

Public Notice of New Mexico's 1115 Waiver Application to Create the Centennial Care Program

Overview

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

Of the approximately 2 million citizens in the State, more than a quarter (approximately 560,000 people) currently receives their health care through the Medicaid program. This large number of Medicaid recipients presents many challenges for the State including increasing costs, administrative complexities and the difficulty of ensuring quality care for all recipients.

The program is expensive, consuming about 16% of the current State budget—up from 12% last State fiscal year (SFY) and rising to 20% next SFY. Specifically, in 2011, New Mexico and the federal government spent approximately \$3.8 billion on Medicaid services for New Mexicans. The rate of growth in costs precedes the approximately 175,000 additional people who will be added to the program beginning January 2014 under the PPACA and for whom the State will ultimately bear some of the costs.

The New Mexico Medicaid program is also administratively complex. Today, the program operates under 12 separate waivers as well as a fee-for-service (FFS) program for those either opting out of or exempt from managed care, and seven (7) different health plans execute this complicated delivery system.

Finally, and perhaps most importantly, the State is not 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, New Mexico believes that now is the time to modernize Medicaid to assure that the State is buying the most effective, efficient health care possible for our most vulnerable and needy citizens and to create a sustainable program for the future.

Pursuant to CFR, Section 431.408 (a)(i)

(A) Program Description, Goals and Objectives:

Overall Program Description

The State seeks approval of a Section 1115 waiver to create a comprehensive, managed care delivery system under which contracted health plans will offer the full array of current Medicaid services, including acute, behavioral health, home and community based and long term institutional care. Home and community based, long term institutional and self-directed home and community based services provided to the DD population under existing 1915(c) waivers will not be included in the 1115 waiver. Services offered to the Medically Fragile through the existing 1915(c) waiver will be folded into the managed care service delivery structure in July 2015.

The key to the coordinated service delivery system that the State seeks to build is a person-centered care coordination system through which those at the highest level of acuity and risk for poor health outcomes will be guided through the system and assisted in developing personalized plans to care to assure that all necessary services are provided.

The key components of the managed delivery system include:

- The integration of benefits all provided through contracted managed care health plans;
- Reduction in the number of health plans to a more manageable number using the State's competitive procurement process;
- The comprehensive care coordination system referenced above and described in great detail in the proposed waiver document;
- A focus on health literacy using community health workers, community health representatives, promotoras and other trained, lay-workers to help individuals through the system;
- The development of Health Homes as described under the PPACA. The initial focus will be on recipients with a behavioral health diagnosis but over time health homes will be developed for individuals with chronic physical health conditions or co-morbid conditions;
- A focus on the further development of patient-centered primary care medical homes to continue the trend towards a focus on good primary care;

- Pilot payment reform projects to begin to focus more on the quality of the services offered rather than on the quantity;
- Modest co-payments on legend drugs for which a generic equivalent is available and for the non-emergent use of the ER (described more fully in another section of this notice and in the waiver document at pages 31 and 32)

These key features of the program are described in more detail in the waiver document. See pages

The goals and objectives of the program include:

- Assuring that Medicaid recipients in the program receive the right amount of care at the right time and in the most cost-effective or “right” settings;
- Ensuring that the care being purchased by the program is measured in terms of its quality and not its quantity;
- Slowing the growth rate of costs or “bending the cost curve” over time without cutting services, changing eligibility or reducing provider rates; and
- Streamlining and modernizing the program in preparation for the potential increase of up to 175,000 recipients beginning in January 2014.

The design of the program has been driven by four guiding principles:

1. Developing a comprehensive service delivery system that provides the full array of benefits and services offered through the State’s Medicaid program;
2. Encouraging more personal responsibility so that recipients become more active participants in their own health and more efficient users of the health care system;
3. Increasing the emphasis on payment reforms that pay for performance rather than for the quantity of services delivered; and
4. Simplifying the administration of the program for the State, for providers and for recipients where possible.

Beneficiaries Impacted

All current beneficiaries of the Medicaid program will be impacted by the development and implementation of Centennial Care except: Qualified Medicare

Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualified Individuals; Refugees, Undocumented aliens and children with subsidized adoption placements in other states. For a more thorough description of the beneficiaries included and excluded by Centennial Care, see the waiver document at pages 4-7.

(B) Proposed Delivery System, Eligibility Requirements, Benefit Coverage, and Cost Sharing

Delivery System

As stated above, the State proposes to develop a comprehensive managed care service delivery system with the full range of benefits offered through the plans (with exceptions as noted for DD services). Key features of the delivery system include:

- A reduced number of health plans;
- Comprehensive care coordination;
- A focus on health literacy;
- Health Homes and Patient-Centered Medical homes
- Self-direction for home and community based services
- A behavioral health care in
- Integrated care for the dually eligible

Eligibility

Everyone eligible for Medicaid in January 2014 will be covered by this waiver with the exceptions in the next two sections.

Partially covered by the waiver:

These two groups will be partially covered under the waiver:

1. Members on the Developmentally Disabled (DD) waiver receiving Home and Community Based Services (HCBS): DD HCBS services will continue to be provided outside of managed care, but all non-HCBS services will be handled through managed care
2. Members in the Mi Via program that meet ICF/MR level of care: ICF/MR services will continue to be provided outside of managed care, but all non-ICF/MR services will be handled through managed care

NOT affected by the waiver:

These members will not be covered by the waiver and will continue to receive the same benefits the same way:

1. Low income Medicare recipients receiving cost sharing and premium assistance through Medicaid

2. Refugees and Undocumented Aliens
3. Out-of-state adoption placements

All of the groups covered under the waiver will be eligible for the same benefit packages, although access to some services may depend on a level of need assessment. The groups that currently receive limited benefits packages, like people in the Family Planning or Breast and Cervical Cancer groups, will receive the same Medicaid benefits as everyone else as long as they are eligible for Medicaid and meet the level of needs requirements.

Impact on Eligibility Groups

The main changes to eligibility for the groups covered under the waiver are the following:

1. Everyone covered by the waiver will select a Managed Care Organization (MCO) when they apply for Medicaid, and be enrolled in that MCO if they are eligible
2. Each MCO will manage the full range of benefits for all of its Members, including Behavioral Health and Long Term Care
3. Most people will be enrolled as of the day they become eligible and benefits will begin that day, rather than up to 3 months retroactively
4. Member copays will be required for people with income over 100% of FPL for certain services:
5. Anyone eligible for Medicaid who meets Nursing Facility Level of Care (NF LOC) will be able to receive Community Long Term Care (CLTC) services, including Personal Care Option (PCO) services and HCBS, but there will be maximum cost restrictions that will depend on the person's level of need
6. Those meeting NF LOC who are residents of a Nursing Facility will continue to be eligible if they are below 300% of the Federal SSI standard
7. Those meeting NF LOC who are not eligible for any other group and not residents of a Nursing Facility will continue to be eligible for Medicaid and CLTC on a limited basis (depending on funding availability), if they are below 300% of the Federal SSI standard, but there will be maximum cost restrictions that will depend on the person's level of need

The plans will be expected to cover all Medicaid services except for home and community based and long term institutional care provided to the DD population. See pages 8-10 of the waiver for more detailed information.

Cost-Sharing

There are two cost-sharing components in the waiver. The first is a co-payment for individuals with incomes above 100% of the federal poverty level who choose to access care through an emergency room even after being advised that the presenting health problem is not an emergency. Before a co-payment can be assessed, the hospital must:

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

The amount of the co-pay is:

- For a child whose household income is 100-150% of the FPL, \$6.00
- For an adult whose household income is 100-150% of the FPL, \$25.00
- For a child whose household income is above 150% of the FPL, \$20.00
- For an adult whose household income is above 150% of the FPL, \$50.00

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

The State is seeking a waiver to extend an exemption from all co-payments to the Native American community.

Further description of co-payments can be found in the waiver document at pages 31-32.

(C) Estimates of Expected Increase or Decrease in Annual Enrollment and in Aggregate Expenditures

The proposed waiver program would begin on January 1, 2014 with the five-year demonstration going through December 31, 2018. The five-year term of the demonstration project, covers Calendar Year (CY) 2014 through 2018. The time periods for the five-year demonstration period are detailed in the table below:

Demonstration Year (DY) Time Periods

Demonstration Year	DY1	DY2	DY3	DY4	DY5
Time period	1/1/2014 – 12/31/2014	1/1/2015 – 12/31/2015	1/1/2016 – 12/31/2016	1/1/2017 – 12/31/2017	1/1/2018 – 12/31/2018

The development of cost and caseload projections were based on data from State Fiscal Year 2007 (SFY2007) through SFY2011. The most recent SFY2011 data was incomplete and was used for trending purposes only. SFY10 was chosen as the base year throughout the cost and caseload projections. All historical Medicaid program expenditures were included in the historical and prospective periods with the exceptions of the following programs who were excluded:

- Recipients residing in ICF/MRs;
- Developmentally Disabled Children (1915c services only); and
- Medically Fragile 1915(c) – are excluded for the periods between January 1, 2014 and June 30, 2015. In July 2015 the Medically Fragile 1915(c) services are included.

Additionally, Centennial Care Without and With waiver projections beginning in January 1, 2014 exclude any population in excess of 138% of FPL (133% + 5% Income Disallow), with the exception of children, currently covered under the existing Medicaid program: Specifically these populations include:

- Limited benefit pregnant women above 138%;
- Breast and Cervical Cancer Prevention and Treatment (BCCPT) above 138%; and
- Family planning program participants above 138%.

Budget Neutrality Approach

The proposed budget neutrality limit for Federal Title XIX funding is based on a combined per capita cost method, aggregate DSH and aggregate SCPH method with annual budget targets. The State would not be at risk for conditions (economic or other) that may impact caseload levels in each of the groups for the demonstration years. For the per member per month (PMPM) portion of the budget neutrality, the State is not liable for any caseload growth within a MEG but is liable for excess costs over the PMPM limits. Budget neutrality would not be limited to each individual MEG PMPM, but rather across all MEG PMPMs for the entire five-year demonstration (i.e., PMPM savings in one MEG for the five

years may offset PMPM costs in another MEG for the five years). The five year historical and projected periods include all program expenditures:

- Fee-For-Service (FFS) expenditures
- Managed care capitation program expenditures
- Cost settlements and gross adjustments
- DSH expenditures
- Sole Community Provider Hospital expenditures

Summary of Budget Neutrality

Centennial care is intended to reduce the cost of the program by slowing or reducing the historical cost curve by improving the delivery of care to Medicaid clients. Savings are achieved through a focus on the client which are based on a foundation of a comprehensive delivery system intended to provide recipients with the right services in the right setting. This is accomplished by implementing the following framework intended to identify and provide for the health care needs of the client versus make benefit or reimbursement cuts to services:

- Consolidation and improved integration of the delivery of services such as physical health, behavioral health and long term services through fewer managed care organizations which is intended to eliminate a fragmented method of identifying client needs and consolidating the delivery of health care services. An additional benefit other than removing fragmentation of service delivery is the fact that through consolidation of managed care organizations will take advantage of economies of scale which will generate managed care savings through lower administrative fees to the MCO.
- Focus on client needs by directing care management and coordination to identify and direct appropriate resources to those in the most need of services.
- Implementing and integrating patient centered medical homes and health homes to help recipients manage their health care.
- Utilize technology to bring health care to underserved populations and areas.
- Implementing enrollment targets for each year of the demonstration for home- and community-based eligible recipients. The effect will be the avoidance and/or delay of these eligible recipients from entering nursing facilities which are more costly than HCBS in concert with the goals and objectives of Centennial Care.

(D) Hypothesis and Evaluation

The State will work with stakeholders to finalize an evaluation plan and the waiver progresses through the CMS approval process. However, a major focus of the evaluation is to measure the impact of development a comprehensive community long term care benefit package and offering it without using “slots” to any otherwise Medicaid eligible recipient who meets nursing facility level of care. The State wishes to measure the impact of this policy change in order to determine whether it increase eligibility to long term care benefits to those “at risk” of meeting nursing facility level of care as the program matures and costs begin to stabilize.

In addition, the State’s evaluation design will assess key program objectives such as:

- The role of comprehensive care coordination in increasing access to needed services, ensuring the services are provided in a timely manner and improving health outcomes;
- The effect of payment reform on improving patient health disparities and physician adherence to evidence based best practices; and
- The impact of access to health homes for stabilizing and/or improving conditions for those with behavioral health and/or multiple chronic health conditions.

The evaluation activities will include the monitoring and evaluation of:

- Hospital readmissions within 30 day for certain diagnoses;
- Health disparities
- Utilization of home and community based services and
- The number of recipients enrolled in health homes.

(E) Specific Wavier Authority Sought

The following waivers are requested to enable New Mexico to implement the New Mexico Centennial Care section 1115 demonstration.

A. Title XIX Waiver Requests

1. Reasonable Promptness Section 1902(a)(8)

Consistent with existing HCBS waiver authority (section 1915(c) of the Social Security Act), to the extent necessary to enable the State to establish enrollment targets for certain HCBS for those who are not otherwise eligible for Medicaid. The State will take into account current demand and utilization rates and will look to increase such enrollment targets in order to appropriately meet the long term care needs of the community.

**2. Amount, Duration and Scope of Services Section 1902(a)(10)(B)
42 CFR 400 Subpart B**

To the extent necessary to enable the State to permit managed care plans to offer different value added services or cost-effective alternative benefits to enrollees in Centennial Care.

To the extent necessary to enable the State to offer certain HCBS and care coordination services to individuals who are Medicaid eligible and who meet nursing facility level of care.

To the extent necessary to allow the State to place expenditure boundaries on HCBS and personal care options.

3. Recipient Rewards Section 1902(a)(10)(C)(i)

To the extent necessary to enable the State to exclude funds provided through recipient reward programs from income and resource tests established under State and Federal law for purposes of establishing Medicaid eligibility.

4. Freedom of Choice Section 1902(a)(23) 42 CFR 431.51

To enable the State to require participants to receive benefits through certain providers and to permit the State to require that individuals receive benefits through managed care providers who could not otherwise be required to enroll in managed care.

Moreover, all services will be provided through managed care included behavioral health, HCBS and institutional services except for services received under the existing Developmental Disabilities 1915(c) waiver and the accompanying Mi Via program for those who meet ICF/MR level of care.

5. Retroactive Eligibility Section 1902(a)(34) 42 CFR 435.914

To enable the State not to extend eligibility prior to the date that an application for assistance is made. Notwithstanding the foregoing, the State will comply with maintenance of efforts requirements of the PPACA. Moreover, this provision (along with the rest of the Centennial Care program) will not be implemented until January 1, 2014.

6. Cost Sharing Sections 1902(a)(14) and 191642 CFR 447.51-447.56

To permit the State to impose a copayment for non-emergency use of the emergency room on populations with household incomes above 100% of the federal poverty level that is in excess of the amount permitted pursuant to section 1916A of the Act. Copayments will not be imposed on individuals for whom Indian health care providers, as specified in section 1932(h) of the SSA, have the responsibility to treat.

7. Self-Direction of Care Section 1902(a)(32)

To permit persons receiving certain services to self-direct their care for such services.

B. Expenditure Authority Waiver Requests

Under the authority of SSA section 1115(a)(2), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration, be regarded as expenditures under the Medicaid State Plan but are further limited by the special terms and conditions for the section 1115 demonstration.

1. Expenditures made under contracts that do not meet the requirements in section 1903(m) of the SSA specified below. Managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m), except the following:
 - Section 1903(m)(2)(H) and Federal regulations at 42 CFR 438.56(g) but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90-days or less in the same managed care plan from which the individual was previously enrolled.
2. Expenditures for recipient reward's programs.
3. To the extent necessary, expenditures for valued added services and/or cost effective alternative services to the extent those services are provided in compliance with federal regulations and the 1115 demonstration.
4. Expenditures for direct payments made by the State to SCPH where hospitals receive payments out of a pool.
5. Expenditures under contracts with managed care entities where either the State or the managed care entity will provide for payment for Indian health care providers as specified in section 1932(h) of the SSA for covered services furnished to Centennial Care managed care plan recipients at the OMB rates.
6. Expenditures for Centennial Care recipients who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under SSA section 1902(a)(10)(A)(ii)(VI) and 42 CFR §435.217 in conjunction with SSA section 1902(a)(10)(A)(ii)(V), if the services they receive under Centennial Care were provided under an HCBS waiver granted to the State under SSA section 1915(c) as of the initial approval date of this demonstration. This includes the application of spousal impoverishment eligibility rules.

7. Expenditures to provide HCBS not included in the Medicaid State Plan to individuals who are eligible for Medicaid.

Pursuant to CFR 431.408(a)(1)

(ii) location and internet address where copies of the demonstration application are available for public review and comment:

The State's Centennial Care Demonstration Waiver application in more detail, can be found on the HSD website at

<http://www.hsd.state.nm.us/pdf/Medicaid%20Modernization/Waiver%20Submission%20to%20CMS.pdf>

(iii) The State continues to solicit comments on the Centennial Care Demonstration Waiver with several options for interested parties to submit comments.

- E-mail: Medicaid.Comments@state.nm.us
- Phone: 1-855-830-5252
- Regular Mail: Centennial Care Comments – Human Services Department
P.O. Box 2348, Santa Fe, New Mexico 87504

(iv) location, date and time of at least two public hearings

HSD conducted a special Medicaid Advisory Committee (MAC) meeting on May 17, 2012 from 9:00 a.m. to 11:00 a.m. at the Garrey Carruthers State Library, 1205 Camino Carlos Rey in Santa Fe, New Mexico with the sole agenda items focusing on the Centennial Care Demonstration Waiver. A complete audio transcript of that meeting can be found on the HSD website at <http://www.hsd.state.nm.us/mad/MMeetings.html>.

HSD will hold two public hearings, another (MAC) meeting and will present before the Legislative Health and Human Services (LHHS) Committee to solicit comments from interested parties on the Centennial Care Demonstration Waiver on:

Date: Monday, June 25, 2012

Time: 1:00 p.m. to 5:00 p.m.

Location: Santa Fe

Legislative Health and Human Services Committee
State Capitol, Room 307 Corner of Old Santa Fe Trail
and Paseo de Peralta, Santa Fe, New Mexico

Date: Tuesday, June 26, 2012

Time: 1:30 p.m. to 4:00 p.m.

Location: Albuquerque

UNM Continuing Education Building
1634 University Blvd. NE, Auditorium
Albuquerque, New Mexico

Date: Wednesday, June 27, 2012

Time: 10:00 a.m. to 12:30 p.m.

Location: Las Vegas

Las Vegas Middle School - Lecture Hall
947 Old National Road
Las Vegas, New Mexico

Date: Monday, July 16, 2012

Time: 1:00 p.m. to 5:00 p.m.

Location: Las Cruces

NM Farm & Ranch Heritage Museum
4100 Dripping Springs Road – Ventanas Room
Las Cruces, New Mexico

Webinar and/or teleconference details will be forthcoming, and will be posted on the Centennial Care page of the HSD website at www.hsd.state.nm.us as well as the state website at <http://www.newmexico.gov/>.

If you are an individual with a disability and require an accommodation to participate in the meeting, please call (505) 827-6245 or e-mail to betina.mccracken@state.nm.us as soon as possible.