

## ***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](mailto: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**

<b>Target Population</b>	<i>All full-benefit Medicare-Medicaid enrollees receiving services in New Mexico</i>
<b>Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide</b>	<i>40,000</i>
<b>Total Number of Beneficiaries Eligible for the Demonstration</b>	<i>40,000 (Approximately 2,200 individuals enrolled in the Developmental Disabilities (DD) waiver will receive their long-term care services outside of the demonstration.)</i>
<b>Geographic Service Area</b>	<i>Statewide</i>
<b>Summary of Covered Benefits</b>	<ul style="list-style-type: none"> <li>• <i>All Medicaid State Plan services, inclusive of behavioral health and home- and community-based care</i></li> <li>• <i>Medicare Parts A, B and D</i></li> <li>• <i>Additional home- and community-based services that enhance optimal health outcomes for recipients</i></li> <li>• <i>Robust care coordination and care management services, as part of the Centennial Care program, with access to health homes and patient-centered medical homes</i></li> </ul>
<b>Financing Model</b>	<i>Capitated</i>
<b>Summary of Stakeholder Engagement/Input</b>	<ul style="list-style-type: none"> <li>• <i>Centennial Care planning stakeholder meetings held statewide</i></li> <li>• <i>Centennial Care tribal consultation</i></li> <li>• <i>Dual-Eligibles Financial Demonstration Subcommittee of the New Mexico Medicaid Advisory Committee (MAC) appointed to include diverse stakeholder representation</i></li> <li>• <i>Tribal notice letter sent to all tribal governors, leaders and major providers</i></li> <li>• <i>Draft proposal posted online on April 30, 2012, with notice of 30-day comment period</i></li> <li>• <i>Three stakeholder subcommittee meetings held prior to submission of demonstration proposal to CMS</i></li> <li>• <i>Plans for ongoing stakeholder</i></li> </ul>

	<i>subcommittee meetings and formal tribal consultation during the demonstration implementation period</i>
<b><i>Proposed Implementation Date</i></b>	<i>January 1, 2014</i>

## **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<sup>1</sup>. 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.

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<sup>1</sup> Houser, Ari, Kassner, Enid, Mollica, Robert, Reinhard, Susan "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older 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**

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

## **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**

<b>Medicare Services</b>	<b>Medicaid Services</b>	<b>Additional Community Support Services</b>
<ul style="list-style-type: none"> <li>• <i>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.</i></li> <li>• <i>Part B Medical Insurance: Physician services; outpatient care; durable medical equipment; other medically necessary services and supplies; and preventive services.</i></li> <li>• <i>Part D Prescription Drug Coverage: Prescription drugs based on formularies and tiered cost-sharing.</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>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.</i></li> <li>• <i>Proposed (summary): Dietary/nutritional care and medication.</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>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.</i></li> <li>• <i>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.</i></li> </ul>



### 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 that 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**

<b>Managed care accountability measures tied to contractual accountability and incentives</b>		
<b>Topic</b>	<b>Core Measures</b>	<b>Data Collection/Measurement Sources</b>
<i>Beneficiary Participation</i>	<ul style="list-style-type: none"> <li>• Percent of clients who do not opt out of the demonstration program (retention rate)</li> <li>• Percent of high-risk clients who receive an assessment (engagement rate)</li> <li>• Reduce skilled nursing facility placements</li> </ul>	<ul style="list-style-type: none"> <li>• Monitored monthly with initial evaluation by state, CMS and the MCO</li> <li>• Examine indirect measurement of client satisfaction</li> <li>• Assessments and skilled nursing facility placements monitored quarterly</li> </ul>
<i>Appropriate Service Utilization</i>	<ul style="list-style-type: none"> <li>• Reduce avoidable hospitalizations: <ul style="list-style-type: none"> <li>– Diabetes, short-term complications</li> <li>– Adult asthma</li> <li>– Congestive heart failure</li> <li>– Hospitalizations with ER activity</li> </ul> </li> <li>• Reduce 30-day hospital readmissions (HEDIS)</li> <li>• Reduce avoidable emergency department use (per 1,000 member months)</li> <li>• Reduce skilled nursing facility placements</li> </ul>	<ul style="list-style-type: none"> <li>• Detailed quality assessment and performance improvement program required of MCOs</li> <li>• Annual review of QA performance</li> <li>• Ongoing client-level monitoring by MCO/State/CMS through software tool</li> <li>• Monitor and evaluate behavioral health home model benchmarks progress</li> <li>• Follow Medicaid Adult Initial Core Set of health care quality measures for Medicaid-eligible adults (Federal Register 1/4/12)</li> <li>• Requirements of NCQA accreditation</li> </ul>
<i>Behavioral Health</i>	<ul style="list-style-type: none"> <li>• Increase follow-up after hospitalizations for mental illness (HEDIS)</li> <li>• Increase initiation and engagement of alcohol and other drug treatment (HEDIS)</li> <li>• Improve medication management</li> </ul>	

### ***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***

<b><i>Timeframe</i></b>	<b><i>Key Activities/Milestones</i></b>	<b><i>Responsible Parties</i></b>
<i>June - August 2012</i>	<ul style="list-style-type: none"><li>• <i>Dual Eligibles Financial Demonstration Subcommittee establishes regular meeting schedule for implementation period</i></li><li>• <i>Subcommittee develops work plan for implementation period</i></li><li>• <i>HSD/CMS communication</i></li><li>• <i>HSD submits State Readiness Data Assessment to CMS</i></li></ul>	<ul style="list-style-type: none"><li>• <i>HSD Medical Assistance Division staff</i></li><li>• <i>Subcommittee</i></li><li>• <i>CMS</i></li></ul>
<i>September 2012</i>	<ul style="list-style-type: none"><li>• <i>HSD issues request for proposals (RFP) to procure Centennial Care contracts, including requirements for the demonstration model</i></li></ul>	<ul style="list-style-type: none"><li>• <i>HSD Medical Assistance Division staff</i></li></ul>
<i>October 2012 – December 2012</i>	<ul style="list-style-type: none"><li>• <i>HSD conducts ongoing stakeholder meetings; plans tribal consultation</i></li><li>• <i>Ongoing HSD/CMS communication</i></li><li>• <i>HSD initiates required regulation and system changes</i></li><li>• <i>HSD enters negotiations with MCOs and awards contracts in December</i></li></ul>	<ul style="list-style-type: none"><li>• <i>HSD Medical Assistance Division staff</i></li><li>• <i>Subcommittee</i></li><li>• <i>CMS</i></li></ul>
<i>January 2013</i>	<ul style="list-style-type: none"><li>• <i>HSD begins yearlong Centennial Care readiness review with selected MCOs</i></li></ul>	<ul style="list-style-type: none"><li>• <i>HSD Medical Assistance Division staff</i></li><li>• <i>MCOs</i></li></ul>
<i>June-July 2013</i>	<ul style="list-style-type: none"><li>• <i>HSD initiates outreach, education and communication strategies</i></li></ul>	<ul style="list-style-type: none"><li>• <i>HSD Medical Assistance Division staff</i></li></ul>
<i>January 2014</i>	<ul style="list-style-type: none"><li>• <i>Demonstration model begins as part of Centennial Care</i></li></ul>	<ul style="list-style-type: none"><li>• <i>HSD Medical Assistance Division staff</i></li><li>• <i>MCOs</i></li></ul>

## **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.

## Appendix A

**Medicaid Advisory Committee  
Dual-Eligibles Financial Demonstration Subcommittee**

**Thursday, May 3, 2012  
2:00-4:30pm**

**HSD Behavioral Health Services Division  
37 Plaza La Prensa  
Santa Fe, NM  
Large Conference Room**

**Meeting Agenda**

I.	Welcome, Introductions and Charge to the Subcommittee	Julie Weinberg	15min.
II.	Overview of Demonstration Principles and Draft Proposal	Kari Armijo	30min.
III.	Review Timeline and Objectives	Kari Armijo	15min.
IV.	Comments and Discussion	All	45min.
V.	Opportunity for Public Comment	Audience	15min.
VI.	Discuss Future Subcommittee Schedule and Meeting Agendas	All	15min.
	a. Topics for discussion		
	b. Future meeting schedule		
	c. Additional appointees		
VII.	Schedule Next Meeting	All	10min.
VIII.	Wrap-Up and Adjourn	All	5min.

**Medicaid Advisory Committee  
Dual Eligibles Financial Demonstration Subcommittee  
Thursday, May 3, 2012**

**Meeting Notes**

***Subcommittee Members Present***

Randella Bluehouse (National Indian Council on Aging); Ray Espinoza (Indian Area Agency on Aging); Joie Glenn (NM Association for Home & Hospice Care); Jim Jackson (Disability Rights New Mexico); Agnes Maldonado (Developmental Disabilities Planning Council); Jenny Martinez (Non-Metro Area Agency on Aging Collaborative); Carlos Moya (Aging & Long-Term Services Department, Aging & Disability Resource Center); Jim Parker (Governor's Commission on Disability); Lisa Schatz-Vance (Senior Citizens Law Office); Mike Eckness (NM Health Care Association); Cynthia Shelton (Behavioral Health Services Division); Gene Varela (AARP New Mexico)

***Audience Members Present***

Michael Parks (Mandy Pino Center); Jeremy Dressen (United Healthcare); Mary Morse (BCBS NM); Eugene Sun (BCBS NM); Kevin Kandalaft (United Healthcare); Diane Bilodeau (Amerigroup)

***HSD/MAD Staff Members Present***

Julie Weinberg; Nancy Smith-Leslie; Kari Armijo; Ellen Costilla; Susan DeGrand; Elizabeth Cassel

***Overview***

- Julie Weinberg reviewed the subcommittee charge and announced that the first meeting would be primarily for organizing and reviewing key demonstration principles.
- Kari Armijo presented the demonstration principles and announced that a draft proposal had been posted online for public comment until May 31, 2012. Kari announced HSD's intent to begin the demonstration on January 1, 2014.

***Summary of Subcommittee Comments***

- HSD should ensure that it uses empowering language in its demonstration proposal. Phrases such as "special needs" are not empowering. The focus should be on patient self-direction and choice.
- Several subcommittee members expressed concern about how the demonstration will work in rural, frontier and tribal areas.
- It was suggested that HSD examine the PACE model and outcomes.
- Concern was expressed that Medicare Advantage plans do not always pay fair reimbursement to providers.
- Several subcommittee members stated that members must be involved and educated as much as possible, and that outreach must include strategies to include tribal communities. It was suggested that the subcommittee meet at community centers in tribal communities for some of its meetings.

- It was asked what HSD will do with the savings generated from the demonstration; and was suggested that the department reinvest savings in preventive care.
- It was suggested that the demonstration include incentives to encourage wellness and self-sufficiency.
- It was remarked that tribal consultation is imperative. There is a current sense of confusion about all of the changes at Medicaid. HSD should strive to implement a model that is replicable in other tribal states.
- Several subcommittee members remarked that provider network and provider outreach/engagement are critical. HSD should be working with providers directly. Many duals will only participate if their provider is in the network.
- It was suggested that HSD use the demonstration as an opportunity to reach high-need duals by bringing services to them at home.
- It was suggested that HSD involve disabled individuals as much as possible in the program design.
- The subcommittee requested additional data about the duals that will be served (e.g., approximate number of unidentified duals, projections for the future).
- The subcommittee discussed the potential enrollment method and agreed to address this topic during its next meeting.
- It was suggested that HSD examine VA benefits and ensure that the demonstration includes them.
- It was suggested that the demonstration include a “navigator” system to help people access care.

### ***Summary of Audience Comments***

- It was suggested that the demonstration be use MCO star ratings to align reporting and tie funding to performance.

### ***Next Meeting***

The next meeting was scheduled on May 15, 2012, from 10am-noon in Albuquerque.

## **Medicaid Advisory Committee Dual-Eligibles Financial Demonstration Subcommittee**

### ***Subcommittee Charge***

The Dual-Eligibles Financial Demonstration Subcommittee is charged with developing, discussing and proposing the major components of a federal demonstration program that would allow New Mexico to align financing between the Medicare and Medicaid programs to support improvements in the quality and cost of care for full benefit Medicare-Medicaid enrollees (also called “dual-eligibles”). Subcommittee members will work together with staff of the Human Services Department, Medical Assistance Division (HSD/MAD) to share program ideas, analyze data and research findings, and develop policy recommendations related to the state’s implementation of the proposed demonstration model.

There will be a minimum of two subcommittee meetings prior to submission of a demonstration application to the Centers for Medicare and Medicaid Services (CMS) on May 31, 2012; and the subcommittee will continue to meet 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.

The role of subcommittee members will be to advise HSD/MAD 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 allowed to participate in formal subcommittee discussions.

### ***Subcommittee Background***

In July 2011, the CMS Medicare-Medicaid Coordination Office announced a new opportunity for states to participate in demonstration projects that will test financial alignment models for Medicare-Medicaid enrollees using either a capitated or managed fee-for-service approach. HSD will seek approval from CMS to participate in this demonstration opportunity using a capitated model, which will use managed care organizations (MCOs) to deliver medical, behavioral health and long-term services and supports to individuals who are eligible for both Medicare and Medicaid. If approved, New Mexico’s demonstration program will last for three years, beginning on January 1, 2014.

The Medicare and Medicaid programs were established separately, with two different pieces of authorizing legislation. Consequently, the programs do not always work well together because they have different billing systems, enrollment processes, eligibility requirements, appeals procedures and provider networks. Medicare-Medicaid enrollees often experience multiple chronic conditions and have limited financial resources. These individuals are more likely than other Medicare recipients to have mental health care needs, live in nursing homes, be hospitalized, use emergency rooms and require long-term care and supports. New Mexico’s opportunity to participate in this demonstration program presents the state with the chance to

implement innovative changes that will facilitate better care and reduce administrative complexities for these individuals.

Under the demonstration, 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. The demonstration program aligns with the state's Centennial Care Medicaid modernization plan by helping New Mexico create a unified, comprehensive service delivery system to assure cost-effective care and focus on quality over quantity.

### ***Subcommittee Principles***

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:

- Service excellence for people with complex, chronic and long-term needs;
- Promotion of 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;
- Individual choices respected 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.

**Medicaid Advisory Committee  
Dual Eligibles Financial Demonstration Subcommittee**

**Tuesday, May 15, 2012  
10:15am-12:15pm**

**North Domingo Baca Multigenerational Center  
7521 Carmel, NE  
Albuquerque, NM**

**Meeting Agenda**

- |       |  |             |        |
|-------|--|-------------|--------|
| I.    | Welcome and introductions  | Kari Armijo | 5min.  |
| II.   | Demonstration enrollment method <ul style="list-style-type: none"><li>• Opt-in/opt-out</li><li>• Passive enrollment versus active selection</li><li>• Lock-in and lock-out periods</li><li>• Incentives for self-selection</li></ul>           | All         | 20min. |
| III.  | Network adequacy <ul style="list-style-type: none"><li>• CMS standards and requirements</li><li>• Exceptions</li><li>• Rural and frontier regions</li><li>• Robust MCO standards</li><li>• Provider outreach</li></ul>                         | All         | 20min. |
| IV.   | Rural and frontier service delivery <ul style="list-style-type: none"><li>• Differences in how services are rendered</li><li>• Transportation and care coordination needs</li></ul>  | All         | 20min. |
| V.    | Native American issues and concerns <ul style="list-style-type: none"><li>• Cultural sensitivity</li><li>• Navigation points</li></ul>   | All         | 20min. |
| VI.   | Opportunity for public comment   | Audience    | 15min. |
| VII.  | Obtaining letters of support   | Kari Armijo | 5min.  |
| VIII. | Future meeting logistics <ul style="list-style-type: none"><li>• Subgroups – decide now or later</li><li>• MAC reporting</li><li>• Frequency and location of future meetings</li><li>• Communication</li><li>• Schedule next meeting</li></ul> | All         | 15min. |
| IX.   | Adjourn  |             |        |



**Medicaid Advisory Committee  
Dual Eligibles Financial Demonstration Subcommittee  
Thursday, May 15, 2012**

**Meeting Notes**

***Subcommittee Members Present***

Ray Espinoza (Aging & Long-Term Services Department, Indian Area Agency on Aging); Joie Glenn (NM Association for Home & Hospice Care); Jim Jackson (Disability Rights New Mexico); Agnes Maldonado (Developmental Disabilities Planning Council); Francesca Martinez (Non-Metro Area Agency on Aging Collaborative); Carlos Moya (Aging & Long-Term Services Department, Aging & Disability Resource Center); Guy Surdi (Governor's Commission on Disability); Lisa Schatz-Vance (Senior Citizens Law Office); Cynthia Shelton (Behavioral Health Services Division); Gene Varela (AARP New Mexico)

***Audience Members Present***

Michael Parks (Mandy Pino Center); Jeremy Dressen (United Healthcare); Mary Morse (BCBS NM); Kevin Kandalaft (United Healthcare); Diane Bilodeau (Amerigroup)

***HSD/MAD Staff Members Present***

Kari Armijo; Ellen Costilla

***Enrollment Method***

The subcommittee discussed issues specific to the enrollment method that New Mexico will propose for the demonstration model. Topics of discussion included opt-in and opt-out rules; passive enrollment versus active selection; lock-in and lock-out periods; and incentives for self-selection.

***Subcommittee Comments***

- If individuals are passively enrolled but have the option to opt out at any time, the MCOs may not take the demonstration seriously. The program must be designed to incent the MCOs to be actively engaged in managing the dual population.
- There are currently a low number of individuals who choose MA plans, despite heavy marketing. The top three reasons that individuals do not join MA plans are: 1) potential increases in out-of-pocket costs; 2) their current providers are out-of-network; and 3) the formulary does not meet their needs. The demonstration needs to be designed to address these issues.
- Enrollment into the demonstration should be designed in a way that will not inadvertently interrupt care that individuals are currently receiving with certain provider(s) or who are residing in a facility. Passive enrollment might disrupt care for these individuals, especially if they are enrolled with an MCO with which their provider does not participate. Protections might include ensuring that individuals maintain their current course of treatment for a certain timeframe after being enrolled into the demonstration; and including out-of-network providers for a defined period of time.

- Passive enrollment is not the preferred method and should be minimized as much as possible by encouraging self-selection; however, if the state chooses passive enrollment, safeguards are needed to support individuals in selecting the right MCO. For example, the state should consider contracting with organizations that can act as navigators for these individuals.
- Passive enrollment could create billing issues and confusion for recipients.
- If the state chooses passive enrollment, a strong upfront education strategy is going to be critical.
- Auto enrollment was done when the state brought up the CoLTS program because recipients had difficulty choosing between the MCO options offered or did not want to enroll. This was due to misunderstanding about the program and confusion about which providers would be part of the MCO networks. The demonstration needs to be designed to avoid these problems going forward.
- Messaging about the demonstration needs to be tailored to where individuals live in the state (e.g., rural, frontier, tribal, or urban areas). One of the problems with messaging around CoLTS was that the strategy did not work in rural/tribal areas. Messaging also needs to target providers to ensure their participation.
- Carefully think about the call center strategy for the demonstration to avoid confusion as much as possible.
- Consider a phased-in enrollment approach, beginning with the duals who are already in CoLTS.
- Incentives to encourage self-selection into the demonstration might include focusing on: dental/vision benefits, transportation, assistive technology/devices, other Medicaid supplemental benefits, and monetary incentives.

### ***Provider Issues***

The subcommittee discussed issues specific to the network adequacy for the demonstration model. Topics of discussion included CMS standards and requirements; exceptions; rural and frontier regions; MCO care coordination standards; and provider outreach.

### ***Subcommittee Comments***

- Provider network adequacy must be ensured during readiness review.
- Provider participation is critical. Without it, individuals will opt out as soon as they can.
- Examination of provider payment issues is important. There are different reimbursement methodologies on the Medicare FFS side from the Medicaid MCO side. FFS rates are higher than they are in managed care, which might prevent providers from participating.
- There are also provider trust issues due to delays in payment from MCOs. These issues need to be addressed.
- More information is needed concerning the current gaps in provider network and current standards around provider adequacy. The subcommittee should include more input from the provider community on these issues.
- Incentives should be built into provider rates (e.g., higher rates for discharge collaboration).
- The demonstration should require the MCOs to participate in discharge planning for their members. Unless the MCOs are involved in coordinating the long-term and acute care

needs of the duals, the demonstration will not achieve any real differences from the current system.

- The state should further examine the PACE model and how it will fit into the demonstration.

### ***Other Issues***

Additional comments that were made by members of the subcommittee included:

- The demonstration will save more money on the Medicare side than on the Medicaid side. Will these savings come back to the state?
- The state is bringing up its various programs, including Centennial Care, health care reform, and the duals demonstration too quickly. This is going to create confusion for everyone. Messaging about the change taking place on all fronts should be coordinated.
- The subcommittee should think further about the extent to which the demonstration might offer flexibility with Medicare marketing standards and additional standards that might be necessary on the Medicaid side.
- More information is needed about projected cost savings from the demonstration and how the state will use those savings.
- The demonstration may create additional work for other agencies (e.g., ALTSD may need additional people to help individuals enroll). Will HSD support an expansion of FTE at other agencies?

### ***Audience Comments***

- Concern was expressed that there is insufficient oversight of the MCOs, so that the policy decisions that the state makes are not actually enforced. The state needs to think about how it will ramp up MCO oversight (e.g., via an ombudsman).
- The state should be clearer regarding how it will handle transitions for beneficiaries. This is also unclear in the 1115 Centennial Care waiver.
- If the state chooses to do passive enrollment, will it coordinate lock-in and opt-out periods with enrollment for drug plans?
- There is significant readiness review necessary for the demonstration that does not apply to the rest of Centennial Care. Specialists may be needed at the MCOs to focus on care coordination specifically for duals.
- Concern that there are not enough details provided in the 1115 Centennial Care waiver and that stakeholders are not involved in work groups.

### ***Next Meeting***

Tuesday, May 29, 1:00-3:00pm, at the HSD Administrative Services Division, 725 St. Michael's Dr., Plaza San Miguel, Large Conference Room.

**Medicaid Advisory Committee  
Dual Eligibles Financial Demonstration Subcommittee**

**Tuesday, May 29, 2012  
1:00-3:00pm**

**HSD Administrative Services Division  
725 St. Michael's Dr., Santa Fe, NM  
Plaza San Miguel  
Large Conference Room**

**Meeting Agenda**

- |      |  |             |        |
|------|--|-------------|--------|
| I.   | Welcome and introductions  | Kari Armijo | 5min.  |
| II.  | Review and discuss draft proposal key topics <ul style="list-style-type: none"><li>• Enrollment method (p.10)<ul style="list-style-type: none"><li>- Navigators</li><li>- Outreach and education</li></ul></li><li>• PACE/Project ECHO (p.11)</li><li>• Intersection with Centennial Care<ul style="list-style-type: none"><li>- Benefits (p.12)</li><li>- Care coordination (p.13)</li><li>- Health homes (p.15)</li></ul></li><li>• Beneficiary protections (p.20)</li><li>• Ongoing stakeholder feedback (p.21)</li><li>• Quality targets (p.24)<ul style="list-style-type: none"><li>- Enrollment targets</li><li>- Service utilization</li><li>- Access</li></ul></li><li>• Demonstration impact on costs (p.26)</li><li>• Implementation timeline (p.27)</li></ul> | All         | 55min. |
| III. | Review and discuss public comments received and subcommittee comments <ul style="list-style-type: none"><li>• Handouts</li></ul>   | All         | 25min. |
| IV.  | Opportunity for public comment   | Audience    | 15min. |
| V.   | Obtaining letters of support   | Kari Armijo | 5min.  |
| VI.  | Future meeting logistics <ul style="list-style-type: none"><li>• Subgroups – decide now or later</li><li>• Work plan development</li><li>• MAC reporting</li><li>• Frequency and location of future meetings</li><li>• Schedule next meeting</li></ul>   | All         | 15min. |
| VII. | Adjourn  |             |        |

**Medicaid Advisory Committee  
Dual Eligibles Financial Demonstration Subcommittee  
Tuesday, May 29, 2012**

**Meeting Notes**

***Subcommittee Members Present***

Joie Glenn (NM Association for Home & Hospice Care); Jim Jackson (Disability Rights New Mexico); Joe Tschanz (Aging & Long-Term Services Department, Aging & Disability Resource Center); Jim Parker (Governor's Commission on Disability); Lisa Schatz-Vance (Senior Citizens Law Office); Cynthia Shelton (Behavioral Health Services Division); Gene Varela (AARP New Mexico); Linda Sechovec (NMAHC); Randella Bluehouse (National Indian Council on Aging)

***Audience Members Present***

Michael Parks (Mandy Pino Center); Mary Morse (BCBS NM); Diane Bilodeau (Amerigroup); Guy Surdi (Governor's Commission on Disability); Maria Zamora-Hughes (InnovAge NM PACE)

***HSD/MAD Staff Members Present***

Kari Armijo; Ellen Costilla; Elizabeth Cassel; Nancy Smith-Leslie; Cathy Rocke

***Review and Discussion of Draft Proposal***

The subcommittee reviewed the draft demonstration proposal. Specific topics of discussion included: enrollment method, PACE, intersection with Centennial Care, beneficiary protections, ongoing stakeholder feedback, quality targets, demonstration impact on costs, and implementation timeline.

***Subcommittee Comments***

- Concern expressed that the model needs to ensure that where payments are blended, home health agencies will still need funding to support operations. This funding is provided included under the RUGS payment system and needs to be incorporated into the demonstration.
- Concern expressed about the MCOs' ability to pay home health agencies via a prospective pay system. They may not have this capacity now. This will require guidance to the MCOs and will have an operational impact.
- What will opt-out procedures be? How will communication to members about their opt-out rights take place?
- There is potential for confusion during the MA open enrollment period. Will people enroll into an MA plan in October, only to be moved to the new program in January?
- Demonstration provides an opportunity to provide more access to therapy and rehabilitative services at home.
- Suggest doing outreach and education at the Southwest Conference on Disability and the Conference on Aging in the fall.
- Request language in the demonstration proposal stating that individuals will have the option to select PACE as attrition in the program occurs.

- Request language in the demonstration proposal stating that additional community support services “will” be provided, rather than “may” be provided.
- The MCOs will require the necessary skill set to perform the robust care coordination that is proposed in Centennial Care and the demonstration.
- The demonstration model should include a way for individuals to perform self-assessments prior to MCO assessment.
- MCOs should have immediate access to health information about beneficiaries via modern technology.
- Care management may be duplicative in some areas. The demonstration should identify where good care coordination already exists and where it is absent.
- Behavioral health homes are being implemented one year prior to Centennial Care in January 2013. Approximately 4,000 duals are expected to participate. (This was identified as a potential agenda item in the future.)
- The subcommittee needs to better understand the care needs of the duals population. Are there data available that show utilization trends among duals (e.g., behavioral health, primary care, medications, etc.)? Can we get Medicare data with assessment information?
- Request made to see the questions that CMS asks about the proposal and HSD’s responses.

### ***Review of Public Comments Received***

A handout was distributed that categorized all of the public comments that were received to date. Another handout similarly outlining the subcommittee’s comments was distributed. These items will form the basis of future agendas and work plan items as the subcommittee continues its work during program implementation.

### ***Audience Comments***

- The duals demonstration is just a small component of Centennial Care. Has the state considered a phase-in approach of Centennial Care requirements? What will the transition requirements be for the MCOs to address how people are shifted between MCOs or care settings?
- In the Centennial Care waiver budget neutrality proposal, it appears as if there are going to be caps on dollars spent for certain services. Is this the case?
- Project ECHO is a diagnosis-based program. Why not use PACE as the model for implementing in rural areas? This model already exists.

### ***Next Meeting***

Monday, June 16, 9:30-11:30am, in Santa Fe (location to be determined).

## Summary of Subcommittee Comments

<i>Reflective of subcommittee meetings held on May 3, May 15, and May 29, 2012</i>	
<b>Demonstration Topic Area</b>	<b>Summary of Subcommittee Comments</b>
<b>Proposal Language</b>	<ul style="list-style-type: none"> <li>• Suggest that HSD use empowering language in its demonstration proposal; focus on patient self-direction and choice.</li> </ul>
<b>Provider Network Adequacy</b>	<ul style="list-style-type: none"> <li>• Concern about how the demonstration will work in rural, frontier and tribal areas with limited access to providers.</li> <li>• More information and data are needed concerning the current gaps in provider network and current standards around provider adequacy. Need more input from the provider community on these issues.</li> <li>• Provider participation is critical. Without it, individuals will opt out as soon as they can.</li> <li>• Examination of provider payment issues is important. There are different reimbursement methodologies. FFS rates are higher than they are in managed care, which might prevent providers from participating.</li> <li>• Need to address provider trust issues due to delays in payment from MCOs.</li> <li>• Incentives should be built into provider rates (e.g., higher rates for discharge collaboration).</li> <li>• Concern that MA plans do not always pay fair reimbursement to providers.</li> <li>• Concern that the model needs to ensure that where payments are blended, home health agencies will still need funding to support operations. This funding is provided under the RUGS payment system and needs to be incorporated into the demonstration.</li> <li>• Concern that the MCOs' won't be able to pay home health agencies via a prospective pay system. This will require guidance to the MCOs and will have an operational impact.</li> </ul>
<b>PACE</b>	<ul style="list-style-type: none"> <li>• Suggest that HSD examine the PACE model and outcomes, and seek to replicate or expand PACE under the demonstration.</li> <li>• Request language in the proposal stating that individuals will have the option to select PACE as attrition in the program occurs.</li> </ul>
<b>Outreach &amp; Education</b>	<ul style="list-style-type: none"> <li>• Members must be involved and educated as much as possible; outreach must include strategies to include tribal communities. Subcommittee should hold some of its meetings at tribal community centers.</li> <li>• Provider outreach and engagement are critical. HSD should be working with providers directly. Many duals will only participate if their provider is in the network.</li> <li>• Include a navigator system to help people access care.</li> <li>• Messaging about the demonstration needs to be tailored to where individuals live in the state (e.g., rural, frontier, tribal or urban areas). One of the problems with messaging around CoLTS was that the strategy did not work in rural/tribal areas. Messaging also needs to target providers to ensure their participation.</li> <li>• Need to carefully think about the call center strategy for the demonstration to avoid confusion as much as possible.</li> <li>• Incentives to encourage self-selection into the demonstration might</li> </ul>

	<p><i>include focusing on: dental/vision benefits, transportation, assistive technology/devices, other Medicaid supplemental benefits, and monetary incentives.</i></p> <ul style="list-style-type: none"> <li>• <i>Messaging about all the change taking place in Medicaid (e.g., Centennial Care, health reform and the demonstration) should be coordinated to avoid confusion.</i></li> <li>• <i>Suggest that additional thought be given to the extent to which the demonstration might offer flexibility with Medicare marketing standards and additional standards that might be necessary on the Medicaid side.</i></li> <li>• <i>Suggest doing outreach at the Southwest Conference on Disability and the Conference on Aging in the fall.</i></li> </ul>
<b>Demonstration Savings</b>	<ul style="list-style-type: none"> <li>• <i>What will HSD do with the savings generated from the demonstration?</i></li> <li>• <i>Suggest that savings be reinvested in preventive care.</i></li> <li>• <i>The demonstration will save more money on the Medicare side than on the Medicaid side. Will these savings come back to the state?</i></li> <li>• <i>More information is needed about projected cost savings from the demonstration and how the state will use those savings.</i></li> </ul>
<b>Supplemental or Value-Added Benefits</b>	<ul style="list-style-type: none"> <li>• <i>Suggest inclusion of incentives to encourage wellness and self-sufficiency.</i></li> <li>• <i>Suggest using the demonstration as an opportunity to reach high-need duals by bringing services to them at home.</i></li> <li>• <i>Request language that additional community support services “will” be provided, rather than “may” be provided.</i></li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>• <i>Examine VA benefits and ensure that the demonstration includes them.</i></li> <li>• <i>Demonstration provides an opportunity to provide more access to therapy and rehabilitative services at home.</i></li> </ul>
<b>Stakeholder Involvement</b>	<ul style="list-style-type: none"> <li>• <i>Tribal consultation is imperative. There is a current sense of confusion about all of the changes at Medicaid. HSD should strive to implement a model that is replicable in other tribal states.</i></li> <li>• <i>Suggest involving disabled individuals as much as possible in the program design.</i></li> <li>• <i>The demonstration may create additional work for other agencies (e.g., ALTSD may need additional people to help individuals enroll). Will HSD support an expansion of FTE at other agencies?</i></li> </ul>
<b>Data</b>	<ul style="list-style-type: none"> <li>• <i>Request for additional data about the duals that will be served (e.g., approximate number of unidentified duals, projections for the future).</i></li> <li>• <i>Request for additional data about the care needs of the duals population (e.g., utilization trends).</i></li> </ul>
<b>Enrollment Method</b>	<ul style="list-style-type: none"> <li>• <i>Concern that if individuals are passively enrolled but have the option to opt out at any time, the MCOs may not take the demonstration seriously. The program must be designed to incent the MCOs to be actively engaged in managing the dual population.</i></li> <li>• <i>There are currently a low number of individuals who choose MA plans, despite heavy marketing. Reasons that people don’t join are: 1) potential increases in out-of-pocket costs; 2) current providers are out-of-network; and 3) formulary does not meet their needs.</i></li> <li>• <i>Enrollment must be designed in a way that will not inadvertently interrupt care that individuals are currently receiving with certain provider(s) or who are residing in a facility. Concern that passive enrollment might</i></li> </ul>



	<p><i>disrupt care for these individuals, especially if they are enrolled with an MCO with which their provider does not participate. Need for protections to address these issues.</i></p> <ul style="list-style-type: none"> <li>• <i>Passive enrollment is not the preferred method and should be minimized as much as possible by encouraging self-selection. If the state chooses to request passive enrollment, safeguards are needed to support individuals in selecting the right MCO.</i></li> <li>• <i>Passive enrollment could create billing issues and confusion for recipients.</i></li> <li>• <i>If the state chooses passive enrollment, a strong upfront education strategy is going to be critical.</i></li> <li>• <i>Auto enrollment was done with the state brought up the CoLTS program because recipients had difficulty choosing between the MCO options offered or did not want to enroll. This was due to misunderstanding about the program and confusion about which providers would be part of the MCO networks. The demonstration needs to be designed to avoid these problems going forward.</i></li> <li>• <i>What will the process for opt-out be? How will communication to members about their opt-out rights take place?</i></li> <li>• <i>There is potential for confusion during the MA open enrollment period. Will people enroll in an MA plan in October, only to be moved to the new program in January?</i></li> </ul>
<b>Timing</b>	<ul style="list-style-type: none"> <li>• <i>Concern that Medicaid is doing all its initiatives too quickly. Consider a phased-in enrollment approach, beginning with the duals who are already in CoLTS.</i></li> </ul>
<b>Care Coordination</b>	<ul style="list-style-type: none"> <li>• <i>The demonstration should require MCOs to participate in discharge planning for their members. Unless the MCOs are involved in coordinating the long-term and acute care needs of the duals, the demonstration will not achieve any real differences from the current system.</i></li> <li>• <i>The MCOs will require the necessary skill set to perform the robust care coordination that is proposed in Centennial Care and the demonstration.</i></li> <li>• <i>Individuals should be able to perform self-assessments prior to an MCO assessment.</i></li> <li>• <i>MCOs should have immediate access to health information about beneficiaries via modern technology.</i></li> <li>• <i>Care management may be duplicative in some areas. The demonstration should identify where good care coordination already exists and where it is absent.</i></li> </ul>

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<b>Demonstration Topic Area</b>	<b>Summary of Comments Received</b>
<b>Health Homes</b>	<ul style="list-style-type: none"> <li>• Agree with New Mexico's intent to develop a more robust role for health homes; expanded primary care is essential to improving care for dual eligibles, particularly those with co-morbid conditions.</li> <li>• Suggest that the demonstration model not include a broad requirement to have all dual eligibles served in a health home or patient-centered medical home model, but rather create incentives through the demonstration to move as many as possible to these delivery systems. This will allow for certain areas of the state that cannot support health homes and for providers that are vital to the delivery system but are not able to participate as part of this solution.</li> <li>• Encourage HSD to commit itself to the establishment of additional PACE programs in diverse geographical areas, and to clarify its commitment to continuing the existing PACE program.</li> <li>• Project ECHO is a diagnosis-based program. Why not use PACE as the model for implementing in rural areas? This model already exists.</li> </ul>
<b>Supplemental Benefits</b>	<ul style="list-style-type: none"> <li>• Agree that supplemental benefits are key to addressing the broad and complex needs of dual eligibles.</li> <li>• Suggest that HSD structure supplemental benefits similar to existing MA plans and SNPs to avoid any undue competitive positions or incentives for non-participation or opting out among beneficiaries.</li> <li>• Encourage HSD to require the development of supplemental benefits in Centennial Care that compliment the health plan's model of care; request that these benefits be appropriately funded to avoid an unlevel playing field to Medicare offerings that are not participating in Centennial Care.</li> <li>• Encourage HSD to allow for health plan flexibility to determine appropriate supplemental benefits to allow for competitive positioning and differentiation.</li> </ul>
<b>Financing</b>	<ul style="list-style-type: none"> <li>• Encourage HSD to consider a model in which individual experience, risk and frailty drives the development of rates with appropriately structured incentives to reduce the reliance on more costly services.</li> <li>• Suggest that HSD not use movement between stratification levels because maintenance within a level may be an appropriate and reasonable goal.</li> <li>• Encourage HSD to continue its foundation with effective Medicaid managed care models, including long-standing methods of determining reasonable savings and appropriate assumptions of savings as compared to improved cost trend.</li> <li>• Caution HSD against ensuring that unreasonable Medicaid savings be applied to the rate development above those already assumed in CoLTS; the true savings opportunity in the demonstration model will come from improving Medicare utilization and leveraging the ability to manage Medicare and Medicaid benefits.</li> </ul>

<b>Quality</b>	<ul style="list-style-type: none"> <li>• Agree that quality withholds are an appropriate incentive.</li> <li>• Request that metrics be developed that are specific for the dual eligible population and are complimentary to the overall goals of Centennial Care; first year metrics should be tied to improved efficiencies, and beneficiary impact metrics should be addressed in later years.</li> <li>• Suggest using MCO star ratings to align reporting and tie funding to performance.</li> </ul>
<b>Enrollment Method</b>	<ul style="list-style-type: none"> <li>• Agree with HSD's concerns regarding opt-out risks for the demonstration; suggest that HSD consider additional ways to minimize enrollee opt-out and opt-out campaigns.</li> <li>• Recommend that HSD negotiate with CMS a lock-in period that allows for appropriate relationship development between the beneficiary and the MCO.</li> <li>• Suggest that HSD consider additional participant incentives to encourage participation; focus incentives on access to Medicaid or waiver benefits only through a coordinated approach.</li> <li>• Encourage HSD to focus on enhanced enrollment incentives rather than lock-in; clarify that dual eligibles will, upon Centennial Care opt-out, be entitled to switch to a Part D plan; and clarify how switching to a Part D plan will be accomplished without a gap in coverage.</li> <li>• Encourage HSD to clarify how it plans to specifically target dual eligibles with special and separate educational efforts than those for Centennial Care; and to iterate its commitment to working cooperatively with, including support for, the state Aging and Disability Resource Center in helping educate and assist dual eligibles.</li> </ul>
<b>MA and SNP Experience</b>	<ul style="list-style-type: none"> <li>• The state is offered the best flexibility in creating integration on a statewide basis by leveraging plan participation as set forth by CMS, rather than requiring MCOs to have statewide MA plans or SNPs; Centennial Care can create integration without creating unnecessary and ongoing administrative barriers between Medicare and Medicaid, and minimizing a competitive threat to the success of integration by having available Medicare offerings outside of the integrated approach.</li> <li>• Encourage HSD to clarify its commitment to continue contracting with willing and qualified MA SNPs.</li> </ul>
<b>Model of Care</b>	<ul style="list-style-type: none"> <li>• Demonstration is an opportunity for HSD to work with CMS to ensure that the model of care for dual eligibles is based on the model of care established for the Medicaid population so that dual eligibles have consistent care delivery as compared to other recipients of Medicaid.</li> <li>• Leveraging a single model of care, appropriately aligned to the population, as part of Centennial Care, aligns with the vision of creating a more streamlined and consistent approach.</li> </ul>
<b>Co-Pays</b>	<ul style="list-style-type: none"> <li>• Encourage HSD to clarify the extent to which it proposes to apply co-pays for duals, as outlined in the Centennial Care waiver.</li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>• Encourage HSD to include (and include in its subsequent rate negotiations with CMS) a specific proposal to have transpiration to and from all medical services covered for dual eligibles.</li> <li>• Encourage HSD to include (and include in its subsequent rate negotiations with CMS) a specific proposal to eliminate the home health "homebound" restriction.</li> <li>• Will the exact same services/benefits outlined in the proposal be</li> </ul>

	<p>available to all Centennial Care enrollees?</p> <ul style="list-style-type: none"> <li>• The 1115 waiver application refers to expenditure limits for eligibility groups and boundaries for HCBS services. Whatever those complicated features mean, will they apply equally to duals under the demonstration?</li> </ul>
<b>State Oversight</b>	<ul style="list-style-type: none"> <li>• Concern that there is insufficient oversight of the MCOs, so that the policy decisions that the state makes are not actually enforced. The state needs to think about how it will ramp up MCO oversight (e.g., ombudsman).</li> </ul>
<b>Care Coordination</b>	<ul style="list-style-type: none"> <li>• There is significant readiness review necessary for the demonstration that does not apply to the rest of Centennial Care. Specialists may be needed at the MCOs to focus on care coordination specifically for duals.</li> <li>• Agree that successful outcomes for a coordinated care program will be dependent on making sure multiple provider types are able to provide their services to beneficiaries; this should include the multitude of services provided by community pharmacies. Including community pharmacists as part of the coordinated care models for dual eligibles is one of the many ways of using a pharmacist's skills to improve patient outcomes.</li> <li>• The appropriate utilization of pharmacist-provided medication therapy management services can play an important role in helping New Mexico meet its goals of better managing care for dual eligible beneficiaries while lowering costs and allowing the state to share in the savings achieved.</li> <li>• Medication therapy management services should be provided in a setting that is convenient and comfortable for the beneficiary; this is especially true for beneficiaries transitioning from the inpatient hospital setting or long-term care setting.</li> <li>• Will the exact same process for risk stratification group assignments and assessments discussed in Section 4 of the 1115 waiver application (i.e., phone call contact combined with available records assessment, followed by initial assignment to one of three groups, with specified contact and assessment parameters) be used under the demonstration? Will the same assessment standards and tool be used?</li> </ul>
<b>Technology</b>	<ul style="list-style-type: none"> <li>• Encourage adding Electronic Visit Verification™ (EVV™) for community-based long-term services and supports as a component of the demonstration project. Community-based long-term care services are a critical component to a successful integrated dual demonstration project, and the use of EVV can support key areas of focus to a successful integrated care program.</li> </ul>
<b>Drug Coverage/ Part D</b>	<ul style="list-style-type: none"> <li>• Regarding drug coverage, will each MCO be able to apply its own utilization control methods (e.g., prior authorization, step therapy, quantity limits, exceptions) or will the state establish a uniform standard?</li> <li>• Urge HSD to not only maximize its utilization for medication therapy management services for beneficiaries currently eligible for the Part D medication therapy management program, but also to use this as an opportunity to expand the use of medication therapy management to include both dual eligibles entering Medicare for the first time as well as beneficiaries in transitions of care. Utilizing the medication therapy management services provided by community pharmacists for this purpose would be consistent with HSD's goals.</li> </ul>

	<ul style="list-style-type: none"> <li>• <i>Concerned that beneficiaries' prescription drug coverage may be inadvertently, but significantly, disrupted if the demonstration is implemented as proposed. Urge New Mexico to: 1) require MCOs participating in the demonstration to either become a Medicare Part D plan subject to all Part D requirements, or contract with the patients' Part D plan; 2) ensure that participating MCOs offer the same level of access to medicines covered through Medicare Part B as offered by MA plans and in FFS Medicare; 3) significantly reduce planned enrollment in the demonstration to avoid destabilizing Part D for non-dual beneficiaries and risking significant disruptions of care for beneficiaries in New Mexico, as well as to be consistent with the experimental nature of this initiative and to allow for appropriate evaluation; 4) protect beneficiary choice and avoid disruptions in care during the demonstration by exempting from passive enrollment in the demonstration all beneficiaries who have made an affirmative choice to enroll in MA plans or SNPs, or who have affirmatively chosen a Part D plan; and 5) protect continuity of care by establishing a transition period of at least six months during which beneficiaries can access their current providers and maintain their current prescriptions.</i></li> </ul>
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<b>Transitions of Care</b>	<ul style="list-style-type: none"> <li>• <i>Encourage HSD to include further details regarding the scope of transitional care; to iterate its commitment to including all transitional care requirements for the Centennial Care MCO; and to provide that the continued access elements of transitional care continue for at least 90 days or longer.</i></li> <li>• <i>What will transition requirements be for the MCOs to address how people are shifted between MCOs or care settings?</i></li> </ul>
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# New Mexico Human Services Department

Susana Martinez, Governor  
Sidonie Squier, Secretary

## Office of the Secretary

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May 30, 2012

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
US Department of Health & Human Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Ms. Bella:

As Cabinet Secretary of the New Mexico Human Services Department (HSD) it is my pleasure to submit the state's application to participate in the Capitated Financial Model to Integrate Care for Medicare-Medicaid Enrollees Demonstration Initiative. This demonstration proposal builds upon my commitment to modernize the New Mexico Medicaid program, and aligns clearly with the state's Centennial Care blueprint to deliver quality, cost-effective care through a unified and comprehensive service delivery system. One of the stated principles of our Centennial Care waiver concept is that New Mexico will work with CMS to develop a strategy for streamlining care for dual eligibles to ensure seamless care and reduce costs to both programs. New Mexico proposes to implement demonstration authority on January 1, 2014, to align with the proposed timing of the state's Centennial Care 1115 Global Demonstration waiver.

As this proposal reflects, New Mexico is favorably poised to leverage its past experience in utilizing a managed long-term care model to provide better care for dual eligibles statewide through a capitated demonstration program. The proposed demonstration will allow our state to address the remaining programmatic and fiscal challenges that are inherent to current contracting models; to simplify and coordinate processes for dual eligibles using a unified set of rules; to reduce regulatory conflicts, fragmentation and cost-shifting between the Medicare and Medicaid programs; and to achieve cost-savings while at the same time providing higher quality care to dual eligibles in the most appropriate settings possible.

The HSD, as the single state agency for Medicaid, will act as the lead agency for this project. The HSD will coordinate with other state agencies, community partners, and the New Mexico Legislature as needed to develop and implement the proposed demonstration model in a way that is reflective of collaboration and consensus. HSD will serve as the locus for coordinating and facilitating data collection; evaluating financial, technical and policy considerations; and ensuring fulfillment of demonstration standards and conditions.

Please be assured that HSD staff will participate in demonstration-related activities, including the CMS evaluation. Our state is committed to collecting and sharing data about the project with CMS, HSD's project partners in New Mexico, and other demonstration states, and will comply with all reporting requirements to monitor progress toward quality benchmarks. New Mexico will capitalize on this opportunity to cultivate a working partnership with the CMS Medicare-Medicaid Coordination Office and with other states that are involved in and concerned with improving care and cost-effectiveness in serving dual eligibles. Our state looks forward to contributing to the success of this project by creating a demonstration model that can be disseminated, shared and replicated, particularly by states with similar cultural, economic and social compositions as New Mexico.

Thank you for your consideration of our state's demonstration application. I am confident that the proposed model will result in meaningful health care change for the people of New Mexico.

Sincerely,

A handwritten signature in cursive script that reads "Sidonie Squier".

Sidonie Squier  
Cabinet Secretary



NEW MEXICO  
**Developmental Disabilities  
Planning Council**

810 W. San Mateo Street, Suite C  
Santa Fe, NM 87505-4144  
Website: [www.nmddpc.com](http://www.nmddpc.com)

*Susana Martinez*  
Governor

*Denise Weaver*  
Chairperson

*Agnes Maldonado*  
Executive Director

505-476-7321 VOICE/TTY

(888)-779-6183 TOLL FREE

505-476-7320 FAX

May 29, 2012

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Ms. Bella:

The New Mexico Developmental Disabilities Planning Council (DDPC) is pleased to send you this letter of support for the New Mexico Human Services Department's application to participate in the Financial Demonstration Model to Integrate Care for Medicare-Medicaid Enrollees. We believe that New Mexico's application to participate in a capitated demonstration model represents an important opportunity for our state to move toward providing better quality care to dual eligibles in a unified and comprehensive service delivery system.

In support of New Mexico's demonstration project, DDPC will continue to participate in the Dual Eligibles Financial Demonstration Subcommittee of the New Mexico Medicaid Advisory Committee to provide input into the state's overall program design. We recognize that there are some program details that are not specific at this time, and we are committed to working with HSD to discuss and refine these areas so that New Mexico's demonstration program is reflective of stakeholder collaboration and consensus.

We look forward to working together with HSD and, as necessary, with your organization under the auspices of this project to further develop and evaluate the demonstration model that will work best for New Mexico. If you have any questions about DDPC's level of support for this project, please don't hesitate to contact me at (505-670-9552).

Sincerely,

A handwritten signature in black ink, appearing to read "Ag Maldonado".

Agnes Maldonado  
Executive Director



May 30, 2012

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Ms. Bella:

The New Mexico Association for Home & Hospice Care is pleased to send you this letter of support for the New Mexico Human Services Department's application to participate in the Financial Demonstration Model to Integrate Care for Medicare-Medicaid Enrollees. We believe that New Mexico's application to participate in a capitated demonstration model represents an important opportunity for our state to move toward providing better quality care to dual eligibles in a unified and comprehensive service delivery system.

In support of New Mexico's demonstration project, the New Mexico Association for Home & Hospice Care will continue to participate in the Dual Eligibles Financial Demonstration Subcommittee of the New Mexico Medicaid Advisory Committee to provide input into the state's overall program design. We recognize that there are some program details that are not specific at this time, and we are committed to working with HSD to discuss and refine these areas so that New Mexico's demonstration program is reflective of stakeholder collaboration and consensus.

We look forward to working together with HSD and, as necessary, with your organization under the auspices of this project to further develop and evaluate the demonstration model that will work best for New Mexico. If you have any questions about the New Mexico Association for Home & Hospice Care's level of support for this project, please don't hesitate to contact me at (505) 889-4556.

Sincerely,

Jole Glenn, RN, MBA, CAE  
Executive Director



New Mexico State Office  
535 Cerrillos Rd., Suite A  
Santa Fe, NM 87501

May 25, 2012

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Ms. Bella:

AARP New Mexico is pleased to send you this letter of support for the New Mexico Human Services Department's application to participate in the Financial Demonstration Model to Integrate Care for Medicare-Medicaid Enrollees. We believe that New Mexico's application provides an opportunity to explore whether a capitated model is a viable option for providing better quality care to dual eligibles.

In support of New Mexico's demonstration project, AARP New Mexico will continue to participate in the Dual Eligibles Financial Demonstration Subcommittee of the New Mexico Medicaid Advisory Committee to provide input into the state's overall program design. We recognize that there are some program details that are not specific at this time, and we are committed to working with HSD to discuss and refine these areas so that New Mexico's demonstration program is reflective of stakeholder collaboration and consensus. Some issues we are concerned about include the capacity of the managed care organizations to provide services in rural area, options for opting in or opting out, options for Native American dual eligibles, the acknowledgement and role of the PACE program and the protection of coverage and services in the transition period.

We look forward to working together with HSD to further develop and evaluate the model that will work best for New Mexico. If you have any questions about AARP's level of support for this project, please don't hesitate to contact Gene Varela at (505) 946-3604.

Sincerely,

A handwritten signature in black ink, appearing to be "Stan Cooper", written over a horizontal line.

 Stan Cooper  
Senior State Director



# STATE OF NEW MEXICO

## GOVERNOR'S COMMISSION ON DISABILITY



*Susana Martinez*  
**Governor**  
*Jim Parker*  
**Director**

Lamy Building  
491 Old Santa Fe Trail  
Santa Fe, New Mexico 87501  
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gcd@state.nm.us  
www.gcd.state.nm.us

May 22, 2012

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Ms. Bella:

The Governor's Commission on Disability (GCD) is pleased to provide this letter of support for the New Mexico Human Services Department's application to participate in the Financial Demonstration Model to Integrate Care for Medicare-Medicaid Enrollees. GCD believes that New Mexico's application to participate in a capitated demonstration model represents an important opportunity for New Mexico to move toward providing better quality services and supports to dual eligibles in a unified and comprehensive service delivery system.

In support of New Mexico's demonstration project, GCD will continue to participate in the Dual Eligibles Financial Demonstration Subcommittee of the New Mexico Medicaid Advisory Committee to provide input into the State's overall program design. GCD recognizes that there are some program details that are not specific at this time, and is committed to working with HSD to discuss and refine these areas so that New Mexico's demonstration program is reflective of stakeholder collaboration and consensus.

GCD looks forward to working together with HSD and, as necessary with CMS, the auspices of this project to further develop and evaluate the demonstration model that will work best for New Mexico. If you have any questions about GCD's level of support for this project, please don't hesitate to contact me at 505 476-0412.

Sincerely,

*Jim Parker*

Jim Parker  
Director

**'Creating Opportunities for Barrier Free Futures'**



Susana Martinez, Governor  
Retta Ward, Cabinet Secretary  
Gino Rinaldi, Deputy Secretary

May 22, 2012

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Ms. Bella:

The Aging and Long-Term Services Department is pleased to send you this letter of support for the New Mexico Human Services Department's application to participate in the Financial Demonstration Model to Integrate Care for Medicare-Medicaid Enrollees. We believe that New Mexico's application to participate in a capitated demonstration model represents an important opportunity for our state to move toward providing better quality care to dual eligibles in a unified and comprehensive service delivery system.

In support of New Mexico's demonstration project, Aging and Long-Term Services Department will continue to participate in the Dual Eligibles Financial Demonstration Subcommittee of the New Mexico Medicaid Advisory Committee to provide input into the state's overall program design. We recognize that there are some program details that are not specific at this time, and we are committed to working with HSD to discuss and refine these areas so that New Mexico's demonstration program is reflective of stakeholder collaboration and consensus.

We look forward to working together with HSD and, as necessary, with your organization under the auspices of this project to further develop and evaluate the demonstration model that will work best for New Mexico. If you have any questions about Aging and Long-Term Services Department level of support for this project, please don't hesitate to contact me at 505-576-4590.

Sincerely,

A handwritten signature in blue ink that reads "Retta Ward".

Retta Ward  
Cabinet Secretary





A PARTNERSHIP FOR THE FUTURE OF HEALTH CARE

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicaid and Medicare Services  
7500 Security Boulevard  
Baltimore Maryland 21244

Regarding: LETTER OF SUPPORT

May 29, 2012

Dear Ms. Bella,

*HealthInsight* New Mexico is pleased to express its support for the New Mexico Human Services Department's (HSD) application to participate in the Financial Demonstration Model to Integrate Care for Medicare-Medicaid Enrollees. We believe that New Mexico's participation in a capitated demonstration model represents an important opportunity for our state to move toward providing more streamlined, better quality care for individuals who are dually eligible for Medicare and Medicaid with the goal of facilitating seamless care and reducing overall costs to each program resulting in a unified and comprehensive service delivery system.

*HealthInsight* New Mexico supports the key principles that are instrumental to this proposed demonstration model:

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

However, we recognize that there some programmatic details that are still in development, which will need to be further specified and we, as a premier quality improvement healthcare review and consulting organization with over 40 years of experience, are committed to working with the HSD to discuss and refine these areas. We note the importance of welcoming stakeholder collaboration and input into the process of developing and refining New Mexico's demonstration program with the goal of achieving consensus.

We fully support the concept of this demonstration model knowing that change to the overall program needs to occur in order to make both individual programs more efficient, cost saving and more easily navigated by patients and their families. Continuing the current system of separate funding streams has led to fragmentation, lack of best health results and an increase

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in high care costs such as avoidable emergency room visits, hospitalizations and institutional interventions.

As New Mexico's federally-designated quality improvement organization, State Medical External Quality Review Organization (EQRO), Aligning Forces for Quality grantee and major participant in the Regional Health IT Extension Centers initiative in New Mexico, *HealthInsight* New Mexico is committed to improving the health of all New Mexicans. We commit as an organization to fully support HSD's proposal and will bring all of our resources, expertise, connections and pledge to work towards the success of this important undertaking.

I am readily available to discuss *HealthInsight* New Mexico's participation with HSD, as appropriate, to further develop and evaluate the demonstration model.

Sincerely,

A handwritten signature in black ink, appearing to read "Wm. Boyd Kleefisch", with a large, stylized circular flourish at the end.

Wm. Boyd Kleefisch  
Executive Director, *HealthInsight* New Mexico

# CENTENNIAL CARE



**Ensuring care for New Mexicans for the next  
100 years and beyond...**





# Centennial Care: Ensuring Care for New Mexicans for the Next 100 Years and Beyond

## Executive Summary

### The Vision

As the State moves forward to further refine and implement its modernization plan, New Mexico seeks to try a different approach to slowing the rate of growth in the program while avoiding cuts. Our vision is to build a service delivery system that delivers the right amount of care at the right time in the right setting. Our vision is to educate our recipients to become more savvy health care consumers, promote more integrated care, properly case manage the most at-risk members, involve members in their own wellness and pay providers for outcomes, rather than process. New Mexico believes that the up-front investment in “seeding” medical and health homes and investing in health literacy will return a healthier population and a reduction in the spiraling rate of growth.

### The Goals:

- Create a unified, comprehensive service delivery system to assure cost-effective care and to focus on quality over quantity;
- Slow the rate of cost growth (bend the cost curve) in the program over time through better management of care while avoiding cuts; and
- Streamline and modernize the program in preparation for the potential increase in membership of up to 175,000 people beginning January 1, 2014

### How Do We Accomplish These Goals?

- In order to avoid cuts in eligibility, services, and payments to providers, we develop a comprehensive system of care that focuses on:
  - » Care Coordination;
  - » Health Literacy by increasing the work of community health workers, the promotoras;
  - » Prevention and patient-centered medical homes;
  - » Payment reforms to reward cost-effective, “best-practices” care;

- » The use of technology to bring healthcare to the rural and frontier areas of our state; and
- » Encouraging more engagement in personal health decisions while rewarding those who engage in healthy behaviors. This encouragement will include both a small, sliding co-pay for non-emergency use of an emergency room, as well as rewards for engaging in healthy behaviors, or actively participating in a recipient's care plan.
- Administratively we:
  - » Combine most of our existing waivers into a single, comprehensive waiver to reduce internal bureaucracy and the number of programs over which the federal government has control; and
  - » Build effective management capacity and capability to hold our private sector partners accountable through all levels of the program, while reducing the number of managed care plans.

### Why is this Good for New Mexico?

- It modernizes the Medicaid program without cutting back on eligibility or necessary services, or hurting our providers;
- It aligns incentives in the system so that all parties—the state, the plans, the providers and the recipients—are working towards the same goal of better health at less cost;
- It puts New Mexico among the leading states in the design and implementation of a modern, efficient Medicaid program; and
- It introduces “state of the art” techniques arrayed in a single, comprehensive system of care.

## CONCEPT PAPER

In June of 2011, New Mexico embarked on an ambitious plan to modernize its Medicaid program to accomplish the following goals:

- To assure that Medicaid enrollees in the program 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 individuals beginning January 2014.

The State believes now is the time to create a modern, innovative, financially and operationally sustainable program for the future.

### Why Modernization and Why Now?

New Mexico is one of the poorest states in the nation and has a faster-than-average growth in its elderly population. These two facts combined place growing demands on the Medicaid program, even before the inclusion of the “newly eligible” under the Affordable Care Act.

Of the approximately 2 million citizens of the State, more than a quarter or 560,000 people currently receive their health care through the Medicaid program. The challenges are many. The program is expensive, consuming about 16% of the current state budget—up from 12% last fiscal year. And, the rate of growth in costs precedes the addition of approximately 175,000 additional people who will be added to the program beginning January 2014 under the Affordable Care Act.

The program is administratively complex, also adding cost. Today, the program operates under 12 separate waivers as well as a fee-for-service program for those either opting out or exempt from managed care. This complicated delivery system is run through 7 different health plans.

Finally, and perhaps most importantly, the State isn’t necessarily buying quality; rather rates are determined and payments made based on the quantity of services offered. The State pays for services without regard to whether they represent best practices in medicine and without regard to whether those services help make people healthier or help them manage complex medical/behavioral conditions.

For all of these reasons, the State believes that now is the time to modernize Medicaid to assure that we buy the most effective, efficient health care possible for our most vulnerable and needy citizens and to create a sustainable program for our future.

### Current Program Structure

The program is currently operated under a myriad of federal waivers and a fee-for-service component that combined make it administratively inefficient and difficult to manage as well as difficult to navigate for the beneficiaries. Currently the State operates:

- A fee-for-service 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 program;
- A 1915(b) and a 1915(c) for its Coordination of Long Term Services (CoLTS) 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 AIDS;
- Two 1115 waivers; one for childless adults and one for the parents of CHIP children (the SCI program);
- One 1115 waiver for the CHIP program; and
- A 1915(c) waiver for home and community based services for those with Developmental Disabilities.

See the chart below for more information about the current waivers.

Under these various waivers, the State contracts with seven (7) managed care organizations: 4 for Salud, 1 for behavioral health, 2 for CoLTS. In addition, the State pays its Medicaid Management Information System (MMIS) vendor to process fee-for-service claims, to collect and process encounter data from the MCOs, and to serve as the Financial Management Agency (FMA) for the Mi Via programs. It also contracts with a plan to act as a Third Party Administrator (TPA) to conduct level of care determinations, determine medical necessity for some services in the fee-for-service program, and to review and approve budgets for the Mi Via programs.



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.

In addition, despite the amount of time and money that flows into the program, New Mexico has no clear indication that it is purchasing quality care. While plans are reporting scores at or near the national average, and in some cases above, on various quality measures, those measures do not include actual health outcomes. It is on the outcomes and paying for quality, that New Mexico wishes to focus its energy and, towards that end, believes it is time to modernize its service delivery system.

## Waiver populations and expenditures

Waiver Name	Waiver Type	Expiration Date	Population Covered	SFY 10 Enrollment	SFY 10 Expenditures	Wait List
Salúd!	1915(b)	6/30/13	Traditional Medicaid	390,571	\$1,135,112,000	NA
Behavioral Health Services	1915(b)	6/30/13	Traditional Medicaid	430,969*	\$238,228,000	NA
CoLTS	1915(b) 1915(c)	1915 (b) - 7/31/12  1915 (c) - 10/31/11* currently on rolling extensions	Medicare & Medicaid Duals and Nursing Facility Level of Care	42,934	\$800,245,000	NA
MiVia	1915(c)	9/30/14	ICF Level / Self Directed	215	\$6,705,000 w/o Admin \$7,503,000 w/Admin	NA
MiVia	1915(c)	9/30/14	NF Level / Self Directed	AIDS – 8 D&E – 512 BI – 358	\$20,300,000	NA
DD	1915 (c)	Renewed 7/2011	Developmentally Disabled	3,684	\$286,092,000 w/o Admin \$287,738,000 w/Admin	5400
Medically Fragile	1915 (c)	6/30/15	Individuals with both a Medically Fragile Condition and a Developmental Disability	176 Traditional	\$1,712,495 w/o Admin \$1,824,000 w/Admin	
AIDS	1915 (c)	6/30/15	Disabled Individuals with AIDS	9	\$316,000 w/o Admin \$320,000 w/Admin	
CHIP	1115		185-235% of FPL	9,884	\$20,919,000	NA
SCI	1115	9/30/14 Child/ Adult  9/30/12 SCI Parents	Below 133% FPL	47,818	\$403,332,000	31,858
SCI	1115	9/30/14 Child/ Adult  9/30/12 SCI Parents	Above 133% FPL	3,431		

\*Individuals enrolled in CoLTS and Salud receive their BH services through this program as do individuals receiving services in the fee-for-service system.

## Modernization: Guiding Principles

As a beginning place for the development of a modernized Medicaid program, the State articulated 4 guiding principles:

- Developing a comprehensive Service Delivery system that provides the full array of benefits and services offered through the State's Medicaid program;
- Encouraging more personal responsibility so that beneficiaries become more active participants in their own health and more efficient users of the health care system;
- Increasing the emphasis on payment reforms that pay for performance rather for the quantity of services delivered; and
- Simplifying administration of the program for the state, for providers and for beneficiaries where possible.

The ideas behind these concepts were fleshed out over a series of public stakeholder meetings, suggestions and comments delivered to the state via the internet, email and "snail mail," cross-stakeholder workgroups and Tribal Consultation. As a result of this widespread consultation, the State's vision has emerged more clearly. (See Attachment A for a summary of stakeholder comments).

## Modernization: The Vision

Managed care has been the primary service delivery system for Medicaid in New Mexico for more than a decade. The State began its Salud program in 1997, managed care for behavioral health in 2005 and its CoLTS program in 2008. Like managed care companies everywhere, New Mexico's plans have proven that they know how to manage the dollars they receive in capitation and, by and large, how to establish a network and pay claims in a timely and accurate manner. What New Mexico now challenges its plans to do is manage care and deliver outcomes that can be measured in terms of a healthier population. In order to effectively drive the kind of system change New Mexico seeks, plans will have to think and behave differently and support the movement towards care integration and payment reform.

In order to implement this approach, the State will file a single Section 1115 waiver and then, through procurement and contract, New Mexico will seek managed care organization (MCO) partners who will be challenged to encourage the growth of robust, patient-centered medical homes which will offer primary care, case management and linkages to community supports as well as health literacy and education to their patients. MCOs will be further challenged to support care integration through the proliferation of health homes, targeted first at those with a behavioral health condition plus a chronic physical condition and, over time, towards 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."

Plans will be expected to manage an aggressive program, using local community resources, to promote health literacy so that beneficiaries have the tools necessary to manage their health care and to become a part of the team for purposes of managing their health conditions.

Further, plans will be challenged to support payment incentives targeted at physicians and hospitals and other health care providers who employ evidence based practices and achieve benchmarked health outcomes.

Over the course of the five years of initial waiver authority, New Mexico will introduce progressive quality goals focused on health outcomes, employ pilot projects based on both geography and specific populations to develop medical and health homes, and challenge its MCO partners to work cooperatively with the provider community and with the State to achieve a health care delivery system that is efficient and effective, controls costs by improving the health of the people the system serves, and reduces health disparities.

The rest of this concept paper introduces some of the specific ways in which New Mexico intends to pursue its vision.

### **Bending the Cost Curve**

Medicaid costs are a function of three things: the numbers of people enrolled in the program; the service package offered; and the rates paid to providers of care. The levers that states have historically used to reduce costs are blunt at best. States have, in the past, reduced eligibility to individuals who are members of optional coverage groups; eliminated optional services and/or put arbitrary limits on mandatory services and/or reduced provider rates and/or increased enrollee cost sharing.

In today's environment, reductions in eligibility are prohibited by federal law until 2014 for adults and 2019 for children; states that violate this prohibition risk Federal Financial Participation (FFP) for their whole program. States have done some "tinkering" around the edges of the service package but elimination of optional benefits rarely yield much savings and arbitrary limitations on the mandatory services is generally less acceptable than asking MCOs to manage services to a standard of medical necessity. Provider rates for Medicaid services are always lower than rates offered either by Medicare or commercial payors and a continuation of rate cuts results in serious access problems.

And yet, costs continue to soar and states struggle under the growing weight as Medicaid consumes increasing percentages of state budgets.

New Mexico seeks a different approach to reduce costs. Its vision is to build a service delivery system that delivers the right amount of care at the right time in the right setting. Its vision is to educate its members to become more savvy health care consumers, promote more integrated care, properly case manage the most at-risk members, involve members in their own wellness and pay providers for outcomes rather than process. **New Mexico believes that the up-front investment in “seeding” medical and health homes and investing in health literacy will return a healthier population and a reduction in the spiraling cost curve.**

Based on the current program without “counting” the impact of new eligibles under the Affordable Care Act or any legislative changes to the program, the State estimates that the program as described more fully below will reduce the trend rate of the program’s growth in costs by somewhere between 2.75-4% over the initial 5-year life of the waiver. That translates into a reduction in expenditures of between \$140-\$205 million general fund dollars that would otherwise have been spent if the program were to grow as it is currently configured and operated. Accompanying this reduction in the trend rate, the State believes that the system described below will also, and most importantly, have a positive impact on the health of our people.

## Principle 1: A Comprehensive Service Delivery System

### Key Features:

- A smaller number of plans will deliver the full array of Medicaid services except for home and community based and institutional services to the DD population;
- A comprehensive care coordination system lies at the heart of comprehensive service delivery; members will be stratified by risk and capitation will be adjusted by risk to maximize directing resources to those most in need of health care services;
- Health literacy will become an essential component of comprehensive service delivery;
- The State will encourage integration through the expansion of patient centered medical homes and health homes with intensive care management provided at the point of service to help beneficiaries manage their health and their use of the health care system;
- The State will work with CMS to develop a strategy for streamlining care for those dually eligible for Medicaid and Medicare to ensure seamless care and reduce costs to both programs.
- The State will emphasize the use of technology to bring health care to underserved populations; it will also seek to maximize the use of alternative care settings, like school based clinics, as an alternative to emergency rooms as a primary care setting.

## Comprehensive Care

The comprehensive service delivery system has several major components. First, the State plans to reduce the number of managed care plans from 7 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 fee-for-service and all existing waivers except for the Developmental Disabilities (DD) waiver for home and community based services and the accompanying Mi Via program for those who meet Institutional Care Facility/Mentally Retarded (ICF/MR) level of care. A list of these services is appended to the back of this concept paper (Attachment B).

In order to maximize the integration of health care services, the state will “carve in” all Medicaid behavioral health services and all home and community based and institutional services now provided under the non-DD waivers. Plans will be expected to manage this full array of services as well as 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.

## Care Coordination

Fundamental to the kind of comprehensive system of care that New Mexico seeks to provide under the 1115 Waiver is a robust care coordination system. 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 includes:

- Assessing each member’s physical, behavioral, functional and psychosocial needs;
- Identifying the medical, behavioral and long-term care services 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 needed in order to promote each member’s health, safety and welfare.

The requirements for care coordination currently under consideration are as follows:

### Screening and Initiation of Care Coordination

The initial care coordination contact for each member will be performed upon entry into a 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 to 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 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, and current needs, presence of mental health issues and/or substance abuse and living arrangements. If the member is assigned to a minimum level of need, it is an indication that they appear to be in stable health and have low needs for support and coordination. These members may have the following characteristics:

- No complex or co-morbid health conditions;
- Low ER use;
- Stable housing and social supports; and/or
- No behavioral health or substance abuse treatment needs.

For these low-risk members, no further assessment may be needed unless and until claims, encounters or real-time health information data or a trigger event signals a change in status.

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 ER use in the past 3-month period;
- Has a low-risk mental health or substance use disorder that is stable or presents with minimal functional impairment in home, school/work and community settings; and/or
- Is receiving substance abuse services.

Some members will require intensive coordination, typically those with the most expensive or high-risk service needs. The following is an example of this profile in which the member:

- Is medically complex or fragile;
- Has had high ER use in the past 3-month period;
- Has a high-risk mental health diagnosis or is an individual who is Seriously and Persistently Mentally Ill (SPMI);
- Is transient and without a natural support network;
- Has co-occurring mental health and substance abuse diagnosis; and/or
- Meets institutional level of care criteria.

The initial assignment of a member to a risk-stratification group will be based on the entry assessment and will dictate how cases are processed (e.g. time-frames, frequency and type of contact). However, the completion of a comprehensive assessment may be necessary to establish a fully informed risk group assignment. The group assignment may change based on results of the comprehensive assessment that provides more information about the members individualized needs, current risk and future risk-factors.

### Comprehensive Assessment/Care Planning

Once members are assigned an initial risk group a care coordinator will contact members who appear to have complex needs and a higher level of risk and 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 the member's 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, the member's care givers, care coordinator and providers.

The MCO may utilize a care coordination team to manage the tasks related to care coordination and assign certain tasks to team members with appropriate education and training. However 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 improve care.

### Ongoing Care Coordination

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

- Delivery of initial and on-going 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 the State 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.

New Mexico will rely on certain events and/or data to trigger a review of a member's health status and needs. These triggers will include events such as 1) Abuse/Neglect reports involving the member; 2) New diagnosis with significant health or safety impact; 3) New diagnosis involving behavioral health or substance abuse; 4) Hospitalization; 5) Request by provider or family member; and 6) Any other indication that the member may need to move to a new risk group. In addition, plans will be expected to have software that will enable the care management staff to access patient records in real time and on demand from all providers in the system. When a trigger event occurs for a member, the MCO will assign a care coordinator to complete a comprehensive assessment for low and medium risk members or deploy the assigned care coordinator to update the assessment for a member who is already receiving complex case management.

Care coordination for members who either receive or are in need of behavioral health services and/or substance abuse treatment will include referrals for service, monitoring of wait times for services, and compliance with recommended treatment including medication. It is anticipated that these care plans may require more frequent contact by the care manager

and more intensive coordination efforts. For those members with SPMI, the care manager will focus efforts on reducing emergencies and improving overall stability. For members with substance abuse treatment needs, the care manager will focus on prevention of relapse and reduction of physical health issues. In both cases the care manager will develop a care plan that considers and addresses the physical, behavioral and social support needs of these members. The care plan team will include any ancillary care members and/or community services provided to address the complex nature of these cases.

### **Aligning Care Coordination and Capitation**

In order to maximize the alignment of care coordination intensity with the capitation rate structure, the state 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 and focus both dollars and care coordination strategies on those who are most at risk. The state believes that the combination of money and care coordination resources maximize the chances that the plans will manage utilization to achieve maximum health outcomes and maximum efficiency in the system. In addition, the state 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.

### **Care Coordination/Patient-Centered Medical Homes and 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 the care coordinators in these "point of service" models full access to all of the MCO resources and utilization and encounter data that would be required for a care coordinator to understand the entire spectrum of a beneficiaries needs.

Several other features of the comprehensive system of care include:

## Health Literacy

New Mexico has some success stories helping beneficiaries understand their health needs and how to access the health care system. The Federally Qualified Health Centers (FQHCs) in particular rely on community health workers called promotoras. However, the promotoras are not statewide and not all providers are allied with them. The State will require plans to do much more aggressive outreach to their patients and offer information both about how to navigate and most efficiently use the health care system as well as how to manage their health conditions. Much of this work can be most effectively done through the use of a trained, “lay” workforce to work with beneficiaries to engage in their own health. Whether the plans “make or buy” this service, it will be a contractual requirement that community health workers be available as a resource to both the Care Coordination staff and to beneficiaries who seek to educate themselves about their health. In addition, plans will be expected to develop culturally sensitive, relevant and accessible materials on using the health care system and addressing chronic health care issues.

## Patient-Centered Medical Homes

New Mexico has contractually encouraged its Salud MCOs to work towards 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 new requirement in the Affordable Care Act (ACA) to pay primary care physicians at 100% of the Medicare rate will be helpful in furthering the establishment of primary care medical homes. For the years 2014-2016, the federal government will make up the difference between current payment rates and the new requirement. 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.

## Health Homes

The next step in the integration of care is the establishment of health homes. New Mexico is currently working with a 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. The State’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. This model for behavioral health homes is being designed in conjunction with the physical health MCOs and the model 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 assure 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.

### Self Direction

The State intends to continue but modify the self-directed programs currently offered under 1915(c) waivers for those with AIDS, those who are medically fragile, those with Traumatic Brain Injury and those who otherwise qualify for Home and Community Based Services because they meet nursing facility level of care. As is the case today, beneficiaries choosing to self-direct must take responsibility both for hiring their care providers and developing their own budgets. The State will contract with an outside vendor to perform the functions of the FMA but the plans 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.

### Behavioral Health Carve-In

Based on feedback from expert panels and other stakeholders about the most efficient way to achieve full integration of physical and behavioral health, New Mexico has determined that behavioral health services will be "carved in" and provided by the contracted MCOs under the 1115 waiver. It is important to the State to ensure that transparency is maintained in how behavioral health dollars are spent and collect data that informs on which services and systems are effective. Therefore, the State intends to apply the following standards:

- The MCO will not be permitted to subcontract management of behavioral health services to a managed, risk-bearing Behavioral Health Organization (BHO);

- The MCOs will receive a sub-capitation rate for behavioral health services which will protect current service dollars in the system; however, plans will be given more flexibility in the expenditure of behavioral health funds as they demonstrate their ability to meet performance measures, including maximizing integration of physical and behavioral health;
- The MCOs will be required to employ a licensed, clinical behavioral health psychiatrist as a part of its medical management team to take an active role in clinical and policy decisions; and
- The MCOs will be required to contract with either Core Service Agencies (CSAs) and/or qualified core service provider networks to manage much of the delivery of behavioral health services. Some of the service dollars will be kept by the MCO as money that can be used to incentivize maximum integration of physical and behavioral health.

Currently, New Mexico operates forty-one CSAs located throughout the State for children and adults. These entities provide prevention, early intervention, treatment and recovery services related to behavioral health. These CSAs will be a big part of the delivery system and will:

- Provide behavioral health services to those members who choose the CSA as their provider;
- Deliver all out-of-home assessment and service planning; and
- Provide care coordination to members with a primary diagnosis of SMI or Serious Emotional Disturbance (SED) as well as being part of an interdisciplinary team of care coordination for members with co-morbid diagnoses.

The benefit package for behavioral health services is still undergoing review for possible changes or expansion of key services. Potential expansions of the benefit package include: additional addiction services, respite, peer support, family support and transition services.

## The Dually Eligible

The population that is eligible for both Medicaid and Medicare is costly. In 2010, the dual eligibles made up 15% of the total Medicaid population nationwide but they accounted for 39% of total Medicaid costs. To a large extent, those costs are a product of their demographic and morbidity characteristics. The duals are older, sicker, and more likely to be disabled than the population in general.

The high cost of caring for the dual eligible population is also the product of uncoordinated and at times conflicting policies between the two programs. One example of this is the rule on “homebound” care in Medicare. This severely limits the home care options provided to

Medicare Beneficiaries, and shifts an undue burden of the care for the dual eligibles onto Medicaid. To the extent that Medicaid accepts that burden and even amplifies the home care provided to the duals through programs like Mi Via, 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 re-admission rate in the Medicare program was 16.1%; 13.9% in the Albuquerque area. However, those hospital savings accrue entirely to the Medicare program that is primary payer of hospital services under Part A. The State of New Mexico does not share in those savings, despite the fact that it was the state's home care initiative that was largely responsible for reducing hospital stays and re-admissions.

New Mexico has a long history of exploring avenues to realize savings for dual eligible population. The CoLTS program was a first step in placing the Medicaid benefit for the duals under managed care. But the separate silos of Medicaid and Medicare dollars continue to reduce the economic benefit for the state. In September 2011, New Mexico submitted a Letter of Interest (LOI) to CMS to pursue the capitated integrated care model described in a "Dear State Medicaid Director (SMDL # 11-008)" letter. The letter was issued by the Medicare-Medicaid Coordination Office established under Section 2602 of the Patient Protection and Affordable Care Act of 2010.

The capitated care option provides for a three-way contract between the state, CMS, and the health plans to provide the full range of Medicaid and Medicare benefits. Under this approach, the health plans would receive a single payment for Medicare and Medicaid services. CMS is working on the development of a proposed rate which would incorporate savings for both the federal and state government.

### A Word About Access

Every stakeholder with whom the State met mentioned lack of access as a big problem for New Mexico. Not only is the state medically underserved, but the distances between towns and, especially cities large enough to attract a full array of physicians and other professionals, is much greater than in the average state. The State will continue to look at creative ways to both increase the size of the workforce and to employ creative technologies to expand access. Three strategies, in particular, are under discussion and include:

- The University of New Mexico runs an excellent telemedicine program called ECHO that uses traditional physician training practices such as chart rounds and leverages web conferencing to train primary care providers to become "specialists" in treating complex conditions and illnesses such as opioid addiction, hepatitis C, pediatric obesity and high risk pregnancy. The State will seek ways to support the ECHO program and make it more widely used by primary care practices throughout the state;

- The State will look for ways to encourage the use of school based clinics, not only to treat children and adolescents during school hours but to use the facilities as potential places to supply urgent care services outside of school hours to the wider community.
- 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.

### Quality Assurance and Quality Management Strategies

We believe that New Mexico's modernization will result in improved quality of life and satisfaction with services for those 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 and the system.

The State will develop and implement quality assurance and quality improvement strategies to ensure the quality of services provided under the demonstration. Such strategies may include the use of data collection and reporting, outcome measures to measure the results of implemented services and initiatives, and mechanisms for direct feedback from members and family or other caregivers regarding the quality of services provided.

### The Affordable Care Act

New Mexico is exploring the various options for the implementation of the Affordable Care Act. At a minimum, the state anticipates that up to 175,000 individuals will become eligible for the benchmark benefit that will be defined by the federal government and offered through the Medicaid plans. Streamlining the system now should assist the health plans in their ability to more easily absorb this new group of eligibles beginning in January 2014.

### Focus on Managed Care

The State believes that with its focus on second generation managed care and a much tighter set of contractual requirements, our Medicaid recipients will receive better care, leading to better outcomes in managed care. In order to minimize any residual fee-for-service program, the State will also seek CMS authority to:

- Waive the requirement that the State pay for prior quarter coverage; under this waiver, the State would not be required to pay for services that recipients received in the quarter prior to their determination of eligibility for Medicaid; and



- The State will require that recipients choose a health plan at the time of their application for Medicaid eligibility or, at a minimum, on the date of their eligibility determination. This will enable individuals to be enrolled more quickly in a health plan and begin receiving coordinated services sooner.

## **Principle 2: Personal Responsibility**

### **Key Features:**

- **Waiver authority to implement the sliding scale co-payment already enacted in State law, 27-2-12.16;**
- **A modest co-pay on brand name drugs when a generic substitute is available; this will not apply to psychotropic drugs;**
- **Incentives to reward individuals for key preventive activities like a yearly health scan and, for the more complex and at-risk population, compliance with a plan of care they contributed to forming; and**
- **Long Term Care Insurance Partnership Plan.**

The State believes that there is merit in engaging individuals more in the process of staying and/or getting healthy and in using the health care system more efficiently. Towards those ends, the State is seeking authority to pursue a properly aligned array of incentives to facilitate that engagement.

### **Changing Behavior: Co-Payments**

In 2009, the New Mexico legislature enacted statute to impose a sliding scale co-payment on Medicaid recipients with incomes above 100% of the federal poverty level. The legislation provides that a co-payment may be assessed when the hospital from which the recipient seeks services:

- Does an appropriate screening to assure that the recipient does not require emergency services;
- Informs the recipient that he/she does not have a condition requiring emergency services;
- Informs the recipient that if he/she still wants the service, he/she will be subject to a co-pay;
- Provides the recipient with the name and address of a non-emergency Medicaid provider; and
- Offers to provide the referral to the non-emergency provider to facilitate the scheduling of the service.



The amount of the co-pay in state statute is:

- For a child whose household income is 100-150% of the federal poverty level, \$6.00;
- For an adult whose household income is 100-150% of the federal poverty level, \$25.00
- For a child whose household income is above 150% of the federal poverty level, \$20.00; and
- For an adult whose household income is above 150% of the federal poverty level, \$50.00

The State will include a request for waiver authority to implement this existing state law because, as the legislature believed at passage, this approach is one way to incentivize individuals to seek care in more appropriate settings. This is particularly true when coupled with incentives to both the hospitals and the MCOs to also participate in a statewide effort to make appropriate care settings available. The total amount of money assessed to Medicaid recipients calculated in this co-payment would be deducted from the capitation paid to the plans. The amount of the aggregate deduction would be based on historical data already being analyzed by the State's actuaries. However, the State would preclude the plans from passing the amount of the deduction on to the hospitals (pursuant to the statute) and would contractually require the plans to absorb the deduction but seek ways to incentivize their provider networks to do things to help alleviate the problem such as keeping non-traditional office hours, working more closely with patients to help educate them on when the ER is appropriate and when care can be provided in a more efficient setting and/or setting up nurse triage lines to help people make better decisions about when to access the ER. In this way, the system shares in the push to keep people out of the ER for routine and non-emergent care.

In addition to the co-pay for the non-emergent use of the emergency room, the State will seek to implement a modest co-pay of \$3.00 for the demand for a legend drug when there is a generic substitute readily available. This co-pay will not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions.

No co-pays will be required for individuals whose health care needs are the responsibility of the Indian Health Service.

### Changing Behavior: Incentives

The State is also planning to pursue an incentive program that will reward members for certain healthy behaviors. Currently, the recommendations from our stakeholders, including plans, physicians, Federally Qualified Health Centers (FQHCs), and advocates is that we focus on strategies that everyone can participate in. The State is considering several different approaches to focus on helping recipients be active participants in their health care. One

idea is to tie a reward (probably in the form of a Gift Card to either a retailer and/or a local Farmer's Market that would be offered through the MCOs) to a "high-risk" beneficiary who participated in the development of a plan of care and complied with that plan for six months or a year. For children, the incentive event might be a wellness visit and follow-up with any issues identified during that visit. For healthy adults, the reward might be tied to quantifiable participation in a regular exercise program or assuring that their children received all appropriate immunizations.

The State is also exploring the potential to implement an Electronic Benefit Transfer (EBT) card with points that a member could earn for certain healthy behaviors either in addition to or in lieu of the individual gift card approach. Points could be used to purchase over-the-counter drugs or other items that Medicaid does not pay for.

### Education:

The State is exploring the cost/benefit of sharing, at least with "frequent flyer" members, e.g. those who overuse the ER, those who are drug seeking or using 5 or more prescriptions a month, a quarterly Explanation of Benefits (EOB) that would inform the member of the costs of the care being provided and explore with the member whether those costs are leading to better outcomes and how, working with a care coordinator, that member might begin to use the system more efficiently.

### Long Term Care Partnership Plan

As a part of its effort to increase the sense of personal responsibility, the State of New Mexico will submit a State Plan Amendment to CMS in order to become a long term care insurance partnership state. That means that individuals will be able to purchase private long term care insurance at market rates that have the potential to cover much if not all of their eventual long term care needs. This has great potential to avoid middle income people from having to spend down their savings and assets in order to qualify for Medicaid to gain access to long term care. To the extent that individuals eventually do apply for Medicaid, the program can "count" the full value of the policy as an asset which has the effect of delaying entry into the system until the full value of the policy has been spent on services. On the other side, Medicaid agrees not to go after estate recovery at least to the extent of the value of the policy. This is an excellent first step in helping folks plan for taking care of their long term care needs.

## Principle 3: Payment Reform (Pay for Performance)

### Key Features:

- **MCO focused performance measures that will include both process and outcome measures**
- **Pilot projects for both physicians and hospitals to test payment reforms tied to quality outcomes and best practices**

The medical care system in the United States has been cited repeatedly as the costliest in the world, and yet one where the outcome measures of morbidity and life expectancy trail behind most of the rest of the developed nations. The reasons for this disconnect between medical expenditures and outcomes are complex, but fundamentally they reflect a system where providers are rewarded for the volume of the services that they provide, rather the health outcomes of the patients that they serve.

### HEDIS Measures

Over the past three decades much of the commercial and the Medicaid population has been enrolled into some form of managed care with the intention that a managed care organization that bears risk for the health of its members would be incentivized to deliver care proactively to avoid more costly episodes of care in the emergency room and hospital inpatient settings. As a way of holding the MCOs accountable for the delivery of preventive services, the industry developed a series of process measures to assess the effectiveness of the delivery of preventive health measures known as the Health Effectiveness Data and Information Set (HEDIS). The New Mexico Human Services Department has incorporated many of these HEDIS measures as contractual requirements for the Salud managed care plans, including:

- ER Utilization
- Ambulatory care utilization
- Well Child visits in the first 15 months of life
- Childhood immunizations
- Use of appropriate asthma medications
- Breast cancer screening
- Comprehensive diabetes care
- Timeliness of prenatal and postpartum care
- Frequency of ongoing prenatal care

This list of process measures will be evaluated and most kept. However, the State will implement additional measures to focus more specifically on the elderly and disabled and those with behavioral health needs.

### Payment Reform

In addition, the State plans to move beyond process measures to begin to align incentives and reward providers directly for achieving measureable health outcomes for their patients such as:

- Successful management using evidence-based, best practices for the treatment of conditions prevalent in New Mexico; and
- Reduced rates of readmission to the hospital for the same condition; and

Payment incentives for the health plans and the providers can take a variety of forms ranging from the non-financial like the reporting of peer to peer comparative data on the use of evidence based best practices to financial incentives like the development of bundled rates for hospitals targeted towards reducing the number of readmissions for the same diagnosis within 30 days. New Mexico would like to pilot both of these approaches as follows:

- **Reporting of Peer to Peer Comparative Data:** The State proposes to work with physicians in the State to develop metrics that represent best practices for the treatment of adults with diabetes and of children with asthma. We will turn these metrics into data points that will be collected via the MCOs and reported within the physician community. We will focus on these two disease states to start and examine whether the reporting on best practices begins to change the practice patterns of the physician community. To the extent that this simple, non-financial incentive works, the State will work with the physician community to add other disease states prevalent in New Mexico to our list over time.
- **Bundled Rates for Urban Hospitals:** The second pilot the State seeks to pursue is to work with our actuaries to develop a bundled rate for an initial hospital stay and the 30 days post-discharge for two disease states: pneumonia and coronary disease. These are two of the disease states for which there is the most frequent readmission of patients to inpatient hospital for the same diagnosis as the original within 30 days. The State wishes to explore whether using a bundled rate will reduce the number of readmissions within 30 days for the same diagnosis and will challenge hospitals, care managers and plans to become more vigilant about post-discharge planning and follow-up with patients.

The State will pursue other quality initiatives over time but believes that beginning with several small pilots will help inform about what kinds of payment reform strategies might lead to better quality outcomes over time.

## Principle 4: Administrative Simplification

### Key Features:

- **Streamline the Service Delivery System, thereby freeing state staff to better manage contracts and focus on system improvements**
- **Exploration of other simplification techniques, e.g. consolidated credential and re-credentialing processes**

Medicaid was created by an act of Congress in 1965, but it was not the program that we know today. Over the years, succeeding administrations have added a plethora of new coverage groups beyond the initial AFDC entitled population. The range of service options has also been expanded to include long-term care; home and community based care; and managed care.

The product in the states of this growth by accretion is a bewildering array of different Medicaid eligibility coverage groups and service delivery options, each of which must be memorialized in a Medicaid State Plan and/or various waivers before the state can draw down federal matching funds. As noted above in this paper, the New Mexico Medicaid program currently operates a fee-for-service system and three managed care programs, under twelve different waiver programs. Each of these programs has its own series of federal reporting requirements which place an ever increasing administrative burden on Medicaid staff. And yet each of these programs provides at their core *the same set of primary care and ambulatory care services to their recipients*, basic services such as hospital inpatient and outpatient care, physician services, lab, x-ray, etc.

Under the Global waiver approach, all of these programs (except home and community based and self-directed services for the DD population) would be subsumed under a single CMS Research and Demonstration Waiver authorized by the Secretary of Health and Human Services under section 1115 of the Social Security Act. The benefits to the state of New Mexico would include:

- Reduced administrative burden in terms of federal reporting;
- Reduced activities involved in renewing federal waiver approval;
- Increased accountability for the more limited number of MCOs that will contract for the entire Medicaid population and their service array;

- Greater ease of provider compliance in dealing with the billing, authorization, formulary, and credentialing requirements of a more limited number of MCOs; and
- More focus from the State on the evolution of a service delivery system that focuses on outcomes and quality.

In addition, the State continues to seek ways to make the system less complex and burdensome on both beneficiaries and providers. The State believes that the comprehensive delivery system is an excellent place to make the program less complex to our beneficiaries and reduce the “siloeing” of individuals depending upon their eligibility categories.

### Single Credentialing Agency

The State is also exploring the concept of procuring the services of a single entity to credential and re-credential providers. While this approach may not save significant dollars, the State believes it will reduce administrative efforts for the medical community. The State would procure the services of a NCQA accredited agency in order to assure that no plan would put its NCQA status at risk. A centralized credentialing entity will assist in assuring that providers’ information is accurate and up-to-date to minimize risks that payments will be delayed because a provider isn’t properly “registered” in the state system.

## Native Americans

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 IHS is often the only accessible health provider in the more remote frontier areas of the state. However, many Native Americans have found that they cannot rely solely on IHS to fulfill that obligation. Medicaid plays an increasingly significant role in funding health services for the Native American population in the state. In 2009, the state share of Medicaid cost of services provided to Native Americans off the reservation (\$93 million) exceeded the 100% federal Medicaid share claimed for services provided to Medicaid-eligible Native Americans at either IHS or tribally contracted 638 health care facilities.

Despite the efforts of the Human Services Department and their providers:

- Native Americans continue to experience the greatest negative health disparities of any population in the state in terms of morbidity, mortality, and the consequences of substance abuse

- Over 60,000 Native Americans who are likely to be eligible for Medicaid have never enrolled
- Native Americans are confused as to where to go to seek care (IHS vs. private providers)

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 the Medicaid-eligible Native American population in managed care.

Recognizing that there is legitimate concern among the Native American communities about being required to enroll in managed care, the state, in addition to the Tribal Consultation held in August, directed the consultants to convene informal workgroups and consultations in order to invite the community to work towards the goal of taking more control over parts of the system. (See Attachment C for a complete list of informal meetings).

During two days of an informal workgroup including Native American advocates and providers as well as representation from the IHS, the discussion focused on how the State might encourage the tribes to play a greater role in the management of their care through one of the following options:

- Requiring the MCOs to contract with IHS and or 638 clinics as part of their networks so that Tribes who are able, are paid to provide primary care, care management and/or transportation and other basic health care services;
- Transforming existing clinics or other provider sites to function as Health Homes for Native American's with chronic conditions;
- Providing a subset of Medicaid services as a sub-capitated provider to the MCOs under the Global waiver; and/or
- Forming a Native American MCO that would contract directly with the state.

At this time it is the State's intent to move the Native American population into the comprehensive delivery structure but, at a minimum, require the plans to contract with on-site care managers and to engage a Native American clinical person to assist in developing strategies to reduce the enormous health disparities that continue to cost lives and money, while enhancing cultural appropriateness of care coordination, services and care delivery.

The State will work with the tribes to provide technical support towards converting existing clinics and/or developing provider sites that can function as integrated health homes for the care of those with chronic conditions. This will further enhance the opportunity for Native American Medicaid recipients to receive care and care coordination in their communities as well as potentially provide economic opportunities to the tribes.

In the past, the federal government has engaged in the process of contracting with Tribes for the delivery of health care services financed by the Indian Health Service. These activities were authorized by Congress under Public Law 93-638. The State is interested in extending this “638” self-determination process by exploring the use of “mini block grants” to any tribe or community that seeks to take greater control of Medicaid service delivery for their members. These mini-block grants can benefit the Native American communities by:

- Offering greater control of the service delivery system;
- 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;
- Encouraging the development of Native American care delivery systems as potential engines of economic opportunity; and
- Providing more opportunity for the Native American communities to serve their members regardless of whether those members are Medicaid eligible or not.

The option of creating a full-risk Native American MCO may not be feasible in the short-term due to the lack of capital and administrative infrastructure and expertise. However, in the future it should not be ruled out as a way for the tribes to design and manage health care that is accountable to their own people and their values.

These ideas will be explored more fully in both Tribal Consultation and informal workgroup settings.



## New Mexico Stakeholder Input

### Attachment A: New Mexico Stakeholder Input

During the months of July & August 2011, the State conducted a series of public stakeholder meetings to collect the concerns, opinions and advice of members, advocates, providers and citizens of all regions of New Mexico. 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 & 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

The following tables represent individual public comments made by attendees. The comments are categorized according to the four principles of the Medicaid modernization project.

#### Principle 1: Comprehensive Coordinated Delivery System

Comment/Consideration	Program Area
Single provider coordinating care for cancer patients.	Care Coordination
Outcome Measures focused on screening, care coordination, quality of life.	Quality
PACE model of care is best for Pueblo communities to deliver long-term care.	LTC
Include SSP services to the deaf/blind community as a Medicaid covered service.	Benefits
Need to increase the ability for small businesses and individuals to provide in small areas.	Providers
Support for community health workers. Have preventive care at home or community based or school based health centers	Access
More support for care givers. Programs like Mi Via people can hire their own support.	Benefits
Make it easier for people to keep working and get services at home.	Access
Respite for care givers. People who provide long term services develop their own problems.	Benefits
Not penalizing docs for conditions they can't control. Can't monitor when people eat or going to gym.	Benefits
Ending gross receipts tax for doctors.	Providers
Co-pays hurt patients and providers. Docs see fewer patients and patients seek fewer care.	Benefits
Improve access to services and resources to rural areas and create a competition; Transportation in rural areas.	Access
Comprehensive directory of providers would be helpful to patients; Even just a once a month clinic that came in to release pressure could relieve costs.	Access

Comment/Consideration	Program Area
Better verification of eligibility.	Access
Early intervention and preventative care make a big difference and are working. Would like to see more of that.	Quality
Integrate physical and behavioral health.	Benefits
Individualize teaching and training for a specific client or caregiver or family to take better care at home.	Model
Consumer wants to have more input into their care plan.	LTC
Respite hours based on acute level. Ability to bank that respite if not used one year. Roll over to the next year or get credit back at least.	Care Coordination
Supply coordination. Continuing to get supplies that they don't need. Huge waste. Local recycle deposit for the supplies	Model
More vouchers for assisting people with rent.	Benefits
Services coordinators for MCOs have too large caseloads.	Care Coordination
Better management of Fraud and abuse.	Quality
Don't cut attendant care hours. This leads to other things that cost more – example: hours cut and suffered injury while attendant wasn't there.	Benefits
Reward patient and providers for getting and giving preventative care, rather than charging co-payments for services. Would be a true partnership between patient and provider.	Model
Long-term care – 30 day requirement to get the waiver from a long-term care facility to home. Instead waive these requirements so people can get out when they want to get out. Cost savings will justify.	LTC
Adult Daycare may help people stay in home Occupational Therapy, PT and Speech Therapy Home based services.	Benefits
Criteria of services needs to be addressed.	Benefits
Quicker assessments;  Base assessments on what the client is telling them instead of prompting them on what they may need.	Care Coordination
Define the diagnosis of developmental disability.	Benefits
Incentives. Giving people an incentive to go to work to get programs. Example: SSI or SSDI Ticket to Work program.	Model
More education to people about resources, i.e. behavioral health.	Model
Increase income limits, the guideline to obtaining waiver services.	Model
More Preventive services.	Benefits
Expand Tele-health.	Model
Cover vision services.	Benefits
Extend reenrollment; Express eligibility, if a child qualifies for free food, auto-enroll in New MexiKids.	Model
Healthcare for undocumented.	Model
Reduce prior auths required by MCO.	Model
Increase hours for TBI.	Benefits
Keep PCO.	Benefits

## Principle 2: Personal Responsibility

Comment/Consideration	Program Area
Include health education; More education on taking medications. Keep them out of hospital; Quality of care givers under PCO. There needs to be better quality care givers. More than 40 hours of training and training should be specialized, especially with those people with Developmental Disabilities. Caregivers may not have the experience or training to support needs; Need outreach workers that go to communities.	Model
Include assistance scheduling preventive care.	Benefits
Offer nutrition classes.	Benefits
Offer access to exercise facilities.	Benefits
Study Native American populations separately when designing programs for health promotion and disease prevention; Reward and incentives need to be client specific.	Model
Internet access is not reliable in rural areas; Phone-based for those without internet	Access
Stop smoking aids	Benefits
Access to healthy foods in rural areas	Access
Don't make documentation by providers too labor intensive	Providers
Support service providers are working well	Benefits
Comprehensive Health Plan where everybody played a part – providers and patients <ul style="list-style-type: none"> <li>• Skill building activities</li> <li>• Utilizing PCP to set goals</li> <li>• Preventative services as a mandatory benefits for participant of Medicaid</li> <li>• Mandatory training</li> <li>• Education</li> <li>• Economics</li> </ul> All in conjunction with BH, agree with Parity.	Model
Providers responsibility <ul style="list-style-type: none"> <li>• Rewarding patient by acknowledgement</li> <li>• Nurses are big on preventative care and can be an example</li> <li>• Provider incentives when patient gets healthier and stays healthier</li> <li>• Patient should see a benefit too by decreased co-pays.</li> </ul> Universal electronic medical records will help with keeping track of medications	Model
Cut off payment after 2nd baby – Pay for 2 babies only; Time limit to program. . . moves to stair-step program to get them off.	Benefits
In ER, to prevent a violation the client has to be seen by a medical providers. . . could that be a nurse practitioner or MD who says this is not an emergency situation go to walk-in clinic.	ER
Need more dental health willing to take Medicaid	Benefits
If you don't have an area where a medical professional is available, do a triage and have a medical hotline that has the professional education to ask the right questions about an ER situation – Make mandatory.	ER

Comment/Consideration	Program Area
Keep Medicaid in schools and funding for School based health centers.	Access
Better transportation and access.	Access
Nurse and medical hotline.	Access
Extended hours for urgent care centers.	Access
Child care assistance.	Benefits
Co-payment for non-emergency ER if urgent care is open.	ER
Ensure more behavioral health and substance abuse providers.	Access
Financial incentives – gas cards and school supplies.	Model
State needs to be better, effective outreach programs.	Model
Develop a stair-step program to get people off Medicaid.	Model
Better regulation on TANF and Food Stamps (can't buy candy or pop or cigarettes).	Model
Could be a sliding scale to co-pays; No co-pays for non-generic drugs. Generic medications react different with some people.	Benefits
Volunteer to help pay for the premiums.	Model
Often times people go to ER because they run out of medications. – Need a better way to get them their medications.	Access
Health home for physical care – What about a pharmacy home? Coordination between pharmacies to help manage the medications.	Model
Funding mobile crisis response in rural areas.	Access
No shows, cost money. Needs to be some kind of consequence that is very sensitive and tailor made.	Model
IHS should be a performance based pay provider using bench marks and quality control measures.	Quality
IHS needs to develop secondary services based on epidemiology data, chronic disease patterns.	Access
Reward PCPs who achieve healthy behaviors of their patient panels.	Model
Limited access to PCP in rural areas <ul style="list-style-type: none"> <li>• Access to specialists</li> <li>• Follow up services</li> <li>• Preventative services</li> <li>• Telemedicine</li> </ul> Crisis units in rural areas	Access
Cost to copy records.	Technology
Access between physicians. Physicians not talking to each other.	Providers
Electronic Medical Systems not universal.	Technology
Service duplication due to records.	Technology
Information not being shared between doctors and hospitals.	Technology
Helping providers hold people accountable – need more doctors that can spend a longer period of time with patients to get to know them and develop a relationship to encourage them to take more responsibility for their own care.	Providers
Relates to recruitment and retention of doctors in rural and frontier areas.	Access

### Principle 3: Pay for Performance

Comment/Consideration	Program Area
Should be rewards built in for preventative health care, particularly there seems to be a lack of services for adults on the Medicaid side.	Model
Coordination of care activities for both PH and BH need to have parity with face to face contact or treatment activities to coordinate care.	Care Coordination
ECHO program – Telemedicine/telehealth program that is involved with educating providers as well as volunteers, aimed at chronic disease. Now been informed that Molina is paying providers to present cases. In a larger area not a big deal, but in rural area it is. Can it be incorporated at some level in Medicaid Modernization.	Benefits
Expansion of promatras throughout the state.	Model
Doctors not getting adequate reimbursement.	Providers
Lose middle management.	Model
Have all service fees the same across the board for all providers.	Providers
State needs to focus on the top five arenas of physical and mental health.	Model
Operational definitions need to be identified.	Model
Look at high users and provide incentive goals to lower use.	Model
Let providers develop and incentivize.	Model
On recipient end – have levels of co pays. People who do not take doctor's advice to improve their health will be charged higher co pays after the first year on the program.	Model
Part of Medicaid eligibility requirement is to make a mandatory one year screening package. Saves catastrophic down the road.	Model
Incentives – like car insurance if you don't have accidents you get money back. Under Health Care Reform would be good to have incentives for not over utilizing care.	Model
Keep all 12 waivers as we have them. Global gives opportunity below 1902 baseline. Very risky to manage ourselves.	Model
Home visits generated by providers. If providers generate it will help keep people healthy. Check-ups would reduce visits to hospital.	Benefits
Money incentives to stay healthy.	Model
Make recipients aware of the costs. Send out information on how much their visits cost.	Model
System change, such as student loan forgiveness program for Medicaid providers. Look at percentage of Medicaid clients they take throughout their career.	Model
Needs to be an easier process for prescribing doctors to be able to order medication. MCOs need to be better at helping people get the right medications.	Access
Need to see people more quickly before an ER visit.	ER
Rural areas, such as Hatch and Anthony don't have urgent care and their only option is ER; Urgent care is not available or closes early.	ER
Need to use a hot/warm line staffed by nurses to determine if an ER visit is necessary.	ER
How come Medicaid only covers certain transportation companies and not a wider variety.	Access
Community based health at the schools.	Access
Alternative hours/extended hour.	Access
Penalty fee for no shows and cancellations.	Model
Incentivize clinics for holding patients accountable.	Model

## Principle 4: Administrative Simplicity

Comment/Consideration	Program Area
Native Americans should be allowed to opt-out for CoLTS and Salud.	Model
Consider a waiver specifically for Native American “carve-out” and make them totally dependent on federal funding thus relieving the state of FMAP.	Model
Understanding eligibility is problematic in reservation communities.	Model
Design and implement a centralized Managed care; Financial Accounting and Analysis Bureau (MCFAAB) Meet all financial reporting requirements Complete capitation reconciliation Managed care enrollment Desktop Recoupments MCO/state expenditure analysis Related performance measure computations Provide data to actuaries, Legislative committee, etc	Model
Hospitals would like to see a reduction in the number of MCOs to negotiate with.	Providers
Include behavioral health to coordinate physical and behavioral through a single MCO.	Model
Streamline physical and administrative access of Native Americans to the healthcare system.	Model
Slowly decrease non-mandatory services by reducing services to the healthy first and chronically ill last.	Model
Do not introduce additional premiums or co-payments.	Model
Review Scopes of Practice and allow providers to work at the “top of their scope” and to the fullest extent of their education and NM law.	Providers
Consider competitive bidding.	Model
Simplify re-enrollment process, especially with chronic conditions.	Model
Simplify the credentialing process for providers.	Model
Increase provider incentives to work in rural areas.	
Tort reform brought up to increase doctors who want to practice in NM and reduce overutilization of services.	Model
Have to have a one-stop shop for eligibility.	Model

## New Mexico Waivers

## Attachment B: Waiver Services

	Salúd! 1915(b)	Behavioral Health Services 1915(b)	CoLTS 1915(b) 1915(c)	MiVia 1915(c) (ICF/MR and NF Waivers)	DD 1915 (c)	Medically Fragile 1915 (c)	AIDS 1915 (c)	CHIP 1115 (services for which a co-pay is required)	SCI (services for which a co-pay is required)
Accredited Residential Treatment Center Services		✓							
Adult Day Health			✓						
Ambulatory Surgical Services	✓		✓						
Anesthesia Services	✓		✓						
Assertive Community Treatment Services (ACT)		✓							
Assisted Living			✓	✓					
Assistive Technology					✓				
Audiology Services	✓		✓						
Behavior Support Consultation				✓	✓	✓			
Behavior Management Skills Development Services		✓							
Behavioral Health and Substance Abuse: Outpatient Office Visit and Outpatient Substance Abuse Treatment Inpatient Behavioral Health and Inpatient Detox								✓	✓
Case Management	✓		✓		✓	✓	✓		
Community Direct Support				✓					
Community Integrated Employment Services									
Community Transition Relocation Specialists					✓				
Community Transition Services			✓						

	Salúd! 1915(b)	Behavioral Health Services 1915(b)	CoLTS 1915(b) 1915(c)	MiVia 1915(c) (ICF/MR and NF Waivers)	DD 1915 (c)	Medically Fragile 1915 (c)	AIDS 1915 (c)	CHIP 1115 (services for which a co-pay is required)	SCI (services for which a co-pay is required)
Comprehensive Community Support Services		✓							
Consultant Support Guide				✓					
Crisis Supports					✓				
Customized Community Supports				✓	✓				
Customized In-Home Living Supports				✓	✓				
Day Treatment Services		✓							
Dental Services	✓		✓		✓			✓	✓
Diabetes Treatment									✓
Diagnostic Imaging and Therapeutic Radiology Services	✓		✓						✓
Dialysis Services	✓		✓						✓
Durable Medical Equipment and Medical Supplies	✓		✓						✓
Emergency Response			✓	✓					
Emergency Services (including emergency room visits)	✓		✓					✓	✓
Employment Supports				✓					
Environmental Modifications			✓	✓	✓				
EPSDT	✓		✓						
EPSDT Personal Care	✓		✓						
EPSDT Private Duty Nursing	✓		✓						
Family Planning	✓		✓						
Federally Qualified Health Center Services	✓								
Home Health Aide				✓		✓			



	Salúd! 1915(b)	Behavioral Health Services 1915(b)	CoLTS 1915(b) 1915(c)	MiVia 1915(c) (ICF/MR and NF Waivers)	DD 1915 (c)	Medically Fragile 1915 (c)	AIDS 1915 (c)	CHIP 1115 (services for which a co-pay is required)	SCI (services for which a co-pay is required)
Home Health Services	✓		✓						✓
Homemaker/Direct Support Services				✓					
Homemaker/Personal Care							✓		
Hospice Services	✓		✓						
Hospital Inpatient	✓	✓	✓					✓	✓
Hospital Outpatient	✓	✓	✓					✓	✓
Independent Living Transition Service					✓				
Inpatient Hospitalization in Free Standing Psychiatric Hospitals		✓							
Intense Behavioral Support					✓				
Intense Medical Living Supports					✓				
Laboratory Services	✓		✓						
Licensed Alcohol and Drug Abuse Counselors		✓							
Living Supports					✓				
Multi-Systemic Therapy Services		✓							
Non-Accredited Residential Treatment Centers and Group Homes		✓							
Nursing					✓				
Nursing Facility Services			✓						
Nutritional Counseling				✓	✓	✓			
Nutritional Services	✓		✓						
Occupational Therapy			✓		✓				✓
Oral Surgery									✓
Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospital		✓							

	Salúd! 1915(b)	Behavioral Health Services 1915(b)	CoLTS 1915(b) 1915(c)	MiVia 1915(c) (ICF/MR and NF Waivers)	DD 1915 (c)	Medically Fragile 1915 (c)	AIDS 1915 (c)	CHIP 1115 (services for which a co-pay is required)	SCI (services for which a co-pay is required)
Outpatient Health Care Professional Services		✓							
Personal Care Services			✓						
Personal Plan Facilitation				✓					
Personal Support/Companion					✓				
Personal Support Technology/On-Site Response Site					✓				
Pharmacy Services	✓	✓	✓						
Physical Health Services	✓		✓						
Physical Therapy			✓		✓				✓
Physician Visits		✓			✓			✓	✓
Pregnancy Termination Procedures	✓		✓						✓
Preliminary Risk Screening and Consultation Related to Inappropriate Sexual Behavior					✓				
Prescriptions								✓	✓
Preventive Services	✓		✓						
Private Duty Nursing			✓	✓	✓	✓	✓		
Prosthetics and Orthotics	✓		✓						
Psychosocial Rehabilitation Services		✓							
Reconstructive Surgery									✓
Rehabilitation Services	✓		✓						✓
Related Goods				✓					
Reproductive Health Services	✓		✓						
Respite			✓	✓	✓	✓			
School-Based Services	✓	✓	✓						

	Salúd! 1915(b)	Behavioral Health Services 1915(b)	CoLTS 1915(b) 1915(c)	MiVia 1915(c) (ICF/MR and NF Waivers)	DD 1915 (c)	Medically Fragile 1915 (c)	AIDS 1915 (c)	CHIP 1115 (services for which a co-pay is required)	SCI (services for which a co-pay is required)
Service Coordination			✓						
Skilled Maintenance Therapy Services (including OT, PT and Speech)			✓						
Skilled Therapy for Adults				✓		✓			
Socialization and Sexuality Education					✓				
Specialized Medical Equipment and Supplies						✓			
Special Rehabilitation			✓						
Specialized Therapies				✓					
Speech and Language Therapy			✓		✓				✓
Telehealth Services	✓								
Tot-to-Teen Health Checks	✓		✓						
Transplant Services	✓		✓						
Transportation (Medical)	✓		✓						
Transportation (Non-medical)				✓	✓				
Treatment Foster Care	✓								
Treatment Foster Care II	✓								
Vision Services	✓		✓						
Women's Health Services									✓

## Attachment C: Outreach to Native Americans

Meeting and Attendees	Date
<p>Tribal Consultation, Pueblo Cultural Center, Albuquerque. 79 individuals attended.</p> <p>Secretary Squier outlined the 4 principles of the Modernization effort and the State's desire to create a comprehensive, integrated system of care for New Mexico. There was mixed feedback from the attendees ranging from an emphasis on the state and the federal governments honoring the treaty obligations to provide health care to Native Americans to concerns about managed care to advocating of managed care as a way of decreasing health disparities.</p>	August 3, 2011
<p>As part of the outreach effort, the Department of Human Services and Alicia Smith &amp; Associates scheduled a 2-day workgroup with invited staff from the Indian Health Service and the tribes. The meetings were held at the HSD offices in Santa Fe, New Mexico. The attendees included:</p> <p>Brent Earnest – Deputy Secretary HSD  Theresa Belanger – Native American Liaison HSD  Betina McCracken – Secretary's Office HSD  Kim Horan – HSD  David Antle – Pueblo of Isleta  Roxanne Spruce Bly – Bernalillo County off-Reservation Native American Health Commission  Robin Clemmons – Pueblo of Acoma  Richie Grinnell – IHS  Earlene Groseclose – IHS  Lisa Maves – Pueblo of Jemez  April Wilkinson – Pueblo of Acoma  Jennifer Nanez – Pueblo of Acoma  Sandra Winfrey – IHS</p> <p>Comments included:</p> <ul style="list-style-type: none"> <li>Concerns with the managed care experience with the CoLTS program. Some stated that their members had never seen a care coordinator from the CoLTS plans;</li> <li>Both the tribal and IHS participants expressed their opposition to the elimination of the "opt/out" option from managed care enrollment for Native Americans on Medicaid.</li> <li>Recent experiences with Salud plans have been better;</li> <li>A full-blown Native American MCO is probably not an option at this point, although there was interest in managing discrete portions of the Medicaid benefit;</li> <li>Discussion of the role that IHS and tribal 638 facilities could play in managed care as Patient Centered Medical Homes and/or Health Homes as both a means of economic opportunity and a way to let Native American's play a more active role in providing care;</li> <li>Care coordination and case management must be done locally if it is to be meaningful and successful for tribal members</li> </ul>	September 28-29, 2011
As a follow-up to the workgroup meetings, Alicia Smith and David Parrella from Alicia Smith & Associates met with Governor Luarkie at the Laguna pueblo to discuss economic opportunities that could be available to the tribes under a managed care model.	October 4, 2011
Alicia Smith met with Dr. Ron Lujan and his son, Eric as well as with Robin Clemmons from Acoma to discuss their concerns and desire for a more active role in providing care to their own Tribes. They also shared their concerns that the current plans in New Mexico do not contract with and/or reimburse Tribes for care management and transportation services they provide. They would like to see a replication of a PACE-like model.	Week of October 10th, 2011

Meeting and Attendees	Date
<p>David Parrella travelled to Window Rock to meet with Roselyn Begay, the Director of the Navajo Nation Department of Health, and the members of her staff. Also in attendance was Floyd Thompson from the Window Rock Area Office of the Indian Health Service.</p> <p>Comments included:</p> <ul style="list-style-type: none"> <li>• Interest in contracting with the state to manage some portion of the Medicaid budget, but frustration that they could not contract directly with CMS.</li> <li>• One stated goal was that ultimately the Navajo Nation would like to be able to manage its own Medicaid program as a carve out from the Four Corners states (New Mexico, Arizona, Utah, Colorado)</li> <li>• Any contract with the state to manage Medicaid benefits would need to include risk corridors to protect the tribe from catastrophic costs</li> <li>• Eligibility intake at the IHS facilities is an issue since many tribal members lack transportation and have to hitch-hike to the hospital for services. When they are referred to out-stationed eligibility workers for Medicaid intake, they often do not have the necessary documentation with them and are required to make another trip to apply.</li> </ul>	November 4, 2011
<p>David Parrella met with Dr. Ron Lujan and his son, Eric, from the Taos Pueblo in Albuquerque.</p> <p>Comments included:</p> <ul style="list-style-type: none"> <li>• Dr. Lujan was opposed to any attempt to force the enrollment of Native Americans in private for-profit managed care companies. He was very clear about his desire for the state to maintain the “opt out” option from managed care for Native Americans.</li> <li>• Dr. Lujan is interested in a model where the state would contract to a consortium of Native American service providers for the elderly along the lines of the PACE program.</li> </ul>	November 4, 2011
David Parrella met with members of the Albuquerque Area Indian Health Board	December 8, 2011
Second Tribal Consultation	March 20, 2012