Centennial Care – Restructuring the State’s Medicaid Program
Summary and DRNM Comments on New Mexico’s 1115 Waiver Application
May 29, 2012

Overview
New Mexico is asking for federal approval of a plan that would significantly change the state’s Medicaid service delivery system. The proposal is in the form of an application for a waiver under Section 1115 of the Social Security Act. These “1115” waivers are intended to demonstrate new and more effective ways to provide health care services to Medicaid participants.

The state’s plan, “Centennial Care”, is scheduled to go into effect in January 2014. Instead of having separate managed care programs for physical health (“Salud”), behavioral health (through Optum Health), and long term services (“CoLTS”), a few MCOs (Managed Care Organizations) would be responsible for providing the full range of Medicaid benefits. Services currently provided through the Developmental Disabilities waiver will not be included in the new program. However, individuals on that waiver will receive their physical health services through the new MCOs selected for Centennial Care.

The new approach emphasizes care management and care coordination, intended to assure that Medicaid participants promptly get the care they need in order to reduce or avoid hospitalization or other expensive services. The state plans to begin some pilot projects that would take on responsibility for coordinating all aspects of a person’s health care needs (“health homes”) and others that would base provider payments on health outcomes rather than simply on the specific services or treatments provided (“pay for performance”). Participants are expected to take more responsibility for their health care needs, getting small rewards for “doing the right thing” and facing penalties in the form of co-pays for unnecessary use of hospital emergency rooms or insisting on brand name drugs when generic versions are available (though this would not apply to psychotropic medications).

Centennial Care features a new approach to long term services that promises to provide help to a large number of people who need these services but are on waiting lists, but it seems to finance this expansion by limiting and/or reducing services for those already receiving them. Some new services and a heavy emphasis on service coordination are a central theme to behavioral health services in the proposed new program.

Unfortunately, the state’s plan generally lacks important details about how the program will be implemented. This makes it difficult to predict whether key features of Centennial Care will turn out to be helpful or harmful.

CMS, the federal agency that is considering the state’s application, is currently accepting comments from the public about the state’s proposal. Comments should be submitted by June 8th.
to insure that they are considered by CMS. Comments can be submitted through the following CMS web site: https://cmsideas.uservoice.com/forums/161090-section-1115-demonstrations-new-mexico-centennial#settings

Background and Current Status

About a year ago, the state Human Services Department (HSD), which runs the Medicaid program, contracted with Alicia Smith and Associates to develop a new design for Medicaid, on the theory that the current program was becoming too expensive and was "unsustainable". The initial hints about the new approach were contained in four "principles" released by HSD: care coordination, personal responsibility, pay for performance, and administrative simplification. Public meetings were held in six New Mexico cities in the summer of 2011 to receive input on these general ideas. But with no specific proposals or details provided, there was no opportunity for stakeholders to engage in meaningful dialog or discussion. Interested groups, including DRNM and The Disability Coalition, provided various recommendations for program design but received little if any feedback on HSD's real plans.

A few days after the 2012 state legislative session ended, HSD released its "concept paper" on Centennial Care. This provided a bit of detail but still gave only a glimpse of what the new program would look like. Just two months later, without any opportunity for the public, the legislature or the official Medicaid Advisory Committee to comment on its proposal, HSD submitted its waiver application to CMS on April 25, 2012 and asked for an expedited approval process. This submission occurred just two days before new federal rules, announced in February, went into effect governing 1115 waiver applications. The new rules emphasize public involvement and review of state proposals prior to submission for federal consideration. The last minute application by HSD in advance of the effective date allows HSD to dodge these new transparency rules. However, as noted above, CMS is providing a 30 day period for the public to comment to them on New Mexico HSD's waiver application.

Implementation Timeline

HSD has indicated that it expects it will take about six months of negotiations and modifications to obtain CMS approval of its application. HSD plans to issue a Request for Proposals in September 2012 inviting MCOs to submit bids to administer the program, and to select the winning MCOs in this competition by the end of December 2012. Throughout calendar year 2013, HSD will work with the selected MCOs in an effort to assure that each one is fully prepared and operational by January 1, 2014, when the program goes into effect and consumers will begin receiving services from the MCOs. This is the same day that the expansion of eligibility for Medicaid and the implementation of state health insurance exchanges, both called for under federal health care reform, are scheduled to go into effect.

Major Changes to Medicaid Under Centennial Care

• Combines almost all physical health, behavioral health and long-term services for all Medicaid recipients into one integrated program. All current Medicaid benefits will still be available. Participants probably will have 3 - 4 MCOs to choose from, and each MCO will be required to offer all these Medicaid services statewide. DRNM is concerned that some MCOs may not have the expertise and capacity to provide the full range of Medicaid services state-wide. And since HSD intends to reduce the number of Medicaid MCOs and may even select new ones that don't currently participate in the program, many consumers will have to try to
compare various provider networks to see which ones include their current medical providers. During past Medicaid transitions this information has not been readily available.

- The state proposes to require Native American Medicaid recipients to enroll in Centennial Care. Currently, Native Americans who are eligible for CoLTS are required to enroll in that program in order to get Medicaid services, but those who are eligible for Salud may choose whether to enroll in managed care, and only about 20% of those eligible have chosen to enroll in Salud. Native American tribal governments in New Mexico are largely opposed to the state’s plan for mandatory enrollment.

- All Medicaid participants will be screened to determine the extent of their current health care needs, and special emphasis will be placed on care coordination and case management services for those with more intensive needs. It is not clear whether this is intended to be an extension of the CoLTS model of care coordination to additional participants, or a new and improved version for all who need it. DRNM has heard from many CoLTS participants that it is hard to reach their care coordinators and that they seem to receive little benefit from this service.

- Participants who use a hospital emergency room for a condition that turns out not to be an emergency will have to pay a co-pay if alternative services are available but the person insists on receiving treatment in the ER. The proposed co-pay amounts exceed what's currently allowed by federal law. DRNM notes that there are few if any alternatives to ERs on evenings or weekends and shares the concerns of many advocates and providers that this will be difficult to administer.

- The state proposes to waive the current requirement that Medicaid cover the cost of medical services provided in the three months before a person applies for Medicaid (if they are found eligible for Medicaid at the time of application and for the preceding months). Since many people don't apply (or re-apply) until after they have started to receive necessary medical services, such a waiver would mean that the bill for such earlier services would not be covered by Medicaid and the cost would have to be paid by the low income individual or the health care provider(s) simply wouldn’t get paid.

- Several groups of adults who are currently eligible for Medicaid will lose eligibility under Centennial Care if their income is above 138% of the federal poverty level or FPL (e.g. above $20,880 per year for an adult couple or $31,809 per year for a family of four). This includes some people with disabilities who qualify for the Working Disabled Individual program, which offers Medicaid coverage up to 250% of FPL, including certain individuals who have become eligible for Social Security Disability benefits but are in the two year waiting period for Medicare benefits. Other groups that will lose Medicaid include those with incomes above 138% FPL who currently have coverage based on breast or cervical cancer, pregnancy, or for family planning services. The ability to maintain Medicaid coverage is a crucial incentive for adults with disabilities who want to go to work but would be unable to afford comparable private insurance coverage.

- Individuals who are not currently eligible for Medicaid but will become eligible in 2014 due to the expanded coverage under federal health care reform will receive a “benchmark” Medicaid plan that may not include all of the services provided to current Medicaid participants. HSD has not indicated what services will be included (or not included) in the benchmark plan.
Long-term Services

The Centennial Care plan would make several major changes to the current system for providing long-term services under Medicaid:

- Long-term services available will include attendant care (Personal Care Option or PCO) services and the services that are currently provided only to those in the CoLTS-C (Disabled and Elderly) waiver program, such as assisted living, skilled maintenance therapy, private duty nursing, respite, etc.

- **Everyone** who is income-eligible for Medicaid (up to 138% FPL in 2014, due to federal health care reform) and meets the “nursing home level of care” will be eligible to access the full range of long-term services they need **without having to be in a D&E waiver slot**. This will quickly and substantially expand the number of people who can get these needed services. Many such individuals are currently on the hopelessly long waiting list for waiver services. Those who are at this income level and are already on the D&E waiver can give up their slot without losing eligibility or services, which will free up waiver slots for individuals at slightly higher income levels. *This approach to services is consistent with recommendations provided to HSD by DRNM and The Disability Coalition.*

- Those with incomes between 139% and 225% FPL will need a D&E waiver slot in order to get long-term services. HSD’s plan promises that everyone who is already in the D&E waiver program and in that income range will continue to receive these services. In addition, a limited number of waiver slots – HSD hasn’t said how many – will be available for individuals wanting to transition from nursing homes into the community, and for some of those on the waiting list for the D&E program. There are around 17,000 people on that list now because virtually no one has come off it in the last few years.

- All those who qualify for long-term services will be classified, according to a functional assessment, into a “moderate needs” or “high needs” category. The amount of services each person receives will be established in an annual service plan and will be based on their individual needs, **but will be limited within a range that will be established for each category**. There will be “expenditure boundaries” that will cap the amount of services that individuals in both categories will be able to receive. *HSD’s plan does not indicate what the ranges will be, but arbitrary limits could be a major problem if they prevent recipients from receiving the level of services they need to maintain health, avoid nursing home placement and be integrated into community life.*

- HSD will continue to maintain a waiting list for the D&E waiver, but it may change the way it allocates waiver slots, giving priority for allocations based on the extent and the urgency of need rather than just the length of time someone has been on the list.

- Self-direction will be available with respect to most but not all long-term services and for everyone who receives those services and is capable of self-direction, not just those who are in waiver slots and choose the current “Mi Via” self-direction option. However, HSD suggests that it may tighten up the criteria for deciding who is capable of self-direction, and allow MCOs to request permission to deny self-direction in certain circumstances. HSD also plans to contract with a single agency to provide the financial management services that are an important element of the self-directed model.

- HSD’s “Community Reintegration” program, which helps people transition from nursing homes to community services by reserving for them every D&E waiver slot that becomes available, will apparently continue in Centennial Care. *This program is controversial in the disability community because it places these facility residents ahead of everyone already on*...
the waiting list. This creates a perverse incentive to place a person in a nursing home in order to go through the program to transition back into the community with waiver supports and services – services that one would otherwise have to wait years to receive.

Behavioral Health Services

In the current Medicaid program, behavioral health services for children and adults with significant needs are provided through one state-wide MCO (currently Optum Health) through contract with the state’s multi-agency Behavioral Health Purchasing Collaborative.

Centennial Care features a “carve in” approach intended to integrate physical health and behavioral health by making MCOs responsible for providing the full range of Medicaid services that a participant needs, including behavioral health. The goal is a “holistic” approach that coordinates treatment for medical and behavioral health. However, the new model requires the MCOs to delegate much of their behavioral health service delivery to Core Service Agencies, an approach that is already being emphasized by the Collaborative.

In the state’s new plan, all Medicaid participants will be screened to assess the scope and intensity of the health care services they need, including behavioral health. Those with moderate or intensive needs will receive services pursuant to an annual plan of care, although the assessment process appears to rely heavily upon self-reporting. This may be a problem because some individuals may deliberately deny the need for services in an attempt to avoid stigma or unwanted interventions.

Most individuals with intensive needs will be referred to a Core Service Agency, which will provide traditional behavioral health services as well as Comprehensive Community Support Services (CCSS) and some care coordination. Some but not all Core Service Agencies will be designated as a "behavioral health home" and will provide a broader and more extensive level of care coordination and case management.

Three new behavioral health services will be added to the current Medicaid benefit package: peer to peer recovery services, family support, and respite care for families of youth with mental illness.

The plan provides an assurance that funding currently earmarked or channeled into behavioral health will continue to be dedicated to this purpose, but it is not clear how this will be accomplished. The fact that the plan allows some of these dollars to be used for integrating physical and behavioral health creates some doubt about this assurance.