Overview[1] of Centennial Care 1115 Waiver Renewal Draft Application for the NM Legislative Finance Committee October 25, 2017

Beginning its fourth year in 2017, Centennial Care is changing the health care delivery system in New Mexico with a focus on integrated care, including robust care coordination, and emphasis on four key goals:

- To assure the right amount of care, at the right time, and in the most cost effective or "right" setting;
- To advance payment reform and assure that care is measured in terms of its quality and not merely quantity;
- To encourage greater personal responsibility of members and facilitate their active participation in their own health so they can become more efficient users of the health care system; and
- To streamline and modernize the program in preparation for the increase in membership that occurred with the expansion of Medicaid to previously ineligible low-income adults.

Achievements:
• ***Streamlining administration of the program*** *by consolidating a myriad of federal waivers that siloed care by populations. Today, four managed care organizations (MCOs) administer the full array of services in an integrated model of care.*
• ***Building a care coordination infrastructure*** *that promotes a person-centered approach to care. Evidence of the success--lower costs associated with inpatient stays and increased utilization of primary care office visits, preventive care, and behavioral health services.*
• ***Increasing access to long-term services and supports (LTSS)*** *for people who previously needed a waiver slot to receive such services. Today, more than 29,000 individuals are receiving home and community based services (community benefit) which is an increase of 10.5% per year between 2014 and 2016.*
• ***New Mexico continues to lead the nation*** *in spending more of its long-term care dollars to keep members in their homes and in community settings rather than institutional settings.*
• ***Demonstrating both cost-effectiveness and improved utilization of health care services***—enrollment in the Medicaid program has grown 8.5% per year while per capita costs have decreased 1.5% between 2014 and 2016.

Building on these successes and accomplishments, the New Mexico Human Services Department (HSD) has identified opportunities for continued improvement as well as opportunities to leverage successful initiatives for the next iteration of **Centennial Care—Centennial Care 2.0 in 2019**. The following sections provide more detail about the Centennial Care waiver renewal goals that will further refine the current program.

[1] The draft application and additional information is available here: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Target Care Coordination

Care Coordination remains central to the effort of ensuring the right care, at the right time, and in the right place. Improvements to care coordination include targeting members with high needs/high costs through initiatives that promote integration of physical health, behavioral health and long-term services and by leveraging partnerships with programs that are person-centered and delivering improved health outcomes.

Increase Care Coordination at the Provider Level:

- Build upon medical home models that effectively coordinate care for members by leveraging best practices and value-based purchasing (VBP) initiatives.
- Establish two approaches for care coordination delegation—Full Delegation Model allows providers to accept risk for an attributed membership through a VBP arrangement; Shared Functions Model allows the MCO to retain some care coordination activities while sharing others with providers and partners such as Core Service Agencies, Community Health Workers, Community Health Representatives, school-based health centers, local governments, and personal care agencies.

Improve Transitions of Care:

HSD intends to improve transitions of care by implementing measures that enhance care coordination for members and provide situation-specific assistance for short-term transition periods, including, but not limited to:

- Discharge from an inpatient or nursing home stay;
- Frequent emergency department visits in a short period of time;
- Release from incarceration or detention facilities among justice-involved individuals;
- Community placement from a residential or institutional facility; and
- Children returning home from a foster care placement.

Expand Successful Programs that Target High Need Populations:

- Continuing to incentivize innovative collaborations between the MCOs and community agencies, such as paramedicine providers, wellness centers, PCS agencies and Project ECHO;
- Continuing efforts to build capacity and provide flexibility for the use of Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists, to provide care coordination functions;
- Piloting a wraparound approach (intensive care coordination) for youth involved with the CYFD to improve health outcomes and reduce stays in residential treatment centers

Initiate care coordination for justice-involved prior to release from incarceration:

- Allow care coordination activities to be conducted by county/facility prior to release
- Strengthen MCO contract requirements regarding after-hour transitions and require a dedicated staff person with each MCO to serve as a liaison with the facilities

Obtain 100% federal funding for Native American members for services received through Indian Health Services (IHS) and/or Tribal 638 facilities to leverage CMS's reinterpretation of federal guidance

Benefit and Delivery System Modifications

Benefit design changes and delivery system modifications include:

Provide a single, comprehensive benefit package for most Medicaid adults:

- The renewal proposes to cover most adults, including both the Medicaid Expansion adults and the Parent/Caretaker Adults under a single, comprehensive benefit plan similar to the Alternative Benefit Plan.
- Individuals who are considered "Medically Frail" may be determined exempt from the adult package coverage and receive the standard Medicaid benefit package without coverage limitations.
- Eliminate habilitative services from the ABP, but add a limited vision benefit similar to the standard Medicaid vision benefit.
- Expand service providers for the non-emergent medical transportation benefit to include ride sharing companies and leverage new technologies such as mobile apps
- Waive the federal EPSDT rule for adults in the Expansion or Parent/Caretaker categories who are 19-20 years old.

Develop buy-in premiums for dental and vision services for adults, if needed:

If HSD needs to eliminate optional dental and/or vision services for adults to contain costs, then it proposes to offer dental and vision riders that members may purchase from the MCO as is standard practice with most private insurance coverage.

Continue to increase access to home and community-based services (HCBS) while managing costs and aligning benefits:

- Allowance for costs of start-up goods when a member transitions from agency-based community benefits to self-directed community benefits (SDCB).
- Address the need for additional caregiver respite, specifically for caregivers of children with special health care needs by increasing the number of hours available from the current limit of 100 to 300 hours.
- Establish limitations on costs for certain services in the SDCB model.
- Implement an ongoing automatic Nursing Facility Level of Care approval with specific criteria for members whose condition is not expected to change over time.
- Partner with nursing facilities and Project ECHO for consultation services to nursing home staff to better manage members with complex conditions.
- Continue to work with Tribal providers to develop their capacity to enroll as Long-Term Services and Supports providers for Agency-Based Community Benefits.

Develop a home-visiting program focused on pre-natal, post-partum and early childhood development services:

- Collaborate with the Department of Health and Children, Youth and Families Dept. to implement a home visiting pilot in designated counties to provide Medicaid-reimbursable services to eligible pregnant women.

Develop Peer-Delivered, Pre-Tenancy and Tenancy Support Services:

- Expand supportive housing services to improve health outcomes for active participants with serious mental illness (SMI). The pre-tenancy and tenancy support services would be delivered by peers in two supportive housing programs—Linkages and Lead Agencies.

Request waiver from limitations imposed on the use of Institutions for Mental Disease:

- Federal financial participation is limited for when individuals between the ages of 21 and 64 are utilizing this service. This proposal would improve the availability of residential inpatient treatment services for those needing such services.

Improve the integration of behavioral health and physical health services through expansion of the Health Homes:

- In April 2016, HSD launched its Health Home model that focuses on members with serious mental illness and severe emotional disturbance to ensure a continuum of care. HSD plans to leverage its experience with two pilot sites to expand Health Homes to additional counties and providers.

Support Workforce Development:

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

Request waiver authority for enhanced administrative funding to maintain an inventory of Long Acting Reversible Contraceptives for certain providers.

Expand Payment Reform Initiatives

Payment reform efforts in Centennial Care are achieving better value by driving improvements in quality and slowing the growth of spending in the program. Currently, the Centennial Care MCOs are required to have 16% of all provider payments in VBP payment arrangements. For purposes of the 1115 Demonstration renewal, HSD proposes the following VBP goals:

Continue to drive value by improving provider readiness to participate in risk-based payment arrangements and increasing the share of provider payments that are risk-based.

Leverage VBP arrangements that drive key program goals in the areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes.

Align the Safety Net Care Pool (SNCP) Program with Improved Quality Outcomes:

- The SNCP is comprised of two programs—the Uncompensated Care (UC) pool and the Hospital Quality Incentive Initiative (HQII) pool. The UC pool provides funding to 29 eligible hospitals for uncompensated care expenditures while the HQII provides incentives for hospitals that achieve certain quality metrics.
- From 2014 to 2016 there was a 30% decrease in requests for funding from the 29 hospitals participating in the Safety Net Care Pool's UC program.
- HSD proposes an incremental shift of the funding ratio between the two pools so that a greater amount of funding is allocated to the HQII pool. This ratio better aligns with the goal of ensuring that care is measured by its quality and not solely by quantity.
- Given the success of the SNCP, HSD is considering expanding the SNCP to include other provider types such as nursing facilities.

Increase Member Engagement and Personal Responsibility

Advance the Centennial Rewards Program

HSD proposes to restructure rewards to focus on new conditions and to promote more proactive engagement. Modifications include:

- Designing rewards criteria to promote proactive participation, such as lowering blood pressure, meeting weight loss goals or smoking cessation;
- Utilizing earned rewards to apply toward monthly premium payments; and
- Improving the promotion of Centennial Rewards by requiring targeting outreach, including mobile app technology to expand member engagement and participation.

Implement premiums for populations with income that exceeds 100% of the federal poverty level (FPL):
Applies to three categories of eligibility:

- Children's Health Insurance Program (CHIP)
- Working Disabled Individuals (WDI)
- Adults in the Expansion category with income above 100% FPL (OAG)

FPL Range	Annual Household Income (HH of 1)	Applicable COEs	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
101-150% FPL	$12,060-$18,090	OAG, WDI, TMA	$10	$20	$20	$40
151-200% FPL	$18,091-$24,120	WDI, TMA, CHIP	$15	$30	$30	$60
201-250% FPL	$24,121-$30,150	WDI, TMA, CHIP	$20	$40	$40	$80
251-300% FPL	$30,151-$36,180	TMA, CHIP	$25	$50	$50	$100

- Native American members will be exempt from premiums;
- Implementation Date of Premium Requirements: HSD proposes to implement the premium payments requirements within six months of the effective date of the Centennial Care 2.0 program; and
- HSD also proposes leveraging the Member Rewards vendor to assist with premium collection and also incorporating the use of earned rewards to offset the premium payment as outlined above.

Require co-payments for certain populations:

	CHIP	WDI	Expansion Adults	All Other Medicaid
Population Characteristics and Service	Age 0-5: 241-300% FPL Age 6-18: 191-240% FPL	Up to 250% FPL	Co-pays for individuals with income greater than 100% FPL.	
Outpatient office visits • Preventive visits exempt • BH outpatient exempt	$5/visit	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	$50/stay	$50/stay	$50/stay	No co-pay
Outpatient surgeries	$50/surgery	$50/surgery	$50/surgery	No co-pay

Prescription drugs, medical equipment and supplies ● Psychotropic drugs and family planning drugs/supplies exempt ● Not charged if non-preferred drug co-pay is applied	$2/prescription	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs ● Psychotropic drugs and family planning drugs/supplies exempt	$8/prescription All FPLs and COEs, certain exemptions will apply			
Non-emergency ER visits	$8/visit All FPLs and COEs, certain exemptions will apply			

The following populations would be exempt from all copayments:

- Native Americans;
- ICF-IID individuals;
- QMB/SLIMB/QI1 individuals;
- Individuals on Family Planning-Only;
- Individuals in the PACE program;
- Individuals on the DD waiver; and
- People receiving hospice care

Seek authority to modify the tracking requirements for cost sharing.

HSD seeks authority to change the frequency of tracking of annual cost sharing maximum amounts to align more closely with commercial insurance. HSD proposes to track the five percent out-of-pocket maximum on an annual basis and to allow the member to track his/her out-of-pocket maximum and report to the MCO when he/she has reached the maximum

Expand opportunities for Native Americans enrolled in Centennial Care.

- Continue to work with the MCOs to expand contractual and/or employment arrangements with CHRs throughout the State.
- Collaborate with tribal provider to develop their capacity to become a Health Home provider and LTTS provider.
- Seek authority to collaborate with Indian Managed Care Entities (IMCE) as defined in Section IV of the Federal Indian Health Care Improvement Act and 42 CFR section 438.14, including a pilot project with Navajo Nation. An IMCE may operate in a defined geographic service area, but would be required to meet all other aspects of federal and state managed care requirements, including but not limited to, financial solvency, licensing, provider network adequacy and access requirements.

Simplify Administration through Refinements to Eligibility

The following policies are intended to streamline aspects of the Centennial Care program. Streamlining eligibility processes will reduce administrative costs to HSD, simplify the program for beneficiaries, and, in some instances, reduce health care expenses.

Eliminate the three month retroactive eligibility period for Centennial Care members:

- This retroactive period is accompanied by an intensive reconciliation process and substantial administrative burden. In CY 16, 1% of the Medicaid population requested this coverage.
- Hospitals and Safety Net Clinics are able to immediately enroll individuals at point of service through the Presumptive Eligibility program and receive payment for services.
- Native American members and individuals residing in nursing facilities would remain eligible for the three month retroactive period.

Accelerate the transition off Medicaid for individuals who lose eligibility due to increased earnings by requesting a waiver of the Transitional Medical Assistance (TMA) program, which provides an additional year of coverage to Parents/Caretakers who have increased earnings that make them ineligible for the program:

- Since the implementation of the ACA, this program has become less needed as evidenced by declining enrollment; most individuals with increased earning move to the Adult Expansion category, which has a higher income threshold. Individuals with income above the Adult Expansion group guidelines can receive subsidies to purchase coverage through the Exchange.

Implement an automatic Nursing Facility Level of Care re-approval for certain members whose condition is not expected to change over time.

Incorporate eligibility requirements of the Family Planning program:

- HSD proposes to better target the Family Planning program to those who are accessing these services by designing it for individuals through the age of 50 who do not have other health insurance coverage.

Request waiver to cover former foster care individuals up to age 26 who are former residents of other states.