Medicaid Advisory Committee-MAC meeting
Monday, November 5, 2018
MINUTES

Time: Start-1:04pm End-3:44pm Location: Garrey Carruthers State Library, 1205 Camino Carlos Rey, Santa Fe, 87507

Chair: Larry A. Martinez, Presbyterian Medical Services

Recorder: Alysia Beltran, Medical Assistance Division

Committee Members:
Sylvia Barela, Santa Fe Recovery Center
Michael Batte, Public Member
Natalyn Begay, Ohkay Owingeh
Jim Copeland, NM Department of Health
Ramona Dillard, Pueblo of Laguna
Jeff Dye, NM Hospital Association
Mary Eden, Presbyterian Healthcare Services
Michael Hely, NM Legislative Council Service
Daniel Bourgeois, Medicaid Population
Ruth Hoffman, Lutheran Advocacy Ministry NM
Gary Housepian, Disability Rights
Monique Jacobson, NM Children, Youth and Families Department
Mark Freeland, Navajo Nation
Kim Jevertson, Public Member
KyKy Knowles, Aging & Long Term Services Department
Meggin Lorino, NM Association for Home and Hospice Care
Carol Luna-Anderson, The Life Link/Behavioral Health Planning Council
Richard Madden, NM Chapter of the American Academy of Family Physicians
Rodney McNease, UNM Hospital
Carolyn Montoya, UNM College of Nursing
Eileen Goode, NM Primary Care Association
Jason Espinosa, NM Health Care Association
Laurence Shandler, Pediatrician
Gene Varela, AARP New Mexico
Dale Tinker, NM Pharmacists Association

Absent Members:
Natalyn Begay, Ohkay Owingeh
Daniel Bourgeois, Medicaid Population
Mark Freeland, Navajo Nation
Kim Jevertson, Public Member

Staff & Visitors Attending:
Nancy Smith-Leslie, Medicaid Director
Angela Medrano, HSD/MAD
Russ Toal, Consultant
Mary Kay Pera, NMASBHC
Ruby Ann Esquibel, LFC
Ellen Pinnes
Nancy Rodriguez, NM Alliance for School-Based Health Care
Susan Kelly, Spark Therapeutics
Michael Gutierrez, AIT/MASC
Jennifer Vigil, HSD/MAD
Erica Archuleta, HSD/MAD
Laurence Shandler, Pediatrician
Jody Harris, UNM Hospitals
Sun Vega, Consultant
Jason Sanchez, HSD/MAD
Sallyanne Wait, HSD/MAD
Liz Lacouture, PHP
Jenny Felmly, Legislative Finance Committee
Sam Brandt, X-Ray Associates of NMPC
Heather Ingram, Presbyterian
Brian Alvarado, Area Agency on Aging
Krista Brooker, AIT/ MASC
David Scrase, UNM Health Sciences
Mika Tari, BHSD
Kim Carter, HSD/ MAD
Sharon Huerta, BCBSNM
Gia McLean
Mike Nelson, HSD Deputy Secretary
Wayne Lindstrom, BHSD
Karen Jackson, Trividia
Casey Crotty, San Juan IPA
Michael McGrory, X-Ray Associates of NMPC
Karen Wiley, NMDVR
Jaclyn Herrera, HSD
Thomas Garcia, NCNMEDD
Crystal Ginithan, AIT/ MASC
Tracy Smith, Project ECHO
Karen Meador, BHSD
David Nadar, UHC
Scott Allocco, Sellers Dorsey

DISCUSSION ITEM	OUTCOME	FOLLOW-UP ACTION	RESPONSIBLE PERSON/ DEPARTMENT	EXPECTED OR REQUIRED COMPLETION DATE
I. Introductions	Larry Martinez convened the meeting and led the introductions. Larry introduced appointed members, staff and guests as they arrived during the meeting.	None	Larry Martinez, MAC Chairperson	Completed
II. Approval of Agenda	The agenda for this meeting was approved by all committee members in attendance, with no recommended changes.	None	Larry Martinez, MAC Chairperson	Completed
III. Approval of Minutes	The minutes from the August 6, 2018 meeting held at Garrey Carruthers State Library were approved by the committee with no corrections.	Finalized minutes will be posted on the HSD website.	HSD/MAD Director's office	Completed
IV. Medicaid Budget Projections	**Jason Sanchez presented the Medicaid Budget Projection:** **Enrollment:** The overall Medicaid and CHIP population (column K) peaked in early 2017. The decline since then reflects HSD's compliance with federal and state requirements to re-determine eligibility at least every 12 months based on modified adjusted gross income (MAGI). Since early 2018 the projection reflects improving economic conditions, higher incomes, as well as higher employment. Enrollment levels reached 833,611 in September 2018 and are currently projected to grow to 844,967 by June 2019 and 847,740 by June 2020. This represents a decrease of 20,313 for June 2019 and 26,903 for June 2020 from the previous projection. Most of this decrease can be attributed to further reductions in the Family Planning population due to a policy change which will generally limit this population to individuals 50 years of age and under. The full benefit population (column D) for September 2018 has reached 480,421 individuals, a decrease of 8,554 from the previous projection. This population is currently projected to grow to 494,879 by June 2019, a decrease of 2,544 compared to the previous projection and 503,731 by June 2020. The Medicaid expansion population reached 250,571 individuals in September 2018, a decrease of 5,202 from the previous projection, and is projected to grow to 255,832 by June 2019, a decrease of 4,113, and the June 2020 estimate is 258,391.	None	Jason Sanchez, Deputy Director, Medical Assistance Division, Human Services Department	Completed

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	The largest change to enrollment in this projection occurs in the family planning population (column E). This population is now projected to reach 62,045 individuals by June 2019, a decrease of 12,132 from the previous projection and 52,771 individuals by June 2020 a decrease of 21,440 from the previous projection. The QMB population (Column F) is projected to reach 21,009 by June 2019, and 21,593 by June 2020, while the SLIMB, and QI1 populations (columns F & G) are projected to remain at roughly the same levels as previously projected. Monthly growth rates are projected at an annualized rate of 1.5% in FY19 and 0.75% in FY20 in the Physical Health (PH) and Other Adults Group (OAG) populations (lower than previous growth rates). Annual growth rates in the Long-Term Services and Supports (LTSS) population are projected at 2% in FY19 and FY20. The Medicaid and CHIP populations enrolled in managed care organizations in June 2018 is an estimated 668,859 individuals. In FY18 there was a retroactive decrease in the OAG population and a corresponding increase in the TANF Adult PH Cohorts which can be observed between January 2018 and June 2018. The current projection for June 2019 is 678,113 individuals, a decrease of 4,460 from the prior projection while the projection for June 2020 is now 683,844 a decrease of 6,342 individuals. These declines primarily occur in the PH and OAG Populations. The LTSS population projection remains at roughly the same level as previously projected. **FY18 Expenditures: In Patient Hospital-** The estimate is revised down by $4.2 million compared to the previous projection. Impatient costs are decreasing due to lower utilization. **Others -** The estimate is revised down by $1.1 million compared to the previous projection. Most of this change was due to additional HMS recoveries. **Developmentally Disabled and Medically Fragile Traditional, and Mi Via Waivers (DOH) -** The amount shown is the portion that can be supported by the state funds available and shows minimal change from the previous projection. The estimate increases by $3.1 million compared to the previous projection due to the re-evaluation of the gross receipts tax (GRT) blended rate and some procedure changes, including supported living individual intensive behavioral supports as of March 2018. As a result, the push forward to FY 19 is $7.4 million expenditure or $2.1 million in general fund. **Centennial Care - Physical Health -** The estimate decreases by $7.7 million compared to the previous projection due to higher enrollment than previously projected and a lower PMPM due to changes in the cohort mix. The higher member months increase the estimate by $3.7 million, while the lower PMPM reduces it by $9.9 million, and other adjustments reduce the estimate by $1.5 million. **Centennial Care – Long Term Services (LTSS) -** The estimate increases by $2.3 million compared to the previous projection due to higher enrollment than previously projected			

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	and a lower PMPM due to changes in the cohort mix. The higher member months increase the estimate by $0.7 million, other adjustments increase the estimate by $2.6 million. while the lower PMPM reduces it by $1.0 million. **Centennial Care - Behavioral Health -** The estimate decreases by $4.6 million compared to the previous projection due to higher enrollment than previously projected and a lower PMPM. The higher member months increase the estimate by $0.8 million, the lower PMPM reduces it by $1.6 million, and other adjustments reduce the estimate by $3.8 million. **Centennial Care Medicaid Expansion – Physical Health -** The estimate decreases by $12.5 million compared to the previous projection due to lower enrollment than previously projected. The lower member months reduce the estimate by $7.6 million, and other adjustments reduce the estimate by $4.9 million. **Health Information Technology-** The estimate decreases by $6.6 million compared to the previous projection based on year-to-date expenditures. **FY18 Revenues: Federal Disallowance -** The federal revenue is adjusted down by $3.1 million pending a data reversal correction to the IHS referrals prior to April 2018. **Department of Health Appropriation -** The general fund appropriation to DOH includes a supplemental of $2 million increasing the total amount to $107.0 million and a surplus from FY16 that was booked in FY18. **Department of Health Additional Need / (Surplus) -** The estimated additional state fund need of $2.1 million has been pushed forward into FY19. The DOH shortfall is partially because of a push forward of $0.95 million from FY17. **Drug Rebates -** Drug rebates recognized is $34.8 million, a decrease of $5.0 million from the last projection. **General Fund Need -** The General Fund need is $912.5 million, an increase of $4.7 million from the last projection. **State Revenue Surplus/ (Shortfall) -** The estimated revenue surplus is $3.1 million, a decrease of $4.7 million from the last projection. HSD has reverted $2.3 million which leaves a surplus of $0.8 million. **FY19 Expenditures: Inpatient Hospital-** The estimate is revised down by $1.1 million compared to last projection. Inpatient claims declined in the first quarter due to lower utilization. **Developmentally Disabled and Medically Fragile Traditional, and Mi Via Waivers (DOH) -** The projection increases by $12.4 million from the previous projection. This total projection reflects a 2% rate increase on January 1, 2019 for most services. Other changes include: the transition of members as of March 2018 to the new procedures submitted in the waiver renewal, an increase in the GRT blended rate, the allocation of 80 new clients, attrition replacement, and $7.4 million from FY18. **Centennial Care - Physical Health -** The estimate decreases by $23.9 million compared to the previous projection. The estimate declines by			

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	$7.7 million due to lower projected enrollment and by $19.8 million due to lower PMPM due to changes in the cohort mix, while it increases by $3.6 million from other adjustments. **Centennial Care – LTSS -** The estimate increases by $15.2 million compared to the previous projection. The estimate increases by $0.9 million due to higher projected enrollment, and another $15.8 million from other adjustments, while it decreases by $1.6 million due to a lower PMPM due to changes in the cohort mix. **Centennial Care - Behavioral Health -** The estimate increases by $5.4 million compared to the previous projection. The estimate declines by $1.5 million due to lower projected enrollment, and another $2.9 million from other adjustments, while it increases by $9.9 million due to a higher PMPM from provider rate increases and benefit changes. **Centennial Care Medicaid Expansion – Physical Health -** The estimate decreases by $6.4 million compared to the previous projection. The estimate declines by $7.3 million due to lower projected enrollment while it increases by $0.7 million from other adjustments, and by $0.2 million due to a higher PMPM due to changes in the cohort mix. **Centennial Care Medicaid Expansion – Behavioral Health -** The estimate increases by $5.5 million compared to the previous projection. The estimate declines by $0.7 million due to lower projected enrollment and by $0.6 million from other adjustments, while it increases by $6.8 due to higher PMPM from provider rate increases and benefit changes. **Medicare Part B -** The estimate increases by $1.1 million compared to the previous projection, mostly due to retroactive premium payments in the last three months. From the CMS Part B monthly data file, the retroactive adjustments go back as far as December 2006 with the majority back to 2014. **Health Information Technology -** The estimate increases by $6.4 million to match the federal maximum allowed. This expenditure has no impact on the general fund need as it is 100% federally funded. **Centennial Care 2.0 Initiatives -** The estimate increases by $3.0 million compared to the previous projection. **FY19 Revenues: Department of Health Appropriation -** The Department of Health FY19 appropriation is $111.1 million. This includes $1.47 million from DDSD FY18 fund balance which will be barred in FY19. **Department of Health Allocation Need / (Surplus) -** The Department of Health received an appropriation of $2.0 million for new allocations. DOH is projected to have a surplus of $1.1 million from this appropriation. **Department of Health Additional Need / (Surplus) -** Including the $2.1 million push-forward from FY18, the shortfall for DOH is $3.9 million. When combined with the $1.1 million surplus the total shortfall is $2.8 million. **Safety Net Care Pool -** The SNCP revenues were updated based on the most recent gross receipts tax data in FY18, an increase of $0.7 million from the last projection. **Drug Rebates -** The revenues were updated based on the most recent FY18			

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	collection, an increase of $0.3 million from the last projection. **General Fund Need -** The General Fund need is $941.7 million, a decrease of $2.8 million from the last projection. **State Revenue Surplus / (Shortfall) -** The revenue shortfall is $8.1 million, an increase of $2.8 million from the last projection. **FY20 Expenditures: Inpatient Hospital -** The estimate is revised down by $1.1 million compared to last projection. Inpatient claims decreased in the first quarter of FY19 due to lower utilization. **Developmentally Disabled and Medically Fragile Traditional, and Mi Via Waivers (DOH) -** The projection increases by $7.5 million from the FY20 budget request. This total projection reflects a 2% rate increase on January 1, 2019 for most services. Other changes include: the transition of members as of March 2018 to the new procedures submitted in the waiver renewal, an increase in the GRT blended rate, the allocation of 80 new clients, and attrition replacement. **Centennial Care - Physical Health -** The estimate decreases by $30.1 million compared to the previous projection. The estimate declines by $13.5 million due to lower projected enrollment and by $20.3 million due to lower PMPM due to changes in the cohort mix, while it increases by $3.7 million from other adjustments. **Centennial Care – LTSS -** The estimate increases by $10.2 million compared to the previous projection. The estimate decreases by $4.0 million due to lower projected enrollment, $1.6 million from a lower PMPM due to changes in the cohort mix while it increases by $15.8 million from other adjustments. **Centennial Care - Behavioral Health -** The estimate increases by $4.3 million compared to the previous projection. The estimate declines by $2.9 million due to lower projected enrollment, and another $2.9 million from other adjustments, while it increases by $10.1 million due to a higher PMPM from provider rate increases and benefit changes. **Centennial Care Medicaid Expansion – Physical Health -** The estimate decreases by $9.1 million compared to the previous projection. The estimate declines by $9.9 million due to lower projected enrollment and increases by $0.6 million from other adjustments, and by $0.2 million due to a higher PMPM due to changes in the cohort mix. **Centennial Care Medicaid Expansion – Behavioral Health -** The estimate increases by $5.4 million compared to the previous projection. The estimate declines by $1.0 million due to lower projected enrollment and by $0.6 million from other adjustments, while it increases by $7.0 million due to a higher PMPM from provider rate increases and benefit changes. **Medicare Part D -** The estimate decreases by $1.1 million compared to the previous projection. This change is due to lower projected enrollment. **Centennial Care 2.0 Initiatives -** The estimate increases by $4.0 million compared to the previous projection.			

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	FY20 Revenues: Department of Health Appropriation - The Department of Health FY20 base appropriation request is $109.6 million. **Department of Health Allocation Need / (Surplus) -** The Department of Health is projected to need $3.6 million above their FY20 appropriation request. **County Support Medicaid Fund (CSMF) -** The CSMF revenues were updated based on the most recent gross receipts tax data in FY18, an increase of $1.0 million from the budget request. **Safety Net Care Pool -** The SNCP revenues were updated based on the most recent gross receipts tax data in FY18, an increase of $0.8 million from the budget request. **Drug Rebates -** The revenues were updated based on the most recent FY18 collection, a decrease of $1.0 million from the last projection. **General Fund Need -** The General Fund need is $997.0 million, a decrease of $7.7 million from the budget request. **State Revenue Surplus / (Shortfall) -** The revenue shortfall is $63.4 million when compared to the FY19 appropriation, or a decrease of $7.7 million from the budget request.			
V. Director's Update	**Nancy Smith-Leslie presented a Director's update to the NM Medicaid Advisory Committee and a Behavioral Health Update by Sally Wait:** **Centennial Care 2.0 Enrollment:** Open Enrollment is from October 1, 2018 – November 30, 2018. During these two months, CC enrollees can choose the MCO to provide their Medicaid services. Any enrollment selections made during open enrollment will be effective on January 1, 2019. Any individual currently enrolled with Blue Cross or Presbyterian, who does not choose a new MCO will be re-enrolled with his/her current MCO. All other Centennial Care enrollees who do not choose an MCO will be auto-assigned to a MCO. MCO choices and assignments will be effective on January 1, 2019. All CC enrollees who choose or are assigned to a MCO during open enrollment will have three months (starting January 1, 2019) to change their MCO. **CC 2.0 1115 Waiver Update:** 1115 waiver negotiations with CMS continue. Collaborating on a new Special Terms and Conditions document that will include all of the federal approvals for CC 2.0, similar to a contract between the State and CMS. HSD expects to receive final approval from CMS in December 2018. In the interim, a letter from CMS with guidance about certain program changes so that we could move forward with rule promulgation process and stay on track to launch all of the 2.0 changes on January 1, 2019. **CC Home Visiting Pilot:** Home-visiting pilot is a program that focuses on pre-natal, post-partum and early childhood development. CC is collaborating with CYFD to expand two evidence-based early childhood HV programs that are recognized by the U.S. Department of Health &	None	Nancy Smith-Leslie, Director, Medical Assistance Division, Human Services Department	Completed

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	Human Services Maternal, Infant and Early Childhood HV programs, ie., Nurse Family Partnership (NFP) and Parents as Teachers (PAT). HSD-Designated Counties as of 1/1/2019: Bernalillo County: UNM Center of Development and Disability (UNM CDD) has NFP- Hiring a team of 5-6 nurses to serve 25 families per nurse. PAT- is expanding its team of non-licensed, certified home visitors with experiences working with children and families with a supervisor (for UNM, a licensed mast social worker). Curry & Roosevelt Counties: ENMRSH, Inc. is launching the PAT program shortly after January 1, 2019. **Pre-Tenancy and Tenancy Services:** There are new supportive housing services for members with Serious Mental Illness (SMI) to assist with acquiring, retaining and maintaining stable housing. HSD plans to use existing infrastructure and network of provider agencies associated with the Linkages Supportive Housing Program to deliver services, and Linkages will be expected to utilize peers for service delivery. **Expand Substance Use Disorder Continuum of Care Services:** HSD will extend screening, brief intervention, and Referral to Treatment (SBIRT) services through primary care, community health centers and urgent care facilities. HSD will provide SUD treatment in accredited residential treatment centers for adults who require an enhanced lever of care. In addition, allow inpatient services in IMD for members with SUD diagnosis. Waiver of limitation for IMD include: requested authority to waive limitations imposed on use of Institutions for Mental Disease (MD). CMS has been allowing 15 days as an "in lieu of" service in the managed care program only – which is difficult to operationalize when stays exceed 15 days. HSD expect CMS to grant the waiver but only for those with a substance use disorder. A recent federal law was signed to allow for up to a 30-day IMD stay for those with SUD, which was effective 10/1/2019. **New Co-Payments for Two Services:** Beginning March 1, 2019, there will be: new co-payments for two services; sunsetting existing co-pays for Children's Health Insurance Program (CHIP) eligible members and the Working Disabled Individuals; co-payments for non-preferred prescription drugs (psychotropic drugs and family planning drugs/ supplies are exempt) will be $8 per prescription, for all FPLs and COEs; co-payment for non-emergency ER visits (hospital determines if emergent) will be $8 per visit, for FPLs and COEs. The following populations will be exempt from copayments: Native American members, individuals in a fee for service category of eligibility (COE), individuals on the DD Waiver, individuals in an institutional care COE, individuals with a household (HH) income of 0 percent FPL and people receiving hospice care. **Premiums for adults with income above 100% FPL: July 2019:** A $10 monthly premium for Other Adult (Expansion) and Transitional			

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	Medical Assistance (TMA) adults in Centennial Care. Monthly premiums in subsequent years can be up to $20 at state's option. Member rewards program will have the option to apply earned credits toward premium payments. If premium is not received by the monthly due date, there will be a grace period before services are suspended. If premium payment is not received by the end of the grace period, disenrollment and a lock out period of three months will occur. Native American members are exempt from premiums. **Other Program Changes:** The phase out of 3-month retroactive (retro) eligibility for most CC members. In 2019, allow one month of retro coverage and 2020 eliminate retro coverage. Some CC members can continue to receive retro coverage with requested: Individuals eligible for Institutional Care (IC) categories of eligibility, pregnant women, children under age 19, and Native Americans in fee for service Medicaid. Family planning services will be designed specifically for men and women through the age of 50 who do not have other health insurance coverage, but also include individuals under age 65 who have only Medicare coverage. Continuous Nursing Facility Level of Care (NF LOC) for members who are expected to always meet NF LOC, must meet state criteria of MCO Medical Director Review and Attestation from Physician. **Community Benefit Changes:** The Community Benefit provides home and community-based services so members who meet a NF LOC can stay in their homes and communities instead of moving to a nursing home. Changes to the Community Benefit include: increase annual limit for Community Benefit Respite for people with long term care needs from 100 to 300 hours; nutritional counseling was added to Agency-Based Community Benefit (ABCB), new benefit for new self-directed members: start-up funds up to $2,000, for items that may include a computer, printer, or fax machine; annual limits on certain SDCB services for new members entering SDCB on or after January 1, 2019 (existing SDCB members are grandfathered); related goods $2,000; specialized therapies $2,000; and non-medical transportation $1,000. SDCB Non-Medical Transportation Billing, currently, providers can bill for transportation by time, trip, mileage, or carrier pass (bus pass or taxi), Billing for time and trip will no longer be allowed for new or renewed SDCB plans after January 1, 2019, and only mileage and bus/taxi pass will be allowed. **Provider Rate Increases:** Phase two of the Behavioral Health increase is effective January 1, 2019 and include, increases for group homes; addition of group therapy rates where there have been only individual rates; restructuring of methadone treatment center rates; partial hospitalization rates, Cognitive Enhancement Therapy; Opioid Treatment Program counseling, Interdisciplinary Teaming; Peer Support Group and Crisis Triage Centers; restoration of 2016 rate reduc-			

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	tion for Community Benefit personal care services (one percent); increase in rates for administration of Long-Acting Reversible Contraceptives (LARC); new rates for Home Visiting services and for UNM/ Project ACCESS – tele-neurology program. **Pharmacy Update:** A letter of direction to the MCOs was issued in April 2018 to implement changes to community-based pharmacy reimbursement to ensure that the pharmacy payment structure more realistically reflects the buying power, buying volume and price negotiating potential of the CB pharmacies; MCOs must ensure the Maximum Allowed Cost (MAC) for ingredient cost for generic drugs is no lower than the current NADAC listed for the drug, and when NADAC price not available, the MAC must be no lower than the published Wholesaler's Average Cost (WAC) plus six percent. MCO contractual changes are effective January 1, 2019 requiring the MCOs to report the amount paid to the pharmacies, not amount paid to the Pharmacy Benefit Managers (PMBs) on its encounter submissions. In addition, contractual requirements also include requiring the MCOs to implement pass through pricing methodology with the PBMs by January 1, 2020 and will no longer allow spread pricing methodology. One of the three 2.0 MCOs is already compliant with the above requirement, a second will be compliant on January 1, 2019, and the third by January 1, 2020. **Replacement of Medicaid Management Information System (MMIS) Update:** MMIS has over 10 million transactions per year. MMIS is responsible for approximately. $6 billion in Medicaid payments and MMIS preforms all non-eligibility functions for Medicaid. **MMIS Replacement:** MMISR is a multi-year project to replace the current MMIS. MMISR is a modular approach per CMS requirements and includes multiple procurements and vendors. MMISR projected completion date is by December 2021. The following information includes updates for each module: IV&V – CSG was contracted in August 2016; System Integrator Module – turning Point Global Solutions contracted in March 2018; Data Services Module – IBM contracted in October 2018; Quality Assurance Module – In procurement process; Benefit Management Services Module – Finalizing RFP for release in November 2018; Financial Services Module – RFP submitted to CMS for review; and Unified Customer Portal and Consolidated HSD Customer Service Center is finalizing for release. **Behavioral Health Update:** Sally Waite presented on the challenges facing the NM Behavioral Health program and HSD's responses. Please see the power point presentation on the HSD website at http://www.hsd.state.nm.us/Meetings.aspx. **Medicaid Dashboards:**			

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	Total Centennial Care Monthly Enrollment have decreased by three percent. Total Centennial Care costs have increased by three percent for the current year; however, per capita costs have increase by six percent.			
VI. Value Based Purchasing and Nursing Facilities	**Dr. David Scrase, Tracy Smith and Erica Archuleta presented on Value Based Purchasing and Nursing Facilities** **Follow-Up on Hepatitis C:** In 2018 there is a projected 90% approval of authorization for HCV treatment of about 1400 members treated. **Important Differences in Health Services Use Rate in Older Population Demographics:** Use rates for all adult healthcare services are higher for those over age 64. Use rates for ages 65-84 are 2.0 to 3.5 times use rates of those under age 65. Use rates for ages 85 and above are 3.5 to 11.5 times use rates of those under age 65. The aggregate impact of population growth and use rates will require NM to expand virtually all categories of healthcare services, by 30 to 45 percent, between 2010 and the year 2030. Nursing home use in NM could double. **Brief Overview of VBP in the U.S.:** In 1983, the federal government implemented DRG's the first VBP program, which: stopped paying per diem rates, and started paying a fixed fee for hospitalizations by diagnosis. CMS has been a consistent leader in program development since then. **What does "Value" Mean?:** What you get divided by what you pay for (Quality/Cost), Fee for Service payments reward providers for doing more, not necessarily for doing "better", and Payers are now moving to payment systems to reward quality of care and outcomes. **Why Implement VBP Programs in Nursing Facilities?:** Robust data (MDS) and established reporting system, Changing CMS incentives, and Manageable number of providers. The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This was established and refined in the mid-1900s. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. **Skilled Nursing Facility Value Based Purchasing Program: 4.5.2014 A Hospital Readmissions Reduction Program for SNFs:** H.R. 4302, the Protecting Access to Medicare Act of 2014 legislates a values-based purchasing (VBP) program for skilled nursing facilities (SNFs). Establishes a hospital readmission reduction program for these providers, encouraging SNFs an incentive pool for high performers. The Congressional Budget Office scored the program to save Medicare $2 billion over the next 10 years.	None	David Scrase, Tracy Smith, and Erica Archuleta	Complete

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	Key NM Medicaid Nursing Facility Facts: Medicaid pays for about 1.4 million nursing facilities (NF) days per year. Medicaid is the primary payer for more than 90% of Long Term Care Facility days. There are only 76 licensed NFs in New Mexico (compared to more than 1000 in California and Texas) **VBP in New Mexico Medicaid:** How VBP "Works": Pay MCOs for value delivered to their total membership per VBP arrangement (Whether contracted or not). MCOs will drive providers to improve their values to increase their premium and their returns. VBP arrangements and insight in the potential performance of providers vs their target budgets will be actionable entry point for MCOs. Members receive better quality care at lower overall cost for the state, slowing further re-investment of Medicaid dollars in delivery system. **Centennial Care Timeline:** In 2014 Centennial Care Initiated. October 2016 to June 2017 Centennial Care 2.0 Stakeholder Input which included Subcommittee of the MAC, Tribal Consultation, Concept paper and Public meetings. In 2017, Waiver Application and Public Comment were drafted as well as the Final Waiver Application, CMS Review and Approval. In 2018, Centennial Care 2.0 Contractors Named. Effective January 1, 2019 is Centennial Care 2.0. **VBP Requirements in CC 2.0 RFP:** VBP Level 1 Minimum Requirements – Long term care providers including nursing facilities. Must include a mix of physical health, behavioral health, long term care and nursing facility providers. VBP Level 2 Minimum Requirements- Actively build readiness for Long Term Care providers and actively build readiness for nursing facilities. At least five percent of the overall total Contract Year Percentages in Levels 2 and/or Level 3 VBP contracting must be with high volume hospitals and require avoidable readmission reduction targets of at least five percent of the hospital's CY 2017 or MY 2017 baseline. Level 3 Minimum Requirements- Implement a Contractor led LTC and/or nursing facility provider level workgroup to design full-risk model. **Project ECHO:** The Project ECHO Model uses technology to leverage scarce resources, share "best practices" to reduce disparities, case-based learning to mast complexity, and web-based database to monitor outcomes. For the Medicaid Nursing Facility Quality Improvement and Hospitalization Avoidance (QIHA) Program Project ECHO is used to expand workforce capacity, utilize multidisciplinary approach, disseminate best practices, engage learners in continuous learning system & partner them with specialist mentors. **Nursing Facility Quality Improvement and Hospitalization Avoidance (QIHA) Program in New Mexico:** Structure of project includes Project Leadership, Community Advisory Board, MCO VBP Workgroup and Provider Advisory Group. The			

DISCUSSION ITEM	OUTCOME	FOLLOW-UP ACTION	RESPONSIBLE PERSON/ DEPARTMENT	EXPECTED OR REQUIRED COMPLETION DATE
	Common Principles for both MCO VBP Workgroup and Provider Advisory Groups are; Evidence based benchmarks (tied to clinical outcomes and evidence), Rewards for both improvement (with defined tiers) and reaching targets, All providers have the opportunity to "win", and there are early wins, Payouts based on Medicaid bed days (volume in each facility), Quarterly or semi-annual payments, Specialty facility special considerations e.g., behavioral health and wound care facilities), and Transparent feedback to providers.			
VII. Public Comment	Nancy Klukas had a public comment about recommending an additional rate increase for nursing homes.	None		Complete
VIII. Adjournment	The meeting adjourned at 3:44pm. Date for the next regular meeting was not announced.	See HSD website for upcoming meeting date(s)	Larry Martinez, MAC Chairperson	Completed

Respectfully submitted: Alysia Beltran — December 12, 2018

Recorder — Date