources and clinical service delivery models to impact utilization. The model may be applicable for New Mexico in combination with other initiatives that are in place or planned, including patient centered medical homes (PCMHs), Section 2703 health homes, Community Behavioral Healthcare Clinics and provider delegated care coordination models.

**Note:** Contract language would need to be adjusted to reflect the methodology used to identify care coordination levels targeted toward cases where it may be possible to impact utilization prospectively.

**North Carolina** — Although an 1115 waiver application has been submitted to CMS to implement managed care, North Carolina plans to build on the gains from its existing care management and coordination models. The current system uses an array of approaches including primary care case management, PCMHs, and targeted care management and care coordination models. Clinical “buckets” using the same CRG software used by Denver Health, to analyze claims, demographic, chronic conditions, medications, treatments, duration, intensity and other factors are used to identify beneficiaries’ risk and generate an “impactability” score. Based on the results, intensive care management is directed to beneficiaries that will likely benefit, such as targeted groups once hospitalized and cohorts that have above expected costs for their expected clinical group. The system also employs real-time notification of hospital admission, discharge and transfer, supporting rapid deployment of care management resources to reduce readmissions. There are distinct care management programs for children, pharmacy, behavioral health and pregnancy, and the nature and intensity of the care management interventions vary by population.

**Summaries of Models from Other States** — Two documents from 2013 — one from the Center for Healthcare Strategies and an Informational Bulletin from CMS — offer summaries of “super-utilizer” programs from across the country, including models from Minnesota, Washington, Oregon, Michigan, New Jersey, North Carolina, Maine, Vermont, New York and San Francisco. The descriptions show a wide array of models, and all require an up-front

investment in analytics to support a data-driven process. The data infrastructure included web-based provider portals with patient data; real-time utilization data with ED visits, inpatient admissions and key clinical information; and decision support tools to identify and prioritize high risk individuals. Structures for care management or coordination included centralized resources from the state or Medicaid MCOs, organizations designed to support a network of primary care practices, community-based interdisciplinary care teams, and short-term interventions by super-utilizer or ambulatory ICU clinics. There are a number of Medicaid financing strategies through Section 2703 health homes, case management, PMPM payments to Medicaid MCOs, and per-episode of care payments for program services. When services are provider-based, reimbursements range from fee for service and per-episode payments to PMPM or risk-sharing. One of the barriers for implementation at the provider level is the start-up period when the tools and team must be built prior to reaching full capacity for reimbursement purposes.

### **Enhancements to Our Existing Model**

The following are specific ideas which may improve the focus and return on the significant care coordination resources currently utilized in Centennial Care.

**Emergency Department Information Exchange (EDIE)** — HSD is currently working with the MCOs to implement EDIE in New Mexico to allow providers and MCO care coordinators to access real-time information about ED visits. This coupled with ED-focused rapid response care coordination teams could significantly impact ED utilization and recidivism. Once implemented, the MCO's can put processes into place to work with these members on identifying gaps and solutions prior to the crisis that results in the need for unnecessary ED visits.

**Next Generation of Data Analytics** — HSD and the MCOs can work collaboratively to refine analytics from the first two and half years of Centennial Care data in the manner described by Denver Health and other models to better target individuals whose utilization is most likely to be impacted by care coordination. 3M has worked with some states to do a no-cost initial run on state/MCO data using the CRG system which helps to determine the potential impact of using the approach. A collaborative approach could be used to develop consistent criteria for more targeted care coordination, and provide potential metrics for HSD to monitor how the MCOs are identifying individuals for care coordination, and to compare outcomes across MCOs.

**Reporting** — Move toward reporting of outcomes versus transactional activities. For example, Report #6 collects data that measures completion rates for activities specific to the HRAs, CNAs and CCPs. Opportunity exists to capture both short and long-term or longitudinal data relevant to stabilization of conditions (physical, behavioral, and social), improved quality of life, cost of care, increased social connectedness, etc.

**Brief Intervention Teams** — These teams would be targeted for follow-up with members after ED visits or hospitalizations for up to 30 days to assure rapid interventions to link to community resources and reduce risk of readmissions or additional ED visits. Criteria would be developed to determine whether the member should be integrated into on-going care coordination or simply monitored through routine analytics. The goal is to target resources to this high-risk period, and reduce the need for on-going care coordination for individuals who return to

functional baseline or are otherwise stable. Determining appropriate staffing levels for specialized care coordination teams and “routine” care coordination will be an operational challenge that may require the ability to flex individuals and/or care coordinators, particularly during the early months of implementation. It will be essential to design this model so that care coordinators can contact members while they are in the ED or within 24 hours after discharge.

**Child Teams** — Children and adolescents at risk of out-of-home placement and those already placed, constitute substantial current costs and set the stage for long term costs as they transition to adult services. Most of these young members are involved with multiple, complex systems including schools, juvenile justice, and CYFD. Care coordination is further complicated for these members due to the typically chaotic family situations and long history of traumas. Dedicated child teams could ensure care coordinators who are expert in multi-systems supports and needs, ensure a trauma informed approach, and could be specifically trained for family engagement.

**Care Coordination by Providers** — Members tend to trust their providers and providers often have the most frequent contact with members. Care coordination could be enhanced by developing a feasible process whereby qualified providers can assume responsibility for all or a portion of care coordination activities. Delegation of care coordination should include a process to qualify or credential providers to assure the competencies to complete required activities, and MCOs should be responsible for monitoring provider compliance with contracted care coordination responsibilities. HSD policies, payment and reporting mechanisms will need to be developed and aligned to assure feasibility and accountability.

**Note:** The current MCO contractual timelines and reporting requirements cannot simply be passed to providers since the risk of sanctions and the corresponding financial impact are likely a barrier for providers to assume care coordination responsibilities. A delegated care coordination model should incorporate specific provider responsibilities, MCO and HSD monitoring, and appropriately scoped sanctions and incentives for performance at or above contractual requirements.

**Considerations:**

- Use more efficient resources than the CBSQ tool –can use pamphlets, quick reference guides or other methods to offer information (CBSQ takes at least 45 minutes each). Consider using technology, such as YouTube videos, to explain CBS.
- Leverage video visits or skype as an alternative to in-person visits to support more efficiency in scheduling and care coordination resource management. This would also support better matching of members with care coordinators who possess expertise in specific conditions, regardless of where the care coordinator is based.
- Allow for additional time to assess Native Americans, Members with TBIs/SMI, or other conditions that make it difficult to complete the comprehensive needs assessment process.
- Limit in-home assessment mandate to those members who are being evaluated for HCBS service eligibility.
- Identify improved ways to further develop our member-centric care coordination by segmenting members based on clinical needs, condition severity, and availability of natural supports. Care coordination intensity, including frequency of assessment and contacts

should be driven by clinical determinations and care planning—not just diagnosis. Some members score the same based on diagnosis, but because they have more natural supports or better provider support they don't have the same need for MCO care coordination intensity. Delineate chronic/stable members from acute care members and tailor their needs as they are different. Consider a 'treat first' model that allows a member of the care coordination team to connect with members quickly, to ascertain immediate needs, and allow CCL2 and CCL3 members to participate in optional telephonic assessment and updating of care plan. Also, there are other abbreviated tools that can be quick to complete related to risk for readmission and other indicators or predictors which can be leveraged rather than utilizing a robust tool like the current CNA for all changes in conditions or periodic reassessment.

- Support a member's choice when it comes to care coordination instead of persisting when members refuse. Use data to group members based on the ability to impact health and the severity of needs. Allow process to be fluid and allow for members to move through the tiers of care coordination more readily. Not once a level 3 always a level 3 for example.
- Require members receiving LTC benefits to remain engaged in CC as a condition of receiving services. Currently some members participate in care coordination until services are approved then they disengage until time to renew authorizations.
- Better define needs for waiver members. Just because members are on a waiver doesn't mean they need a specific level of care coordination. Many have long term stability and supports and should thus not automatically require a high level of care coordination.
- Care coordination outcomes should be measured based on completion of care plan goals rather than against completion of required tasks.

### **Recommendations:**

Consider using a model such as that developed by Denver Health, employing Clinical Risk Groups and associated tiering, to include impactability measures. Such impactability measures could include a combination of risk scoring and amenability to intervention, with the latter taking avoidable (versus unavoidable) costs, readiness to change, and actionability (ability to implement care plans – to include level of social support, degree of stability, provider engagement and barriers) into account.

Develop process and outcome measures to substitute for task-related activities. The continuum of care includes chronic care (palliative) and end of life (hospice) care. This is an opportunity to empower Members to self-manage and to have increased satisfaction with their quality of life, at all stages of the life cycle. Additionally, the measure of success for episodic case management, care coordination, as well as population health includes a focus on outcomes, including cost of care, and utilization of best practices and standards of care for specific populations, e.g., pre-diabetes, morbid obesity. Examples include the percent of members in level 3 care coordination who received an ICPT meeting, percent of members who report having adequate or higher level of knowledge related to self-care or of their condition and decrease in readmissions or in ambulatory sensitive admissions.



## **New Mexico Children, Youth and Families Department (CYFD) – Monique Jacobson**

- Recommendation for enhanced care coordination as a part of transitions for:
  - Children/youth transitioning in/out of all levels of out-of-home behavioral health placements, to include inpatient, residential treatment centers, group homes, treatment foster care, transitional living services, etc.
  - Youth experiencing behavioral health needs exiting JJS secure facilities, county detention centers, and shelter care.
  - Parents of children/youth in CYFD custody and/or JJS involvement transitioning from jail release, inpatient stays, etc.
  - Parents of children/youth entering/exiting CYFD custody and/or JJS involved experiencing behavioral health needs.
  
- Incentives for outcomes of a successful discharge:
  - Attend follow up PCP visit (7-, 30 day follow-up from inpatient).
  - No unnecessary ED visit post discharge for 30 days.
  - No preventable readmission post discharge for 30 days.
  - Filling medications.
  - Completing medication reconciliation.
  - Board certified child and adolescent psychiatrist preferred for children and youth, who follow best practices for pharmacological intervention with traumatized and/or substance using children and adolescents.
  - Children/youth transition to recommended level of care (in lieu of discharge to precarious placement such as CYFD office, shelter, lower level of care than recommended).
  - Children/youth transition with an identified team. Team may include the parent/guardian, youth, CYFD worker, CCSS worker, psychiatrist, school, behavioral health providers, natural supports, etc.
  - Child/youth and family team is actively involved in transition planning. Out-of-home placement provider joins child/youth and family team meetings to plan for discharge; possibly increase occurrence of child/youth and family team meetings during out-of-home placements.
  - Child/youth successfully transitions to the identified education plan.
  - Reduced incidents of repeat maltreatment related to behavioral health needs of child/youth and/or parent/guardian.

### **Focus On Higher Need Populations**

- Recommendations for higher need populations to be considered:
  - Children/youth involved with CYFD; to include children ages 0–5.
  - Parents of children/youth in or at-risk of CYFD custody and/or JJS involvement.
  - Youth involved in Juvenile Justice Services or identified as high-risk in need of diversion programs consisting of behavioral treatments and/or support services (Juvenile Community Corrections or Youth Support Services).
  - Transition age youth: Youth transitioning out of CYFD involvement (aging out of foster care or exiting Juvenile Justice Service secured facilities); transition-age youth transitioning from children’s behavioral health system to adult behavioral health system (youth ages 16-26).
  - CYFD-involved pregnant and parenting youth and their children.
  - Children/youth with identifiable developmental or intellectual disabilities.

- Recommendation for targeted education to youth/young adults as well as parents involved with CYFD to increase health literacy and decrease risk.
- Recommend use of the trauma-informed Child and Adolescent Needs and Strengths (CANS) tool, to include an ACE algorithm and ID/DD module.
- Recommend requirement of American Society of Addiction (ASAM) protocol for adults and adolescents to determine levels of care for substance use services. ASAM is a nationally recognized substance and co-occurring assessment protocol used to determine severity and level of care placement.

### **Provider's Role in Care Coordination**

- Increase availability and coordination of Respite supports to families statewide. Per CMS: Respite services are intended to assist children to live in their homes in the community by temporarily relieving the primary caregivers. Respite services provide safe and supportive environments on a short-term basis for children with mental health conditions when their families need relief. Respite services are provided either in the home or in approved out-of-home settings.
- CYFD involved children and youth with severe and complex behavioral health issues are a special population experiencing complex trauma. The current tiered model of care coordination has not successfully addressed these populations' needs. Outcomes are not met and costs are not contained, resulting in increased out-of-home placement, both in- and out-of-state.
  - Recommendation for implementation and expansion of CYFD's demonstration project "To Provide a Medicaid Behavioral Health Wraparound Model and Service Package for Fifty Eligible Children/Youth and Their Families in Bernalillo County under the High-Fidelity Wraparound Delivery and Financing Model". Part of the proposed benefit design derives from results obtained from the demonstrations conducted by US Department of Health and Human Services (DHHS) related to CMHI and PRTF.1 Per DHHS, 1 Joint SAMHSA and CMCS Bulletin, May 7, 2013 <http://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf>
    - "Demonstration programs offered an array of services to meet the multiple and changing needs of children and youth with behavioral health challenges and the needs of their families. While the core benefit package for children and youth with significant mental health conditions offered by these two programs included traditional services, such as individual therapy, family therapy, and medication management, the experience of the CMHI and the PRTF demonstration showed that including a number of other home and community-based services significantly enhanced the positive outcomes for children and youth. These services include intensive care coordination (often called wraparound service planning/facilitation), family and youth peer support services, intensive in-home services, respite care, mobile crisis response and stabilization, and flex funds."
  - The Wraparound Model and Service Package design of CYFD NM Wraparound CARES follows from the above and includes behavioral health services that are currently part of NM Medicaid as well as intensive care coordination (Wraparound), family peer support services (as currently being developed), and access to flex funds. The actual services provided as part of the Wraparound Model and Service Package would vary by youth/family in accordance with their needs, strengths, and plan. Services provided will be tracked by encounter data submitted by the provider to the MCO.

## **New Mexico Children, Youth and Families Department (CYFD) – Bryce Pittenger**

### **HIGH FIDELITY WRAPAROUND**

Children in New Mexico have been the topic of national attention in regard to the critical issues of poverty, obesity, substance abuse, child abuse and neglect, and teen pregnancy. According to a 2014 survey from the U.S. Census Bureau, the national average of children living in poverty was 22%; NM reported 28% with some counties as high as 43%. The national average of teen birth rates for 2015 was 24%; the NM statewide average was 34.2% with two counties as high as 73%. Poverty is associated with parental stress, inadequate early care and education, and family or community violence. Experiencing or witnessing violence and abuse increases a child's risk of experiencing social, emotional, and behavioral health problems. Adverse Childhood Experiences are directly related to overall health and wellbeing throughout the lifespan.

The World Health Organization (WHO) defines social determinants of health as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Mental health is shaped to a great extent by the social, economic, and physical environments in which people live.

“Children are most vulnerable to these conditions. Delivery systems for children deserve focused attention because of the differences between children and adults. These differences include higher rates of ethnic diversity, higher poverty rates, greater disparities in care, continuous physical, social-emotional and cognitive development, dependence on adults, and other different needs, conditions, and services.”  
(Medicaid.gov)

The U.S. Department of Health and Human Services established care coordination as a priority and is dedicating resources to this effort, including grant funding, policy guidance, and technical assistance. Care coordination is used to describe a range of activities that link people to services and increase their wellbeing while decreasing symptomology. The treatment of children and provision of care coordination is almost always conducted in the context of the family. Care coordination focuses on connecting a child to services while assisting the family in providing for the child's care (Medicaid.gov). Intended outcomes includes reducing duplication of effort, easing transitions, and limiting gaps between service providers.

Children involved with the NM Children, Youth and Families Department (CYFD) have more Adverse Childhood Experiences, higher rates of Serious Emotional Disturbance (SED), and lower rates of achieving social determinants of mental health than non-CYFD involved children in NM. It is imperative that children have people in their lives who care about them, not just for them, as it is the engaged and caring relationship of a non-exploitative adult that builds resiliency in children. Intensive care coordination, such as high fidelity Wraparound, is required for this special population within the CYFD system to build lives worth living that contribute to society. Multiple systems, multiple plans, and lack of social capital become barriers to this

success. High fidelity Wraparound brings together all key stakeholders to create a plan that builds upon strengths and underlying needs and uses adult relationships and behavioral health services to meet the family's goals.

The 1115 Waiver grants states the authority to design and test delivery systems and benefit plans that improve care, increase efficiency, and reduce costs for specialized populations of Medicaid covered children. New Mexico is designing and developing care management entities that provide a full array of services to children experiencing SED, including intensive care coordination utilizing a high fidelity Wraparound approach, peer-to-peer supports, and other services. The intent of these efforts is to achieve better outcomes for these children and their families at less cost than other institutional and more restrictive approaches.

The importance in designing, developing, and implementing this type of demonstration project is that children experiencing SED represent the costliest segment of the Medicaid population of children. While comprising of only 10% of the Medicaid population, children experiencing SED consume 38% of all Medicaid expenditures for children. A significant reason for this high cost is due to the high rates of inpatient psychiatric care and residential treatment placement.

In May 2013, CMS and SAMHSA issued a federal bulletin on behavioral health services. The bulletin sought to help states design innovative delivery systems and comprehensive benefit plans that stress the importance and inclusion of intensive care coordination and wraparound approaches. That joint bulletin suggested that states utilize a variety of federal Medicaid waivers including the 1115 to design these services.

Wraparound is an approach and process of service planning that utilizes a dedicated, full-time care coordinator who works with a small number of children and their families. Those ratios are different than adult models using case managers because of the more frequent, weekly contact required for children, the need for crisis response, and other cross-system needs of children. Intensive care coordination approaches are often called "high fidelity" Wraparound and typical ratios do not exceed 1:8 to 1:10 care coordinators to families. Such approaches are associated with achieving the best outcomes for children based on studies (nine by the National Wraparound Initiative-NWI) and experiences of nationally recognized programs like Wraparound Milwaukee.

While adult case management models have per client costs of \$50 to \$80 per month, programs utilizing care coordination for children tend to range from \$780 to \$1300 per child per month. These models employ the use of high fidelity, intensive care coordination.

The Center for Health Care Strategies (CHCS) developed scans of states and communities nationwide that have developed Care Management Entities (CME) and use intensive care coordination. The scans were done in 2010 and 2012 and the following summarizes the care coordination ratios and monthly rates approved through 1915a, 1915b, 1915c and 1115 waivers:

1. Louisiana - Statewide CMEs developed by the Department of Children under 1915c and b use a 1:10 care coordinator to family ratio and the care coordination monthly rate is \$1035;
2. Massachusetts - Statewide targeted case management through Medicaid state plan amendment uses a 1:10 ratio and an estimated care coordination rate of \$1200 per month;
3. Michigan - Department of Community Mental Health under 1915c uses a 1:10 ratio and an estimated care coordination rate of \$824 to \$1248 per month;
4. Nebraska - Department of Mental Health and Human Services uses a 1:10 ratio and an estimated care coordination rate of \$840.70 per month;
5. New Jersey - System of Care has a 1115 waiver and uses a 1:10 ratio with a case rate for care coordination and training of \$1034 per month;
6. Cuyahoga County (Cleveland) - Tapestry CME uses a 1:12 ratio and an estimated care coordination rate of \$686.70 per month;
7. Dane County (Wisconsin) - CME called Children Come First uses a 1:10 ratio and an estimated care coordination rate of \$800 per month; and
8. Wraparound Milwaukee - Wraparound Milwaukee is a CME providing a variety of mental health services and supports to Medicaid covered children and uses a 1:8 ratio and an estimated care coordination rate of \$850.00 per month.

All of the above programs and many others nationwide have reported positive outcomes and reduced cost for children experiencing SED served utilizing a high fidelity Wraparound approach:

1. Indiana CHOICES, a CME that has served children experiencing SED for over fifteen years, has demonstrated a reduction in risk behaviors for juvenile offenders' reevaluation tools such as the Child and Adolescent Needs and Strengths (CANS) tool. The rate of out-of-home placement for CHOICES is 1.77 versus 2.64 for the non-CME children served by the Indiana Department of Child Services (DCS). The reduced Length of Stay (LOS) for children admitted to residential treatment centers served by CHOICES is 222 days versus the DCS' 585 days. The lower cost per child for a child served in Indiana CHOICES is \$126.94 versus \$293.21 per day for non-CME children served by the DCS.
2. The Maryland CHOICES care management model, which has a \$970.00 care coordination rate but an overall per month per child rate of \$3650 for all mental health services it provides, served as an alternative to residential treatment under a PRTF Medicaid demonstration project. It achieved an annual cost of \$32,987 for children diverted from residential treatment center (RTC) placement versus \$153,417 for children placed in RTC.
3. The Ohio CHOICES program, which has a \$3365 monthly rate (\$850 for care coordination costs) has significantly reduced RTC placements by 40%, and 68% of youth experienced a significant reduction in juvenile justice contacts.
4. New Jersey's statewide CME models in twelve regions of the state experienced a reported \$30 million savings in Medicaid expenditures over a three-year period related to a reduction in acute psychiatric hospitalization of children and a 50% reduction in

residential treatment. Almost all of the 375 children in out-of-state residential treatment placements returned to community-based care in New Jersey since 2008.

5. Wraparound Milwaukee, a CME serving children experiencing SED and their families, was recognized by the President's Mental Health Commission and by Harvard University as the Best Innovation in American Government. Operating as a special managed care entity by Medicaid, it has reduced the number of youth in residential treatment centers from nearly 400 on a daily average to about 100. It has also reduced length of stay for children in RTC from nearly fourteen months to only 120 days. Psychiatric hospitalization of children represents only 3.5% of all expenditures for behavioral health care for the 1240 youth enrolled daily in this CME, or about \$80.00 per month per enrolled child (which is slightly under one day per year per enrolled child). The average cost per child per month for children in Wraparound Milwaukee is \$3400 over the past six years versus over \$10,000 per month for children placed in a RTC. The number of inpatient hospital beds has also decreased for children in the Milwaukee area by one-half.

Most of these projects have reported increases in school attendance, decreases in juvenile re-offending, and higher rates of child permanency. The joint bulletin issued by CMS and SAMHSA states "that implementation of care coordination and other home-based services for this (SED) population have made significant improvement in the quality of life for these children, youth and families". The report notes the following outcomes across these programs:

1. Reduced costs of care for community-based care versus residential treatment (25% on average less in one of these CME community-based care models);
2. Improved school attendance and performance (44% of children improved their school attendance and 41% their grades);
3. Increased behavioral and emotional strengths (33% of children improved in this capacity);
4. Improved clinical and functional outcomes (40% improved; used tools such as the CBCL and CANS);
5. Reduced suicide attempts (within six months of service, the number of youth reporting thoughts of suicide decreased by 51% and suicide attempts decreased by 64%); and
6. Decreased contacts with law enforcement (nearly 50% reduction across programs providing community care and Wraparound services).

CYFD proposes that New Mexico can continue to demonstrate the CME model using high fidelity Wraparound care coordination, family peer supports, and enhanced Medicaid benefit design to meet the needs of children experiencing serious emotional and mental health needs and their families. CYFD also proposes that new financing models for children's mental health may be tested such as:

1. Pooled or "braided" funding across child serving systems such as child welfare, juvenile justice or education so that Medicaid funding can be joined with other funds to cover non-Medicaid services essential to meeting the needs of these children and their families;

2. Redirection and reinvestment of savings from reduced need for institutional placement for children such as residential treatment and psychiatric hospitalization to be used to fund the development of community-based services for them;
3. Development of mobile crisis response and stabilization services to be funded through Medicaid and/or pooled funding to divert children from unnecessary institutional care; and
4. Creation of provider networks where comprehensive mental health services and supports are centralized with aspects of “pay-for-performance” or specific outcome measures established.

Thank you for the opportunity to represent the behavioral health needs of the children, youth, and families involved with CYFD.

## **New Mexico Medical Society – Rick Madden**

Re: Kaiser Health News article 11/22/2016 Clinics Help Keep People with Serious Mental Illness Out of ER by Liz Szabo

### **Rationale**

Because Emergency Departments encounter so many people with serious mental illnesses, and because helping these people with appropriate care in the behavioral health world is so hard to come by, a rapid access “transitional clinic” after the ED visit provides a timely stepping stone to a longer term care setting. This would help keep people out of the ED because they have received appropriate care.

The model in San Antonio, TX referenced in this article uses behavioral health professionals who provide appropriate care and link the patient to a long term professional for their future care as one becomes available. The transitional clinic does provide follow up apparently until that transfer is made. This saves the patients lots of trouble and saves the hospital lots of resources. The return to ED rate for these patients went down from 10% to 2.5% over three months of follow up.

One caveat that came up at the end of the article: there aren't enough psychiatrists to go around for the seriously mentally ill, and that is in part because they aren't paid enough by Medicare-Medicaid and private insurances. Payment increases would help.

Kaiser Health News article: Clinics Help Keep People with Serious Mental Illness Out of ER.



## **New Mexico Alliance for School-Based Health Care (NMASBHC) — Mary Kay Pera**

Care coordination is fundamental to Centennial Care’s success and is designed to ensure that members obtain the services they need. Each Centennial Care member receives a health risk assessment (HRA) to assess his/her needs, determine the level of care coordination needed, and develop a care plan. This process is applied to all Centennial Care members, including adolescent members. It is thought that adolescents and young adults are generally healthy, but several critical health and social problems either peak or start during these years, and when addressed early can promote health and prevent tragic outcomes. Adolescents who come to a school-based health center (SBHC) also receive a health risk screen, called the Student Health Questionnaire (SHQ), to identify their risks for physical and behavioral health problems and evaluate their potential for resiliency. SBHCs and the Centennial Care managed care organization (MCO) care coordinators each seek to identify and treat unmet needs and, thus, are ideal partners in reaching and treating adolescents.

In practice, however, there are obstacles to provision of care coordination for youth, particularly minor adolescents. For example, an adolescent’s Centennial Care HRA may likely be done by his/her parent on the phone, and there is limited ability for the student to complete the assessment confidentially. As a result, health risks can be missed, as was illustrated in the risk screenings of students using New Mexico SBHCs:<sup>1</sup>

- 32% felt down, depressed, irritable, hopeless (female 38%/male 22%).
- 12% thought, planned, or attempted suicide (female 15%/male 7%).
- 48% were having sex, while only 64% of those were using condoms.
- 14% were physically, sexually, or emotionally abused (female 19%/male 7%).

Secondly, student surveys show that youth trust their SBHC providers more than other providers and are more likely to share their thoughts and concerns with the SBHC provider. In this regard, there is lack of clarity about what a SBHC provider who has identified a student at risk and in need of confidential services can share with the MCO care coordinator and vice versa.

SBHCs’ role in Care Coordination: NMASBHC’s Recommended Opportunities for Improvement:

- SBHC providers can be on site members of the students’ care coordination teams:
  - The SBHC provider team, with appropriate reimbursement, could assist MCOs in finding “unreachable” members who could then receive care in the SBHC.
  - The SBHC provider could make the initial risk level assignment of a Centennial Care student member, in collaboration with the Centennial Care MCO care coordinator, using the comprehensive risk and resiliency-screening instrument called the Student Health Questionnaire (SHQ). Through information from the SHQ, along with the medical history taken by the SBHC provider, a student’s health needs could be identified and a level of risk could be assigned.
  - The SBHC provider could complete the more comprehensive needs assessment, in collaboration with the Centennial Care MCO care coordinator, for a student member with complex needs and at higher risk, e.g., those who are medically complex or fragile, have high ER use, have a high risk mental health diagnosis or are seriously and persistently

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<sup>1</sup> New Mexico School-Based Health Centers Status Report 2015

mentally ill, are homeless (SBHCs may be the only way to reach homeless youth); or pregnant.

- The SBHC provider and staff, based on the assessment, could then participate with the student, family and the MCO care coordinator in development and implementation of the student's care plan (unless the care being provided is confidential, in which case the family would not be involved).
- SBHC providers and staff have extensive experience in coordinating physical and behavioral health services within their clinics and with community resources.
- SBHC providers and staff are strategically positioned to partner with the MCO care coordinators in working with students who have certain chronic conditions, such as asthma, diabetes, obesity and depression.
- SBHCs are strategically positioned to partner with the MCO care coordinators in working with pregnant and parenting teens.

### **Other NMASBHC Recommendations**

- Specify an age requirement, e.g., X age and above, (matching State minor confidentiality laws), to permit a student Centennial Care member to complete the assessment him/herself.
- Make the HRA available to adolescents online.
- Provide guidance to SBHC providers and the MCOs as to the circumstances under which information regarding minor adolescents can be shared, given HIPAA laws and state laws and regulations.
- Include key data in the new MMIS replacement to assist SBHC providers in serving children and youth, such as the date of the last EPSDT exam and date of the last visit with the PCP; this information would help immensely to assess needs, coordinate care, and prevent duplication.

### **Conclusion**

SBHC providers and staff are uniquely qualified and positioned to be on site members of Centennial Care adolescent members' care coordination teams, as outlined in the aforementioned recommendations. NMASBHC respectfully requests full consideration of these recommendations and welcomes the opportunity to work with the NM Human Services Department Medical Assistance Division toward this end.

## **New Mexico Association of Counties – Lauren Reichelt**

The two populations served most frequently and effectively by counties are also the two populations most likely to drive up the cost of medical care through frequent visits to the ED. These are seniors and individuals suffering from untreated substance use and other behavioral disorders.

Counties invest significant funding in senior centers, which are underutilized and which could be used for outreach campaigns and preventive activities.

County jails serve as cyclical warehouses for persons suffering from substance use disorders, untreated learning disabilities and behavioral health disorders.

The following is a list of recommendations to better incorporate senior centers and jails into the health care system.

- Permit Medicaid administrative claiming for counties and correctional institutions and their contractors for services such as Medicaid application assistance, case management, vivitrol or other MAT and treatment groups in a jail setting.
- Permit pre-release planning to be funded by Medicaid including Narcan/Naloxone distribution and other medications.
- Allow jails and correctional institutions to act as PE determiners (done).
- Grant individuals leaving medical institutions access to long-term services and supports including case management, residential and outpatient care.
- Allow preventive activities such as immunizations, medication management, Alzheimer's support, and other services to be provided and billed at senior centers.
- Improve DOH facility licensing process enabling counties to provide services such as adult day care and preventive senior care.
- Fix Medicaid provider application process to make it more applicable to counties and local government.
- Streamline provider application process so only one full application is necessary per provider.
- Create a single provider portal so there are not four separate billing processes.
- Better oversight and tracking of Comprehensive Needs Assessments required of MCOs to insure timeliness of assessment.

## Rio Arriba Health County — Lauren Reichelt

As per your request, I am writing up the recommendations I made at the November 1115 waiver subcommittee for improvement of utilization of care coordination/case management services by clients and their families:

- Allow reimbursement for incentives such as Walmart cards to be given out to clients upon achievement of key goals. Cards need to be tracked and accounted for meticulously, but they are useful both in incenting clients and for evaluation purposes.
- Allow agencies other than CSAs to bill for intensive case management.
- Reimburse for transport of clients to agencies providing intensive case management. It is useful to have them transport to and participate in appointments, intakes, etc., as their advocacy role is an essential part of access. It is not unusual at all for clients to be turned away without an advocate present to help get same day TB tests, medical clearances or to otherwise meet requirements. Families are often unable to do this.
- Provide PCS style payment for family members, especially in the case of ambulatory detox, but also for assistance making appointments or other care.
- Case management ratios for ICM services for substance abuse and SMI should not be any higher than 1:30 or in some cases, 1:15.
- Reimburse ICM services based on achievement of outcomes, utilizing the Pathways methodology.

## **New Mexico Association for Home and Hospice Care — Joie Glenn**

I would like to address my comments referring to guiding principles. I think when we began our journey for the original 1115 waiver, MAD did presentations based on guiding principles and expected outcomes.

Care coordination was a core component of the original waiver application and was described within the guiding principles as a comprehensive service that stakeholders should expect to see the most significant change within the Medicaid program under Centennial Care. Therefore, translating to right care, right time, right place, right provider for services and with all that better outcomes. I believe all stakeholders supported this and set their expectations high.

With those principles as goals for a comprehensive coordination of care, I would offer these suggestions:

- Please honor existing community services that are already in place such as home care and hospice agencies coordinating services for their clients. That infrastructure existed before Centennial Care and I believe the MCOs would have partnered with the agencies if they had been given the option. I believe Centennial Care missed an opportunity to enhance already existing services. Most of the MCOs already had a working relationship with home care and hospice agencies because of other lines of business.
- Please acknowledge that home health skilled services have been underutilized in Centennial Care. Unfortunately, they were underutilized before Centennial Care and implementing a comprehensive program such as Centennial Care did not improve that metric.
- Please acknowledge that existing proven programs such a Program All-Inclusive for the Elderly (PACE) should have been an option in Centennial Care. There are many beneficiaries that could and would have benefitted from the intensive care management of such a program. The frailest population within Centennial Care are entitled to all of the services that PACE participants receive, yet PACE has not been an option. Lessons learned from Medicaid expansion has shown that the expansion population was more frail and sicker than predicted. Certainly there are many that would have benefitted from these wrap around services within the PACE model. Again not everyone needs this kind of intensive care management, but many do and changing behaviors needs time, attention and professional services.
- Skilled home health agencies concentrate on chronic disease management and work hard to have all participants functioning at their highest level. Population health is all about prevention, education, health literacy and appropriate services. Skilled home care agencies work with individuals using evidence based tools and programs to assist with assessments, education, health literacy and coaching to better outcomes. These services exist and should be utilized to address the challenges of the journey to population health.

## **Indian Health Services (IHS) — Sandra Winfrey**

I have the following comments to submit thus far into the process:

- Any changes to Centennial Care should be discussed with the tribes at a formal State/Tribal Consultation
- The state should implement a payment mechanism to facilitate and support the care coordination that the tribes are currently providing through their community health representative (CHR) programs for tribal patients. Neither the MCOs nor the State are reimbursing the tribes for significant care coordination services that are occurring through the tribal CHR programs.
- The state should require the MCOs to comply with the patient assessment requirements of their Centennial Care contracts and pay the tribes adequately if they are involved in assisting the MCOs in accomplishing those requirements.

## **New Mexico Department of Health – Dawn Hunter From Turquoise Lodge**

- Contact from care coordinators varies across the MCOs, but most are consistent and prompt. Have consistent standards around communication, and provide education on the different types or levels of “coordinator.” If there is a way to standardize this to some degree across the MCOs and to reduce process variance, it would be beneficial.
- Care coordinators are a valuable resource for helping connect clients to resources in their own communities and on-going care.
- Clients appear to appreciate the additional resource and generally are open to meeting with them (care coordinators) while here.
- More clients are beginning to come in already familiar with their care coordinators.

### Other NMDOH Feedback on Care Coordination and initial info provided regarding Population Health

- While the Committee has spoken extensively about transitions of care from hospitals, other setting should be considered as well, such as from behavioral health or crisis centers. Behavioral health consumers are a high risk or higher needs population.
- Unstable housing is an important concept to address when focusing on higher needs populations. When addressing housing, particularly as a population health issue, it may be useful to clarify that housing should be “stable and appropriate.”
- Exploring the integration and use of peer navigators is an important part of care coordination, particularly if focused on specific needs (like chronic disease, behavioral health, substance use and misuse, etc.).
- Increased emphasis on monitoring for established benchmark quality indicators, including mortality rates, increased assistance in activities of daily living, etc.
- Telemedicine could be an effective adjunct for this program. Clients could be professionally assessed and visits scheduled based on clinical need.
- NMDOH has programs that are an extension of the care coordinators the MCOs employ:
  - Children’s Medical Services – provides care coordination by social workers throughout the state to children with special healthcare needs.
  - Families First – provides care coordination and home visiting for Medicaid high risk pregnant women and children from 0-3.

## New Mexico Hospital Association – Beth Landon

These cover three of the seven requested topic areas: Care Coordination, Expansion of VBP, and BH/PH Integration.

1. **Hospital Quality Improvement Incentive (HQII) Program** – see Appendix A
2. **Managed Care Organization Consistency and Uniformity** – see attached Prior Authorization and Utilization Management Reform Principles
3. **Safety Net Care Pool Program (SNCP)** – Jeff Dye to submit separately
4. **Transformation of Care**
  - a. Refine care coordination – NMHA is currently developing a rural hospital pilot to test delegated care coordination with interested small hospitals, using CHWs funded by interested MCOs and trained/evaluated by UNM. Based on the hospital experience and the evaluation (which will assess topics such as cost savings and HEDIS measure improvements), HSD would collaboratively determine how to **implement delegated care coordination with other rural hospital providers in the 1115 renewal**.
  - b. Expand value based purchasing – Select, small/frontier NMHA members are interested in testing a new payment and delivery model that employs a global budget. Currently, WA State’s SIM grant includes funding for a rural hospital demonstration and Pennsylvania recently received a CMMI grant to test global budgets with rural facilities. If planning and infrastructure resources could be identified in the near term, **testing of the rural, global budget model could occur during the next waiver period. Hospitals are interested in starting with Medicaid and quickly expanding to Medicare**; conversations with CMS for a CMMI-funded multi-state collaborative are underway.
  - c. Continue efforts for BH and PH integration – Many NMHA members seek integrated BH and PH in their emergency departments; NMHA has secured proposals from vendors out-of-state as well as UNM Hospital. Unfortunately, the cost of tele-behavioral health is prohibitively high. NMHA is researching current Medicaid expenditures for psychiatric evaluations in EDs to understand state spending. **A subsidy or creative collaboration that improves the coordination of services and patient outcomes**, without increasing Medicaid spending, would be mutually beneficial.



## Appendix A. Hospital Quality Improvement Incentive (HQII)

### Background

This document was developed at the invitation of the New Mexico Human Services Department. Its purpose is to present Key Learnings and Recommendations for waiver renewal to the HQII program. We believe there may be continuing issues related to the HQII program, and appreciate the ability to continue to work with HSD for renewal analysis.

Implementation of the Centennial Care HQII (STC 83) includes ten Domain 1 and eight (now seven) Domain 2 quality measures. Waiver language required that, by April 14, 2014, identification of: 1) High performance levels and 2) Minimum performance levels for each outcome measure, to be used to help hospitals help set targets for improvement. Further, allocation and payment methodology, due April 2014 was to be based on standard target setting, monitoring, oversight of milestone achievement, calculation and assessment, and any additional requirement needed to evaluate the demonstration and make HQII payments.

All 29 Safety Net Care Pool Hospitals (SNCP) reported their historical, 2014 data at the end of CY2015 (DY-2) and their 2015 data at the end of CY2016 (DY-3); this enabled them to remain eligible for the program and receive their payments. However, SNCP hospitals did not have technical specifications for five of the thirteen measures until May 2016. The five measures (ADE, CAUTI, CLABSI, SSI, and VAE-formerly VAP) were self-reported from hospitals based on available, collected data; the other thirteen are extracted from Hospital Inpatient Discharge Data (HIDD) by the NM Dept. of Health. The first full year for which hospitals will be able to collect data in alignment with the technical specifications is 2017, which they will then submit in 2018 (DY-5). This significantly complicates the allocation methodology for DY-3 and DY-4.

### Key Learnings

#### 1. DATA CONSISTENCY CHALLENGES.

HSD released technical specifications in May 2016. The first full year during which data may be consistent is CY-17, available in HIDD and self-report by October 2018.

#### 2. DATA INTEGRITY CHALLENGES.

Staffing resources are insufficient for successful program implementation. A tight timeline exists between clean HIDD data from NM Dept of Health in October, and hospital data validation before the end of the calendar year. At this time, no dedicated staff mine the data; instead, HIDD staff in the NM Dept. of Health run analyses amidst an existing workload. Given the changes in ICD-9 to ICD-10 in October 2015, the myriad national definition changes (for example CAUTI and VAE from NHSN and AHRQ Patient Safety Indicator definitions and exclusion changes), changes in Dept. of Health software to collect accurate HIDD data, it is a challenge to secure clean analyses in a timely fashion.

#### 3. MEDICAID ADJUSTED DAYS

Cost report data are insufficient to calculate “adjusted” Medicaid days which incorporate any outpatient volume. Using only “as filed” Medicaid days results in a heavy allocation to the University Hospital. The inclusion of outpatient volume would create a more balanced resource allocation.

#### 4. DOMAIN 2 MEASURES

Measures of population-focused prevention are unsuitable due to limited resources in the HQII fund pool to make a difference. Domain 2 measures likely work well in states with considerably

larger resource pools, enabling hospitals to focus on health outside the hospital walls. In the first year of the HQII distribution (CY2015), more than half of the SNCP hospitals received under \$60,000. This is barely enough to support the creation of systems to collect Domain 1 measures, and certainly not enough to invest in new staff and programs focused on community health. Given the limited pool of resources, the funding should focus on hospital quality improvement.

## 5. ORGANIZED DECISION MAKING

There is a lack of organized decision-making for HQII. Currently, one knowledgeable individual leads program management and makes recommendations to the Bureau Chief and others. Decision-making appears compromised due to lack of coordinated communication across content experts. Essentially, no “brain trust” exists for program implementation and management.

### Recommendations for Program Improvement

#### Standard Terms & Conditions (STC) Waiver language

- I. **Problem:** Manual data collection is problematic for hospitals, and resource-intensive. The only Domain I measure requiring manual data collection in the initial 1115 waiver is Adverse Drug Events (ADE). All other Domain 1 measures may be pulled from the Hospital Inpatient Discharge Dataset (HIDD) or National Healthcare Safety Network (NHSN).

**Recommendation I:** Adverse Drug Events (ADE) should be excluded from the HQII program as it must be collected and tracked manually, which is a resource-intensive process.

- II. **83(d) (iv) (p. 51)** *The state must review achievement of HQII milestones before making HQII payments and must share HQII reporting results on its state website. Hospitals’ reports must contain sufficient data and documentation to allow the state and CMS to determine if the hospital has fully met the specified metric, and hospitals must have available for review by the state or CMS, upon request, all supporting data and back-up documentation.*

**Recommendation II:** Reporting on the state website should name hospitals and measures they are eligible to submit. Given the complexity of information and the high likelihood of misinterpretation, actual numbers should not be provided. Qualitative summaries may be considered for public view.

- III. **Attachment H (p. 106)** *“Initial Calculation Formula” - The volume of Medicaid patients will be based on Medicaid “adjusted patient days” (APDs) and each hospital will be allocated a portion of APM#2 based on their percentage of the total APDs.*

**Problem:** Adjusted patient days – as used in hospital finance terminology – is an adjustment to allow a measure of gross revenue as a ratio to patient care. This includes inpatient revenue as well as outpatient revenue. In the first year of the HQII program, HSD allocated funds by patient days without inclusion of hospital outpatient revenue.

**Recommendation III:** Include outpatient experience in future calculations of adjusted patient days.

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### Additional Recommendations from Key Learnings

- IV. Dedicated Data & Clinical Support: NMHA recommends two content experts be specifically resourced for HQII program support. The first person would be approximately 0.4 FTE focusing during the second half of the calendar year in preparing for and conducting analyses of HIDD data. Ideally, the person would be a state employee with demonstrated HIDD analytics experience. The work would include but not be limited to: updating and testing data queries for changes in federal technical specifications, modifying data queries according to software changes (when necessary), responding to hospital queries for aberrant or confusing data, and supporting HSD staff in program implementation. This person would participate in the HQII brain trust. The second person would be approximately 0.1 FTE focused on problem-solving related to Domain 1 measures. Ideally, the person would be a state employee with demonstrated clinical quality experience. This person would participate in the HQII brain trust. *NMHA supports some use of HQII pool dollars to support this capacity.*
- V. Omit Domain 2 Measures: NMHA recommends elimination of Domain 2 Measures for the next waiver period. Domain 2 focuses on population health; while we respect the importance of this topic, it extends far beyond the scope of HQII funding to hospitals. Instead, hospitals should focus within their walls on meaningful clinical quality improvement. Investments in population health require considerably more dedicated staffing and program capacity than is available in the program.
- VI. Organize a “brain trust” to manage the program: NMHA recommends creation of a group to guide and support HSD staff in program implementation. The chair would report directly to HSD top leadership and provide recommendations as appropriate. This structure would enable more timely and organized thinking and decision-making. Membership would include but not be limited to: Victoria Stratton, a member of the DOH HIDD team, a member of the MAD Quality Bureau, Bureau Chief for the Financial Management Bureau, NMHA, and up to three hospital Chief Quality Officers. It bears mention that without this structure, the current approach is untenable; NMHA staff invested staff resources easily seven times the value of the HSD contract for program implementation in the first two years. Much of that effort, as well as the HSD staff investment, would have been avoided with more structured communication across content experts.

We also provide recommendations on two topics not as relevant to the larger audience and not on your agenda: SNCP's Hospital Quality Improvement Incentive (HQII) program and Medicaid Managed Care Organization consistency and uniformity. The attached .pdf provides the Prior Authorization Reform Principles for this latter issue.



PA Reform Principles  
(003).pdf

# LONG-TERM SERVICES AND SUPPORTS

## **Rio Arriba Health and Human Services Department – Submitted by Lauren Reichelt**

As requested, I am including my recommendations for changes to the 1115 waiver to streamline services for the elderly.

Counties possess significant resources for the purposes of providing services to senior citizens. These resources might be able to be used more effectively through collaboration with HSD, but this can only occur if barriers to that collaboration are removed. Please consider the following suggestions, some of which may require changes to the waiver, and some of which can be enacted administratively through departments.

1. There are no Medicaid supported Adult Day Care facilities north of Santa Fe. Counties have staff and facilities that could be used to supply this service, but they must first get facilities licensed through DHI. The licensing requirements for an ADC seem to be based in the assumption that clients are non-ambulatory. For example, buildings require sprinkler systems, which most counties can't afford. Also, the staff at DHI make it difficult for people who are not engineers or architects to understand requirements. The facility licensing process should be easier to navigate.
2. Counties are capable of supplying PCS services but the codes and allowable billing do not always match administrative requirements. There are two designations for PCS services: delegated and agency directed. The higher unit-billing rate is for delegated care, but agencies are required to conduct monthly home visits without a commensurate administrative fee, which is especially difficult in rural counties where distances are significant. Under directed care, agencies are only responsible for quarterly home visits, requiring less in the way of staffing, but *do* receive an administrative fee, which seems backwards. There is an administrative billing rate for directed care even though staffing requirements are fewer. So in short, it is more expensive to provide delegated care and billing rates are lower. The greater number of home visits required for delegated should be reimbursed especially for large rural and frontier counties. It is difficult for clients to switch designations. This is even more problematic now that billing rates, but not staff costs, have decreased. HSD has also closed the opportunity for spouses to be caregivers. This is difficult in remote rural communities where the spouse may be the only available caregiver.
3. Since the state switched to EVV, the system slows down several times per week making it necessary to repeatedly upload the same claims. Sometimes it can take over a day to upload them. This requires a great deal of staff time.
4. There are many unexplained exceptions that can only be corrected through the help desk, wasting both agency staff time and staff time at First Data. MCOs often enter incorrect authorization dates causing an exception because it appears as if the agency has gone past the authorization date. This can only be cleared up by working with both First Data and the MCO, wasting the time of staff of three agencies.
5. EVV is not intuitive and it takes a great deal of staff time to correct exceptions on claims over 30 days.

6. ADC reimbursement rates are too low to be operable in rural areas, which is why none exist. The rate needs to cover the cost of actually billing Medicaid (See items 2-4). There is a big differential between the Area Agency on Aging rate for ADC and the Medicaid rate, with Medicaid being much lower. ADC must be staffed at a rate of 1:5, which is almost impossible, and in rural areas where transport needs to be included, is impossible.
7. Authorization for ADC services is in two-hour increments. In a rural area it is important that all clients of an ADC be authorized for the same time period, preferably a full day, because no transportation is available other than the agency, and rates will not support an all day taxi service, making trips back and forth for a single client.
8. State procurement code, or the manner in which DFA is interpreting state procurement code, creates a barrier to counties providing services through Medicaid. Medicaid operates through reimbursement, meaning that if a county expands a service by adding caregivers and clients, (or in the case of ADC, staff) the next wave of reimbursements will not cover the actual cost of services. Since there is no profit center for a county, there are frequently shortfalls (at least on paper). Reimbursement is further slowed because the board of county commissioners must first approve the budget increase (which, depending on the county can take two weeks to a month) and then it must be sent to DFA for approval (an additional five days), before reimbursements can be included in the budget. Furthermore, most counties operate on a cash, rather than an accrual basis, causing the fund supporting Medicaid services to appear to be in deficit. DFA does not allow a fund to appear in the red. HSD might want to consider putting together a work session with counties and DFA to find ways to make it feasible for counties to provide Medicaid-supported ADC at senior centers.
9. Rates of immunizations for seniors increased dramatically in Rio Arriba County after the county partnered with DOH, Española Hospital and local clinics to hold immunization fairs at senior centers. Medication management clinics held at senior centers have been similarly effective. If some of the obstacles listed above are resolved, HSD could conduct a pilot project providing basic preventive care at senior centers through collaborations between counties, state agencies and community based providers.

## **Aging and Long-Term Services Department (ALTSD) – Submitted by Secretary Miles Copeland**

Beyond the feedback I've offered verbally, I wanted to be sure I made explicit the need for the 1115 waiver renewal to continue the activities allowable under HSD's current GSA with the Aging and Long-Term Services Department.

ALTSD's role includes educating Medicaid recipients on community based (CB) services, as well as risks involved when a member declines certain benefits. ALTSD's Aging and Disability Resource Center (ADRC) and Care Transition Bureau (CTB) play important roles in care coordination and connection to long-term services and supports. For the past three years, the ADRC and CTB have provided Medicaid beneficiaries with information about the long-term services and supports (institutional, residential and community based) available to them through Centennial Care. ALTSD staff provide assistance in navigating and accessing healthcare services and supports. ALTSD staff serve as advocates and assist individuals in linking to both long-term and short-term services and resources within the Medicaid system and community resources. These staff also ensure that services identified as needed are provided by the MCO, MCO subcontractors or other community provider agencies. The main purpose is to help consumers identify and understand their needs and assist them in making informed decisions about appropriate long-term services and support choices in the context of their personal needs, preferences, values and individual circumstances.

If any further detail would be helpful, please contact our Consumer and Elder Rights Division Director Carlos Moya, included here.



# POPULATION HEALTH

## New Mexico Children, Youth and Families Department (CYFD) – Monique Jacobson

- Recommendation to target the following populations:
  - Parents of children/youth involved with CYFD (Protective Services, Juvenile Justice, Early Childhood, and Behavioral Health).
  - Homeless/precariously housed children/youth involved in CYFD Protective Services and Juvenile Justice Services or identified as high-risk in need of diversion programs consisting of behavioral treatments and/or support services (Juvenile Community Corrections or Youth Support Services).
  - Transition age youth: Youth transitioning out of CYFD involvement (aging out of foster care or exiting Juvenile Justice Service secured facilities); transition-age youth transitioning from children’s behavioral health system to adult behavioral health system (youth ages 16-26).
- Recommend use of the trauma-informed Child and Adolescent Needs and Strengths (CANS) tool, to include an ACE algorithm and ID/DD module.
- Recommend ongoing statewide dissemination of information regarding the CYFD *PullTogether* (PullTogether.org) campaign for support in finding help, locating resources, and offering assistance to others.
- **Non-Medicaid Services:** The following services, currently NOT available as part of the Medicaid array as fee-for-service, are recommended as services to support children, youth and their families:
  - **Infant Mental Health Services:** Infant/Early Childhood Mental Health (IECMH) Treatment Services target the relationship between the child and the parent (or primary caregiver). They are grounded in attachment theory and the science of brain development; they are relationship-based, developmentally appropriate, and trauma-informed IECMH treatment services are an array of therapeutic and developmental services designed to reduce both the acute and chronic behavioral, social and emotional disorders and disruptions in the relationship between a child and parent (or primary caregiver), that are some of the most significant results of toxic stress and major trauma. CYFD has developed Service Definitions for Infant Mental Health. Core service components include:
    - Provide Parent Infant Psychotherapy/Child Parent Psychotherapy in order to alleviate and remediate behavioral health issues interfering with healthy parent infant relationships.
    - Services target infants and young children (birth to three) who have been comprehensively assessed by a licensed clinician and diagnosed with a Severe Emotional Disturbance (SED). Children who are admitted for service before age 3 (36 months) remain eligible to receive services up to age 4 (48 months).
    - Services target young children (three to five, 60 months of age) who have been comprehensively assessed by a licensed clinician and diagnosed with a Severe Emotional Disturbance (SED). Children who are admitted for service before age five remain eligible to receive services up to age six (72 months).
  - Intensive Care Coordination (Wraparound) — Per CMS: The wraparound approach is a form of intensive care coordination for children with significant mental health conditions. It is a team-based, collaborative process for developing and implementing individualized care plans for children and youth with complex needs and their families. This approach focuses on all life domains and includes clinical interventions and formal and informal

supports. The wraparound “facilitator” is the intensive care coordinator who organizes, convenes, and coordinates this process. The wraparound approach is done by a child and family team for each youth that includes the child, family members, involved providers, and key members of the child’s formal and informal support network, including members from the child serving agencies. The child and family team develops, implements, and monitors the service plan.

- **Family Peer Support Specialists** — These Specialists engage and maximize the participation of parents and legal guardians in wraparound and other service delivery processes. This is a strengths-based approach that promotes family voice and choice and strives to build partnerships between families, providers, and other key stakeholders. This approach utilizes caregivers who have “lived-experience” in raising a child who has experienced emotional, behavioral, mental health and/or substance use challenges. Specialists assist parents and legal guardians in identifying community and natural resources; enlisting advocates to participate on child and family teams; navigating complex child-serving systems; developing effective coping and problem-solving skills; and understanding the complexities and diagnoses and service interventions.
- **Youth Support Services** — YSS provides specific and usable *Life Skills* that include an array of activities, resources, relationships, and opportunities for services designed to assist an individual’s integration into the community. Participation in youth support services must be appropriate to need, and is intended to foster a satisfactory life in the community. Life Skills are not treatment oriented and are not strictly remedial in nature, but are focused on experiential education regarding normal functions and abilities that aid navigating complex social systems with some degree of comfort.
- **Supportive Housing** — Increase availability statewide of Supportive Housing for CYFD involved transition-age youth and parents of children/youth in or at-risk of CYFD PS custody and/or JJS involvement.
- **Intensive In-Home Services** — Recommend inclusion of Functional Family Therapy (FFT) and additional variations of Multi-Systemic Therapy (MST), prioritizing MST Child Abuse, Child Neglect (CAN) Evidence-Based Program (EBP).

**New Mexico Department of Health (DOH) – Dawn Hunter**

Opportunities exist to focus more on upstream prevention through evidence based models or programs. This could include the National Diabetes Prevention Program, My Chronic Disease Self-Management, obesity prevention, and tobacco cessation initiatives. These interventions can lower costs through reduced ER visits and hospital admissions.

## **Child and Adolescent Subcommittee of the New Mexico Behavioral Health Planning Council – Michael J. Ruble, JD, Co-Chair, CASC**

### **Proposal for Youth Peer to Peer Supports**

#### **Youth Peer-to-Peer Support Network Development Project (P2P)**

The NM Child and Adolescent Subcommittee (CASC) of the Behavioral Health Planning Council is embarking on a collaborative project (Project) involving the NM Children, Youth and Family Department – Behavioral Health Services (BHS) and the NM Human Services Department – Behavioral Health Services Division (BHSD). The Project’s primary purpose is to develop a cadre of certified youth peer specialist workers (CYPSW) in New Mexico, who will support youth and young adults who are transitioning from the children’s system of behavioral health services to the adult system of behavioral health services – which includes youth aging out of the care of the Healthy Transitions – New Mexico grant initiative, the Juvenile Justice Services system, and the Child Protective Services system. The Project would also encompass youth who are being discharged from the Department of Corrections, or released from a mental health facility or short/intermediate term substance use treatment facility. It would also include a family peer-to-peer element, to assist families whose youth or young adult is transitioning into the adult system of care.

Currently, in New Mexico, there is a certification process for adults with “lived experience” to provide peer supports to adults in navigating their system of care. Much of the infrastructure is already in place to be able to modify the adult peer-to-peer network to meet the needs of youth, young adults and their families. There are three key elements that, if in place, would support the foundation for the Project. These three key elements are the ones the CASC is asking the Medicaid Advisory Committee to consider in its renewal application for the Medicaid demonstration waiver for Centennial Care. They are as follows:

- a. Expand the definition of peer-to-peer supports to include youth serving youth and a family member who already has a youth in the service system serving families with youth and young adults *about* to enter into the system;
- b. Develop a similar structure for billing/reimbursement as is currently used to reimburse member agencies employing CPSW s for the proposed expansion of the definition above; and
- c. Allow for reimbursement of certified youth peer specialist worker and certified family peer specialist worker providing peer-to-peer transitional services in the community.

#### **Rationale for the Request:**

- As is being demonstrated by the Healthy Transitions grant initiative, youth will relate and respond much better to other youth with “lived experience” than they do to adults, or someone who has academic credentials only.
- Youth who will continue to need behavioral/mental/substance use services after leaving any type of system in New Mexico, tend to “fall through the cracks” because they return to their community without guidance, support, and practical advice from a parent, caregiver, case manager, or someone whose role is to provide the critical “safety net”

until the person builds confidence on their own or is given a “warm hand-off” to an CPSW (adult) after a reasonable length of time.

- Incentivizing a youth’s “lived experience” by offering them the opportunity to earn a certification, which leads to possible employment is one mechanism for providing a solution to increasing the capacity of New Mexico’s workforce in the area of social work, or other types of behavioral health care services.
- The Project is an innovation, which may lead to systemic changes, and fosters a new, sensible approach to delivering behavioral health services to youth and young people by making these services more youth-friendly, youth-driven, and youth-implemented.

# BEHAVIORAL HEALTH — PHYSICAL HEALTH INTEGRATION

## **New Mexico Alliance for School-Based Health Care (NMASBHC) – Submitted by Mary Kay Pera**

New Mexico School-Based Health Centers (SBHCs) are the essence of an Integrated Practice Model, Level 6, as defined in the Milbank Memorial Fund Report.<sup>2</sup> For over 15 years, New Mexico SBHC physical and behavioral health providers have been providing care together – under one roof – to students right on their school campuses. It is a model that is working and should not only be preserved but expanded in the next phase of Centennial Care.

It is a model whereby SBHC providers identify physical and behavioral needs as well as substance abuse issues of children and youth they serve, and ensure a linkage to treatment and improved health outcomes.

Consider the following: In health risk screenings of NM students using a SBHC in 2015, it was found that:

- 32% felt down, depressed, irritable, hopeless (female 38%/male 22%);
- 12% thought, planned, or attempted suicide (female 15%/male 7%);
- 48% were having sex, while only 64% of those were using condoms, and 72% use any method to prevent pregnancy;
- 19% used tobacco, 23% drank alcohol, 22% used marijuana;
- 14% carried a weapon for protection (female 10%/male 18%); and
- 14% were physically, sexually, or emotionally abused (female 19%/male 7%).<sup>3</sup>

Many NM students face serious health and social challenges, best met by a coordinated, integrated approach on the part of their providers at a time when early intervention is the key to a successful health outcome. Working together, NM SBHC physical and behavioral health providers:

- assess and identify needs;
- coordinate services;
- provide an immediate “warm hand-off” to the “other” provider when needed, making appointments that are more likely to be kept as a result;
- share decision-making;
- provide physical and behavioral health services; and
- share the responsibility for improved health outcomes.

### **Other Considerations**

Student surveys show that youth trust their SBHC providers more than other providers and are more likely to share their thoughts and concerns with the SBHC provider. In this regard, there is lack of clarity about what a SBHC provider who has identified a student at risk and in need of confidential services can share with the managed care organization (MCO) care coordinator and

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<sup>2</sup> Collins C, Hewson DL, Munger R, Wade T. Evolving Models of Behavioral Health Integration in Primary Care. New York, NY: Milbank Memorial Fund; 2010.

<sup>3</sup> New Mexico School-Based Health Centers Status Report 2015



vice versa. Thus it is recommended that the NM Human Services Department/Medical Assistance Division provide guidance to SBHC providers and the MCOs as to the circumstances under which information regarding minor adolescents can be shared, given HIPAA laws and state laws and regulations.

In addition, physical and behavioral health provider teams are not reimbursed for the time they spend planning for and managing the care of co-morbid conditions. Financial incentives, such as a bundled payment, should be considered for managing all aspects of the student's health needs.

### **Conclusion**

One recent story demonstrates how SBHC provider integration works so well. This involved a 12 year old boy who came to the SBHC with his father for a sports physical. During the sports physical, the provider determined the child had been having respiratory issues. During follow-up visits, they diagnosed him with allergies and asthma and provided him with rescue medications in case of an asthma exacerbation. Also, with utilization of the NM Department of Health-mandated student health questionnaire, it was determined that he was experiencing many psychosocial stressors. He started therapy with their behavioral health provider, and they also set him up with the dentist at their clinic. Starting with a simple sports physical, they were able to give this child physical, dental and behavioral health care, and he has reportedly been doing very well.

In summary, the NM SBHC integration model is working and should not only be preserved but expanded in the next phase of Centennial Care. NMASBHC respectfully requests full consideration of these recommendations and welcomes the opportunity to work with the NM Human Services Department Medical Assistance Division toward this end.

# ELIGIBILITY AND BENEFIT ALIGNMENT

## Indian Health Service - Sandra Winfrey

- IHS would like the State to re-consider requesting a waiver of the three-month retroactive eligibility period. This retroactive period is vital to Native Americans. Native Americans are not subject to all of the mandatory insurance requirements of the ACA and without the retroactive period, they could be penalized for not adhering to a law that does not cover them. This could result in additional costs at federal and tribal service units for PRC eligible Native Americans, or significant debts and collection issues for Native Americans that are not eligible for PRC. The issues with removing the retroactive eligibility period was discussed extensively with the tribes and CMS during the Centennial Care implementation. The tribes were very vocal as to the necessity of retaining this Medicaid provision.
- The State's consideration of allowing cost-effective non-covered services as an alternative to opioids for pain management for patients enrolled in an MCO should also be considered as an alternative for Fee For Service Medicaid recipients. Approximately 70% of Native Americans are not enrolled in an MCO and would not benefit from this Opioid alternative. Acupuncture and chiropractic services should also be allowed for Native American patients that are not enrolled in an MCO.
- The State's consideration of possibly reducing the Dental and Vision benefits or using "riders" to cover these services should exempt Native Americans. The State receives 100% FMAP when these services are provided at an IHS federal or tribal facility and there is no cost to the state for these services. Dental and Vision services are vital to the Native communities and shouldn't be reduced, especially when there is no cost savings to the State from this proposed reduction.
- IHS continues to encourage the State to hold the planned tribal consultations on the above topics as well as the other anticipated changes that were discussed during the 1115 Waiver meetings.

## Presbyterian Health Plan – Mary Eden

When it comes to treating chronic pain, conventional treatments have been shown to have limited benefit in improving overall patient outcomes and to pose substantial risk when chronic opioid use is the chosen treatment modality. Complementary and Alternative Medicine therapies may offer additional options in the management of pain, although the scientific literature is limited by poor quality and inconsistent results, and results appear to differ across the types of pain experienced. Scientific literature shows that Cognitive Behavioral Therapy (CBT) may help in reducing certain types of pain and in improving quality of life<sup>1</sup>.

Although acupuncture has been used for thousands of years in China, its efficacy in treating chronic pain is not well established. The National Coverage Determination (NCD) for acupuncture<sup>2</sup> states, “Three units of the National Institutes of Health, the National Institute of General Medical Sciences, National Institute of Neurological Diseases and Stroke, and Fogarty International Center have been designed to assess and identify specific opportunities and needs for research attending the use of acupuncture for surgical anesthesia and relief of chronic pain. Until the pending scientific assessment of the technique has been completed and its efficacy has been established, Medicare reimbursement for acupuncture, as an anesthetic or as an analgesic or for other therapeutic purposes, may not be made. Accordingly, acupuncture is not considered reasonable and necessary within the meaning of §1862(a)(1) of the Act..” Furthermore, Hayes, Inc.<sup>3</sup> rates acupuncture for treatment of the variety of pain conditions (arthritis and fibromyalgia, neck and shoulder pain, low back pain, headache, and as an adjunct to traditional post-operative medications) as “C” – “potential but unproven benefit; some published evidence suggests that safety and impact on health outcomes are at least comparable to standard treatment/testing, however, substantial uncertainty remains about safety and /or impact on health outcomes because of poor-quality studies, sparse data, conflicting study results, and/or other concerns.”

Still, there is some evidence that wrist-ankle acupuncture may be effective<sup>4,5</sup>, although poor methodology and small sample size of clinical trials limit the validity of current literature to support WAA. A 2010 review<sup>6</sup> revealed that acupuncture for chronic nonspecific low back pain was associated with significantly lower pain intensity than placebo but only immediately after treatment. However, acupuncture was not different from placebo in post-treatment disability, pain medication intake, or global improvement in chronic nonspecific low back pain. Acupuncture did not differ from sham-acupuncture in reducing chronic non-specific neck pain immediately after treatment.

A very recent systematic review<sup>7</sup> conducted in the UK and involving nearly 18,000 patients synthesized the evidence from high-quality trials of acupuncture for chronic pain, including neck and low back pain, osteoarthritis of the knee, and headache and migraine pain. The authors concluded, “We have provided the most robust evidence from high-quality trials on acupuncture for chronic pain. The synthesis... found that acupuncture was more effective than both usual care and sham acupuncture. Acupuncture is one of the more clinically effective physical therapies for osteoarthritis and is also cost-effective if only high-quality trials are analyzed.” In

summary, while still largely considered investigational, there appears to be emerging literature on the efficacy of acupuncture in treating pain.

In the 2010 review mentioned above, chiropractic manipulation showed some promise over no treatment in treating low back and neck pain. Comparison studies of chiropractic manipulation versus massage, medication, and physical therapy were inconsistent, as were studies on cost of such therapies. In that same study, massage was superior to placebo or no treatment in reducing pain amongst subjects with acute/sub-acute low back pain, but not chronic back pain or for neck pain, and it was noted that massage may be associated with greater cost than general care.

Finally, some studies reported patients experiencing soreness or bleeding on the site of application after acupuncture and worsening of pain after chiropractic manipulation or massage, and in two case-control studies cervical chiropractic manipulation was shown to be associated with vertebral artery dissection or vertebrobasilar vascular accident.

1. Williams, AC et al, *Psychological therapy for adults with longstanding distressing pain and disability*. *Cochrane Database of Systematic Reviews*, 2012(11), Article No CD007407

[http://www.cochrane.org/CD007407/SYMPT\\_psychological-therapy-adults-longstanding-distressing-pain-and-disability](http://www.cochrane.org/CD007407/SYMPT_psychological-therapy-adults-longstanding-distressing-pain-and-disability)

2. National Coverage Determination (NCD) for Acupuncture (30.3)

<https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx?bc=AgAAAAAAAAAA&>

3. Hayes, Inc.

<https://www.hayesinc.com/subscribers/subscriberHome.do>

4. Bi, HJ et al, *Wrist-ankle Acupuncture Increases Pain Thresholds in Healthy Adults*. *Altern Ther Health Med*. 2017 Jan;23(1):20-25.

<https://www.ncbi.nlm.nih.gov/pubmed/28160760>

5. Zhu, LB et al, *Wrist-ankle acupuncture for the treatment of pain symptoms: a systematic review and meta-analysis*. *Evid Based Complement Alternat Med*. 2014;2014:261709. doi: 10.1155/2014/261709. Epub 2014 Jul 15.

<https://www.ncbi.nlm.nih.gov/pubmed/25132858>

6. Furlan, AD et al, *Complementary and alternative therapies for back pain II*. *Evid Rep Technol Assess (Full Rep)*. 2010 Oct;(194):1-764.

<https://www.ncbi.nlm.nih.gov/pubmed/23126534>

7. MacPherson, H, et al, *Acupuncture for chronic pain and depression in primary care: a programme of research*. Southampton (UK): NIHR Journals Library; 2017 Jan.  
Programme Grants for Applied Research.

<https://www.ncbi.nlm.nih.gov/pubmed/28121095>

## **NM Coalition for Healthcare Value – Patricia Montoya**

Under overall recommendations moving forward: (I am not sure where this would go maybe just overall in recommendations moving forward?)

I would just encourage language some place in the document or recommendation (perhaps intro) acknowledging that this work is going on within a period of great uncertainty (State Budget implications for Medicaid as well as the uncertainty at the Federal level with a new Administration in transition, new leadership, different philosophy and not being clear on implications for the ACA, Health Insurance Exchange, and Medicaid in general).