Medicaid 1115 Wavier Renewal Subcommittee Meeting

Meeting Minutes

December 16 — 8:30am – 11:45am

Administrative Services Division / Human Services Department, 1474 Rodeo Road, Santa Fe, New Mexico

Subcommittee Members:

Myles Copeland, Aging & Long-Term Services Department	Joie Glenn, New Mexico Association for Home & Hospice Care
Doris Husted, The Arc of New Mexico	Lauren Reichert (proxy for Steve Kopelman), New Mexico Association of Counties
Bryce Pittenger, Children, Youth and Families Department	Patricia Montoya, New Mexico Coalition for Healthcare Value
Dawn Hunter, Department of Health	Linda Sechovec, New Mexico Health Care Association
Jim Jackson, Disability Rights New Mexico	Rick Madden, New Mexico Medical Society
Sandra Winfrey, Indian Health Service	David Roddy, New Mexico Primary Care Association
Christine Boerner, Legislative Finance Committee	Lisa Rossignol, Parents Reaching Out
Carol Luna-Anderson, The Life Link	Liz Lacouture (proxy for Mary Eden), Presbyterian Health Plan
Mary Kay Pera, New Mexico Alliance for School-Based Health Care	

Absent Members:

Kris Hendricks, Dentistry for Kids	Carolyn Montoya, University of New Mexico, School of Nursing
Jeff Dye, New Mexico Hospital Association	Dave Panana, Kewa Pueblo Health Corp.

Staff and Visitors Attending:

Kristin Jones, CYFD	Jeanene Kerestes, Blue Cross Blue Shield of New Mexico
Rachel Wexler, DOH	Shawna Romero, Blue Cross Blue Shield of New Mexico
Shannon Cupka, HSD/ALTSD	Ellen Pinnes, The Disability Coalition
Gail Trotter, HSD/ALTSD	Leonard Thomas, Indian Health Services
Lisa Howley, HSD/BHSD	Debi Peterman, Health Insight New Mexico
Wayne Lindstrom, HSD/BHSD	Andrew Conticelli, Molina Healthcare of New Mexico
Karen Meador, HSD/BHSD	Steve DeSaulniers, Molina Healthcare of New Mexico
Theresa Belanger, HSD/MAD	Mary Kate Nash, Molina Healthcare of New Mexico
Michael Nelson, HSD	Deanna Talley, Molina Healthcare of New Mexico
Kari Armijo, HSD/MAD	Theresa Turietta, New Mexico Association for Home & Hospice Care
Kim Carter, HSD/MAD	

Dan Clavio, HSD/MAD	Michael Ruble, New Mexico Behavioral Health Planning Council
Crystal Hodges, HSD/MAD	Tom Starke, Santa Fe Behavioral Health Alliance
Angela Medrano, HSD/MAD	Sarah Howse, Presbyterian Medical Services
Megan Pfeffer, HSD/MAD	Kira Ochoa, Santa Fe County Community Services Department
Nancy Smith-Leslie, HSD/MAD	Sylvia Barela, Santa Fe Recovery Center
Tallie Tolen, HSD/MAD	Jean Crosbie, Senior Link
Robyn Nardone, HSD/NMICSS	Mark Abeyta, United Healthcare
Jared Nason, Mercer	Amilia Ellis, United Healthcare
Jessica Osborne, Mercer	Raymond Mensack, United Healthcare
Son Yong Pak, Mercer	Curt Schatz, United Healthcare
Cindy Ward, Mercer	Elly Rael, United Healthcare
	Ruth Williams, Youth Development, Inc.

Agenda Item	Details	Discussion
I. Introductions	• Angela Medrano delivered opening comments. • Review minutes. • Feedback from the November 18th 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. • October 14th meeting focused on care coordination, November 18th meeting focused on population health and today's meeting is focused on long-term services and supports (LTSS) and behavioral health/physical health (BH/PH) integration. • Summary of recommendations for care coordination and population health are in the packet. • MAD has not received any comments to the October 14th meeting minutes. Therefore, the draft meeting minutes is finalized. • Draft meeting minutes from the November 18th meeting is included and comments are requested by the next meeting, January 13, 2017.
II. Long-Term Services and Supports (LTSS)	• Automatic renewal of nursing facility (NF) level of care (LOC) for certain members. • Align benefits for the Agency-Based Community Benefits (ABCB) and the Self-Directed Community Benefits (SDCB). • Establish levels for ABCB and SDCB budget ranges based on need that may include provisions for one time transition costs. • Implement new MCO reimbursement methodology for members who use fewer PCS hours. • Diversification of services provided by nursing homes. • Explore provider fees / taxes:	• In regards to the Consumer Directed Model under personal care services (PCS), Lauren commented that there are additonal complexities with billing the administrative fees related to required administrative activities of the agency. HSD and the MCOs will provide technical assistance to Rio Arriba Senior Services as needed to ensure that they are informed of how to bill correctly. • Joie commented that the provider reimbursements for ABCB and SDCB do not take into consideration the cost for performing supevision and that supervisory requirements should be factored into the reimbursement. • Doris echoed that it makes sense to align benefits for ABCB and SDCB as the current benefits are very confusing.

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	– Legislative process. – The Centers for Medicare and Medicaid Services approval.	• Lisa commented that individuals over eighteen years of age receive homemaker services. For those under eighteen years of age, she wants the possibility of access to similar support under Centennial Care rather than wait for a waiver slot. • In regards to assessing a child's ADLs, Lisa commented that assessors need to ask questions related to the child's development level to accurately obtain the child's ADL needs and set aside their own personal biases. • Jessica commented that as part of the assessment process, MCOs are assessing the whole situation including the member's natural supports, the caregiver's stress and they need to be cognizant about what is working and not working for the family. • Lauren commented that the DOH licensure requirements for adult day care is challenging to work with as DOH staff do not explain the requirements and refer proivders to the statute. Also, the adult day care reimbursement rate does not take into consideration no-shows and transportation costs, which could endanger the program. She recommends that the reimbursement rate should take these costs into consideration for the agency's financial viability and increase the billing unit from 2 hours to half day and per diem. • Joie commented that adult day care regulations are outdated and has asked DOH to re-visit the regulations. Also, she stated that MCOs would like to have adult day care as an option of care model. • Jim cautioned the Department about moving towards limiting access such as increasing the number of ADLs to access services. He commented that the Department could look at different payment levels based on the

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		outcome of the assessment. • Jim also asked why hours are decreasing for those individuals with no health status changes durding the annual renewal process. In order to maintain their hours, these individuals are forced to go through the fair hearing process. Instead, Jim stated that we need a process for renewing services when there is no change in status as this would be easier for the recipient and the State. • Jim commented that although he appreciates that the Department is doing more waiver allocations for LTC services, he is discouraged that not more people are eligible. • Tallie commented that the Department makes a concerted effort to conduct outreach to allocated individuals by sending multiple packets and tracking them through the eligiblity process. Some do not respond and others are found ineligible. The Department is currently gathering data on attrition of members with waiver slots. • In regards to the NF census, Linda suggested that we need to look at more real time data rather than claims data due to claims lag times. Linda also stated that underfunding of NF must be addressed as mentioned in the Legislative Finance Committee report. Finally, in regards to the NF diversification, she said that NFs can provide adult day care services and provide follow-up services in the community. • Myles commented that NFs can specialize in serving individuals with dementia as part of the diversification strategy. • Dawn commented that increasing the number of ADLs will have an impact on the DOH facilities. She will submit more details in writing.

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		• Wayne commented that we should address how to incentivize NFs to work with members with complex behavoral health needs in the waiver renewal application as this is a critical need. • In regards to the NF access issues, Linda commented that we need to better understand the root cause in order to address this issue. For example, a 5 pm admission on a Friday and lack of beds would require different approaches. • In regards to value-based purchasing (VBP) for NFs, Dawn commented that the DOH/DHI lincensing bureau is identifying quality measures that could be helpful to the Department. • Linda thanked Molina Healthcare for its VBP proposal that focuses on incentives rather than using sanctions to achieve better quality. • Jim encouraged the Department to work with providers groups and explore reimbursement rates since revenue is required for doing the work.
III. Physical Health – Behavioral Health (PH-BH) Integration	• Provider education on PH-BH integration models and best practices. • 3 practice structures and 6 levels of collaboration. • Improve identification of behavioral health and substance use issues and linkage to treatment. • Substance abuse treatment availability. • Improve physical health conditions and reduce in morbidity and mortality. • Direct care management: early assessment; treatment engagement; active follow-up; structured patient	• Linda asked if the Department is interested in PH-BH integration for the LTSS program in addition to collaboration with PH providers, and the response was yes to all. • Carol commented that due to long term drug use, BH providers are seeing physical health issues related to brain atrophy which become long-term service needs. In addition, this impacts staff to client ratio when members can no longer take care of themselves in the community. • In regards to telehealth such as Project ECHO, Lisa asked the Department to speak more about how this is being used. – Karen responded that Project ECHO connects

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	education; standardized psychotherapy. • Linkage to community resources and population health supports beyond health services	specialists, including psychiatrists, to those who need care especially in rural communities. – IHS representative commented that from an Indian Health Services perspective, they began using telehealth to address the shortage of practitioners and having access to practitioners via telehealth has been very successful. – Lisa commented that she is supportive of telehealth and that we should be mindful that some populations such a monolingual population may not like using telehealth. • Rick commented that substance abuse prevention should be a high priority given the epidemic of opioid and prescription drug abuse and dependence. – Wayne commented that both DOH and BHSD have a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to address this issue. – Last week, the federal government signed the 21st Century Cures Act which allows the State to apply for more funding to address the opioid epidemic. We have until Febrary 17, 2017 to apply. – We are putting together a project team and will meet next week to strategize on how to garner stakeholders feedback. – Total amount being requested is $4.8M for the next two years. • In regards to information sharing with in-home service providers, Joie stated that MCOs are not sharing behavioral health information with caregivers and are citing confidentiality issues. Consequently, caregivers are

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		ill prepared and refuse to return if they have encountered unsafe situations. She stated that the caregivers have the right to know about the member's conditions in order to perform their job. – Bryce commented that in the children's world, this is called a run-around and asked the Subcommittee to consider implementing a high-fidelity wrap around with a single care plan. – Wayne echoed that the Subcommittee should investigate how Medicaid can support this model. • Lauren commented that in Rio Arriba County, the county health department conducts a joint case staffing with contracted providers and jails and that this model has been successful. The county's goal is to sustain this program by billing Medicaid. She will submit the details in writing. • David commented that having access to a shared medical record helps with care coordination. • Mary Kay stated that school-based health centers represent a great PH-BH integration model since both PH and BH providers work together and coordinate services and perform shared-decision making. • Dawn echoed Mary Kay's comment by stating that we can support building the SBHC network. Also, she thanked HSD for sharing the Milbank report as it contains good ideas on next steps. • Wayne commented that integration is a heavy lift and encouraged the Subcommittee to consider a broader framework as we work on this issue and reminded the group that integration is not limited to the practice level. – He commented that State departments and MCOs should pay more attention to integration challenges in

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		their respective spheres. – Payment structure is a barrier. We need to move away from fee-for-service which rewards quantity and focus on quality and outcomes by treating individuals more holistically. – Finally, we need to look at the whole lifespan from babies being born with opioid addiction to aging and long-term care. • Rick echoed Wayne's comments and commented that having providers co-located makes a huge difference to achieving integration as it allows practitioners to communicate more readily. Both Rick and Wayne stated that not all co-located practices provide integrated care and emphasized the importance of timely communication among practitioners and a holistic approach to treatment. • Lauren commented that in her county, they co-located all of the departments which forced staff to speak more frequently to one another. She felt that it is not necessarily important to have a co-location, but that the value is in building relationships. • Pat suggested leveraging resources from the Medicare/Medicaid ACOs. • Doris and Bryce commented that we need workforce development to focus on working with individuals with intellectual and developmental disabilities as many BH providers do not know how to treat this population. • Carol suggested that using flexible funding to assist members could be helpful. • IHS representative commented that Screening, Brief Intervention and Referral to Treatment (SBIRT) is a good model for looking at outcomes. – Dawn commented that many states are looking at

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		SBIRT and that Medicaid (in New Mexico) does not pay for it.
IV. Public Comments	• Focus on quality and not cutting services arbitrarily. • In regards to care coordination, utilize youth support workers. • DOH and HSD consider administrative reorganization to co-create and support regionally in rural areas to advance health care. • Care coordination central hub. • The Subcommittee shouldn't be limited to making recommendations. Instead, require MCOs and providers to provide certain services such as medication-assisted therapy and Screening, Brief Intervention and Referral to Treatment.	• Commenter applauded the Committee for its focus on improving outcomes for Medicaid recipients and reducing costs through focusing on quality and not reducing services arbitrarily. However, the discussion on increasing NF LOC from 2 ADLs to 3 ADLs seems arbitrary. • New Mexico is a recipient of the SAMHSA's Healthy Transitions Grant[1], which is aimed to improve support services for adolescents and young adults with, or at risk of, serious mental health conditions. • Peer support workers should be expanded to include youth since youth relates better to young people who share his/her experience(s). • Through the Healthy Transitions Grant, New Mexico is developing a strategic plan that includes developing outreach and engagement activities for targeted adolescents and young adults. • For those rural areas that will not have health homes or patient-centered medical homes, DOH and HSD should consider administrative reorganization to co-create and support the community in how to pay for services (value). In lieu of health homes, health home look alike models could benefit rural communities. • Establishing a regionally appropriate care coordination hub, that is either independent of MCOs or with assistance from MCOs, may be a viable option.
V. Meeting Close	• Follow-up materials • HSD contact protocol	• Comments on population health, LTSS and PH-BH integration comments are due from committee members

[1] For more information on the SAMHSA's Healthy Transitions Grant, visit https://www.samhsa.gov/nitt-ta/healthy-transitions-grant-information .

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	• Next meeting date	by January 6, 2017. • Comments should include recommendations, outcome measures, as well as measurement methods. • Next meeting is on January 13, 2017 in Albuquerque at the Department of Transportation District Three Auditorium.

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
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
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
PMS – Presbyterian Medical Services (FQHC)
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