CENTENNIAL CARE NEXT PHASE
1115 Waiver Renewal Subcommittee
January 13, 2017
<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
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<tbody>
<tr>
<td>Introductions</td>
<td>8:30 – 8:40</td>
</tr>
<tr>
<td>Feedback from December meeting</td>
<td>8:40 – 8:45</td>
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<tr>
<td>Value-Based Purchasing</td>
<td>8:45 – 10:00</td>
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<tr>
<td>Break</td>
<td>10:00 – 10:10</td>
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<tr>
<td>Member engagement and personal responsibility</td>
<td>10:10 – 11:10</td>
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<tr>
<td>Public comment</td>
<td>11:10 – 11:25</td>
</tr>
<tr>
<td>Wrap up</td>
<td>11:25 – 11:30</td>
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Renewal Waiver
Areas of Focus

- Refine care coordination
- Address social determinants of health
- Opportunities to enhance long-term services and supports
- Continue efforts for BH and PH integration
- Expand value-based purchasing
- Member engagement and personal responsibility
- Benefit alignment & Provider adequacy
Value Based Purchasing (VBP)
## VBP

### Opportunities/Goals

- Pay for value, not volume
- Improve quality of care and member outcomes
- Reward care that keeps members healthy or reduces disease burden
- Providers partnering with payers to achieve better outcomes and share in savings
- Bend the cost curve of Medicaid expenditures
- Align VBP strategies with program goals to increase care coordination, improve transitions of care, increase physical and behavioral health integration, reduce health disparities through population health strategies and improve member engagement.
VBP Guiding Principles

- High value care—best health outcomes at lowest cost.
- Phasing-in of increasingly advanced VBP models.
- Allowing for MCO flexibility of models—considering predominance of certain populations, i.e., percentage of long-term care members, as well as prevalence of chronic and/or high-cost conditions in the population.
- Allowing for provider flexibility—different points of readiness and ability to participate.
- Development of uniform quality goals that align with Centennial Care goals.
- Commitment to training, data sharing and technical assistance to support providers.
VBP Models

Lower Risk

- Rewards/Incentives
- Penalties
- Shared Savings
- Bundled Payments
- Global or Capitated Payment

Higher Risk
Current VBP Landscape

- In CY17, MCOs are required to spend a minimum of 16% of provider payments in VBP arrangements.

- Level 1: Incentives/Withholds (5%)
- Level 2: Shared savings and bundled payments (8%)
- Level 3: Some or full-risk capitation (3%)

Delivery System Reforms:
- Health Homes (PMPM)
- Safety Net Care Pool: Hospital Quality Improvement Incentive and Uncompensated Care Pool
- Shared Savings with Patient Centered Medical Homes (PCMHs/FQHCs) – (PMPM)
- Bundled Payments for Episodes of Care
- Capitated Arrangements
# VBP

## Beginning the Discussion

<table>
<thead>
<tr>
<th>Needs</th>
<th>Concepts</th>
<th>Further Discussion</th>
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<tbody>
<tr>
<td>Improving provider readiness for VBP and willingness to bear more risk.</td>
<td>Providers have varied levels of readiness for VBP payment strategies and concerns about bearing more risk.</td>
<td>1. How can we continue to develop our VBP strategy with flexibility for MCOs and providers, but move to more advanced models to achieve greater value and alignment with better healthcare outcomes?</td>
</tr>
<tr>
<td>Providers desire flexibility within VBP options.</td>
<td>Providers need reliable data, particularly related to costs of services they do not deliver, and technical assistance to utilize data sources.</td>
<td>2. How can we support providers who are in early stages of readiness?</td>
</tr>
<tr>
<td>Minimum threshold of attributed lives to participate in some models.</td>
<td>BH and LTSS providers can be particularly challenged by risk based VBP strategies and often require unique models.</td>
<td>3. What modifications are needed in payment structure to facilitate provider transitions to bear more risk over time?</td>
</tr>
<tr>
<td>Actionable and reliable data and reporting.</td>
<td>Quality outcome measures can more resource intensive to collect (Hybrid Measures).</td>
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<tr>
<td>Standardization of quality measures across payers.</td>
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<tr>
<td>Methods to ensure consistent quality measure reporting and validation.</td>
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## VBP

### Beginning the Discussion

<table>
<thead>
<tr>
<th>Needs</th>
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</thead>
<tbody>
<tr>
<td>➢ Eliminating barriers to data sharing/transparency of costs.</td>
<td>➢ Alignment with other payers is challenging due to population differences and quality measure differences.</td>
<td>4. How can models and payments be designed to support care for patients with high non-medical challenges?</td>
</tr>
<tr>
<td>➢ Member engagement in improving health outcomes.</td>
<td>➢ Population–based models require providers to think more broadly about unmet non-medical needs (social determinants of health) and how best to keep patients healthy.</td>
<td>5. What outcomes have the most “value” within the Centennial Care program?</td>
</tr>
<tr>
<td>➢ State staff skill set and resources to monitor/evaluate VBP.</td>
<td>➢ No single entity to convene and coordinate a common vision across payers.</td>
<td>6. What VBP strategies are more effective for BH and LTSS providers?</td>
</tr>
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Member Engagement &
Personal Responsibly
Member Engagement
Centennial Rewards

Incentive program for members to engage and complete healthy activities and behaviors

Reward opportunities in the form of a credit for redemption in catalog:
- Healthy Smiles $25 annual dental visit
- Step-up Challenge $50
- Annual asthma controller Rx maintenance $60
- Healthy pregnancy $100
- Diabetes management $60
- Schizophrenia Rx maintenance $60
- Bipolar disorder Rx maintenance $60
- Bone density testing $35

Members participating in the program vs non-participants:
- Reduction in inpatient admissions
- Higher HEDIS and quality outcomes
- Higher risk members tend to participate in program
- Increase in Rx refills and medication adherence
- Increase in HbA1c testing compliance

Challenges:
- Participation and redemption rates are increasing each year but are only reaching 206k members
Member Engagement
Disease Management

The right care – at the right place – at the right time

- Diabetes Self-Management Programs
- Wellness Programs
- Disease Specific Education Classes
- Communication Coaching
- Telephonic outreach
- Wellness benefits offering up to $50 per year in health/wellness purchases
- Care coordination targeting specific chronic diseases
- Targeted Education and self-help materials

Members participating in the program:
- Learn ways to manage their Diabetes independently
- Incorporate healthier eating opportunities and exercise
- Improved understanding of condition
- Improve confidence when speaking to providers about their condition
- Support smoking cessation needs of members
- Improve health outcomes and quality of life

Additional Member Engagement:
- Member Advisory Committee
- Ombudsman Program to assist Members with MCO processes
- Care coordinators developing alternative methods to engage members who are over utilizing the Emergency Department
Member Engagement
Community Health Workers

- Improve health and health care literacy
- Make linkages to community supports
- Support care coordination
- CHW’s function where the member lives

- Molina community connector
  - Vital member of care coordination team (eyes and ears)
  - Community based (member’s home, providers office, statewide agencies)
  - Face-to-face, hands on with the member

- Presbyterian
  - Tribal-based public health announcements that target priority health conditions and promote health literacy
  - Agreements to have community health representatives assist with completing HRAs
  - Help navigate healthcare systems, educate, and translate

Community health workers role in engaging the member

The right care – at the right place – at the right time
## Member Engagement & Personal Responsibility

### Cost Sharing

| Copayments          | Require copayments for certain services and populations
<table>
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<tbody>
<tr>
<td></td>
<td>- Expansion, Working disabled, CHIP</td>
</tr>
<tr>
<td></td>
<td>- Inpatient stays</td>
</tr>
<tr>
<td></td>
<td>- Outpatient surgeries</td>
</tr>
<tr>
<td></td>
<td>- Office visits</td>
</tr>
<tr>
<td></td>
<td>- Non-ER transportation (urban only)</td>
</tr>
<tr>
<td></td>
<td>- Most populations</td>
</tr>
<tr>
<td></td>
<td>- Non-emergency use of emergency room</td>
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<tr>
<td></td>
<td>- Use of non-preferred drugs</td>
</tr>
<tr>
<td>Premium contribution</td>
<td>- Income based</td>
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<tr>
<td>Appointment no-shows</td>
<td>- Reduce missed appointments</td>
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<td>- Expand treat first model</td>
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Member Engagement & Personal Responsibility
Beginning the Discussion

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<tr>
<th>Needs</th>
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</tr>
</thead>
<tbody>
<tr>
<td>➢ Continue to encourage greater personal responsibility for members engagement in their own health.</td>
<td>➢ Add new areas of focus, conditions, or behaviors for Centennial Rewards.</td>
<td>1. How to further improve member engagement in the Rewards program?</td>
</tr>
<tr>
<td></td>
<td>➢ Changes to Reward values or expanded Rewards for major or sustained improvements.</td>
<td>2. Other ideas for increasing member engagement?</td>
</tr>
<tr>
<td></td>
<td>➢ Allow Rewards for potential cost-sharing requirements.</td>
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<tr>
<td></td>
<td>➢ Improve engagement and participation in Rewards program through data mining, risk assessment, or technology.</td>
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</table>
### Member Engagement & Personal Responsibility

**Beginning the Discussion**

<table>
<thead>
<tr>
<th>Needs</th>
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<th>Further Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Implement policies that will encourage greater personal responsibility and financial accountability for higher income members.</td>
<td>- Reduce no-show appointments.</td>
<td>1. How to structure to incentivize healthy behaviors and use of services?</td>
</tr>
<tr>
<td>- Financial disincentives for accessing health care in the least efficient manner.</td>
<td>- Implement copayments for certain members use of services.</td>
<td>2. Premium hardship waiver circumstances.</td>
</tr>
<tr>
<td></td>
<td>- Implement premiums for higher income members.</td>
<td>3. Other initiatives beyond financial penalties to reduce appointment no-shows</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Other ideas to align member engagement and value based purchasing?</td>
</tr>
</tbody>
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Subcommittee Meetings
Timeframe for Discussion

October 14, 2016
• Goals & objectives
• Waiver background
• Care coordination

December 16, 2016
• BH–PH integration
• Long-term services and supports

February 10, 2017
• Benefit alignment and Provider adequacy

November 18, 2016
• Care coordination
• Population health

January 13, 2017
• Value-based purchasing
• Member engagement and personal responsibility

January 2017

February 2017
Centennial Care Value-Based Purchasing Brief

Background
The need to improve quality and efficiency in state Medicaid programs has led to implementation of a variety of payment reform efforts across the nation. As states face increasing pressures to maximize the value of their Medicaid spending while enrollment continues to increase, many are seeking strategies that will move the delivery system away from payments on a fee for service basis to paying for improved healthcare outcomes for recipients. The most costly Medicaid members with complex medical needs are served, for the most part, by a system that is not incentivized to improve care coordination or healthcare outcomes.

In its 1115 waiver that authorizes Centennial Care, New Mexico included payment reform as a key goal for its Medicaid managed care program. The Centennial Care contractual agreements required the Managed Care Organizations (MCOs) to pilot payment reform projects that focused on paying for value rather than volume of services. In 2015, the MCOs launched 10 pilot projects with an aim to begin to move the delivery system toward payment for improved quality. The New Mexico Human Services Department (HSD) collaborated with the MCOs to develop key performance measures for the projects in an effort to achieve better alignment for the providers, primarily utilizing a set of HEDIS measures in combination with several efficiency metrics, such as decreasing inpatient readmission rates.

In their value-based payment arrangements, the Centennial Care MCOs are expected to expand pay for value strategies within their provider networks using a variety of value-based purchasing models. Models are generally defined based on the level of up-side or down-side risk incurred within the arrangements.

Value-based purchasing models at the lower risk of the spectrum include incentives or pay for performance where providers are rewarded for hitting defined quality of care goals. Shared savings
models reward providers for meeting quality of care outcomes that save money for the program. Providers generally share in a portion of the savings realized. Risk models include capitated payments for providers who incur full or partial risk in caring for their population or panel of members. Bundled or global payment options reimburse providers an agreed upon rate that includes all services provided to address a specific condition. Examples of bundled payments are maternity care and joint replacement surgeries).

In their recent publication summarizing state approaches to value-based payment models in Medicaid, the Center for Health Care Strategies outlined five approaches states are using within their Managed Care Contracts:

1. Requiring MCOs to adopt standardized value-based purchasing models
2. Requiring MCOs to make a specific percentage of provider payments through approved VBP arrangements (a current initiative with Centennial Care MCO contracts)
3. Require MCOs to move toward more sophisticated (more risk based) VBP arrangements over the life of the contract (a current initiative with Centennial Care MCO contracts)
4. Require MCOs to actively participate in a multi-payer VBP alignment initiative
5. Require MCOs to launch VBP pilot projects subject to state approval (a current initiative with Centennial Care MCO contracts)

Delivery system reforms within Centennial Care include shared savings and bonus payment arrangements with Patient Centered Medical Home practices and Federally-Qualified Health Centers, which reward providers for achieving agreed-upon quality measures and improved member experience with the practice; provider-delivered, comprehensive care coordination through Health Homes targeted to members with Serious Mental Illness and Severe Emotional Disturbance; bundled payment arrangements for episodes of care, such as maternity and orthopedic services; subcapitated arrangements for providers willing to assume greater risk; and the Safety Net Care Pool that includes the Hospital Quality Improvement Incentive and Uncompensated Care Pool.

<table>
<thead>
<tr>
<th>VBP Project</th>
<th>Type of Payment Reform</th>
<th>Project Description</th>
</tr>
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<tbody>
<tr>
<td>Accountable Care-Link Model</td>
<td>X</td>
<td>ACO-like model with shared savings for improving quality and reducing total cost of care.</td>
</tr>
<tr>
<td>Bundled Payment for Episodes</td>
<td>X</td>
<td>Bundles for bariatric surgery and maternity.</td>
</tr>
<tr>
<td>Subcapitated Payment for Defined Population</td>
<td>X</td>
<td>For primary care and multi-specialty groups that have care management infrastructure; subcapitation allows both upside/downside risks for defined population.</td>
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<thead>
<tr>
<th>Topic</th>
<th>X</th>
<th>Description</th>
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<tbody>
<tr>
<td>Three-tiered Reimbursement for PCMHs</td>
<td>X</td>
<td>PMPM increases for base care coordination; date transfer to HIE; telehealth; use of EHRs; and performing HRAs. A total performance incentive per member payment is possible if the targets for every measure are met.</td>
</tr>
<tr>
<td>Bundled Payments for Targeted Admission Episodes</td>
<td>X</td>
<td>Working to bundle payments for pneumonia and colonoscopies.</td>
</tr>
<tr>
<td>PCMH Shared Savings</td>
<td>X</td>
<td>Builds upon current PCMH pay-for-performance model that rewards quality by adding shared savings targets after total medical costs are below a budget threshold.</td>
</tr>
<tr>
<td>Obstetrics Gain Sharing</td>
<td>X</td>
<td>Reducing unnecessary primary C-section by developing savings targets that reward appropriate use of C-sections. Obstetricians can earn enhanced payment for meeting metrics related to reducing unwarranted C-sections.</td>
</tr>
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To continue to advance value-based purchasing initiatives, HSD has included new contractual requirements in its 2017 MCO agreements, see Appendix A. In CY17, MCOs are required to spend a minimum of 16% of provider payments in VBP arrangements. Within the 16% HSD identified minimums across the spectrum of three VBP levels in order to ensure flexibility for providers that may not have the level of sophistication or resources needed to bear risk while providing opportunities for those providers that do.

After completing a series of site visits with providers participating in the VBP arrangements, it was evident to HSD that providers wanted flexibility within the VBP options and, in order to bear greater risk, needed comprehensive data and agreed-upon calculations of total cost of care. The MCOs are addressing those needs by regularly meeting with providers and sharing data, including score cards, claims data and, in some cases, providing a software program that enables providers to view utilization and expenditure data for attributed patients.

**Defining Value**

In order to effectively pay for value, the Centennial Care program is working to refine what “value” means for the program and how that value will be measured to ensure quality of care. This means identifying the appropriate metrics and measures, data sources and reporting strategies that are necessary to monitor VBP arrangements with an eye to our overarching goal of driving administrative simplicity and alignment where possible. Areas that Centennial Care is targeting as value areas are those topics being vetting through the subcommittee process and include:

- Care Coordination
- Physical and behavioral health integration
- Long-term services and supports
- Improving transitions of care
- Population Health
Key Considerations
Advancing value-based purchasing models is a change for the Medicaid program and participating providers. Key consideration areas include:

- **Health Care Providers and MCOs**
  - Engaging and supporting providers in migration to risk
  - Data analytics
  - Data sharing
  - Attribution of members and
  - Member engagement in improving health
  - Flexibility—not all providers are able to take on risk
  - Multi-Payer alignment on payment and measurement of quality
  - Lack of single convener across payers/delivery System

- **Improving Provider Readiness**
  - Capital Investments (including software / technology)
  - Technical Assistance
  - Clear and Consistent Path forward with reasonable milestones
  - Provider feedback / engagement in process

- **Data Reporting Quality and Consistency**
  - MCO ability to share information with providers
  - Providers’ ability and capacity to utilize data and reporting

- **State policy development and monitoring**
  - No clear pathway to engage with CMS to work on alignment of federal and state VBP strategies and quality metrics
  - Resources and expertise at state to monitor VBP
  - How best to evaluate VBP models

- **Identifying ideal VBP strategies for behavioral health and LTSS providers**

**Additional Challenges and Barriers**

- Continued Use of FFS Payment in Reform Models
- Simply adding P4P bonuses to FFS structure
- Data for Setting Payment Amounts—need transparency around costs
- Provider accountability for costs not within their control
- Patient Engagement—providers must know their patients to be successful
- Member churn within provider practices
- Current Reforms Favor Larger Providers and require minimum number of members
- Transitional Payment Systems
- Staffing / Resource Challenges—State / Provider
Appendix A

VBP in Delivery System Improvement Targets – Centennial Care MCO Contract Language

Value-Based Purchasing

The CONTRACTOR must implement value-based purchasing as outlined in the table below. In order to meet the target, the CONTRACTOR must have met the percentages established below in all three levels; however, CONTRACTORs with more advanced VBP strategies may substitute higher percentages in Level 2 and/or Level 3 for lower percentages in Level 1 as long as the overall target of 16% of payments in VBP arrangements is met for the calendar year.

<table>
<thead>
<tr>
<th>VBP LEVEL 1</th>
<th>VBP LEVEL 2</th>
<th>VBP LEVEL 3</th>
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<tbody>
<tr>
<td>A minimum of 5% of all CONTRACTOR provider payments* for dates of service</td>
<td>A minimum of 8% of all CONTRACTOR provider payments* for dates of service</td>
<td>A minimum of 3% of all CONTRACTOR provider payments for dates of service</td>
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<tr>
<td>between January 1, 2017 and December 31, 2017 will meet the following</td>
<td>between January 1, 2017 and December 31, 2017 will meet the following</td>
<td>between January 1, 2017 and December 31, 2017 will meet the following</td>
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<tr>
<td>criteria:</td>
<td>criteria:</td>
<td>criteria:</td>
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<tr>
<td>• Fee schedule based with bonus or incentives and/or withhold (at least</td>
<td>• Fee schedule based, upside-only shared savings—available when outcome/</td>
<td>• Fee schedule based or capitation with risk sharing (at least 5% for</td>
</tr>
<tr>
<td>5% of provider payment)—available when outcome/quality scores meet</td>
<td>quality scores meet agreed-upon targets (may include downside risk), and</td>
<td>upside and downside risk); and/or</td>
</tr>
<tr>
<td>agreed-upon targets.</td>
<td>• Two or more bundled payments for episodes of care.</td>
<td>• Global or capitated payments with full risk.</td>
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Additional requirements for VBP in CY17

- At least 3% of the overall 16% in VBP contracting must be with high volume hospitals and require readmission reduction targets of at least 5% of the hospital’s baseline.
- CONTRACTOR must include behavioral health community providers in its VBP arrangements.
- CONTRACTOR must include payments to behavioral health community providers in calculating the percentage of overall spend in its VBP arrangements.

*MCOs may exclude provider payments for dually-eligible members from the calculation.
Overview

One of the core principles of the New Mexico Centennial Care program is to encourage greater personal responsibility of members to facilitate their active participation and engagement in their own health so they can become more efficient users of the health care system. As the Human Services Department (HSD) seeks to renew the Centennial Care waiver, the Department is looking to build on and incorporate policies that seek to enhance beneficiaries’ ability to make informed decisions about their health and health care, and to become more active, responsible and involved participants in the health care system.

Member Engagement – Centennial Rewards

The Centennial Rewards program was developed with the launch of Centennial Care in 2014 as a way of providing incentives to members for engaging in and completing healthy activities and behaviors, including:

- **Healthy Smiles** to reward annual dental visits for adults and children;
- **Step-Up Challenge** to reward completion of a 3-week or 9-week walking challenge;
- **Asthma Management** to reward refills of asthma controller medications for children;
- **Healthy Pregnancy** to reward members who join their MCO’s prenatal program;
- **Diabetes Management** to reward members who complete tests and exams to better manage their diabetes;
- **Schizophrenia and/or Bipolar Disorder Management** to reward members who refill their medications; and
- **Bone Density Testing** to reward women age 65 or older who complete a bone density test during the year.

Members who complete these activities can earn credits, which can then be redeemed for items in a Centennial Rewards catalog.

Centennial Rewards Accomplishments

- Inpatient admissions have decreased among participants in the program, resulting in a cost-savings of approximately $23 million in calendar year (CY) 2015.
- The average redemption rate of earned rewards is 24 percent, with the notable exception of the Step-Up Challenge, which has a redemption rate of 85 percent. This suggests that the proactive enrollment required for the Step-Up Challenge has had a substantial positive impact on member use of their rewards.
- Overall cost-savings attributed to the Centennial Rewards program increased by one-third from 2014 to 2015. Reduced inpatient admissions and costs per admission have been the dominant driver behind cost-savings across conditions. See Table 1, below.
Participants across all conditions had higher compliance with HEDIS measures and other quality outcomes than non-participants.

A comparison of risk scores indicates that higher risk members tend to participate in the Centennial Rewards program.

With a full year of data for the Step-Up Challenge, HSD continues to see positive results regarding cost-savings, utilization and quality measures.

Prescription drug refills are higher for participants compared to non-participants. Medication adherence for schizophrenia and bipolar disorder have both increased substantially year-over-year and were above 90 percent for participants in 2015. See Table 2, below.

HbA1c test compliance for participants increased substantially – nearly 20 percent from 2014 to 2015 – while the year-over-year increase for nonparticipants was only one percent.
Centennial Rewards Challenges

- Despite the decrease in inpatient admissions, emergency room visits were higher among participants in the program than among non-participants. This is true for all conditions in the Centennial Rewards program, except for schizophrenia.
- While the number of participants and redemption rate of rewards continues to increase, HSD seeks to continue growing the number of participants and improve member engagement and motivation. Approximately 206,000 Centennial Care members are currently enrolled in the Rewards program.
- HSD has made some changes to the program to reduce administrative costs and better align rewards with the acuity of the Centennial Care population.

Waiver Renewal Discussion Points

HSD might consider restructuring rewards to either focus on new conditions or to promote more proactive engagement, similar to the active enrollment process for the Step-Up Challenge. Ideas for discussion include:

- **Should Centennial Rewards remain tied to HEDIS or should HSD identify new focus conditions and behaviors?** Examples might include lowering blood pressure, meeting weight loss goals, or smoking cessation, and these conditions might be accompanied by a more proactive opt-in enrollment and tracking process, similar to the Step-Up Challenge.
- **Should the reward values change?** Examples might include items that encourage a healthier lifestyle, such as vouchers for a gym membership or weight loss program, or healthy nutrition assistance through gift cards or the WIC program. Higher-value rewards might also be offered for members that achieve major and sustained improvements in their health (i.e., reversal of diabetes or obesity). Rewards might also include exemptions from cost-sharing requirements, such as co-pays or premiums; or they might be restructured to allow members to accumulate rewards as a type of health savings account that could be used toward payment of cost-sharing responsibilities.
- **How can we improve member engagement through the Rewards program?** Examples might include mining data and risk assessments, using text and email to reach and inform members, and other means to allow members to more easily track their rewards (i.e., through mobile technology).

Member Engagement – Disease Management & Care Coordination

In addition to Centennial Rewards, the Centennial Care program has engaged members through multiple initiatives aimed at helping members better manage their chronic conditions. The Centennial Care MCOs have developed strategies that include member engagement through:

- Diabetes self-management programs and other disease-specific education classes
- Wellness programs
- Communication coaching
- Telephonic outreach
- Wellness benefits offering up to $50 per year in health/wellness purchases
- Care coordination targeting specific chronic conditions
• Targeted education and self-help materials
• Use of community health workers to engage members in meeting their care needs and addressing social determinants of health

The MCOs have also incorporated member engagement through their member advisory committees, ombudsman programs to assist members with understanding MCO processes, and by using care coordinators to develop alternative ways of engaging members who frequently use the emergency department. In addition, members in need of long-term services and supports are able to review Community Benefit services together with their care coordinator to determine which services they are interested in receiving through the Community Benefit Services Questionnaire (CBSQ). Self-Directed Community Benefit members are also actively engaged in developing their plan of care, hiring their own providers and determining rates of pay within the state’s approved range of rates. These members are responsible for completing employer-related tasks, such as approving and submitting employee timesheets to the fiscal management agency for payment.

**Personal Responsibility – Cost-Sharing**

The Patient Protection and Affordable Care Act (ACA) expanded Medicaid eligibility to all nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL). In 2012, the U.S. Supreme Court issued a ruling that effectively made Medicaid expansion optional for states. As of January 1, 2017, a total of 32 states—including New Mexico—have expanded Medicaid. The expansion of Medicaid to new low-income adults has resulted in a significant enrollment surge of nearly 600 percent compared to enrollment of low-income adults before the Adult Expansion. Additionally, enrollment in the Children’s Health Insurance Program (CHIP) has increased by 85 percent since early 2014. Compared to other states, New Mexico has generous eligibility thresholds for both children and adults, with the CHIP program extending to 300 percent FPL for children age 0-5 and to 240% FPL for children age 6-18.

Under today’s Centennial Care program, Medicaid Expansion Adults are not subject to any form of cost-sharing, and co-pays for CHIP recipients are minimal. In New Mexico, there are also minimal co-pays for individuals enrolled in the Working Disabled Individuals (WDI) program, which provides coverage for individuals up to 250 percent FPL.

For the Centennial Care waiver renewal, HSD is considering incorporating policies that will encourage greater personal responsibility and financial accountability for individuals in higher-income Medicaid categories, including the Adult Expansion, CHIP and WDI. Please note that Native Americans would be exempt from any cost-sharing proposal set forth by HSD. Ideas under consideration might include:

- **Requiring co-payments.** HSD is considering requiring co-payments for outpatient office visits, inpatient hospital stays, outpatient surgeries, and non-emergency medical transportation (in urban areas only) for Expansion Adults, CHIP and WDI enrollees. In addition, HSD is considering co-payments that would apply to most Medicaid enrollees for using certain non-preferred prescription drugs and for non-emergency utilization of the emergency room.

- **Assessing premiums for populations above 100 percent of poverty.** Premiums are the norm for private insurance and coverage on the federal marketplace, and HSD is considering whether they should be assessed to certain Medicaid populations as well. Many states are pursuing approval of premiums for the Adult Expansion population from the federal government, with some proposing to charge premiums for recipients with income as low as 50% FPL. For an
individual with income between 101-150 percent FPL, a monthly premium of one percent or less of income would be $10 monthly.

- **Minimizing appointment “no-shows”**. With the Adult Expansion of Medicaid, providers have expressed serious concern about rising rates of missed appointments. Under current rules, Medicaid recipients cannot be required to pay fees or sign financial responsibility forms for missed appointments. HSD might consider whether policies should be implemented under the renewed waiver to either allow providers to charge nominal fees for missed appointments or to more positively incentivize appointment adherence (i.e., expansion of the Treat First model).

**Waiver Renewal Discussion Points**

HSD might consider a movement toward policies that promote greater personal and financial responsibility for members, to include co-pays, premiums and ways to minimize missed appointments. Ideas for discussion include:

- **If cost-sharing (either co-pays or premiums) is imposed, how can it be structured to incentivize healthy behaviors and efficient use of the health care system?** Examples might include waiving cost-sharing requirements for members who engage in healthy behaviors, such as preventive visits and well-child checks, completion of the Health Risk Assessment (HRA) and/or Comprehensive Needs Assessment (CNA), or putting contributions into a health savings account to offset health care costs or to offer vouchers that support healthy behaviors.

- **If premiums are assessed, what type of hardship waiver should be developed?** Examples might include exemptions from premiums for individuals who are homeless, who are late paying their rent, mortgage or utilities, or who have had a large and unexpected increase in basic expenses.

- **What types of initiatives would work to reduce appointment no-shows in lieu of financial penalties?** HSD is considering expansion of the Treat First clinical model, which is designed to reduce the behavioral health missed appointment rate for second appointments. The Treat First approach emphasizes the initial clinical practice functions of establishing rapport, building trust, screening to detect possible urgencies, and providing a response to the reason the individual came to the agency during the first visit – rather than spending time at the first appointment on assessments. Results from the model show that it has reduced no-show rates and improved the quality of assessments and treatment plans over the first four encounters. How can this model be replicated? Is there an adjustment of this model that can be translated in the primary care practice environment?

- **What other ways can be used to align member engagement and value-based purchasing quality metrics?** Strategies could include member collaboration with providers to meet agreed-upon goals, such as adherence to medication, obtaining certain preventive screenings, or other outcomes that align with the member’s individualized health targets.