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CENTENNIAL CARE NEXT PHASE

1115 Waiver Renewal Subcommittee
December 16, 2016

Agenda

Introductions	8:30 – 8:40
Feedback from November meeting	8:40 – 8:45
LTSS	8:45 – 10:15
Break	10:15 – 10:20
PH-BH Integration	10:20 – 11:20
Public comment	11:20 – 11:40
Wrap up	11:40 – 11:45

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Renewal Waiver
Areas of Focus

- Refine care coordination
- Address social determinants of health
- Opportunities to enhance long-term services and supports
- Continue efforts for BH and PH integration
- Expand value-based purchasing
- Provider adequacy
- Benefit alignment and member responsibility

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Long-Term Services and Supports (LTSS)

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LTSS
Overview

Under Centennial Care all members who meet the NF LOC have access to the community benefit

- Increase in the number of unique members who have access to the community benefit:
  - 24,013 users in CY2014
  - 27,836 users in CY2015
  - 27,593 users in 9 months of CY16
  - Community benefit is included in the expansion benefit package
- Average monthly cost of a nursing home is approximately 2.8 times as expensive as the average community benefit
- Recent analysis conducted by the LFC indicated that the overall occupancy rate at nursing facilities has been declining since 2011
- NM ranked in the 2nd best quartile overall in the 2014 national State Long Term Care Scorecard [1]

LTSS Population
Setting of Care Enrollment Mix
(Long Term Nursing Facility vs. Community)

Setting	Nursing Facility	Community Benefit
2011	18.7%	81.3%
2012	18.9%	81.1%
2013	17.3%	82.7%
2014	15.9%	84.1%
2015	14.3%	85.7%

[1] http://www.longtermscorecard.org/

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Community-Based Models for Care

Agency Based Community Benefit (ABCB)

- Community-based alternative to institutional care that maintains members in the home or community
- Member chooses consumer delegated or directed model for personal care services (PCS)

Self Directed Community Benefit (SDCB)

- Community-based alternative to institutional care that facilitates greater member choice, direction and control over covered services
- Member receives annual budget based on need.
- Member directs how to spend the annual budget on services.
- Member (or representative) is common-law employer of providers

Benefits and services vary based on model

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LTSS
Beginning the Discussion

Needs	Concepts	Further Discussion

➢ Streamline NF LOC renewals and improve assistance to individuals
➢ Improve comparability of service offerings between community benefit options and improve transition into SDCB
➢ Continue successes of rebalancing effort between institutionalization and community care
➢ Fiscal sustainability of nursing homes
	➢ Automatic NF LOC renewal for certain members
	➢ Align benefits for ABCB and SDCB
	➢ Establish levels for ABCB and SDCB budget ranges based on need that may include provisions for one time transition costs
	➢ Implement new cohort for members who use fewer PCS hours
	➢ Diversification of services provided by nursing homes
	➢ Explore provider fees / taxes:
	  ➢ Legislative process
	  ➢ CMS approval
	➢ NF LOC ADL change from 2 ADLs to 3 ADLs
	➢ Value-based purchasing arrangements with LTSS providers
		1. What other areas are important to streamline for members?
		2. What other enhancements should be considered for members to remain in the community?
		3. Nursing facility diversification

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Physical Health-Behavioral Health Integration

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BH/PH Integration
Key Terms

Intent of Integration

- "Integration of services through the expansion of patient centered medical homes and health homes with intensive care management provided at the point of service to help recipients manage their health and their use of the health care system."
- "What New Mexico now challenges its plans to do is manage care and deliver outcomes that can be measured in terms of a healthier population. In order to effectively drive the kind of system change New Mexico seeks, plans will have to think and behave differently and support the movement towards care integration and payment reform."

-from current 1115 Waiver

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BH/PH Integration
Models

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice

http://www.milbank.org/publications/evolving-models-of-behavioral-health-integration-evidence-update-2010-2015/

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PH-BH Integration

Opportunities/Goals

- More than mental illness and addiction
- Early onset; early death (>8 million each year)
- Medicaid = largest payer
- Provider and Plan Challenges:
  - Workforce
  - EHR capacity
  - Continuity of care gaps

Increase provider competency to serve members with co-morbid PH-BH conditions

Improve screening for BH conditions, including substance-use disorders

Leverage the emergency department information exchange to identify members who require linkage to mental health and substance abuse treatment

Improve information sharing challenges due to varied interpretations of privacy rules

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PH-BH Integration

Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Increase provider's competency and capacity to manage both physical and behavioral conditions ➢ Increase behavioral health screening across the continuum of care ➢ Remove barriers to sharing information between providers ➢ Value-based payment strategies for integrated care	➢ Provider education on PH-BH integration models and best practices ➢ 3 practice structures and 6 levels of collaboration ➢ Improve identification of behavioral health and substance use issues and linkage to treatment ➢ Substance abuse treatment availability ➢ Improve physical health conditions and reduce in morbidity and mortality ➢ Direct Care management: early assessment; treatment engagement; active follow-up; structured patient education; standardized psychotherapy ➢ Linkages to community resources and population health supports beyond health services	1. Are all three practice models present in New Mexico? What is working well? 2. How can we support provider's capacity to manage co-morbid conditions? 3. How can MCOs encourage patient engagement? Provider engagement? 4. Can MCOs work with local and regional leaders to create stronger forms of integrated care that affect health outcomes? 5. Should HSD identify screening tools that they recommend providers use? 6. What ways can HSD support better information sharing? 7. Can value-based payment models address provider and plan challenges? What models are better suited for integrated providers?

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PH-BH Integration

Ideas

- Increase the number of health homes to additional counties
- Submit an additional health home SPA or amendment to add substance use disorders as primary diagnoses
- Build capacity through additional tele-behavioral health clinical supervision and tele-psychiatry development
- Increase implementation of value-based purchasing or prospective payment methodologies
- Others?

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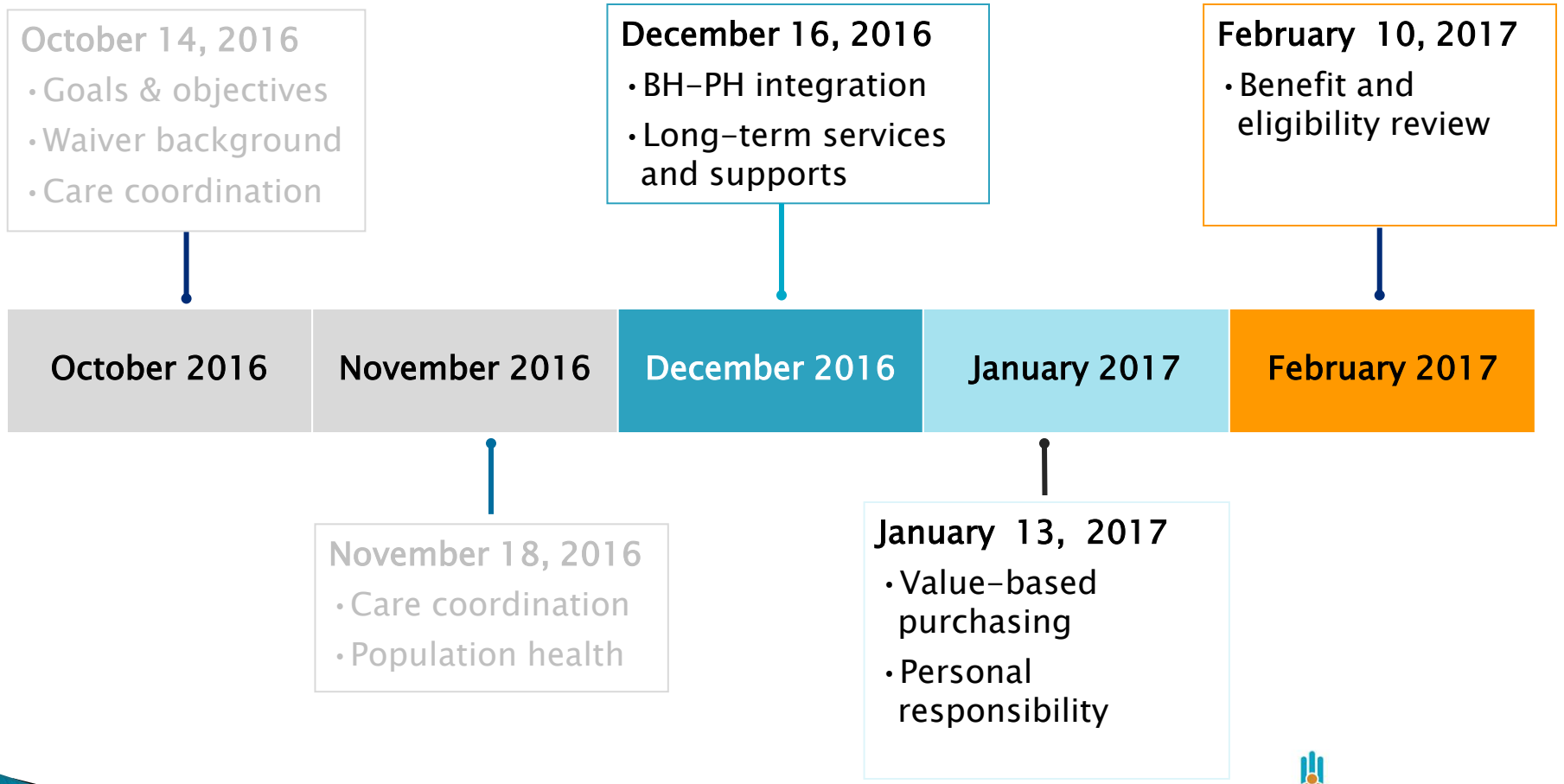
Subcommittee Meetings

Timeframe for Discussion



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