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CENTENNIAL CARE: NEXT PHASE

Kickoff Meeting of the 1115 Waiver Renewal Subcommittee
October 14, 2016

Agenda

- Introductions
- Role of subcommittee
- Subcommittee guidance
- Renewal waiver timeline
- Overview of current waiver
- Key areas for consideration
- Renewal waiver
- Care coordination
- Meeting close/next steps

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Role of Subcommittee

- Provide feedback on key issues for renewal
- Obtain comprehensive and diverse stakeholder input
- Provide input early in the process
- Help to guide development of the concept paper
- Focus on issues relevant for waiver

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Guidance for Discussion

What is waiver vs. non-waiver topics

Waiver

- System Transformation: Items that require waiver authority to implement
- Eligibility changes or expansions
- Benefit packages
- Financing

Non-Waiver

- Policy or implementation issues
- New contract terms, process, or tools
- Modification of provider qualifications
- Implementation of quality strategy and monitoring approaches

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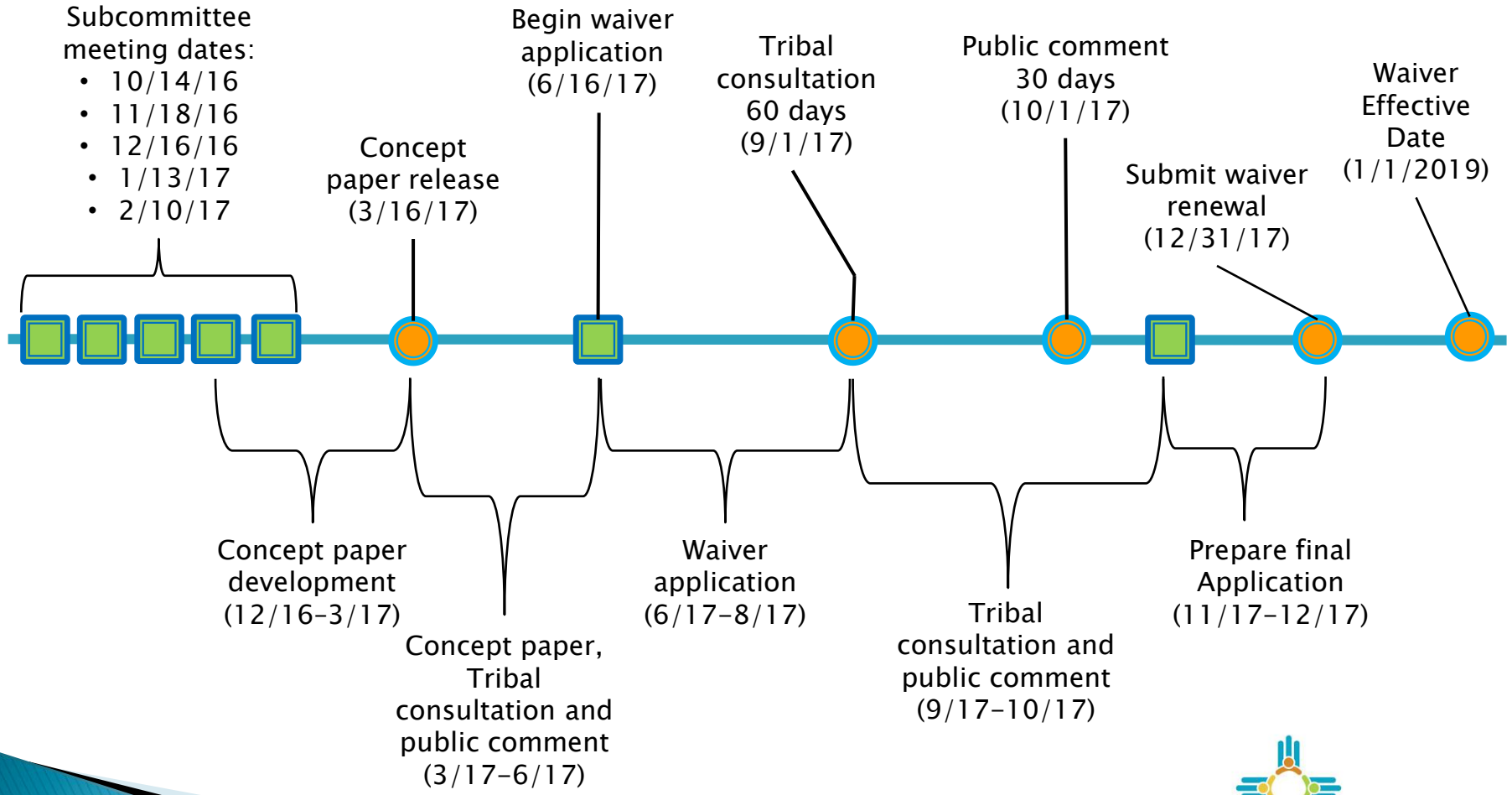
1115 Waiver Renewal

Timeframe



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Overview of Current Waiver

Program Goals

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

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 by members for their own health
- Increasing the emphasis on payment reforms that pay for quality rather than for quantity of services delivered
- Simplifying administration of the program for the state, for providers and for members where possible

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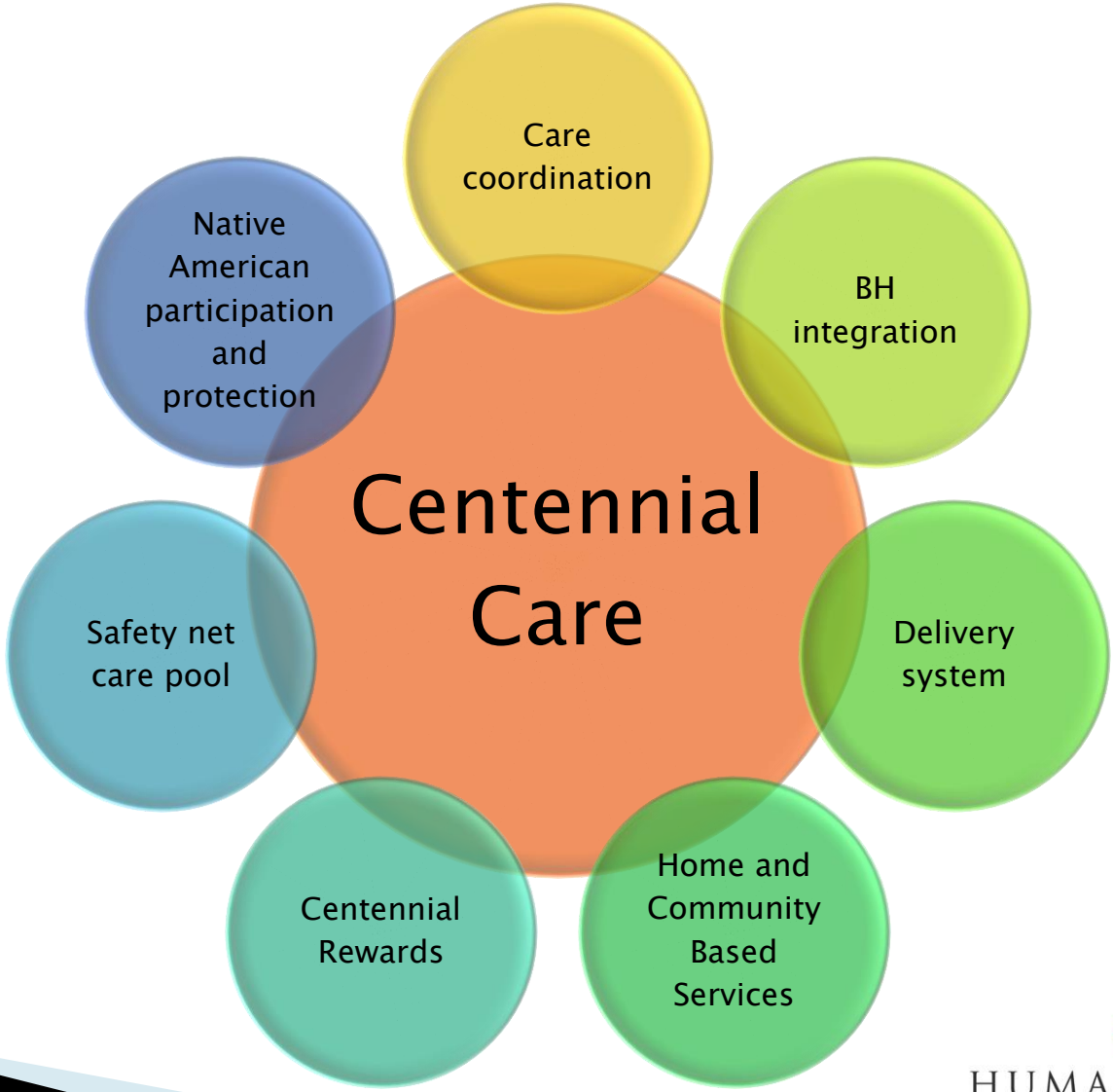
Overview of Centennial Care



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Current Program Successes

Principle 1

Creating a comprehensive delivery system

Build a care coordination infrastructure for members with more complex needs that coordinates the full array of services in an integrated, person-centered model of care

- Care coordination
  - 950 care coordinators
  - 60,000 in care coordination L2 and L3
  - Focus on high cost/high need members
- Health risk assessment
  - Standardized HRA across MCOs
  - 610,000 HRAs
- Increased use of community health workers
  - 100+ employed by MCOs
- Increase in members served by PCMH
  - 200k to 250k between 2014 and 2015
- Telemedicine – 45% increase over 2014
- Health Home – Implemented Clovis and San Juan (SMI/SED)
- Expanding HCBS – 85.5% in community and increasing community benefit services
- Electronic visit verification
- Reduction in the use of ED for non-emergent conditions

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Current Program Successes

Principle 2

Encouraging Personal Responsibility

Offer a member rewards program to incentivize members to engage in healthy behaviors

- Centennial Rewards
  - health risk assessments
  - dental visits
  - bone density screenings
  - refilling asthma inhalers
  - diabetic screenings
  - refilling medications for bipolar disorder and schizophrenia

- 70% participation in rewards program
- Majority participate via mobile devices
- Estimated cost savings in 2015: $23 million
  - Reduced IP admissions
  - 43% higher asthma controller refill adherence
  - 40% higher HbA1c test compliance
  - 76% higher medication adherence for individuals with schizophrenia
- 70k members participating in step-up challenge

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Current Program Successes

Principle 3

Increasing Emphasis on Payment Reforms

Create an incentive payment program that rewards providers for performance on quality and outcome measures that improve members health

- July 2015, 10 pilot projects approved
  - ACO-like models
  - Bundled payments
  - Shared savings

- Developed quarterly reporting templates and agreed-upon set of metrics that included process measures and efficiency metrics

- Subcapitated payment for defined population
- Three-tiered reimbursement for PCMHs
- Bundled payments for episodes of care
- PCMH Shared Savings
- Obstetrics gain sharing

- Implemented minimum payment reform thresholds for provider payments in CY2017 in MCO contracts

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Current Program Successes

Principle 4

Simplify Administration

Create a coordinated delivery system that focuses on integrated care and improved health outcomes; increases accountability for more limited number of MCOs and reduces administrative burden for both providers and members

- Consolidation of 11 different federal waivers that siloed care by category of eligibility; reduce number of MCOs and require each MCO to deliver the full array of benefits; streamline application and enrollment processes for members; and develop strategies with MCOs to reduce provider administrative burden
- One application for Medicaid and subsidized coverage through the Marketplace
- Streamlined enrollment and re-certifications
- MCO provider billing training around the State for all BH providers and Nursing Facilities
- Standardized the BH prior authorization form for managed care and FFS
- Standardized the BH level of care guidelines
- Standardized the facility/organization credentialing application
- Standardized the single ownership and controlling interest disclosure form for credentialing.
- Created FAQs for credentialing and BH provider billing

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Future Outlook and Opportunities

Outlook

- As Medicaid approaches covering almost half of New Mexico's two million population, immense opportunity to drive value and health outcomes for our State
- Continued Medicaid enrollment growth/spending growth combined with reduced oil and gas revenue and an aging population continue to drive—
  - Innovations for LTSS program and better management of dually-eligible population
  - Advancement of value-based purchasing arrangements
  - Strategies to improve care for high utilizers—5 percent of members who account for 50% of spend

Opportunities

- Continue to build upon existing waiver goals and principles
- Improve engagement for unreachable members
- Appropriate level of care coordination for high need populations
- Performance incentives for MCOs and providers

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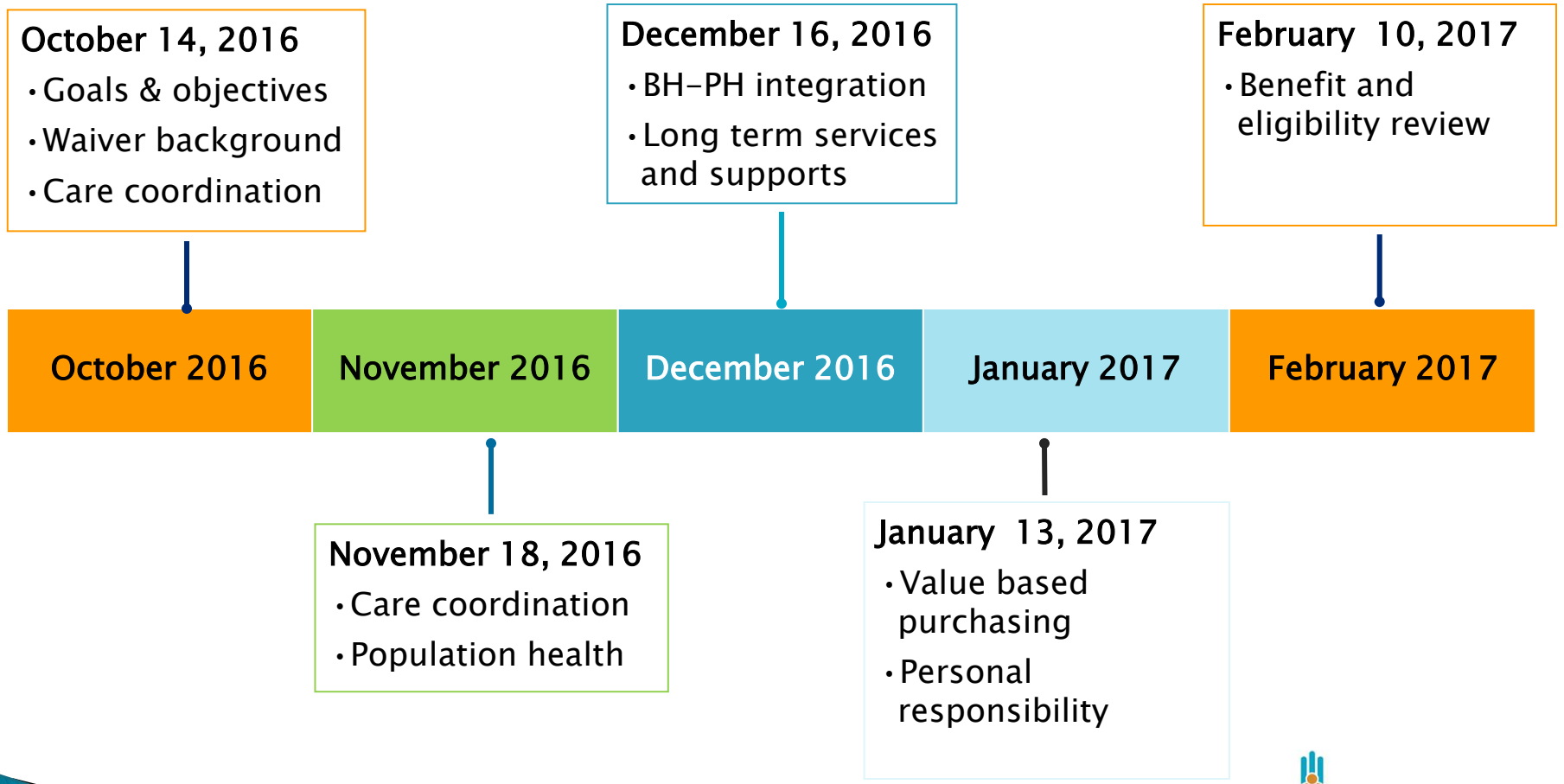
Subcommittee Meetings

Timeframe for Discussion



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Renewal Waiver

- Areas of Focus

Renewal Waiver

Areas of Focus

- Refine care coordination
- Expand value based purchasing
- Continue efforts for BH & PH integration
- Address population health
- Opportunities to enhance long term services and supports
- Provider adequacy
- Benefit alignment and member responsibility

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Care Coordination

Opportunities/Goals

- Improve transitions of care
- Focus on higher need populations
- Provider's role in care coordination

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Care Coordination

Improve Transitions of Care

1. Improve Transitions of Care

- Follow-up after 7 days
- Readmission rates
- Care Coordination chart audits demonstrating opportunities to improve transitions of care
- There is also evidence in Care Coordination audits that suggest a higher-level of care coordination is needed during these critical transitions

Benefit	Challenges	Questions/Feedback
➢ Reduce readmissions ➢ Improve member confidence in their healthcare and providers ➢ Ensure care delivered in the right place	➢ Communication with hospitals/facilities ➢ Engagement of family and other community supports ➢ Member adherence to recommended follow-up	1. What is the value of this initiative to the program overall? 2. What are strategies to improve communication between MCOs and Providers? 3. What are strategies to better engage families? 4. What is the capacity to increase planning and follow-up by care coordinators?

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Care Coordination

Focus on higher need populations

2. Focus on high utilizers, children with special health care needs, difficult to engage members and incarcerated populations

- Use of the Emergency Department (ED) to meet primary care needs
- The largest percentage of high utilizers has a behavioral health diagnosis including mental health and substance abuse.
- Children with special health care needs require unique care coordination interventions due to extent of health needs.
- Incarcerated population requires early interventions prior to release to increase community tenure and recidivism rates.

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Care Coordination

Focus on higher need populations

Benefit	Challenges	Questions / Feedback
➢ Reduced ED use ➢ Reduced hospitalization and re-admission rates ➢ Increase comprehensive holistic care through primary care and specialists ➢ Reduced recidivism ➢ Improved continuity of care	➢ Accessible primary care particularly after-hours ➢ Member understanding/acceptance of appropriate use of the ED ➢ Follow-up care after ED visits ➢ Engaging hard to reach members in care coordination ➢ These populations have high social, economic and resource needs	1. What is the value of this initiative to the program overall? 2. What are other strategies beyond care coordination that may be effective? 3. How can we incentivize participation in care coordination through co-payments (i.e., waive some co-pays for those engaged in care coordination or charge co-payment for non-emergent use of ED)? 4. How can we use Community Health Workers or others as resources for a more intensive touch for these members? 5. What are some interventions to engage hard to reach members?

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Care Coordination

Provider's role in care coordination

3. Increase Access to Care Coordination at Provider Level

- National best practice evidence suggests that provider-based care coordination has the most impact on members who are difficult to engage
- Providers have the most interaction with members and impact on their health
- There are providers in the community who are interested in delivering care coordination and have the capacity and experience to do so
- Additionally providers are increasingly invested in the outcomes for their members as they take on more financial risk through participation in value based purchasing initiatives

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Care Coordination

Provider's role in care coordination

Benefit	Challenges	Questions / Feedback
➢ Efficiency in locating and interacting with members, accessing records and health history ➢ Improve member confidence and trust in their healthcare and providers ➢ Strengthen relationships between members and primary care ➢ Improve preventative care rates ➢ Reduce unnecessary ED utilization	➢ MCO role in quality and provider oversight ➢ Avoiding duplication of efforts ➢ Data sharing and tracking ➢ Reducing confusion for members in transitions ➢ Payment structures ➢ Readiness to deliver all elements of care coordination in the provider community	1. What is the value of this initiative to the program overall? 2. What are challenges we have not already identified? 3. How do we build capacity and readiness in the provider community? 4. Who should be delegated and how does the State encourage delegation (i.e., incentives to MCOs for reaching a percentage of delegation)? 5. Without delegation, what other strategies can we implement to be more inclusive of providers in responsibility for outcomes? 6. What are the minimum staff qualifications to provide care coordination at the provider level?

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Next Steps

- Next subcommittee meeting November 18th
- Subcommittee documents
- Email for follow-up questions/clarifications
  - Email Address: **HSD-PublicComment2016@state.nm.us**
  - Include "Waiver Renewal" in email subject line:
  - Include a background, proposed solution and impact in your correspondence

- **Information Links**
  - Centennial Care (CC) 1115 Waiver Submission Documents:
  - http://www.hsd.state.nm.us/Centennial_Care_Waiver_Documents.aspx

  - Centennial Care 1115 Waiver Approval Documents:
  - http://www.hsd.state.nm.us/approvals.aspx

  - Centennial Care Reports:
  - http://www.hsd.state.nm.us/reports.aspx

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