Medicaid 1115 Wavier Renewal Subcommittee Meeting

Meeting Minutes

January 13, 2017 — 8:30am – 11:30am

District Three Auditorium / Department of Transportation / 7500 Pan American Freeway NE, Albuquerque, New Mexico

Subcommittee Members:

Myles Copeland, Aging & Long-Term Services Department Doris Husted, The Arc of New Mexico Bryce Pittenger, Children, Youth and Families Department Dawn Hunter, Department of Health Ellen Pinnes (proxy for Jim Jackson), Disability Rights New Mexico Sandra Winfrey, Indian Health Service Carol Luna-Anderson, The Life Link Dave Panana, Tribal Representative, Kewa Pueblo Health Corp. Nancy Rodriguez (proxy for Mary Kay Pera), New Mexico Alliance for School-Based Health Care Lauren Reichert, New Mexico Association of Counties	Teresa Turietta, New Mexico Association for Home & Hospice Care Patricia Montoya, New Mexico Coalition for Healthcare Value Linda Sechovec, New Mexico Health Care Association Jeff Dye, New Mexico Hospital Association Rick Madden, New Mexico Medical Society David Roddy, New Mexico Primary Care Association Carolyn Montoya, University of New Mexico, School of Nursing Lisa Rossignol, Parents Reaching Out Liz Lacouture (proxy for Mary Eden), MCO Representative, Presbyterian Health Plan

Absent Members:

Christine Boerner, Legislative Finance Committee	Kris Hendricks, Dentistry for Kids

Staff and Visitors Attending:

Rachel Wexler, DOH Wayne Lindstrom, HSD/BHSD Mark Barnand, HSD/BHSD Theresa Belanger, HSD/MAD Michael Nelson, HSD Kari Armijo, HSD/MAD Dan Clavio, HSD/MAD Angela Medrano, HSD/MAD Megan Pfeffer, HSD/MAD Nancy Smith-Leslie, HSD/MAD	Joie Glenn, Advocacy for Home and Hospice Care Erik Lujan, APCG Health Committee Shawna Romero, Blue Cross Blue Shield of New Mexico Debi Peterman, Health Insight New Mexico Beverly Nomberg, New Mexico Behavioral Health Association and La Familia Gayle Geis-O'Dowd, Molina Healthcare of New Mexico Patty Kehoe, Molina Healthcare of New Mexico Susan Dezavelle, Molina Healthcare of New Mexico Beth Landon, New Mexico Hospital Association

Tallie Tolen, HSD/MAD Robyn Nardone, HSD/NMICSS Jared Nason, Mercer Jessica Osborne, Mercer Son Yong Pak, Mercer Cindy Ward, Mercer	Kathleen Derby, Peer / Certified Peer Support Worker Anthony Yepa, Pueblo de Cochiti Rick Henley, Senior Link Carla V. Martinez, United Healthcare Amilia Ellis, United Healthcare Raymond Mensack, United Healthcare Curt Schatz, United Healthcare Josh Ahrens, United Healthcare Sunah Hoeferkamp, United Healthcare Veronica Esparza, United Healthcare Rodney McNease, University of New Mexico Hospitals

Agenda Item	Details	Discussion
I. Introductions	• Angela Medrano delivered opening comments. • Review minutes. • Feedback from the December 16th meeting. • Presented agenda overview.	• Medical Assistance Division (MAD) would like everyone to have the opportunity to contribute ideas and recommendations for the waiver renewal, and all are encouraged to use the website to submit comments. • This is the 4th Subcommittee Meeting: – October 14th meeting focused on care coordination. – November 18th meeting focused on population health. – December 16th meeting focused on long-term services and supports (LTSS) and behavioral health/physical health (BH/PH) integration. – Today's meeting is focused on value-based purchasing and member engagement and personal responsibility. • MAD has not received any comments to the November 18th meeting minutes. Therefore, the draft meeting minutes are finalized. • Draft meeting minutes from the December 16th meeting is included and comments are requested by January 31, 2017. – Rick commented that on page 9, the meeting minutes need to emphasis the need for a shared electronic medical record to drive integration within a practice. The minutes were amended to reflect the comment.
II. Value-Based Purchasing (VBP)	• Providers have varied levels of readiness for VBP payment strategies and concerns about bearing more risk. • Providers need reliable data, particularly related to costs of services they do not deliver, and technical assistance to utilize data sources. • BH and LTSS providers can be particularly	• Pat commented that New Mexico started aligning quality and focusing on health plans moving towards VBP models under Aligning Forces for Quality (AF4Q). Currently, one of the challenges in implementing VBP is information technology (IT) systems that can manage VBP models at the managed care organization (MCO) and provider levels. She stated that nationally based MCOs tend to lead this charge and asked what they are

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	challenged by risk based VBP strategies and often require unique models. • Quality outcome measures can more resource intensive to collect (hybrid measures). • Alignment with other payers is challenging due to population differences and quality measure differences. • 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. • No single entity to convene and coordinate a common vision across payers.	doing to build on the infrastructure in New Mexico. • Nancy SL.commented that Molina Healthcare of New Mexico (Molina) and Presbyterian Medical Services (PMS) have made a lot of progress with their IT system to support various VBP models. • Susan from Molina commented that it has a software program that shows providers their total cost of care, and it is able to manipulate data by providers to include the total cost of care, gaps in care and quality measures. Molina makes the data available through an online provider portal and is currently working with providers on how to use the data to improve care. • Liz from Presbyterian Health Plan commented that it provides a hard copy report to providers on a monthly basis and holds regular meetings with providers to review reports. Presbyterian Health Plan is currently building an online interface. • Carol, in respons to Molina and Presbyterian Health Plan comments asked if physical health and behavioral health were intergrated. • David R. commented that Federally Qualified Healthcare Centers are participating in VBP and stated that higher number of members are required to participate in risk-based models. In addition, he commented that having access to data is great; however, it is challenging to access data from multiple sources. • Pat commented that there are some barriers to sharing data from the federal and state regulations perspective and stated that we need to address the State statutes during the current legislative session. She also commented that we need to identify the funding streams to build a better infrastructure to support data sharing.

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		• Pat asked if HSD has performed a crosswalk on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) quality measures when building the core Medicaid measures. – Nancy SL. replied that New Mexico has requested the Centers for Medicare and Medicaid Services collaborate with the states on the development of quality measures but has received limited traction since the Medicare leadership's focus differs significantly from Medicaid. • Rick commented that it is important to support providers who are in early stages of readiness such as organizing the data, evaluating reports and data. He further commented that some of the MACRA incentives can help providers who want to participate in VBP but said that incentives are currently limited. • Lauren commented that counties are creating Behavioral Health Investment Zones (BHIZ), which is an accountable care organization (ACO)-like model where providers partner together. She stated that smaller providers and counties get limited attention from MCOs and have limited knowledge about payment structures. She commented that smaller providers and counties would benefits from education and support to get ready for VBP models. • Jeff commented that smaller providers face statistical challenges given the limited volume of members they serve and suggested a phase-in approach for small providers based on established member volume threshold. • Carol commented that small providers would like to participate in VBP and recommended that smaller providers be given an opportunity to participate.

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		• Dave commented that Indian Health Services (IHS) and 638 tribal facilities are not engaged in VBP as they are providing services in a fee-for-service environment and asked for a per member per month (PMPM) payment from HSD so that they can provide more robust care management. – Jessica commented that establishing Health Homes could be a mechanism to draw down a PMPM for coordinating care for IHS and 638 facilities. • Linda commented that the LTSS program has unique challenges and the Medicaid payment model does not support the staffing mix. She recommended a case-mix model which expands staff to accommodate night and weekend admissions in nursing facilities. She further commented that she would be introducing legislation during the legislative session. • Nancy R. commented that the younger generation seeks services from different providers such as minute clinic, urgent care, primary care, so limiting access to a specific provider is challenging. The younger generation wants to take their medical record with them. She recommends building technology where all providers can access information. • Rick commented that this issue is not unique to the younger generation and thinks that this is how most members access care regardless of their age. • Nancy R noted that transportation benefit was important for people when determining where to seek care. • Lauren noted that urgent care is often the last choice because of provider shortages. • Pat commented that the Bailit Health has issued a briefing document for the National Association of

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		Medicaid Directors that contains information on the prospective payment system[1]. She praised the State for establishing VBP targets for MCOs and commented that the Interagency Benefits Advisory Committee is establishing targets in their contracts on the commercial side with the MCOs. In regards to patient engagement, Pat commented that there are existing campaigns such as Choosing Wisely[2], an initiative of the American Board of Internal Medicine Foundation, that focus on advancing conversations between providers and members to help facilitate making wise decisions about the most appropriate care. • Sandra commented that incentives and penalties should be weighed carefully. For example, the Physician Quality Reporting System (PQRS) quality incentive reporting was so onerous and costly that some smaller providers took the penalty instead. • Ellen commented that ability of providers to meet the members' needs varies. Some people are able get a same day appointment while others cannot, and those that cannot get a same day appointment seek care in urgent care or emergency department. She also commented that MCO provider network changes are a factor in fragmentation of care and should be considered as a contributing factor. • Myles commented that VBP for geriatric population should be incentivized differently since their care needs are unique and members require longer examination time to address multiple chronic conditions.

[1] For further information, see http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf
[2] For further information, see http://www.choosingwisely.org/

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		• Carolyn commented that nurse practitioners have full practice authority in the State. She also commented that long wait time and short visits are an access issue. As a result, complex needs may not get addressed. • Doris commented that individuals with disabilities need longer appointments as they have unique challenges such as communication issues and the quality measures for this population may not align with members who are healthy. • Ellen commented that specialty providers are scarce for even those insured by private coverage. There is not enough supply. • Rick commented that New Mexico has a large population of individuals with developmental disabilities and elderly and commented that having advocates that can accompany the member results in better care. • Linda commented that New Mexico has a shortage of workforce, and this requires a critical examination. • Bryce commented that about 65% of New Mexico's children are on Medicaid and many people have adverse childhood experiences that create chronic care conditions. In regards to VBP, providers and MCOs should take on more risk for this population. • Myles commented that we need to look for opportunities to incent partnership with members, families and advocates. • Dawn commented that community health worker could function as advocates. • Lisa commented that pediatricians' workload for children with special needs is high, and pediatricians perform many activities that are not reimbursed by MCOs. She further commented that Colorado families can become

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		certified nursing assistants and receive compensation from insurance companies for performing care coordination activities. • Lauren commented that trained volunteers could become advocates for members with special needs. • Nancy R. commented that pediatric population's needs may not align with Medicare quality measures. • Carolyn commented that larger pediatrics practices have social workers or nutritionists on staff and in the office available for members to see; however, this is not financially feasible for small providers especially in rural areas. • Wayne commented that telehealth and Project ECHO can fill some gap in access to care. Also, he commented that we need to equalize the playing field by taking into consideration of member's severity levels when designing VBP models.
III. Member Engagement and Personal Responsibility	• Add new areas of focus, conditions, or behaviors for Centennial Rewards. • Changes to Reward values or expanded Rewards for major or sustained improvements. • Allow Rewards for potential cost-sharing requirements. • Improve engagement and participation in Rewards program through data mining, risk assessment, or technology. • Reduce no-show appointments. • Implement copayments for certain member's use of services. • Implement premiums for higher income members.	• Liz commented that when the copayment determination is left at the provider's discretion, it becomes even more challenging to collect copay. • Ellen commented that cost / benefit should be evaluated prior to implementing copayments. She believes these practices actually result in increased cost for the system. • Lauren commented that general public is passive / not typically active participants in health care. Advocacy should be incentivized and independence encouraged. • Nancy R. commented that a member must be 18 years of age to access the Centennial Rewards Program. Therefore, the program limits participation from teen parents and recommends modifying the minimum age to 14 years of age. In addition, recommended the Centennial Rewards Program should be more user

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		friendly such as having mobile access. If the State chooses to apply cost sharing, then the Centennial Rewards Program could cover copayments as an incentive. • Lisa commented that she likes the idea of having a mobile option related to the Centennial Rewards Program as many young individuals are technically savvy; however, she noted that many New Mexicans are not technically savvy and do not have access to the Internet. • Dawn recommended including tobacco cessation and partnering with the Public Health Division on this effort. She also commented that we need to assess member experience in Centennial Rewards Program and incorporate their feedback on the program. • Sandra commented that Native Americans do not get the opportunity to participate in the Centennial Rewards Program and recommended that HSD should explore opportunities to grow Native Americans' participation. • Jeff commented about passive enrollment versus active participation in the rewards program and recommended that the program should be designed to encourage active participation for earning rewards point and not count participants who use services in the normal course as participation. • Nancy SL. commented that the reward redemptions rate is increasing as people learn more about the program. • Lisa commented that copays can be very challenging financially for members and members may need to make a choice between paying for their healthcare or other needs such as food, utility. She further commented that providers will end up absorbing the costs, and cost sharing is barrier to care.

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		• Ellen commented that there are many reasons that drive what is viewed as not responsible behavior, and we talk about personal responsibility in terms of finance. She further noted that health system is complicated, and Centennial Care members have added pressures and circumstances. Therefore, she recommended that we need to better understand the drivers for missed appointments rather than consider this population as irresponsible and penalize them. • Dawn recommended that we use data to inform decision making such as evaluating the population who miss appointments and use emergency departments, exploring alternatives to penalties, improving health literacy, teaching members how to use services and accessing right level of care. • Nancy R. recommended that members enrolled in the Children's Health Insurance Program should be excluded from copays. She also commented that clinics already absorb copay costs for children who are accessing "private care", so they cannot afford to absorb more costs. She also commented about poor public transportation in Albuquerque and the long length traveling time. • David commented that he does not support assessing copays and recommends educating on the most cost efficient service such as using generic drugs. • Linda commented that we need to find a way that members could earn enough in rewards to cover copays or other penalties if HSD implement cost share. • Nancy S. reminded the group that HB2 requires the Department to implement cost sharing measures for the Medicaid program.

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IV. Public Comments	• Increase Medicaid spending on certified peer support workers	• Commenter discussed the benefits of using CPSW particularly in BH for below reasons: – It is cost effective. – It is an antidote for mental illness stigma. – It promotes wellness and recovery through shared experience and acceptance of illness.
V. Meeting Close	• Follow-up materials • Next meeting date	• Comments on VBP and member engagement and personal responsibility are due from committee members by January 31, 2017. • Comments should include recommendations, outcome measures, as well as measurement methods. • Next meeting is on February 10, 2017, at the Administrative Services Division/Human Services Department.

Acronym Guide for MAD / HSD 1115 Waiver Renewal Process

ABCB – Agency-Based Community Benefit
ACEs – Adverse Childhood Experiences
ACO – Accountable Care Organization
ADL – Activity of Daily Living
ALTSD – NM Aging and Long Term Services Department
BCBSNM – Blue Cross Blue Shield of NM
BH – Behavioral Health
BHSD – Behavioral Health Services Division of the HSD
CB – Community Benefit
CBSQ - Community Benefit Services Questionnaire
CCBHCs - Certified Community Behavioral Health Clinic
CC – Care Coordination
CCP – Comprehensive Care Plan
CCS – Comprehensive Community Support
CHIP – Children's Health Insurance Program
CHR – Community Health Resources
CMS – Centers for Medicaid and Medicaid Services, division of the HHS
CNA – Comprehensive Needs Assessment
CPSW – Certified Peer Support Worker
CSA – Core Service Agency
CYFD – NM Children, Families and Youth Department
DD – Developmental Disability and Developmentally Disabled
D&E – Disabled and Elderly
DOH – NM Department of Health
DHI – Division of Health Improvement
D-SNP – Dual Eligible Special Need Plan
ED – Emergency Department
EDIE – Emergency Department Information Exchange
EPSDT – Early and Periodic Screening, Diagnostic, and Treatment
EVV – Electronic Visit Verification
FAQ – Frequently Asked Questions
FF – Face to Face
FFS – Fee for Service
FIT – Family Infant Toddler Program
FQHC – Federally Qualified Health Center
HCBS – Home and Community-Based Services
HH – Health Home
HHS – US Health and Human Service Department
HRA – Health Risk Assessment
HSD – NM Human Services Department
IBAC – Interagency Benefits Advisory Committee
I/DD – Intellectual and Developmental Disabilities
IHS – Indian Health Service
IP – In-patient
LEAD – Law Enforcement Assisted Diversion
LFC – Legislative Finance Committee
LOC – Level of Care
LTC – Long Term Care
LTSS – Long-Term Services and Supports

MACRA – Medicare Access and CHIP Reauthorization Act of 2015
MAD – Medical Assistance Division of the HSD
MC – Managed Care
MCO – Managed Care Organization
MH – Mental Health
MMIS – Medicaid Management Information System
MMISR – Medicaid Management Information System Replacement
NATAC – Native American Technical Advisory Committee
NF – Nursing Facility
NF LOC – Nursing Facility Level of Care
NMICSS – NM Independent Consumer Support System
PCMH – Patient-Centered Medical Home
PCP – Primary Care Physician
PCS – Personal Care Services
PH – Physical Health
PH-BH – Physical Health – Behavioral Health
PHP – Presbyterian Health Plan
PMPM – per member per month
PMS – Presbyterian Medical Services (FQHC)
PQRS – Physician Quality Reporting System
SA – Substance Abuse
SAMHSA – Substance Abuse and Mental Health Services Administration, an agency within the US Department of Health and Human Services
SBHC – School-Based Health Center
SBIRT – Screening, Brief Intervention and Referral to Treatment
SDCB – Self-Directed Community Benefit
SED – Severe Emotional Disturbance
SMI – Serious Mental Illness
SOC – Setting of Care
SUD – Substance Use Disorder
UHC – United Health Care
VBP – Value-Based Purchasing