



HUMAN SERVICES
DEPARTMENT

Centennial Care 2.0
1115 Demonstration Waiver Renewal Application – Public Hearings
October 2017
Las Cruces, Las Vegas, Santa Fe, & Albuquerque

Formal Public Hearing

- The Department is accepting comments from the public about the Medicaid program known as Centennial Care and changes to the program being considered as part of the renewal of the Centennial Care federal 1115 waiver that will be effective on January 1, 2019.
- Comments will be accepted until **5:00 pm MST on Monday, November 6, 2017.**
- We are conducting four public hearings in different regions of the state:

Las Cruces – Thursday, October 12, 2017
Farm and Ranch Museum (1:30 pm – 3:30 pm)

Santa Fe – Monday, October 16, 2017
Medicaid Advisory Committee Meeting
NM State Library (1–4pm)

Las Vegas – Wednesday, October 18, 2017
Highlands University – Student Union Building/Student Center (1:30 pm – 3:30 pm)
Call (toll-free) 1-888-850-4523; participant code: 323 675#

Albuquerque – Monday, October 30, 2017
National Hispanic Cultural Center
Albuquerque, NM (5:30 pm – 7:30 pm)

Formal Public Hearing

- Comments are also being accepted directly at HSD-PublicComment@state.nm.us or by mail:

Human Services Department
ATTN: HSD Public Comments
PO Box 2348
Santa Fe, NM 87504-2348

More information about the waiver renewal and public comment process may be found on the Department's website:

<http://www.hsd.state.nm.us/centennial-care-2-0.aspx>

- The Public Hearing process is more formal than the statewide public input sessions conducted by the Department in June 2017 to obtain public feedback about the waiver renewal through release of a concept paper

Year-Long Public Input Process

Public Input Opportunities in the Development of Concept Paper (before May 2017)	Public Input Meetings about Draft Concept Paper (after May 2017)	Other Input Opportunities
<p><u>Medicaid Advisory Subcommittee:</u> October 14, 2016 – 29 attendees (Santa Fe) November 18, 2016 – 34 attendees (ABQ) December 16, 2016 – 62 attendees (Santa Fe) January 13, 2017 – 55 attendees (ABQ) February 10, 2017 – 50 attendees (Santa Fe)</p> <p><i>Public Comment at end of each meeting</i></p>	<p><u>Statewide Public Input Sessions & Attendees:</u></p> <p>Albuquerque – June 14, 2017 – 160 attendees Silver City – June 19, 2017 – 22 attendees Farmington – June 21, 2017 – 41 attendees Roswell – June 26, 2017 – 30 attendees</p>	<p><u>Written Comments:</u> May – July 2017 – 21 letters received</p>
<p><u>Native American Technical Advisory Committee:</u> December 5, 2016 – NATAC Membership (Santa Fe) January 20, 2017 – NATAC Membership (ABQ) February 10, 2017 – NATAC Membership (Santa Fe) April 10, 2017 – NATAC Membership (ABQ)</p>	<p><u>Formal Tribal Consultation</u> June 23, 2017 – 12 tribal officials/ reps & 85 attendees – Albuquerque</p> <p><u>Native American Technical Advisory Committee:</u> July 10, 2017 – NATAC Membership</p>	<p><u>HSD Email Address Established:</u> Ongoing from October 2016– July 2017</p> <p>137 emails received</p>
<p><u>MAC Meetings with Public Input:</u> November 2016 – 77 attendees (Santa Fe) April 2017 – 55 attendees (Santa Fe)</p>	<p><u>MAC Meetings with Public Input:</u> July 24, 2017 – (Santa Fe)</p>	<p><u>Public Hearings to be held in October 2017:</u></p> <ul style="list-style-type: none"> • Las Cruces • Las Vegas • Santa Fe • Albuquerque

Formal Public Hearing

- We appreciate your attendance today and look forward to your comments after the presentation
- Today's presentation is a summary of the proposed changes to the 1115 waiver that are outlined in the draft waiver renewal application that was released on September 5, 2017 (revised on October 6, 2017) and available to review on the HSD website
- As part of the formal hearing process, we will accept and record all of your comments but will not engage in a discussion about the comments today
- Our response to the comments will be documented in a section of the final 1115 waiver renewal application that is submitted to the Centers for Medicare and Medicaid Services in November 2017

Centennial Care 2.0 Waiver Renewal

Oct Nov Dec Jan Feb Mar Apr May June July August Sept Oct Nov Dec

Develop Concept Paper: MAC Subcommittee/NATAC

Concept Paper Release

Public Comment/Tribal

Develop Draft Waiver App

Release App Draft/RFP

Public Hearings/Tribal Consult

Submit App to CMS

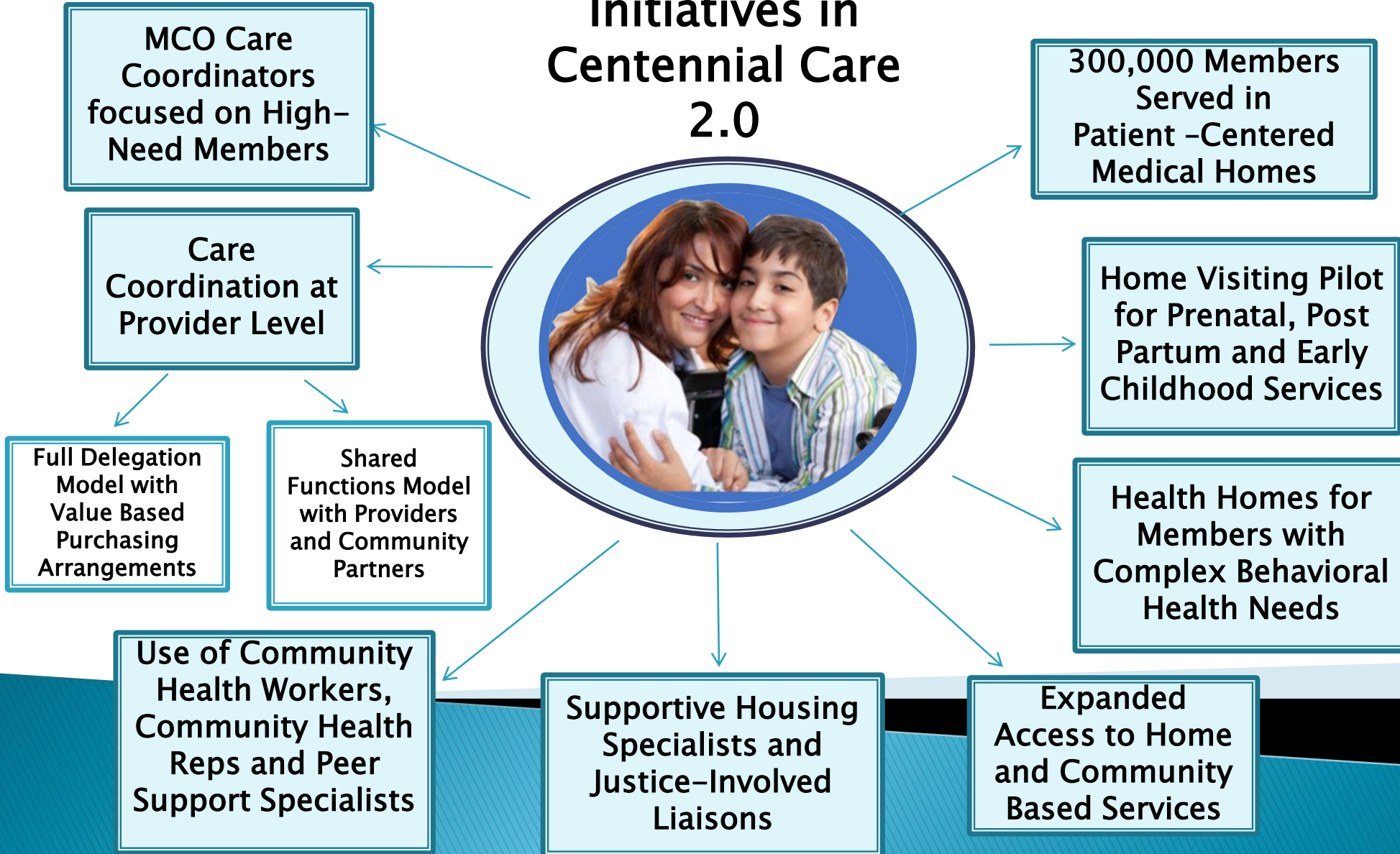


Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Benefit and delivery system modifications
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to eligibility

Person-Centered Initiatives in Centennial Care 2.0



Care Coordination

Proposals

- #1: Increase care coordination at the provider level
 - Full Delegation Model for providers entering into Value-Based Purchasing agreements to manage total cost of members' care and Shared Functions Model for providers and/or community partners conducting more limited care coordination activities

- #2: Improve transitions of care
 - More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

- #3: Expand programs working with high needs populations
 - First Responders, wellness centers, personal care agencies and Project ECHO (Extension for Community Health Outcomes) ;
 - Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists

Care Coordination

Proposals

- #4: Initiate care coordination for justice-involved prior to release from incarceration
- Allowing care coordination activities to be conducted by county/facility prior to release
 - Strengthening MCO contract requirements regarding after-hour transitions and requiring a dedicated staff person at each MCO to serve as a liaison with the facilities
- #5: Obtain 100% federal funding for Native American members for services received through Indian Health Services (IHS) and/or Tribal 638 facilities

Benefit and Delivery System Modifications

Proposals

#1: Cover most adults under one comprehensive benefit plan

- Consolidate two different adult benefit plans under a single comprehensive benefit package by redesigning the Alternative Benefit Plan (ABP) for adult expansion population to also cover the Parent/Caretaker adult population
- Individuals with higher needs who are determined to meet the “medically frail” criteria may receive the standard Medicaid benefit package and not the ABP
- Eliminate habilitative services from the ABP, but add a limited vision benefit similar to the standard Medicaid package vision benefit, expanding access for the 250,000 members currently enrolled
- Expand service providers for the non-emergent medical transportation benefit to include ride sharing companies and leverage new technologies such as mobile apps

#2: Waive federal EPSDT rule for 19–20 year olds enrolled in the single adult plan to further streamline the benefit package so that all adults receive the same comprehensive benefits

#3: Develop buy-in premiums for dental and vision services for adults (if necessary due to budgetary shortfall)

Benefit and Delivery System Modifications

Proposals

- #4: Allow for one-time, start-up funding for Community Benefit members who transition from the agency-based model to self-directed model -- up to \$2,000
- #5: Increase caregiver Community Benefit respite limit (from 100 hours to up to 300 hours annually) for caregivers of both adults and children
- #6: Continue expanded access to Community Benefit services for all eligible members who meet a Nursing Facility Level of Care (NF LOC) but establish annual limits on costs for certain home and community-based services:
 - Related Goods & Services – \$2,000 annual limit
 - Non-medical transportation – \$1,000 annual limit for carrier pass & mileage only
 - Specialized Therapies – \$2,000 annual limit

Benefit and Delivery System Modifications

Proposals

- #7: Pilot a home-visiting program focused on pre-natal, post-partum and early childhood development services
 - Collaborate with the Dept. of Health and Children, Youth & Families Dept. to implement a home visiting pilot in designated counties to provide Medicaid-reimbursable services to eligible pregnant women
- #8: Develop Peer-Delivered, Pre-Tenancy and Tenancy Supportive Housing Services
 - Create a supportive housing service that provides some peer-delivered tenancy support services to participants with complex behavioral health needs
- #9: Request waiver from limitations imposed on the use of Institutions of Mental Disease (IMD)
 - Request expenditure authority for members in both managed care and fee-for-service to receive inpatient services in an IMD so long as the cost is the same as, or more cost effective, than a setting that is not an IMD.

Benefit and Delivery System Modifications

Proposals

#10: Expand Health Homes (CareLink NM) for individuals with complex behavioral health needs who may require more intensive care coordination services

#11: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

#12: Request waiver authority for enhanced administrative funding to expand availability of Long Acting Reversible Contraception (LARC) for certain providers

- HSD has made access to LARC a high priority over past several years by unbundling LARC reimbursement from other services
- Requesting authority to receive increased administrative funding to expand availability by reimbursing DOH or other sponsoring agencies for the cost of purchasing and maintaining LARCs

Payment Reform

Proposals

#1: Pay for improved healthcare outcomes for members by requiring better quality and value from providers and increasing the percentage of provider payments that are risk-based (providers responsible for total cost of care)

- Expand requirements for MCOs to shift provider payments from fee-for-service that pays for volume of services to paying more for quality and improved member outcomes

#2: Use Value Based Purchasing to drive program goals, such as:

- Increasing care coordination at provider level, expanding the health home model, improving transitions of care, and improving provider shortage issues.
- Include nursing facilities in Value Based Purchasing arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff

Payment Reform

Proposals

#3: Advance Safety-Net Care Pool Initiatives

- Incrementally shift the funding ratio between the Uncompensated Care Pool and the Hospital Quality Improvement Incentive Pool so that more dollars are directed toward improved hospital quality initiatives
- Expand participation to all willing hospitals and allow other providers to participate, such as nursing facilities
- Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network

Member Engagement and Personal Responsibility

Proposals

- #1: Advance the Centennial Rewards Program that rewards members for completing healthy activities, such as obtaining preventive screenings
- #2: Implement premiums for populations with income that exceeds 100% of the Federal Poverty Level (FPL).
 - Applies to three categories of eligibility:
 - 1) Adults in the Expansion with income greater than 100%
 - 2) CHIP program (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
 - 3) Working Disabled Individuals (WDI) Category (income extends to 250% FPL)
 - Revised premium amounts to be lower in initial years (1% of household income) with flexibility to be higher in out-years (up to 2% of income)
 - Included a household rate
 - Annual maximum of 5% of household income

Proposed Premium Structure

Annual Household Income (Household of 1)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
\$12,060 – \$18,090	\$10	\$20	\$20	\$40
\$18,091 – \$24,120	\$15	\$30	\$30	\$60
\$24,121 – \$30,150	\$20	\$40	\$40	\$80
\$30,151 – \$36,180	\$25	\$50	\$50	\$100

Proposed Premium Policies

- ▶ The state seeks to develop premium enforcement policies based on its experience operating a premium-based program known as State Coverage Insurance
- ▶ Individuals in a category of eligibility that requires premiums must pay the monthly premium to maintain benefits
- ▶ Effective date of coverage is prospective—on the first day of the first month following receipt of the required premium
- ▶ Failure to pay the premium will result in a loss of benefits after a 90-day grace period
- ▶ Failure to pay will result in a 3 month lock out from the program
- ▶ Eligibility will be suspended rather than terminated
- ▶ Individuals may begin receiving services after the 3 month lock out upon receipt of required premiums

Member Engagement and Personal Responsibility

Proposals

#3: Require co-payments for certain populations

- Seeking to streamline copayments across populations
- HSD currently has copayment requirements for the Children's Health Insurance Program and for Working Disabled Individuals
- Add copayments for the adult expansion population with income greater than 100% FPL
- Most Centennial Care members will have copayments for non-preferred prescription drugs and for non-emergent use of the Emergency Department
- The following populations would be exempt from all copayments:
 - Native Americans
 - Intermediate Care Facility for Individuals with Intellectual Disabilities
 - QMB/SLIMB/QI1 individuals
 - Individuals on Family Planning only
 - Individuals in the Program of All Inclusive Care for the Elderly
 - Individuals on the Developmental Disabilities and Medically Fragile waivers
 - People receiving hospice care

Proposed Co-Payment Structure

	CHIP	WDI	Expansion Adults	All Other Medicaid
Population Characteristics and Service	<u>Age 0–5:</u> 241–300% FPL <u>Age 6–18:</u> 191–240% FPL	Up to 250% FPL	If income is greater than 100% FPL	
Outpatient office visits (non-preventive) • BH visits are exempt	\$5/visit	\$5/visit	\$5/visit	No co-pay
Inpatient hospital stays	\$50/stay	\$50/stay	\$50/stay	No co-pay
Outpatient surgeries	\$50/surgery	\$50/surgery	\$50/surgery	No co-pay
Prescription drugs, medical equipment and supplies • Psychotropic Rx– exempt • Family Planning Rx– exempt • Not charged if non-preferred drug co-pay is applied	\$2/prescription	\$2/prescription	\$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic and Family Planning Rx exempt	\$8/prescription All Categories of Eligibility; certain exemptions will apply			
Non-emergency ER visits	\$8/visit All Categories of Eligibility; certain exemptions will apply			

Outpatient office visits – \$5/visit	<p style="text-align: right;"><u>Exempt Services</u></p> <ul style="list-style-type: none"> • Community benefits and waiver services • Family planning visits/procedures • Preventive visits (ie, Well Child and immunizations) • Preventive dental • BH outpatient • Maternity, prenatal, postnatal care • Diagnostic lab/x-ray • Treatment related to Diabetes
Inpatient hospital stays – \$50/stay	<p style="text-align: right;"><u>Exempt Services</u></p> <ul style="list-style-type: none"> • BH inpatient • NF stays • Labor and delivery; pregnancy-related care
Outpatient surgeries – \$50/procedure	<p style="text-align: right;"><u>Exempt Services</u></p> <ul style="list-style-type: none"> • Family planning procedures • Pregnancy-related care
Prescription drugs, medical equipment and supplies – \$2/prescription	<p style="text-align: right;"><u>Exempt Items</u></p> <ul style="list-style-type: none"> • Psychotropic drugs • Pregnancy-related drug items, including tobacco cessation and prenatal drug items • Family planning items/contraceptives • Not charged if non-preferred co-pay is applied
Non-preferred prescription drugs – \$8/prescription	<p style="text-align: right;"><u>Exempt Items</u></p> <ul style="list-style-type: none"> • Psychotropic drugs (legend drugs that are classified as psychotropic drugs to treat BH conditions) • Pregnancy-related/prenatal drug items • Family planning items/contraceptives • Drugs that are determined by the provider as medically necessary
Non-emergency use of the ER – \$8/visit	<p style="text-align: right;"><u>Exempt Services</u></p> <ul style="list-style-type: none"> • Emergency services

Member Engagement and Personal Responsibility

Proposals

#4: Modify tracking requirements for cost sharing

- Request authority to track the out-of-pocket maximum cost sharing amounts on an annual basis rather than quarterly or monthly
- Apply an annual out-of-pocket maximum based on four FPL tiers

#5: Allow providers to charge small fees for three or more missed appointments

#6: Expand opportunities for Native American members in Centennial Care

- Require MCOs to expand contractual or employment arrangements with Community Health Representatives throughout the state
- Work with Tribal providers to develop capacity to enroll as Long Term Services and Supports providers and/or health home providers
- Seek authority to collaborate with Indian Managed Care Entities (IMCE), including a pilot project with the Navajo Nation. An IMCE may operate in a defined geographic service area, but would be required to meet all other aspects of federal and state managed care requirements

Administration Simplification through Refinements to Eligibility

Proposals

- #1: Eliminate the three month retroactive eligibility period for most Centennial Care members
- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
 - Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services
 - Does not include retroactive status changes processed by the Social Security Administration
 - Native Americans and individuals residing in nursing facilities would be exempt from this provision
- #2: Implement an automatic NF LOC re-approval for certain members whose condition is not expected to change

Administration Simplification through Refinements to Eligibility

Proposals

#3: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caretakers with increased earnings that result in ineligibility per income guidelines

- The individuals previously using the category are now either transitioned to the adult expansion category or are eligible to receive subsidies to purchase coverage through the federal Exchange
- Since the implementation of the Affordable Care Act, use of the category dropped from 26,000 individuals to 2,000 (most Parent/Caretaker individuals with increased earnings now covered under the Adult Expansion)

Administration Simplification through Refinements to Eligibility

Proposals

#4: Incorporate eligibility requirements of the Family Planning program

- Benefits are limited to reproductive health care, contraceptives and related services—not comprehensive coverage
- 6% of population on Family Planning utilize coverage today
- HSD proposes to better target this program by designing it for men and women who are through the age of 50 who do not have other insurance (with certain exceptions)

#5: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

**Thank you for attending and
participating in the public hearing
process**

**We will now receive and record your
feedback related to the information
presented**