Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees

Demonstration Proposal

New Mexico

Summary: In July 2011, CMS released a State Medicaid Directors' letter regarding two new models CMS will test for States to better align the financing of the Medicare and Medicaid programs, and integrate primary, acute, behavioral health and long term supports and services for Medicare-Medicaid enrollees. These two models include:

- Capitated Model: A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

To participate, States must demonstrate their ability to meet or exceed certain CMS established standards and conditions in either/both of these models. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for the selected financial model(s). The New Mexico Human Services Department has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time, interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m. EDT, July 1, 2012. You may submit comments on this proposal to NM-MedicareMedicaidCoordination@cms.hhs.gov.

Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees

Demonstration Proposal
Submitted to the Medicare-Medicaid Coordination Office by the New Mexico Human Services Department

May 31, 2012

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A. Executive Summary

The New Mexico Human Services Department (HSD) has designed the proposed demonstration to align fully with the state's Centennial Care initiative, a blueprint for modernizing the New Mexico Medicaid program by creating a unified and comprehensive service delivery system that will assure cost-effective care and focus on quality over quantity. One of the stated principles of New Mexico's Centennial Care waiver concept is that New Mexico will work with the Centers for Medicare and Medicaid Services (CMS) to develop a strategy for streamlining care for individuals who are dually eligible for Medicare and Medicaid (also called dual eligibles) to ensure seamless care and reduce costs to both programs.

In New Mexico, care for the state's approximately 40,000 dual eligibles is financed separately by the Medicare and Medicaid programs through a combination of payment models and service delivery systems. Consequently, the programs do not always work well together because they have different billing systems, enrollment processes, eligibility requirements, appeals procedures and provider networks. These separate funding streams and delivery systems result in fragmented care that is often uncoordinated and difficult for patients and their families to navigate. This fragmentation also results in a lack of best health outcomes and an increase in high-cost care such as avoidable emergency room visits, hospitalizations and institutional interventions.

Under the proposed demonstration, HSD will enter into a three-way contracting arrangement with CMS and selected managed care organizations (MCOs) to provide the full range of Medicare and Medicaid benefits to dual eligibles throughout New Mexico under a capitated model. The finalization of each contract will follow a joint plan selection process involving CMS and HSD. The three-way contracts will test administrative, benefit and enrollment flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid enrollees by utilizing a simplified and unified set of rules and an integrated payment model. HSD and its selected MCOs will be responsible for meeting all of the demonstration standards and conditions, as outlined by CMS.

Key principles that are instrumental to this proposed demonstration model are:

- Ensuring a well-designed health care delivery system;
- Ensuring strong beneficiary protections;
- Developing a single source for combined Medicare-Medicaid funding and benefits;
- Establishing a culture of quality improvement; and
- Engaging dual eligible individuals and their families in program design and development.

Featured components of the scope of the proposed demonstration will include:

- Ensuring service excellence for people with complex, chronic and long-term needs;
- Promoting home- and community-based care, emphasizing primary care and prevention;
- Providing evidence-based, comprehensive medical and supportive services coordinated by an interdisciplinary team;

- Providing well designed transitional care that allows access to current providers and services, treatments and drug regimens that remain coordinated through different settings of care to reduce hospital admissions and readmissions;
- Respecting individual choices in service plans of care and advanced directives;
- Blending Medicare and Medicaid resources that offer comprehensive care options;
- Developing quality assurance and performance benchmarks that address rates of nursing home admissions and length of hospital stays; and
- Helping HSD determine actual costs and return on investment.

Table 1: Demonstration Overview

Target Population	*All full-benefit Medicare-Medicaid enrollees receiving services in New Mexico*
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	*40,000*
Total Number of Beneficiaries Eligible for the Demonstration	*40,000 (Approximately 2,200 individuals enrolled in the Developmental Disabilities (DD) waiver will receive their long-term care services outside of the demonstration.)*
Geographic Service Area	*Statewide*
Summary of Covered Benefits	• *All Medicaid State Plan services, inclusive of behavioral health and home- and community-based care* • *Medicare Parts A, B and D* • *Additional home- and community-based services that enhance optimal health outcomes for recipients* • *Robust care coordination and care management services, as part of the Centennial Care program, with access to health homes and patient-centered medical homes*
Financing Model	*Capitated*
Summary of Stakeholder Engagement/Input	• *Centennial Care planning stakeholder meetings held statewide* • *Centennial Care tribal consultation* • *Dual-Eligibles Financial Demonstration Subcommittee of the New Mexico Medicaid Advisory Committee (MAC) appointed to include diverse stakeholder representation* • *Tribal notice letter sent to all tribal governors, leaders and major providers* • *Draft proposal posted online on April 30, 2012, with notice of 30-day comment period* • *Three stakeholder subcommittee meetings held prior to submission of demonstration proposal to CMS* • *Plans for ongoing stakeholder*

	subcommittee meetings and formal tribal consultation during the demonstration implementation period
Proposed Implementation Date	*January 1, 2014*

B. Background

i. Overall Vision and Rationale for the Proposed Demonstration

New Mexico Centennial Care: Ensuring Care for New Mexicans for the Next 100 Years & Beyond

HSD has designed the proposed demonstration to align fully with the state's Centennial Care initiative, a blueprint for modernizing the New Mexico Medicaid program by creating a unified and comprehensive service delivery system that will assure cost-effective care and focus on quality over quantity. One of the stated principles of the New Mexico Centennial Care waiver concept is that New Mexico will work with CMS to develop a strategy for streamlining care for individuals who are dually eligible for Medicare and Medicaid to ensure seamless care and reduce costs to both programs.

New Mexico is one of the poorest states in the nation and is experiencing a faster-than-average growth in its aging population. These two facts combined place increasing demand on the state's Medicaid program, even before the expansion of Medicaid to newly eligible populations under the Patient Protection and Affordable Care Act (ACA) in 2014. In June 2011, New Mexico embarked on an ambitious plan to modernize its Medicaid program to accomplish the following goals:

- To assure that Medicaid enrollees receive the right amount of care at the right time and in the most cost-effective or "right" settings;
- To assure that the care being purchased by the program is measured in terms of its quality and not its quantity;
- To bend the cost curve over time; and
- To streamline and modernize the program in preparation for the potential increase in membership of up to 175,000 newly eligible individuals beginning in January 2014.

To avoid cuts in Medicaid eligibility, services and payments to providers, New Mexico will develop a comprehensive system of care that focuses on:

- Care coordination;
- Health literacy, by increasing the work of community health workers called *promotoras*;
- Patient-centered medical homes;
- Payment reforms to reward cost-effective care that is based on best practices;
- The use of technology to bring health care to rural and frontier areas of the state; and
- Encouraging more engagement in personal health decisions while rewarding those who engage in healthy behaviors.

Under the Centennial Care initiative, New Mexico will also make significant administrative changes, including:

- Combining most of the state's existing Medicaid waivers into a single, comprehensive 1115 waiver;
- Requiring the Medicaid MCOs to deliver comprehensive services, including physical health, behavioral health and long-term care services; and
- Reducing the number of Medicaid MCOs with which the state has managed care contracts.

New Mexico is actively seeking approval of an 1115 global demonstration waiver to implement the Centennial Care program from CMS. The state intends to implement the proposed demonstration model as an important and obvious component of Centennial Care, and proposes a start date of January 1, 2014, to align with the timing of the Centennial Care waiver.

Creating a Comprehensive Medicaid Service Delivery System

In New Mexico, care for dual eligible enrollees is financed separately by the Medicare and Medicaid programs through a combination of payment models and service delivery systems. Consequently, the programs do not always work well together because they have different billing systems, enrollment processes, eligibility requirements, appeals procedures and provider networks. These separate funding streams and delivery systems result in fragmented care that is often uncoordinated and difficult for patients and their families to navigate. This fragmentation also results in a lack of best health outcomes and an increase in high-cost care such as avoidable emergency room visits, hospitalizations and institutional interventions.

New Mexico recognizes that there are special needs and characteristics of dual eligibles. On average, Medicare-Medicaid enrollees experience higher levels of disabilities and chronic illnesses such as diabetes, pulmonary disease and stroke than other enrollees. Dual eligibles make up over half of all nursing facility residents in New Mexico, and are more likely than other Medicare recipients to have mental health care needs, be hospitalized, use emergency rooms, and require long-term care and supports. Medicare covers most of the acute care services provided to dual eligibles, such as inpatient hospital, physician, emergency room, and prescription drugs; while most of their long-term care services, such as nursing facility and home- and community-based care are covered by Medicaid. Both programs cover some common services, such as home health and hospice; however, the dividing lines between Medicare and Medicaid responsibility are not always clear. In addition, Medicaid covers some services that Medicare only covers with limitations, such as vision, dental, transportation, and behavioral health, and is responsible for some or all Medicare premiums and beneficiary cost-sharing.

In addition to service fragmentation, the dual eligible population is costly. In 2010, dual eligibles made up 15 percent of the total Medicaid population nationwide, but they accounted for 39 percent of total Medicaid costs. To a large extent, these costs are a product of the demographic and morbidity characteristics of dual eligibles; however, they are also the result of uncoordinated and at times conflicting policies between the Medicare and Medicaid programs. One example of this conflict is the rule on "homebound" care in Medicare, which severely limits the home care options available to Medicare beneficiaries and shifts an undue

burden of the care for dual eligibles onto Medicaid. To the extent that Medicaid accepts that burden and even amplifies the home care provided to dual eligibles through programs like *Mi Via*, the Personal Care Option (PCO) or one of the 1915(c) waivers in New Mexico, Medicare stands to save money through a reduction in its own high readmission rates. In 2010, the nationwide readmission rate in the Medicare program was 16.1 percent; and was 13.9 percent in the Albuquerque, New Mexico, area. Savings from low hospital readmissions accrue entirely to the Medicare program, since it is the primary payer of hospital services under Part A. The Medicaid program does not share in those savings, despite the fact that it was the state's home care initiatives that were largely responsible for reducing hospital stays and readmissions.

New Mexico has a long history of exploring avenues to realize savings for its dual eligible population. In the delivery of long-term care, New Mexico has been considered a leader in overall Medicaid budget expenditures that create rebalancing of the long-term care delivery system from institutional care toward home- and community-based services (HCBS), ranking first in the nation in rebalancing, as evaluated in a 2011 AARP and SCAN Foundation study[1]. The same study ranks New Mexico's additional long-term care system performance improvement along the dimensions of affordability, access, choice of care setting, and providers.

New Mexico's managed long-term care program, called CoLTS, was an important step in placing the Medicaid benefit for dual eligibles under managed care; however, the separate silos of financing for the two programs continue to reduce the economic benefit for the state. The current CoLTS MCOs convey that there are limitations on their abilities to achieve more comprehensive, coordinated care and financial efficiencies since they are unable to fully manage the care of dual eligible recipients. For example, the CoLTS MCOs do not have access to information concerning pharmaceutical interventions or timely access to information on services that are paid by Medicare for their patients to better monitor recipient health care outcomes. While there are Special Needs Plans (SNPs) being offered by each of the CoLTS MCOs, very few recipients are enrolled, with only 3,568 current SNP enrollees statewide.

A special component envisioned for the proposed demonstration model will be the involvement of non-traditional health care workers, such as community health representatives providing trusted support for Native American communities in New Mexico; health *promotoras* serving as health educators and advocates for Spanish-speaking beneficiaries; and other similar peer wellness specialists. These special health care workers can take the person-centered approach beyond the clinic/medical provider visit to supporting recipients in becoming active partners in improving their own health in their homes and in the community. It is an expectation that the contracted MCOs will incorporate these special health educators and advocates into their delivery of health care services for the demonstration population.

[1] Houser, Ari, Kassner, Enid, Mollica, Robert, Reinhard, Susan "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Oder Adults, People with Physical Disabilities, and Family Caregivers." September 2011, available at http://www.longtermscorecard.org/~/medica/Files/Scorecard%20site/Report/AARP.

Integrating Medicare and Medicaid services through the proposed demonstration offers a comprehensive approach for coordinating the delivery of care, financing, technology, and beneficiary experience in a way that will facilitate better health outcomes, reduce system complexity, and improve effective cost utilization for both programs. New Mexico's opportunity to participate in the proposed demonstration program aligns directly with the Centennial Care initiative by presenting the state with a critical chance to implement innovative changes that will ensure better care and reduce administrative complexities for these individuals. New Mexico is concerned that, absent the demonstration, the state will not be doing enough to address the special needs and concerns of dual eligibles, even under its waiver for Centennial Care.

Under the proposed demonstration, the New Mexico Medicaid program will implement a capitated managed care model that will coordinate best medical practice, behavioral health care and long-term services and supports (LTSS) in one seamless continuum of care approach. New Mexico proposes to execute these specific strategies to achieve its integration of care goals under the demonstration:

- Implementation of a fully integrated financial model purchased through Medicaid MCOs, beginning on January 1, 2014. The state's fully capitated financial alignment model will follow all guidelines issued by the CMS Medicare-Medicaid Coordination Office, as detailed in its July 8, 2011, letter to State Medicaid Directors, its guidance memorandum of January 25, 2012, on components of the demonstration plans, and any subsequent guidance issued.
- Establishment of health homes, targeted first at those with a behavioral health condition plus a chronic physical condition and, over time, toward others with chronic and/or co-morbid conditions. In these health homes, all six services prescribed by federal law will be offered, including intensive care management delivered at the point of service.
- Reshaping the current delivery system by implementing a three-way contracting approach between CMS, HSD and selected MCOs. These three-way contracts will blend capitation of Medicare and Medicaid payments and combine performance measures and incentives to align across physical health, behavioral health, and LTSS systems of care. Fundamental to the demonstration – and to New Mexico's Centennial Care waiver initiative – is a comprehensive service delivery system that includes several major components that are described in this proposal.

ii. Description of the Demonstration Population

New Mexico's demonstration will include all full benefit Medicare-Medicaid enrollees statewide. Individuals who receive only Medicare Savings Program benefits such as Qualified Medicare Beneficiary (QMB) and Service Limited Medicare Beneficiary (SLMB) will not be included in the demonstration. Individuals receiving services through the New Mexico Developmental Disabilities (DD) waiver will receive their regular medical benefits through the demonstration; however, their long-term care services will be provided through the Medicaid fee-for-service (FFS) program.

Based on unique enrollees and services received during state fiscal year 2011 (SFY 11), the statewide estimated number of full-benefit Medicare-Medicaid enrollees in New Mexico is 40,000. Of these individuals, approximately 21,900 (or 53 percent) are not projected to receive LTSS. Approximately 18,800 are considered to be at risk of needing LTSS due to their status as dual eligibles. There are approximately 2,200 developmentally disabled dual eligibles who will continue to receive their LTSS services through the state's DD waiver.

The population receiving LTSS is projected to be approximately 19,000 (47 percent) of the target population. An individual receiving LTSS may receive services in an institutional or HCBS setting during the year; therefore, counts for institutional and HCBS services are not mutually exclusive. It is estimated that approximately 5,300 individuals (28 percent) will receive LTSS in an institutional setting for all or part of the year, and that approximately 13,800 (74 percent) will receive LTSS in HCBS settings for all or part of the year.

The target population is estimated to contain 25,740 individuals (64 percent) who are age 65 or older; and 14,260 individuals (36 percent) who are under age 65. Based on the New Mexico diagnostic code-based definitions, 4,800 individuals (12 percent) are expected to require services to treat a serious mental illness.

Table 2: Summary Table of the Demonstration Population

	Overall	***Individuals Receiving LTSS in Institutional Settings***	***Individuals Receiving LTSS in HCBS Settings***
Overall total	*40,000*	*5,300*	*13,800*
Individuals age 65+	*25,740*	*4,880*	*9,800*
Individuals under age 65	*14,260*	*420*	*4,000*
Individuals with serious mental illness	*4,800*	*700*	*2,200*

C. Care Model Overview

i. Description of the Proposed Delivery System & Programmatic Elements

New Mexico will implement a comprehensive, fully-capitated financial alignment demonstration model, integrating the complete array of physical health, behavioral health and long-term services and supports to serve dual eligibles on a statewide basis. The state will implement the demonstration as part of its 1115 global demonstration waiver for the Centennial Care program, and will include the demonstration components in New Mexico's competitive procurement for managed care participation in the Medicaid program. All selected Medicaid MCOs will be required to demonstrate a capacity to provide the full unified range of Medicare and Medicaid benefits to enrollees, including an ability to follow Medicare Advantage (MA) and Medicare Part D prescription drug plan requirements, network adequacy, advanced system technology, acceptable previous performance history in delivering Medicare and Medicaid services, and administrative and financial accountability.

Key elements of the proposed demonstration model will include:

- Assessment of beneficiary strengths and risks, including screening, comprehensive assessment and identification of priority services for highest need recipients and designation of care coordination to support health plan participants;
- Participant/beneficiary and family involvement and engagement in care;
- Development of individualized health care action plans with participants/recipients and family members;
- Comprehensive transitional care between care settings;
- Coordination of behavioral and physical health care;
- Complex care management or intensive care coordination, including interdisciplinary team-based approaches for those assessed to have high needs;
- Health promotion and prevention activities, including building linkages to public health and other community services outside of the health plan, ensuring optimal health of the recipient;
- Coordination and collaborative communications with specialty and inpatient care providers facilitated by the primary care team and care coordinator to support those with intensive care needs;
- Continuity of care, providing feedback to health care providers whenever feasible and appropriate to the recipient's health care action plan;
- Improvements in health conditions and access to treatment;
- Demonstration of capacity to use health information technology to link services, identify and manage care gaps, and facilitate communication and problem-solving among health care providers;
- Use of high quality, evidence-based assessment and intervention protocols in working with beneficiaries for the development of health care action plans; and
- Establishment of a continuous quality improvement program with collection and reporting of data that assists with an evaluation of increased care coordination and

chronic care management, individual and population-based clinical and cost outcomes, the overall experience of care, and quality of care outcomes.

Enrollment Method

Enrollment into managed care for dual eligibles will be mandatory for all Medicaid-covered benefits. During calendar year 2013, when New Mexico is preparing to implement Centennial Care, extensive outreach and education about Centennial Care will be made to all Medicaid recipients. Dual eligibles will be informed about the demonstration program and their health plan enrollment options. In addition to education, the goal of this outreach will be to build interest in enrolling into one of the Centennial Care health plans. HSD intends to work extensively with stakeholders to develop innovative strategies for conducting beneficiary outreach and education specific to the demonstration model. Strategies may include working with agencies outside of HSD to act as navigators that can assist individuals with health plan selection.

During the Medicare open enrollment period (October 1, 2013, through December 31, 2013), Medicare-Medicaid enrollees will be notified of their upcoming enrollment into the Centennial Care managed care program and will be requested to select one of the three to four health plans that will be available. The letter of notification will inform individuals that they will be enrolled in their plan of choice for both their Medicaid-covered benefits and their Medicare-covered benefits, unless the recipient notifies the state of his or her decision to opt out of Centennial Care for Medicare-covered benefits. Participants will be given multiple options for informing the state of their decision to opt out on the Medicare side.

If eligible participants elect to opt out of the Centennial Care program for their Medicare-covered benefits, they will remain enrolled in the Centennial Care program for their Medicaid-covered services. If individuals fail to notify the state of their health plan selection or choice, they will be automatically enrolled into one of the three to four plans that will be available. Once enrolled with an MCO, individuals will be offered the option of switching plans once per year; however, individuals who are passively enrolled into the demonstration will be able to opt out of managed care participation for their Medicare benefits on a monthly basis.

New Mexico proposes to include a six-month lock-in period on the Medicare side for individuals who actively select participation in the demonstration as indicated by their selection of an MCO. These individuals would receive their Medicare benefits through their selected MCO (or through an alternative MCO, if selected during an initial 90-day switch enrollment period) for a minimum of six months. This lock-in period would provide the MCO with sufficient time to initiate a robust care coordination plan for its dual eligible members, and to facilitate needed care in a way that will incent continued member participation.

Availability of Medical and Supportive Service Providers

Under the demonstration, New Mexico will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of

the target population, as described in the CMS Memorandum of Understanding (MOU) template. New Mexico's MCOs have proven that they know how to establish, maintain and monitor provider networks that serve their enrollees. In addition, HSD has implemented regular and thorough processes for supervising, evaluating and ensuring recipient access to and choice of providers.

All of the Medicaid MCOs and their providers will be reviewed for the following competencies:

- Experience with person-centered planning and self-determination;
- Use of evidence-based practices and specific levels of quality outcomes;
- Experience working with people with disabilities; and
- Cultural competence.

During its planning work for the Centennial Care waiver initiative, New Mexico engaged stakeholders to hear about their most significant concerns about the state's Medicaid delivery system. Every stakeholder group with which the state met mentioned a lack of access as a major problem for New Mexico. Not only is the state medically underserved, but the distances between towns and cities large enough to attract a full array of physicians and other professionals is much greater than in the average state. New Mexico will continue to look at creative ways to both increase the size of its health care workforce and to employ creative technologies to expand access. Two strategies, in particular, include:

- The University of New Mexico (UNM) runs a telemedicine program called Project ECHO that utilizes traditional physician training practices such as chart rounds and leverages web conferencing to train primary care providers to become "specialists" in treating complex and/or chronic conditions and illnesses. Under the demonstration, HSD proposes to utilize Project ECHO to support a virtual model similar to the Program of All-Inclusive Care for the Elderly (PACE) or an alternate integrated care model for special high cost populations of dual eligibles.
- As the state reviews its payment reform strategies, it will look at potential ways to incentivize other rural and frontier initiatives that will maximize access to primary and preventive care services.

ii. Description of the Proposed Benefit Design

All of the MCOs that will be selected to participate in the Medicaid program (and also the proposed demonstration) will be expected to deliver a full range of services, including the service packages now provided under the FFS program and all existing waivers (except for long-term care benefits provided under the DD waiver). Under the demonstration, New Mexico will implement a fully integrated model that will ensure the provision and coordination of all necessary services covered by both Medicare and Medicaid, including primary, acute, prescription drug, behavioral health, and long-term services and supports.

A baseline design requirement for the demonstration will be that the MCOs administer Medicare and Medicaid benefits jointly so that participants experience their coverage as a single, integrated care program. It is proposed that the dual eligible component of Centennial Care will cover:

- All Medicare benefits (Parts A, B and D);
- All Medicaid state plan benefits, inclusive of behavioral health and HCBS; and
- Additional HCBS that enhance optimal health outcomes for recipients.

Table 3: Summary of Proposed Demonstration Benefits Under New Mexico Centennial Care

Medicare Services	***Medicaid Services***	***Additional Community Support Services***
• *Part A Hospital Insurance: Inpatient hospital services; inpatient care in a skilled nursing facility; hospice care services; home health care services; and inpatient care in a religious nonmedical health care institution.* • *Part B Medical Insurance: Physician services; outpatient care; durable medical equipment; other medically necessary services and supplies; and preventive services.* • *Part D Prescription Drug Coverage: Prescription drugs based on formularies and tiered cost-sharing.*	• *Current (summary): Inpatient/outpatient hospital services; allergy testing and treatment; emergency room; audiology; dental care; vision care; nursing facility care; behavioral health care, including crisis intervention, community support programs, partial hospitalization, behavioral health counseling, mental health assessment, pharmacologic management, psychiatric diagnostic interview; case management services; prescription drugs; prosthetics/orthotic; physical, occupational and speech therapy; urgent care; transportation; podiatry; diabetic supplies and insulin; durable medical equipment; preventive exams and screening; immunizations; lab and x-ray; home health services; private duty nursing; home- and community-based services; hospice; physician services; pregnancy-related services; family planning services/supplies.* • *Proposed (summary): Dietary/nutritional care and medication.*	• *Community support services will promote independent living and help avert unnecessary medical interventions, e.g., avoidable or preventable emergency room visits and inpatient hospital admissions.* • *May include these and/or other services subject to further analysis: Personal care assistance; home modifications; assistive technologies; assisted living; home delivered meals; telehealth; social work counseling; community transition services; chronic disease self-management; respite; adult day service; nutritional counseling; independent living skills; training; community health representative services; Health* promotora *services; peer wellness specialist services; fitness/exercise services.*

Self-Direction

New Mexico intends to continue but modify the self-directed programs currently offered under 1915(c) waivers for individuals with HIV/AIDS, those who are medically fragile, those with traumatic brain injuries, and those who otherwise qualify for HCBS because they meet nursing facility level of care criteria. As is the case today, beneficiaries choosing to self-direct must take responsibility for both hiring their care providers and developing their own budgets. The MCOs will be expected to take responsibility for assisting beneficiaries in the development of budgets and assisting in the selection of staff through their care coordination systems.

Care Coordination & Care Management

A central vision of the Centennial Care program and proposed demonstration model is to significantly enhance the experience of individuals in accessing the entire health care system, across all providers, services and financing mechanisms. A "seamless" health care system means a system in which beneficiaries no longer experience the frustration of accessing services from a host of disparate providers who may not communicate effectively with one another about beneficiary conditions or treatment plans. Centennial Care will improve beneficiary experience with both the medical system and the LTSS system, as these will be delivered via a single plan that includes robust care coordination to ensure access to a complete continuum of care for the beneficiary. MCOs selected by the state to provide health services to assigned members will be responsible for providing care coordination at a level appropriate to each member's needs and risk stratification.

New Mexico's care coordination system will be based on creating a patient-centered environment in which members are receiving the care they need in the most efficient and appropriate manner. The care coordination approach is continuous and will include:

- Assessing each member's physical, behavioral, functional, and psychosocial needs;
- Identifying the medical, behavioral, long-term care, and other social support services and assistance (e.g., housing, transportation or income assistance) necessary to meet identified needs;
- Ensuring timely access and provision, coordination and monitoring of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities and maximize independence; and
- Facilitating access to other social support services and assistance as needed in order to promote each member's health, safety and welfare.

An initial care coordination contact for each member will be performed upon entry into an MCO. The MCO will use all available information and initiate a phone call with each new member to complete the following:

- Introduce the MCO and provide a brief orientation to benefits and care coordination;

- Obtain additional information about current care needs that were not indicated in encounter and utilization data;
- Identify any immediate or urgent needs;
- Screen for participation in disease management;
- Obtain information about family or other caregivers who may participate in care planning;
- Confirm information about behavioral health or substance abuse care indicated by encounter or utilization data; and
- Make an initial risk level assignment.

Based on the member outreach call and, in the case of current enrollees, utilization and encounter data that the plans will have for their members, individuals will be assigned a risk-stratification group. The stratification process will take into consideration many different elements, including but not limited to age, diagnosis, treatment history, current needs, presence of mental health issues and/or substance abuse, and living arrangements. If the member is assigned to a higher level of need, they may need more intensive care coordination. An example of criteria for a higher level might include that the member:

- Has co-morbid health conditions;
- Has had frequent emergency room use in the past three-month period;
- Has a low-risk mental health or substance use disorder that is stable or presents with minimal functional impairment in home, work or community settings; and/or
- Is receiving substance abuse services.

Many dual eligibles, typically those with the most expensive or high-risk service needs, will require intensive coordination. A care coordinator will contact members who appear to have complex needs and a higher level of risk to complete a comprehensive assessment to confirm that the member is in the appropriate risk group and to inform the development of a written plan of care. A comprehensive assessment will typically take more time and require that the care coordinator include input from a care planning team as appropriate, including the member, family or caregivers (with the member's permission), and providers.

Based on the assessment, a care plan will be developed that includes the services and supports that the member needs to stabilize or improve his or her health, safety and well-being. The care plan document will include all physical health, behavioral health, social and transportation needs identified for the member. This will allow the member to understand what services are available and create a foundation for discussions about health between the member and his or her caregivers, care coordinator and providers. The process will be designed to require a specific care coordinator to act as the liaison or "face of the program" for the member. The design goal is to foster trust and communication, reduce confusion for members, their families and providers, and to improve care.

Ongoing care coordination will be based on the assigned risk group and will include required elements such as:

- Delivery of initial and ongoing comprehensive assessments;
- Required members of the care planning team;
- Frequency and type of contact with members;
- Data monitoring requirements; and/or
- Triggers for reassessment and case review.

As New Mexico finalizes its vision of care coordination, it will seek further stakeholder input. This is one of many places where the input of the community will lead to a stronger program. It should also be noted that New Mexico will seek to implement care management models that are culturally sensitive to the Medicare-Medicaid population being served. Culturally sensitive care management models, which make sincere efforts to build provider networks that reflect the cultural characteristics of their members and are capable of communicating in the primary language of recipients, will be rated highly in the MCO selection process.

Patient-Centered Medical Homes & Health Homes

While the basic care coordination model described above will, at least initially, be the responsibility of the MCOs, the state will, over the next several years, move intensive care coordination to the "point of service" by incentivizing the proliferation of patient-centered medical homes and health homes. As individuals choose or are enrolled in either the medical home primary care model and/or the health home for the management of chronic conditions, those entities will assume responsibility for intensive care coordination. The MCOs will be expected to continue to provide overarching care coordination, technical assistance, and to assure that care coordinators in these point-of-service models receive full access to all of the MCO resources and data that are required to understand the entire spectrum of a beneficiary's needs.

New Mexico has contractually encouraged its MCOs to work toward the development of patient-centered medical homes. Progress has been made, but there is more work to be done to grow both urban and rural medical homes where primary care is provided and the patient is surrounded by both care coordination and access to other community supports. The requirement in the ACA to pay primary care physicians at 100 percent of the Medicare rate will be helpful in furthering the establishment of primary care medical homes. If the medical homes can demonstrate better health outcomes for their patients, the state may consider continuing a higher payment rate to those providers that demonstrate quality metrics.

New Mexico is currently working with an ACA Section 2703 planning grant to design its first state plan amendment (SPA) to establish health homes throughout the state. The initial concentration for the health home model is for individuals receiving services to treat a behavioral health condition. New Mexico's intent is to initially develop health homes in pilot site Core Service Agencies (CSAs) in Albuquerque and expand to other geographic areas of the state as best practices develop. The model for behavioral health homes is being designed in conjunction with the physical health MCOs and will be used

for other populations as the health home concept is expanded. Over time, the state intends to establish health homes for other chronic conditions.

The health homes, once established, will assume responsibility for the six services required by federal law:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

The state will work with CMS and its actuaries to ensure that services provided by the health homes are not duplicated by the MCOs. The intent is to push comprehensive case management to the point of service with oversight and back-up resources provided by the MCOs' care coordination systems.

PACE

New Mexico intends to continue the state's existing PACE program, but does not plan to expand PACE beyond its current capacity. While PACE is a valuable and effective program, HSD does not believe that it is a scalable model and that it is particularly unsuited for a largely rural state where there are long distances to travel, even within its cities. New Mexico plans to leverage opportunities under the financial alignment demonstration model to coordinate care and create medical homes similar to PACE, including using the UNM Project ECHO program to create "PACE-like" models for dual eligibles living in smaller towns and rural settings.

iii. Description of Supplemental Benefits

The MCOs will be expected to provide demonstration participants with health promotion services such as smoking cessation programs, weight management initiatives, diabetes education and counseling, and additional value-added services and benefits that are available to their other Medicaid enrollees. Some recipients may need specialized services or other types of supports that would be uniquely beneficial to their health, improve the quality of care or make strides toward the affordable delivery of services. New Mexico will work with stakeholders to further develop the scope of supplemental benefits that may be offered to the demonstration population.

iv. Use of Evidence-Based Practices

New Mexico's demonstration will utilize nationally recognized evidence-based practices that are implemented across delivery systems in all of the state's Medicaid programs.

v. Current Medicaid Waivers & State Plan Services

The New Mexico Medicaid program is currently operated under myriad federal waivers and an FFS component. The state currently operates:

- A FFS system for certain short-term eligibility groups and for those Native Americans who opt out of managed care;
- A 1915(b) waiver for its *Salud!* physical health managed care program;
- A 1915(b) and a 1915(c) waiver for its CoLTS managed care program;
- A 1915(b) waiver for its Statewide Behavioral Health Purchasing Collaborative system;
- Two 1915(c) waivers for its two *Mi Via* self-directed programs;
- A 1915(c) waiver for the Medically Fragile;
- A 1915(c) waiver for those with HIV/AIDS;
- Two 1115 waivers – one for childless adults and one for parents (the State Coverage Insurance, or SCI, program);
- One 1115 waiver for the Children's Health Insurance Program (CHIP); and
- A 1915(c) waiver for HCBS for those with developmental disabilities.

Under these various waivers, the state contracts with seven MCOs: four for *Salud!*; one for behavioral health; and two for CoLTS. The amount of time and expense it takes to manage this patchwork quilt of service delivery systems and vendors robs the state, and ultimately the beneficiaries, of the needed focus on a comprehensive system of care, governed by one waiver and managed to deliver quality health care.

New Mexico's Centennial Care 1115 global demonstration waiver will incorporate all waivers into a single managed care system. The state plans to reduce the number of managed care plans from seven to a smaller, more manageable number. All of the plans ultimately selected to participate in the program will be expected to deliver a full range of services, including the service packages now provided under FFS and all existing waivers (except the DD waiver, as noted).

To maximize the integration of health care services, the state will "carve in" all Medicaid behavioral health services and all HCBS and institutional services not provided under the non-DD waivers. MCOs will be expected to manage this full array of services and to take primary responsibility for the management of the self-directed services offered under the *Mi Via* waiver that is available to those who meet nursing facility level of care. The capitation for the MCOs participating in the program will be designed to maximize the incentives to support people in their homes and communities and to begin to address the waiting list for services for the current CoLTS program.

D. Stakeholder Engagement and Beneficiary Protections

i. Engagement of Stakeholders

Centennial Care Stakeholder Engagement

The ideas behind New Mexico's Centennial Care initiative were fleshed out over a series of public stakeholder meetings conducted in July and August 2011; and subsequent suggestions and comments delivered to the state via the Internet, email and snail mail, cross-stakeholder workgroups, and tribal consultation. Public meetings were heavily publicized and well-attended in the following locations:

- Clovis, Civic Center – Wednesday, July 6, 2011
- Farmington, San Juan College – Tuesday, July 12, 2011
- Roswell, Public Library – Tuesday, July 26, 2011
- Las Cruces, New Mexico Farm and Ranch Museum – Wednesday, July 27, 2011
- Albuquerque, University of New Mexico – Thursday, July 28, 2011
- Santa Fe, Willie Ortiz Building – Tuesday, August 2, 2011
- Tribal Council, Indian Pueblo Cultural Center – Wednesday, August 3, 2011.

As a result of this widespread consultation, the state's vision for Centennial Care emerged more clearly. Part of that vision, and the impetus behind New Mexico's application for the proposed demonstration, includes the focus on a comprehensive coordinated delivery system. New Mexico's Centennial Care Concept Paper, which was posted online on February 21, 2012, included a statement of the state's intent to apply for demonstration authority through the financial alignment model for dual eligibles.

Dual-Eligibles Financial Demonstration Subcommittee

To engage stakeholders in the planning and submission process specific to this proposal, the HSD Medicaid Director appointed a Dual-Eligibles Financial Demonstration Subcommittee of the state's Medicaid Advisory Committee. The subcommittee is charged with developing, discussing and proposing the major components of New Mexico's demonstration program for dual eligibles. Subcommittee members are currently and will continue to work together with HSD staff to share program ideas, analyze data and research findings, and develop policy recommendations related to the state's implementation of the proposed demonstration model. The role of subcommittee members will be to advise HSD on program ideas and decisions as they relate to dual eligibles who will be affected by the proposed demonstration model. While all subcommittee meetings will be open to the public and will include public input, only those individuals who have been appointed to the subcommittee or their proxies will be invited to participate in formal subcommittee discussions.

Current appointments to the subcommittee represent:

- AARP: New Mexico;
- Albuquerque Area Indian Health Services;

- The Developmental Disabilities Planning Council;
- Disability Rights New Mexico;
- The Governor's Commission on Disability;
- HealthInsight New Mexico;
- The Independent Living Resource Center;
- The Indian Area Agency on Aging;
- The National Indian Council on Aging;
- The New Mexico Aging and Long-Term Services Department, Aging and Disability Resource Center;
- The New Mexico Association for Home and Hospice Care;
- The New Mexico Behavioral Health Services Division;
- The New Mexico Health Care Association;
- The Non-Metro Area Agency on Aging; and
- The Senior Citizens Law Office.

Additional members may be appointed as necessary. Topic-specific workgroups of the subcommittee will be formed on an *ad hoc* basis.

The subcommittee held three meetings (on May 3, 2012; May 15, 2012; and May 29, 2012) prior to submission of this demonstration proposal to CMS. The subcommittee charter, meeting notes and agendas are attached to this proposal at Appendix A.

Public Comment

HSD posted its draft demonstration proposal online on April 1, 2012, to solicit comments from the general public. A summary of the comments that were received prior to submission of this proposal is attached at Appendix B. Many of these comments, together with the suggestions of the Dual Eligibles Financial Demonstration Subcommittee, were incorporated into New Mexico's final demonstration proposal. While some of the comments that were submitted reached a level of detail that New Mexico cannot address in its proposal at this time, these suggestions and concerns will inform the state's future direction and demonstration design as the state works with stakeholders to refine program details during the implementation phase.

Tribal Consultation

New Mexico is home to 22 different tribal nations and pueblos. For over a century, the members of these tribes have looked to the Indian Health Service (IHS) as the federal obligation to provide their access to health care services under the treaties signed in exchange for their lands.

The New Mexico Medicaid program plays an increasingly significant role in funding health services for the Native American population in the state. Native Americans are confronted by a fragmented health care delivery system that functions one way when they reside on the reservation and another way when they do not. One potential solution to this fragmented service delivery system is the enrollment of Native Americans into managed care.

Recognizing that there is legitimate concern among Native American communities about being required to enroll in managed care, the state, in addition to the tribal consultation held in August 2011, convened informal workgroups and consultations in order to invite the community to work toward the goal of taking more control over parts of the system. The ideas that came out of these meetings – e.g., locating the focus of care coordination at the local level where individuals can receive culturally appropriate services from tribal members overcoming the most frequently mentioned barrier to the success of the current CoLTS model in the Native American community – will be explored more fully in ongoing tribal consultation and informal workgroup settings.

Specific to the proposed demonstration, a letter notifying tribal leaders, organizations, members and health care providers with notice of HSD's intention to submit a demonstration application, was mailed on April 3, 2012; and the appointment of members to the Dual Eligibles Financial Demonstration Subcommittee includes multiple tribal stakeholders. Formal face-to-face tribal consultation about the demonstration will take place during the demonstration implementation phase.

ii. Description of Beneficiary Protections

New Mexico will ensure that beneficiary complaints or grievances will be managed effectively and will follow the standard complaints and grievances processes established under the state's Centennial Care program. New Mexico currently follows the Medicaid recommended fair hearing process and provides the 90-day standard timeframe for filing a grievance. If appeals are filed within the established timeframes, benefits will be continued until the point at which a decision is rendered. The state will work with CMS during the contracting process to develop uniform requirements in which the MCOs must adhere to a goal of offering a system that is user-friendly for participants while assuring that state and federal requirements are incorporated.

As New Mexico works to implement the proposed demonstration model, it will ensure that beneficiary protections are designed to ensure their health and safety, as well as access to high quality health and supportive services. Specifically, New Mexico will:

- Establish meaningful beneficiary input processes that may include beneficiary participation in the development and oversight of the model;
- Develop, in conjunction with CMS, uniform and integrated enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the demonstration, including those with disabilities, speech and vision limitations, and limited English proficiency;
- Ensure the privacy of enrollee health records and provide for access by enrollees to such records;
- Ensure that all care meets the needs of beneficiaries, allows for involvement of caregivers, and is delivered in an appropriate setting, including in the home and/or community;

- Ensure access to all services in a manner that is sensitive to the beneficiary's language and culture, including customer service representatives that are able to answer enrollee questions and respond to complaints and concerns appropriately;
- Ensure an adequate provider network;
- Ensure that beneficiaries are meaningfully informed about their care options; and
- Ensure access to grievance and appeals rights under Medicaid, including development of a unified set of requirements for MCO complaints and internal appeals processes.

iii. Plans for Ongoing Stakeholder Feedback

The Dual Eligibles Financial Demonstration subcommittee has an official charter (attached at Appendix A) that specifies its duration to include meeting on a regular basis throughout the approximately 18-month long demonstration implementation phase. Initial meetings will be held in Santa Fe and Albuquerque; however, later meetings may be held at various locations to facilitate statewide input. Topic-specific workgroups of the subcommittee will be formed on an *ad hoc* basis, and focus groups may be held to address certain details of the demonstration. Formal face-to-face tribal consultation about the demonstration will also take place during the demonstration implementation phase.

Demonstration materials will be accessible on the HSD Medical Assistance Division web site, and will be made available in English, Spanish and Navajo; and in alternative formats for individuals with disabilities, as necessary. HSD staff working on the demonstration will collaborate on an ongoing basis with the HSD Communications Director to ensure the effective dissemination of information about the demonstration throughout the implementation period.

E. Financing and Payment

i. Description of Payment Reforms & Identification of the Financial Alignment Model that Will Be Used

New Mexico seeks to use demonstration authority to implement a fully integrated capitated financial model that will follow all guidelines issued by the CMS Medicare-Medicaid Coordination Office, as detailed in its July 8, 2011, letter to State Medicaid Directors, its guidance memorandum of January 25, 2012, on components of the demonstration plans, and any subsequent guidance issued. HSD will enter into three-way contracts with CMS and selected MCOs to provide the full range of Medicare and Medicaid benefits to dual eligibles throughout New Mexico. The finalization of each contract will follow a joint plan selection process involving CMS and HSD. The three-way contracts will test administrative, benefit and enrollment flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid enrollees by utilizing a simplified and unified set of rules and an integrated payment model.

To maximize the alignment of care coordination intensity with the capitation rate structure, New Mexico is working with its actuaries to develop a capitation structure based on risk stratification, and it is the state's goal to align the two to focus both dollars and care coordination strategies on those who are most at risk. New Mexico believes that the combination of money and care coordination resources maximize the chances that the plans will manage utilization to achieve the best health outcomes and efficiency in the system. In addition, New Mexico plans to examine risk stratification methodologies and explore the idea of using maintenance within or movement across stratification levels as a measurable health outcome that may be tied to capitation rates or payment reforms. Simply stated, the goal is that the dollars will follow the plan of care; more complex cases will receive additional resources.

In addition, pay-for-performance initiatives will be integrated throughout the Centennial Care and demonstration services. The measures will include a focus on both process and outcome, and on pilot projects to encourage provider participation in payment reforms linked to quality outcomes and best practices.

ii. Description of How Payments will be Made to Providers

Simplification for providers and beneficiaries is a core goal of Centennial Care, and will be particularly enhanced by the demonstration's ability to eliminate the two-tiered structure of provider reimbursement and service delivery inherent within the current Medicare and Medicaid systems. In addition, beneficiaries who move into or out of the demonstration within Centennial Care should experience a relatively seamless continuation of needed services.

The MCOs will make payments to providers for services that encompass all covered Medicare and Medicaid benefits. Beneficiaries will not be charged Part C or D premiums. Apart from use of a risk-adjusted standardized Part D average bid, regular Part D rules will be utilized for participating health plans.

Actuarially sound rates will be developed based on baseline spending in both programs with savings due to combined programs shared between Medicare and Medicaid. In keeping with Centennial Care implementation, a limited number of plans will be selected to offer demonstration services. Quality withholds of between one and three percent in the first three years of the demonstration, as recommended by the Federal Demonstration Preferred Requirement Standards, will be utilized in conjunction with other quality performance standards inherent to Centennial Care design.

F. Expected Outcomes

i. Ability to Monitor, Collect & Track Data

HSD has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model's quality and cost outcomes for the target population. These metrics include, but are not limited to, beneficiary experience, access to and quality of all covered services (including behavioral health and long-term services and supports), and utilization, in order to promote high quality care for beneficiaries and to inform the demonstration evaluation.

HSD agrees to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:

- Beneficiary level expenditure data and covered benefits for the most recently available three years, including available encounter data;
- Description of any changes to the State Plan that would affect dual eligible enrollees during this three-year period; and
- State supplemental payments to providers during the three-year period.

ii. Potential Improvement Targets

New Mexico believes that the proposed demonstration, as part of the state's Centennial Care Medicaid modernization initiative, will result in improved quality of life and satisfaction with services for dual eligibles who participate and their families. New Mexico will implement a comprehensive quality approach across the entire continuum of services and settings that promotes quality improvement and that focuses on customer perceptions of quality, with mechanisms to ensure ongoing feedback from persons receiving care and their families in order to immediately identify and resolve issues and to improve the overall quality of services.

Proposed performance metrics address the key performance measurement domains of:

- Beneficiary participation (enrollment targets);
- Appropriate service utilization; and
- Access to care.

Enrollment targets will be based on an analysis of the current target population and will be sufficient to support a financial alignment model to ensure a stable, viable and evaluable program. Additional metrics may later be adopted as new measurement standards emerge. Healthcare Effectiveness Data and Information Set (HEDIS) metrics will be used for New Mexico's initial performance measures under Centennial Care.

MCOs selected to participate in the fully integrated capitated managed care model for dual eligibles will be NCQA-accredited and contractually required to provide performance metric data for their enrollees. Given New Mexico's long history of managed care, most potential Medicaid MCOs already have a history of reporting on HEDIS measures. Detailed quality

assessment and performance improvement program plans are also required of the MCOs. Audits are conducted by the HSD/Medical Assistance Division, Quality Assurance Bureau; the New Mexico Department of Health, Division of Health Improvement; and an annual External Quality Review Organization (EQRO).

Key performance metrics that will be considered, but are not limited exclusively, are outlined in Table 4. New Mexico will examine outcomes observed in other states' Medicare-Medicaid integration demonstrations hat have shown integrated plans utilizing the flexibility of pooled capitation to make increased investments in primary and preventive care services. Under the demonstration, New Mexico expects to see an increase in encounters with primary care practitioners, increased use of home visits, increased monitoring of medication adherence, increased focus on post-hospital follow-up care, increased family/caregiver support, and increased use of behavioral health services. There is further expectation to see evidence of decreased nursing home admissions, reduced length of stay for nursing home episodes, reduced hospital readmission rates, reduced emergency room visits, a reduction in duplicative, medically unnecessary tests, and more appropriate use of specialty services.

Table 4: Proposed Demonstration Performance Metrics

Managed care accountability measures tied to contractual accountability and incentives		
Topic	***Core Measures***	***Data Collection/Measurement Sources***
Beneficiary Participation	• *Percent of clients who do not opt out of the demonstration program (retention rate)* • *Percent of high-risk clients who receive an assessment (engagement rate)* • *Reduce skilled nursing facility placements*	• *Monitored monthly with initial evaluation by state, CMS and the MCO* • *Examine indirect measurement of client satisfaction* • *Assessments and skilled nursing facility placements monitored quarterly*
Appropriate Service Utilization	• *Reduce avoidable hospitalizations:* *- Diabetes, short-term complications* *- Adult asthma* *- Congestive heart failure* *- Hospitalizations with ER activity* • *Reduce 30-day hospital readmissions (HEDIS)* • *Reduce avoidable emergency department use (per 1,000 member months)* • *Reduce skilled nursing facility placements*	• *Detailed quality assessment and performance improvement program required of MCOs* • *Annual review of QA performance* • *Ongoing client-level monitoring by MCO/State/CMS through software tool* • *Monitor and evaluate behavioral health home model benchmarks progress* • *Follow Medicaid Adult Initial Core Set of health care quality measures for Medicaid-eligible adults (Federal Register 1/4/12)* • *Requirements of NCQA accreditation*
Behavioral Health	• *Increase follow-up after hospitalizations for mental illness (HEDIS)* • *Increase initiation and engagement of alcohol and other drug treatment (HEDIS)* • *Improve medication management*	

iii. Demonstration Impact on Costs

HSD looks forward to working with CMS as it conducts financial modeling for the demonstration to identify more specifically the impact of the proposed demonstration on Medicare and Medicaid costs. The state will work with CMS to develop detailed financial projections over the next three years for Medicare, Medicaid and total combined expenditures, including estimates of how much savings are anticipated. New Mexico is confident that this financial modeling will demonstrate that the payment model being tested will achieve meaningful savings while maintaining or improving quality for beneficiaries.

G. Infrastructure and Implementation

i. State Infrastructure & Capacity

Managed care has been the primary service delivery system for Medicaid in New Mexico for more than a decade. New Mexico's MCOs have proven that they know how to establish, maintain and monitor provider networks that serve their enrollees. In addition, HSD has implemented regular and thorough processes for supervising, evaluating and ensuring recipient access to and choice of providers.

HSD is confident that it has the necessary infrastructure and capacity in place to implement and oversee the proposed model, including the necessary staffing resources, contractual relationships, and a capacity to both receive and analyze Medicare data as part of a linked database. The HSD/Medical Assistance Division includes two dedicated long-term care bureaus, including one that oversees the existing CoLTS program, and staff that have extensive experience in evaluating encounter data.

ii. Overall Implementation Strategy & Timeline

Timeframe	***Key Activities/Milestones***	***Responsible Parties***
June - August 2012	• *Dual Eligibles Financial Demonstration Subcommittee establishes regular meeting schedule for implementation period* • *Subcommittee develops work plan for implementation period* • *HSD/CMS communication* • *HSD submits State Readiness Data Assessment to CMS*	• *HSD Medical Assistance Division staff* • *Subcommittee* • *CMS*
September 2012	• *HSD issues request for proposals (RFP) to procure Centennial Care contracts, including requirements for the demonstration model*	• *HSD Medical Assistance Division staff*
October 2012 – December 2012	• *HSD conducts ongoing stakeholder meetings; plans tribal consultation* • *Ongoing HSD/CMS communication* • *HSD initiates required regulation and system changes* • *HSD enters negotiations with MCOs and awards contracts in December*	• *HSD Medical Assistance Division staff* • *Subcommittee* • *CMS*
January 2013	• *HSD begins yearlong Centennial Care readiness review with selected MCOs*	• *HSD Medical Assistance Division staff* • *MCOs*
June-July 2013	• *HSD initiates outreach, education and communication strategies*	• *HSD Medical Assistance Division staff*
January 2014	• *Demonstration model begins as part of Centennial Care*	• *HSD Medical Assistance Division staff* • *MCOs*

H. Feasibility and Sustainability

i. Barriers & Challenges

One potential challenge that could have an impact on successful implementation of the demonstration is uncertainty surrounding the measurement of statistically significant savings in the fully capitated managed care approach. New Mexico Medicaid, as most states, does not have experience with the Medicare costs that will be associated with the overall care for dual eligibles. New Mexico has some experience with the PACE model, which has been operational since 1995 in the Albuquerque metropolitan area and has been successful in reducing and realigning both Medicare and Medicaid costs. The proposed demonstration program can build from the viable outcomes evidenced with PACE.

Another possible barrier that is foreseen will be the voluntary opt-out option for enrollees that is provided for the Medicare component of the proposed demonstration, which could impact the cost savings potential of the program and its overall sustainability. New Mexico anticipates working closely with the contracted MCOs on the establishment of strong communications, outreach and education about the benefits of the integrated care model, including the improved care coordination efforts and value-added benefits. Collaboration with the MCOs will ensure that there is a viable network of health care providers and resources available to enrollees providing acceptable access through the integrated plan. Along with this work to secure service access, New Mexico will work with its Dual Eligibles Financial Demonstration Subcommittee to receive continued input on the demonstration model; and with providers to address their concerns and incorporate their recommendations into the demonstration design.

ii. Statutory & Regulatory Changes

New Mexico does not anticipate making any statutory changes to implement the demonstration model; however, HSD will require – and has plans in place to initiate – changes to existing regulations. This process will take place as part of the implementation of the state's Centennial Care waiver, and will follow all required state and federal processes and timeframes.

iii. Funding Commitments

As in most states, funding for the New Mexico Medicaid program is contingent upon passage of a budget by the State Legislature and subsequent signature by the Governor. This funding commitment is necessary before full implementation of the demonstration can begin.

As noted, the proposed demonstration will be implemented as part of New Mexico's Centennial Care waiver; therefore, the demonstration cannot begin without completing the required contracting process for all Medicaid managed care programs in the state.

iv. Scalability & Replicability

As a result of the demonstration, New Mexico expects to develop and implement long-term, meaningful changes to the ways that dual eligibles experience the delivery of their health care statewide, while at the same time conserving costs and ensuring better health outcomes. The demonstration will focus not only on ensuring seamlessness for dual eligibles and their families, but also on developing streamlined systems and processes that are designed to help MCO and HSD staff monitor the care of dual eligibles, reduce paperwork, eliminate unnecessary work time, and modernize technology.

The partnerships that will be developed and sustained under the demonstration will aid in its longevity and sustainability beyond the demonstration period. Repairing service fragmentation for dual eligibles has historically and currently received widespread bipartisan support in the New Mexico Legislature, as well as among policymakers, community leaders, health care professionals, consumers, and advocates. The state is confident that participation in the demonstration will achieve the long-term support needed to sustain meaningful change for dual eligible New Mexicans; and that the model developed will be replicable in states with similar characteristics as New Mexico.

v. Letters of Support

Letters of support for the proposed demonstration project are attached to this proposal at Appendix C.

I. Additional Documentation

New Mexico has included its Centennial Care concept paper and waiver application at Appendix D.

J. Interaction with Other HHS/CMS Initiatives

New Mexico will utilize its demonstration model as an opportunity to interact with and build upon other initiatives developed by the US Department of Health and Human Services (HHS) and CMS, as appropriate for the state. HSD looks forward to working with CMS on the inclusion of these initiatives as part of the implementation process:

- Partnership for Patients;
- HHS Action Plan to Reduce Racial and Ethnic Health Disparities; and
- The Million Hearts Campaign.