

**BY E-MAIL ONLY**

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Dear Ms. Mann and Ms. Wachino:

This letter provides comments from The Disability Coalition and Disability Rights New Mexico (DRNM) on the revised application for a §1115 Medicaid waiver submitted by the New Mexico Human Services Department (HSD) on August 17, 2012. The Coalition includes New Mexicans with disabilities, family members and advocates. DRNM, a private non-profit organization founded in 1979 whose mission is to protect, promote and expand the legal and civil rights of persons with disabilities, is the designated Protection and Advocacy System in New Mexico authorized under federal legislation.

Initially, we would like to express our appreciation for certain changes made by HSD to modify aspects of the proposed program, to be known as Centennial Care, that were included in the original application that was submitted to CMS in April and subsequently withdrawn. These include:

- Keeping income eligibility for Working Disabled Individuals (WDI) and pregnant women at the current levels of 250% and 185% of the federal poverty level (FPL) rather than reducing them to 138% FPL.<sup>1</sup>
- Adding a provision for twelve-month continuous eligibility for adults.

We support certain aspects of the state's proposal but have concerns about many others, as discussed below.

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<sup>1</sup> The state continues to propose reducing income eligibility for Family Planning and Breast and Cervical Cancer coverage, as in the original waiver application. We object to these proposed changes, and note that the proposal appears to be based on the assumption that these individuals will obtain coverage through the new health insurance exchange. However, as noted below, the state has now indicated that the exchange for individuals is not expected to be available as of January 1, 2014, the proposed effective date of these changes. We also question whether exchange coverage will be affordable and adequate for these individuals.

### Lack of specifics about proposed changes

HSD's application lays out a "grand plan" for restructuring its Medicaid program. The plan calls for selecting new managed care organizations (MCOs), requiring each MCO to cover virtually the full range of Medicaid services and populations from healthy newborns to seniors and persons with disabilities who have high medical and long-term services needs, and improving delivery of health care through measures that are as yet not well defined.

All of New Mexico's Medicaid recipients will be affected by the changes. HSD estimates that this will include more than 600,000 New Mexicans covered through the current Medicaid program; an estimated 170,000 more may enter Centennial Care when they gain Medicaid coverage through the expansion provided for in the Patient Protection and Affordable Care Act (ACA).

The state's application invokes a number of current buzzwords in health care, calling for a system that promotes quality and positive outcomes rather than simply emphasizing the quantity of services provided. While we support those goals, we believe the application shows little evidence that HSD has a clear sense of how to achieve them. It is phrased primarily in generalities, provides little information on specifics, and does not lay out how the state intends to test and evaluate the measures proposed.

Both the waiver application and the request for proposals (RFP) for MCOs indicate that HSD's approach is to set out broad principles and largely rely on the MCOs to figure out how to operationalize them. While we believe that it is appropriate for the state to work cooperatively with the MCOs and to draw upon their expertise, it is essential that the state have some sense of what it wants and how to get there so that it can provide appropriate guidance to and oversight of the MCOs and be able to evaluate the approaches they propose.

In addition, the state should not rely solely on the MCOs to develop new approaches; other stakeholders, including consumers and providers, also have valuable experience and expertise and should be included in program development. HSD's approach to stakeholder engagement to this point has been woefully inadequate, as is discussed below.

The state's desire for more "flexibility" in administering the Medicaid program also is worrisome. (See Application, p.46.) There have been repeated statements from HSD that the requested waiver will give the department more flexibility to run the program as it deems fit rather than pursuant to what HSD Secretary Squier has frequently termed a "one size fits all" approach mandated by the federal government. Leaving aside the oddity of a department simultaneously complaining both that it has too many waivers of federal requirements to administer and that it is unduly constrained by uniform federal rules, it is not clear what flexibility the state expects to achieve in Centennial Care or how it will be exercised.

To the extent that the state expects to achieve flexibility that it does not currently have and that goes beyond the specific waiver/expenditure authority requests listed on pp.68-69 of the application, that flexibility and the state's intentions as to how it will be implemented should be clearly stated. On the other hand, if it is true, as HSD acknowledges at p.6 of the application,

that the state “will be subject to all applicable Medicaid laws and regulations, except to the extent such laws and/or regulations are explicitly waived”, it should be made clear that any waiver granted does not give the department vague and unspecified flexibility to change rules at its whim.

#### Over-ambitious implementation schedule

The state intends to select new MCOs for Centennial Care. HSD has said that one of its primary goals in the new program is to reduce the number of MCOs in Medicaid from the current seven (two in the Coordinated Long-Term Services or CoLTS managed long-term care program, four in the Salud physical health program, and one for behavioral health). Statements as to the number to participate in Centennial Care have varied from three to four when the waiver proposal was first unveiled, to “no more than five MCOs unless it is in the State’s best interest to do otherwise” in the RFP released on August 31 (RFP, p.4). The identity of the participating MCOs is unknown at this time but it is virtually certain that some, if not all, of the current MCOs will no longer be part of New Mexico’s redesigned Medicaid program and that new MCOs will be joining the program.

That means that many if not all Medicaid recipients will have to switch MCOs. It also means that many of them will have to change providers because their current providers will not be part of the new MCO’s network. The result will be a huge amount of upheaval as beneficiaries try to navigate the new system, vetting and selecting MCOs, negotiating any changes in the care coordination system, and understanding new procedures put in place by both the state and the MCOs.

This is a particularly important issue for persons with disabilities, who have higher needs for health care (both physical and behavioral) and many of whom have long-term services needs as well. They are therefore at heightened risk of having to change providers, and at greater risk of harm if there are glitches in the transition to the redesigned program, as will inevitably occur.

That risk is increased by the state’s unrealistic implementation schedule. HSD is proposing that all beneficiaries transition to the new program simultaneously as of January 1, 2014. Previous transitions to MCOs have been implemented on a phased basis to try to minimize disruption. For example, the Coordinated Long-Term Services (CoLTS) managed long-term care program, which affected fewer than 40,000 people, was phased in through four stages over the course of a year in 2008-2009. Even so, the rollout was not entirely smooth. Centennial Care, by contrast, will affect hundreds of thousands of people yet the state plans to transition all of them at once.

This is especially problematic because the move to Centennial Care for current Medicaid recipients will not be the only major change occurring at that time. January 1, 2014 is also the start date for the health insurance exchanges called for by the ACA. In addition, as many as 170,000 New Mexicans may be added to Medicaid pursuant to the ACA expansion. Even under the most ideal circumstances, it is impossible that all of these changes can be managed smoothly. We have no confidence that HSD’s ability to manage them is “ideal”.

HSD has pointed to the long period between selecting MCOs and the program's "go-live" date as evidence that there will be adequate time for preparation. That period is currently projected as eleven months from entering into contracts with the MCOs by February 1, 2013 to go-live on January 1, 2014. That period may give the MCOs time to build their networks and otherwise prepare for transition, but it is not clear what, if anything, will be done to educate Medicaid recipients, prepare them for the transition, or make the transition as complication-free as possible for them.

The application says next to nothing about the state's plans for outreach, education or assistance to recipients in selecting, enrolling with, and navigating a new MCO, giving only generalities and vague promises in this regard. Provisions relating to transitions of care when Centennial Care begins and after it is underway are also minimal; the state does not appear to have given any real consideration to transitions that occur after initial enrollment into the program. See Application at p.31: the state "will work with CMS and the selected health plans to develop a transition plan for new recipients", and at p.43: "HSD will work closely with CMS, MCOs, caregivers and current programs to develop a smooth transition period before and after the program begins". The only specific requirements identified are that MCOs will not be allowed to change existing care plans until a comprehensive assessment has been conducted and that MCOs cannot change an individual's providers unless the current provider is not in the MCO's network. (Application, p.43) There is no provision for ongoing access to current providers outside the network, either for a transition period or on a longer-term basis, where appropriate to ensure continuity of care, or for continuation of an existing care plan as needed to ensure a smooth transition for the individual.

HSD apparently has established a workgroup of state staff to work on transition issues and says that "[w]ork is currently being done ... to proactively prepare these at-risk individuals for the transition into managed care with the establishment of [this] workgroup". (Application, pp.43, 31) This is another example of the state's "we'll figure it out later" approach to the new program. In addition, it is not clear how creating a workgroup of state staffers can be deemed to constitute current work to prepare at-risk individuals for the coming changes.

If the waiver is approved by CMS, we urge you to require the state to present a detailed transition plan that is sufficient to ensure that all recipients are moved into the new program without interruption in services or other undue burdens. This should include specifics about outreach to participants to inform them of the coming changes and supports to be provided to them to help them select and enroll in a new MCO and to minimize adverse impacts of the program changes. The state should also be required to provide for continued access to current services and providers for a sufficient period of time to allow for continuity of care and a smooth transition based on the individual's needs. Similar provisions should be in place to ensure adequate planning and services at the time of other transitions experienced by the individual, such as later changes from one MCO to another or discharge from a hospital stay.

#### Lack of meaningful plan for program evaluation

This is a serious flaw in the proposal. The discussion of evaluation in the application is extremely skimpy, consisting of a single page that essentially says the state will figure it out

later. (“New Mexico *will develop* a comprehensive evaluation design to measure the impact and success of Centennial Care” and “*will submit* to CMS a specific design plan”. (Application, p.67, emphasis added.) The undersigned have submitted significantly more detailed evaluation plans in connection with applications for grants of \$20,000 than HSD is submitting here in connection with a multi-billion dollar program affecting the lives of hundreds of thousands of New Mexicans.

Section 1115 of the Social Security Act, 42 U.S.C. §1315, authorizes “experimental, pilot, or demonstration projects” that are “likely to assist in promoting the objectives” of the Medicaid program. (§1115(a)) In order to fulfill the functions of a research and demonstration project, the program must be subject to rigorous evaluation. Not only does New Mexico’s application make clear that it has only a general idea of what it will be demonstrating or researching, it also shows that the state does not know how it will evaluate the program. No waiver should be granted until the state establishes a meaningful plan for evaluation.

The lack of specific criteria and measures for evaluation is of particular importance to people with disabilities because they are especially reliant on Medicaid health care and long-term services, and because managed care for individuals with long-term services needs is still a new concept for which few established quality measures exist.

Unlike physical health services, no national standards have been developed for long-term services and supports (LTSS). It is common for MCOs to use the Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance (NCQA) to measure health plan quality, but those measures are oriented toward primary and preventive care and provide little relevant information on the quality of LTSS. Moreover, quality of life is a critical indicator for people with LTSS needs, and the clinically-focused measures typically used in health care, like those in HEDIS, generally ignore this important aspect of performance evaluation.<sup>2</sup>

As a condition of any waiver, New Mexico should be required to develop and present a detailed evaluation plan that contains meaningful measures of program and MCO performance and quality. That plan should be specific as to criteria for evaluation, measures to be used, and reporting systems to gauge performance and results. In addition to general measures of quality that apply across populations, measures specific to particular populations should be included in the plan. For example, people with disabilities have different needs and experiences in Medicaid and in the health care system than do the able-bodied. The health care and LTSS needs and preferences of seniors will be different from those of younger persons with disabilities; those for people with physical disabilities will differ from those with behavioral health needs or cognitive impairments. A meaningful evaluation plan will identify measures that capture system performance relating to specific population groups as well as general system-wide issues.

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<sup>2</sup> For more information on issues relating to managed care for people with disabilities and for long-term services, we refer your attention to two excellent reports from the Kaiser Commission on Medicaid and the Uninsured: “Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider” (Kaiser Family Foundation #8243, October 2011) and “People with Disabilities and Medicaid Managed Care: Key Issues to Consider” (KFF #8278, February 2012).

### Program oversight

HSD has said that it intends to reduce the number of MCOs in Medicaid so that it will be better able to provide oversight of their operations and performance. However, the extent to which this will result is uncertain. According to the RFP, the state intends to choose as many as five MCOs and may select even more. (RFP, p.4) Although behavioral health will be carved back in and made the responsibility of the MCOs, they will be permitted to subcontract for behavioral health services if they lack the in-house expertise to manage these services. While the prime MCO must continue to bear financial risk, service delivery responsibility will lie with the subcontractor and the state will have to do some degree of oversight as to those entities as well.

The state's capacity to perform adequate oversight of the various entities responsible for Medicaid services is an open question. The application states (p.43) that the department is "evaluating how to best restructure staff and functions to effectively monitor the Centennial Care program and selected MCOs". One would have thought that decisions of this nature would have been addressed before submitting the waiver application. We hope CMS will thoroughly investigate the state's plans for program oversight and its ability to perform that oversight effectively.

### Inadequate stakeholder engagement

The state's waiver application attempts to portray a robust process of public and stakeholder involvement that has taken place in regard to development of the waiver. Unfortunately, that depiction exaggerates the processes that have been pursued up to this point and considerably overstates the degree of engagement that has occurred. Although HSD has indeed provided opportunities through which New Mexicans can provide *input* to the state, opportunities for meaningful *participation* as the proposed program is formulated and developed have been severely limited. Input is not the same as dialogue, consultation, or engagement.

HSD's assurances that it finds public involvement to be invaluable are belied by what appears to be an intentional exclusion of stakeholders from meaningful participation in program development. Promises that the department will continue to seek that supposedly valued involvement provide little comfort in view of the state's inadequate record in this regard.

We note that most of the workgroups created by the state to work on various aspects of Centennial Care development are internal staff committees. The exception is three workgroups that took place in the fall of 2011 to advise the department on three of the four principles of redesign (care coordination, personal responsibility, and pay for performance). Membership was limited and only two consumer representatives were allowed to join each group. While consumer advocates appreciated the opportunity to participate and to provide input to HSD, these workgroups should have been only the beginning of an ongoing engagement process. Instead, each workgroup had a single eight-hour meeting spread over an afternoon and the following morning. It is our understanding that the only ongoing groups working on Centennial Care development and implementation consist entirely of state agency personnel and the state's consultants from Alicia Smith and Associates. It is not even clear that staff from other state

agencies with relevant expertise and responsibilities are involved in the effort or that their input is being solicited.

We urge CMS to require, as a condition of waiver approval, that the state establish procedures for meaningful engagement with stakeholders throughout the process of development, implementation and operation of the Centennial Care program.

#### Managed care organizations

HSD is proposing that each of the MCOs in Centennial Care will be responsible for all Medicaid services, including physical health, behavioral health and LTSS, that are now offered through Salud, CoLTS and the behavioral health statewide entity. That is, every one of the MCOs will be expected to have the ability to serve people with disabilities and frail seniors with high physical/behavioral health and LTSS needs as well as the much larger number of children and adults covered by Medicaid who have more general (and generally a lower level of) health care needs and do not need LTSS. This raises the question of whether all (or indeed any) of the MCOs selected for the program will have the requisite expertise and capacity to take on this broad range of responsibility.

The state's assumption appears to be that any MCO can competently address the needs of frail seniors and people with disabilities, but this is a questionable proposition. These populations not only have needs that are distinct from those of the "moms and kids" categories of Medicaid recipients, but they are themselves a diverse group with widely varying needs. Serving them through capitated managed long-term care systems is a new and still relatively untested concept. Unlike the acute care context, in which managed care has a long track record and for which there are established treatment protocols for specific health conditions and events, LTSS needs are much more individualized and there is limited information on which approaches work best for particular populations. Throwing these individuals into a mix that is dominated by groups with very different needs and situations puts them at risk of being lost in a system that is not well attuned to them and does not serve them well.

Currently, New Mexico serves people with disabilities, including seniors, through two MCOs in its CoLTS program, Amerigroup and United, who were selected because they had expertise in serving populations with long-term services and supports (LTSS) needs and whose New Mexico operations specialize in serving these groups. Even so, CoLTS operations have not been without controversy and problems for enrollees. There are few MCOs in the United States that have demonstrated experience and expertise in working with these populations, so there are questions as to whether New Mexico will be able to find qualified MCOs to take on this responsibility.

One of HSD's goals in Centennial Care is to achieve administrative simplification by reducing the number of MCOs whose contracts the department must oversee. However, while the total number of MCOs in New Mexico's Medicaid program may fall, there will be at least twice as many serving people with disabilities and LTSS needs, including dually-eligible individuals served by both Medicaid and Medicare. Not only does this increase the burden on enrollees who must navigate a system that involves more MCOs than the two in the current

CoLTS program, it also will make it more difficult for the state to monitor MCO performance in serving these high-needs groups. In addition, it will impose additional burdens on LTSS providers who currently have to contract and interact with only two MCOs in CoLTS and will have to work with twice as many or more in Centennial Care. A similar situation pertains as to behavioral health, which is currently managed by a single MCO but will become the responsibility of all those participating in Centennial Care.

The state should be required to establish specifically that all of the MCOs selected for Centennial Care have the necessary expertise, experience and capacity to adequately serve individuals with severe disabilities who may have high health and LTSS needs.

One additional consideration relating to the MCOs in regard to dually-eligible beneficiaries is the state's indication that it plans to require all Centennial Care MCOs to be or become statewide Medicare Special Needs Plans (SNPs) or Medicare Advantage plans, as "a step toward full integration of care for this population". (Application, p.21) This provision was not included in the original waiver application and came as a particular surprise given the state's decision to withdraw its application for a demonstration project integrating care for dual-eligibles. It may be appropriate to move in this direction at a later time, but imposing this requirement at this point adds an additional layer of complexity to the program that it can ill afford. Finding qualified MCOs to participate in Centennial Care will be difficult enough without adding this requirement. And efforts by the MCOs to take on these additional roles will be a distraction from the significant amount of work that will be needed to implement the Centennial Care program as currently envisioned.

#### Needs assessments and care coordination

We appreciate and support one of the major premises underlying Centennial Care: that Medicaid participants should be screened and assessed to identify those who need more extensive services and assistance due to disabilities, chronic disease or other issues, and to assure that those with higher needs will receive intensive care coordination, assistance in managing chronic conditions, and services that will maximize their health and reduce the likelihood of hospitalization, institutionalization, and other expensive interventions.

However, we have concerns that the processes called for in the application are often unclear about how they will lead to the achievement of these objectives and in at least one important area the planned design will interfere with the desired outcomes.

***General and Entry Assessments:*** The state's application indicates that the assessment process will begin with an initial phone contact within 10 days of enrollment (p.27). We appreciate the commitment to promptness but question how this will work when approximately 600,000 people (and many more if the ACA Medicaid expansion is adopted) enroll in the new system more or less simultaneously when it debuts. Although the proposed contract included in the RFP allows the MCOs 30 days to complete the assessments when Centennial Care begins in January 2014 (RFP Appendix I, p.33, contract clause 4.4.2.4.1), this still appears unrealistic. (Assuming that as many as five MCOs are selected, that would mean an average of 120,000



enrollees in each one who would have to be assessed in a single month, or 4,000 each calendar day.)

We also have concerns about the exclusive emphasis on this initial contact being done by telephone. While this may often produce satisfactory results, it is subject to significant limitations. Examples of obvious problems are the relatively large number of Medicaid residents in New Mexico who do not have phones; participants who speak a language not familiar to the employees of the MCOs; and persons with disabilities who have problems in communicating by phone. In addition, many people, especially those with disabilities or complex health conditions, may be reluctant to disclose information by phone to a stranger (see our further comments below in the section addressing behavioral health issues). We encourage CMS to require HSD to specify what other methods (such as in-person home visits) they plan to have the MCOs use to obtain the information needed to complete the initial assessment, and the criteria for determining when such other methods should be employed.

The information derived from this initial contact, along with prior utilization data if available, will determine the initial level of need and the degree of care coordination to be provided. Individuals who appear to be in the lowest need category will get no further assessment unless claims, encounters or health events "signal a change in status". Since it is not clear how such triggering events will be monitored or reviewed, there is a significant risk that those whose needs for care coordination and health care services are in fact higher than the minimum category may be overlooked for a considerable period of time.

We also are concerned about the state's intent to allow each MCO to use its own assessment tools, which creates an obvious potential for inconsistent results depending on the MCO in which an individual is enrolled. See clause 4.4.5.4 of the proposed MCO contract, attached as Appendix I to the RFP.

***Long-term services assessments:*** The state's application gives the MCOs the responsibility of performing level of care (LoC) evaluations for persons who are *not* income-eligible for Medicaid but who may need long-term services (p.14). (We note that it is not clear which MCO would perform any particular LoC determination since individuals who are not income-eligible would not yet have selected or been assigned to a particular MCO). The results of these evaluations will significantly affect the amount of reimbursement the MCO receives to serve that person. The application does not specify which entity will perform the LoC determinations for those who *are already* enrolled in Medicaid but it appears that this function may also be carried out by the MCOs. In addition, the MCOs will conduct the specific needs assessment (p.10) that determines the level of services the individual will receive and thus the amount of money that the MCO will need to spend on that individual. Placing each of the MCOs in the position of controlling both of these processes creates a very problematic incentive to over-identify the need for intensive services (to increase reimbursement) and under-identify the level of services required to meet those needs (to reduce spending). This is a classic fox and hen house scenario.

In the early years of operation of New Mexico's Personal Care Option, service providers were tasked with assessing the level of need and developing care plans. Not surprisingly, this

resulted in care plans calling for very high levels of services, for which providers were reimbursed on an hourly basis without much limitation or oversight. The growth in expenditures in the PCO program led the state to consult with provider and consumer representatives about how to improve the program, and an independent assessment process was established. The state's Centennial Care proposal would reinstate a similar situation in which conflict of interest could affect the determination of an individual's need for services.

***Conflict-free assessment process:*** We urge CMS to require that the LoC and service assessment processes be performed by one or more independent agencies in order to avoid these incentives. A "conflict-free" assessment process will be more objective, is likely to produce more accurate and appropriate results, and will eliminate the perception that the system has been designed to benefit the MCOs rather than the participants. We note that this is the approach taken in our neighboring state of Kansas in connection with its pending §1115 waiver application, that it is a central feature of the Dual Eligibles Demonstration program in Massachusetts, and that it is a component of other state proposals as well. Such an approach should also be considered for the initial screening and needs assessment for all Medicaid recipients.

***Care coordination:*** We support HSD's stated commitment to providing care coordination appropriate to each individual's level of assessed need, including identifying high-needs individuals so they can receive a higher level of coordination. However, questions remain about how this will work in practice.

Currently, individuals with long-term services needs and dual-eligibles who are covered by both Medicaid and Medicare are served through New Mexico's CoLTS program. These individuals have already been identified as having a high level of need and the MCOs are expected to serve them accordingly. In Centennial Care, the assessment and coordination process is likely to again identify them as having high needs. As to these populations, there appears to be no progress in this regard simply by mixing them into the larger population of Medicaid recipients within the same MCO and then having the MCO once again find that they have higher than average needs. The issue thus becomes whether the new program will serve them more effectively than the current program.

From the time CoLTS was under development, the state made assurances that are similar to those now being made concerning Centennial Care, promising that enrollees will receive the necessary coordination and support to ensure that they get needed services. But service coordination in CoLTS has often fallen short, with frequent complaints that the coordinators are overworked, hard for enrollees to reach and unresponsive to enrollee needs, and that it is often difficult to obtain services. The state's application does not even acknowledge the problems encountered in CoLTS and does not explain how the approach in Centennial Care will avoid or remedy those problems.

#### Long-term services and supports

***Access to community-based services:*** The waiver application proposes a significant change in access to home- and community-based services (HCBS) for people with LTSS needs.

Currently, personal care attendant (PCO) services are available through the state plan, but other HCBS, such as assisted living, environmental modifications, skilled therapies and others, are offered only through §1915(c) waivers. The CoLTS-c (formerly Disabled & Elderly) HCBS waiver has a waiting list of more than 17,000 people. A few years ago, HSD implemented a policy that waiver slots are made available only to people leaving nursing facilities to return to the community and not to those on the waitlist, resulting in wait times that are essentially infinite.

We were therefore very pleased to learn that HSD is proposing that HCBS that now are available only through the HCBS waiver will be made available to any individual who is otherwise eligible for Medicaid, and that the state will open up a certain number of slots each year to serve persons on the waitlist who cannot qualify for Medicaid except through the §1915(c) waiver. The intended result is that more people will have access to HCBS that allow them to live in the community. We support this aspect of the state's §1115 waiver proposal.

However, certain questions remain about how the new program will work. We anticipate that a number of people currently on the 1915(c) waiver will qualify for Medicaid without a slot and can therefore give up their slot and make it available for someone else. We also expect that many of the people on the waitlist for HCBS will qualify for services without a slot. It is therefore our hope that a significant number of slots will open up and that the number of people receiving HCBS will grow appreciably. However, the degree to which this will happen is unclear.

The waiver application includes no information – and HSD has not made any publicly available – about the number of people on the waitlist who will become eligible for HCBS without a slot, the number of slots that are expected to open up, or the expected increase in the number of people receiving HCBS. The application says only that available slots will continue to go to people transitioning out of facilities to return to the community and to some people who are waiting for community services. While it appears that everyone in the first group will get a slot, the state does not specify how many in the second group will have access to slots, saying only that a “pre-determined” number of people will get services at the start of Centennial Care and that yearly enrollment targets will be set for succeeding years with the goal of reducing the waiting list in each year of the program. (Application, p.21) We are thus left in the dark as to whether this reduction will be a matter of a handful of people, dozens, hundreds, or thousands. If it turns out to be only a few people each year, that will be very slight progress indeed.

We hope that CMS will require the state to provide more specifics about the number of people who are expected to become eligible for waiver services without a slot, the number of slots that will become available for individuals who are not otherwise eligible for Medicaid, and the number of new slots to be made available in each year of the program.

***Waitlist management:*** We also are concerned about HSD's plans to change the way available waiver slots are allocated to individuals waiting for services. Since the inception of the §1915(c) waivers and until the recent policy of not taking people off the waitlist, New Mexico's practice has been to allocate slots based on length of time on the waitlist. The department now

proposes to change this approach and instead award slots based on the degree of need for services.

According to the application (p.21), the waitlist “will be managed on a statewide basis using a standardized assessment tool and in accordance with criteria established by HSD. Policies for managing the [waitlist] will be based on objective criteria and applied consistently in all geographic areas served. ... This [sic] new criteria will be objective, be consistently applied and take into consideration a person’s functional status as well as their financial eligibility for Medicaid.”

This gives no details about how the new approach will be implemented in practice, raising a host of questions. Will everyone on the current waiting list for the CoLTS-c (Disabled & Elderly) waiver be rolled over to the new waitlist? What criteria will be used to determine who will have access to slots? Who will make that determination, and what will the process for making it be? What assessment tool will be used? Will everyone on the waiting list be assessed as to their functional status and needs? Will they be ranked in order of assessed need? Will there be periodic review of the ranking? Will a person who has been waiting longer for services and who is passed over in favor of someone who is deemed to have a greater or more immediate need for services be given notice of that fact? Will there be an opportunity to challenge that decision? The new approach is likely to be quite complicated as a practical matter, but there is no indication that HSD has thought through the implications of how it will work and how it will be implemented in a manner that is fair and equitable to all individuals seeking services. We urge CMS to require more detail and specific commitments from the state in these regards.

***Self-direction:*** HSD’s proposal calls for moving Mi Via self-directed HCBS waiver services into managed care and having those services managed by the MCOs. This has created a good deal of consternation in the disability community, who are concerned about the obvious contradiction between consumer control and managed care.

We appreciate HSD’s recognition in the waiver application that self-direction is a valuable part of the long-term services system, and the changes made in the revised waiver application to try to address some of the concerns presented. The state has added detail to this section of the application to emphasize the MCO’s duty to provide appropriate supports for self-direction. The revised application also somewhat strengthens consumer protections in cases where the MCO seeks to disqualify a person from self-direction, requiring the MCO to “demonstrate that additional supports and interventions are not sufficient to protect the health and welfare of a recipient” and clarifying that the final decision may be made only by the state, not the MCO.

Despite these modifications, concerns remain. There is an inherent tension between the very concept of “managed” care and the idea of consumer direction, and the application does not clearly address how the state will ensure that self-direction is honored in the managed care environment. Many participants are justly concerned that they will lose access to the independent consultants who have assisted them in directing their services when the MCO, or an entity contracted by the MCO and under its control, takes on this role.

Despite HSD's statements expressing support for consumer-direction, the department has a long history of expressing reservations about self-direction and attempting to limit it in practice. The intention to move self-directed services under MCO control after explicitly excluding them from the MCOs' purview in CoLTS appears to be an extension of this attitude, and the disability community is justifiably worried about how this new approach will work in practice.

As with many other aspects of Centennial Care, this is an area that could benefit from involving stakeholders in program development so that their input can inform the direction and form of the new program and they can feel that their concerns are being taken into account and addressed as the new structure takes shape. We urge CMS to require the state to work closely with stakeholders in a meaningful way to ensure that their concerns are met and that robust self-direction will be available in Centennial Care.

**Spending caps:** In the original application submitted to CMS in April, HSD proposed to apply "expenditure boundaries" on HCBS based on assignment of individuals to low-needs and high-needs categories. We were pleased to see that this proposal was dropped in the revised application now pending with CMS. However, it is troubling that the state now intends to limit the services available to any individual to the cost of nursing facility care. (Application, p.10)

The cost-neutrality applied to §1915(c) waivers may be applied on either an individual or an aggregate basis, and New Mexico's waivers have historically used an aggregate calculation in which the total cost of serving individuals through the waiver does not exceed the cost of institutional care for the group. This ensured that individuals with higher levels of need were able to benefit from HCBS and were not forced into facility care simply because their level of disability was greater; instead, their higher costs were balanced out by waiver recipients with less expensive needs.

In HSD's proposed approach, higher-cost individuals will be barred from obtaining the full level of services they need to live successfully in the community. As a result, they will be forced either to do without services that are essential to their health, safety and well-being, or to enter nursing homes as the only option made available to them. This appears to violate the Americans with Disabilities Act (ADA), 42 U.S.C. §12101 *et seq.*, and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), by discriminating against these individuals based on the level of their disability and by denying them the opportunity for community integration.

The ADA bars public entities from discriminating against people with disabilities, providing that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination... ." 42 U.S.C. §12132. The Supreme Court in *Olmstead* recognized that persons who can benefit from living in the community should not be isolated in institutions and that institutional confinement diminishes the lives of such individuals. The Court held that non-compliance with the ADA's integration mandate is excused only when compliance would require the state to "fundamentally alter" its service system. HSD has not

shown that compliance would require a fundamental alteration. In fact, it is proposing to *make* an alteration to its system that would bring it out of compliance with the ADA.

Recent guidance from the U.S. Department of Justice makes clear that “[a] state’s obligations under the ADA are independent from the requirements of the Medicaid program.” (Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*, 6/22/2011, at p.5) CMS itself has recognized that states may have obligations under other authorities such as the ADA that may go beyond what is permissible under Medicaid law. (State Medicaid Directors Letter #01-006, *Olmstead* Update No. 4, 1/10/2001, at p.4) That Medicaid law may authorize imposition of spending caps is immaterial; the state’s Medicaid program must also comply with the ADA and *Olmstead*.

We note that HSD is seeking to convert the 1915(c) waivers that will become part of Centennial Care into part of the proposed “global” §1115 waiver. If this is permitted, the cost-neutrality requirement applicable to 1915(c) HCBS waivers will not apply. HSD is choosing to apply an individual cost-neutrality standard here simply for the purpose of saving money. (See Application at p.11, where HSD says that this approach will “[c]ontrol costs by ensuring that serving someone at a [nursing facility level of care] is less than caring for that same person in a nursing home.” Emphasis added.) This is a grossly inadequate justification for violating the rights of persons with severe disabilities.

HSD claims that it will provide incentives to serve individuals with LTSS needs in the community rather than in facilities. The plan to cap costs will force people into institutions and appears to fly in the face of this stated intention. The need for the cap is also somewhat mysterious because the MCOs in Centennial Care will be paid a capitated monthly amount to provide services to each Medicaid enrollee. Although HSD has not publicized its proposed rate structure, we assume that it will resemble the structure used in the current CoLTS program and that the MCOs will receive the same or a similar payment for someone with lower needs as for one with higher needs and will balance the costs of higher-needs enrollees with those who are less costly to serve. There appears to be no justification for allowing them to take the “profit” on lower-cost individuals while relieving them of the responsibility to adequately serve those with higher needs.

HSD takes the position that allowing some people to receive a higher level of services will cause capitation rates to increase. However, the state has provided no data to show the degree of any such impact. Again, it seems to be an insufficient excuse to deny services to these individuals. The spending caps should be rejected.

***Community reintegration and community transition services:*** The state’s application reflects a commitment to promote transition from nursing home placement to community-based services, and we support this concept. However, the way in which the state implements this concept is problematic.

The state proposes to establish a certain number of “slots” that will be used to provide the “Community Benefit” (long-term services) for those whose income exceeds the regular Medicaid

income eligibility level. In the first year, the state pledges that there will be enough slots to continue serving everyone in the existing waiver program who needs a slot, *everyone* who needs a slot in order to transition from a nursing home into the community, and some undetermined number of individuals currently on the waiver waiting list.

This approach continues a perverse incentive that HSD has built into its long-term service system: if a person wants and needs community-based services but is above the income eligibility level for Medicaid, s/he can enter a nursing home and immediately begin the process of planning to re-integrate into the community and access Medicaid HCBS. This allows the person to leapfrog ahead of the 17,000 people on the waiting list for these services. Forcing people into institutional care as the quickest (and currently the only) route to community-based services serves the interests of neither the state nor the individuals who need these services.

We believe strongly that HSD should put much more emphasis on *diversion* from nursing home placement as well as on facilitating transition once nursing home placement has already taken place, but this concept is not even mentioned in the waiver application. We believe CMS should require HSD to designate, at a minimum, at least as many slots for nursing home diversion (for those already on the waiting list for community-based services) as it does to nursing home re-integration; we would prefer that there be at least two to three times as many diversion slots as re-integration slots.

In light of the state's commitment to nursing home re-integration, we also recommend that CMS require HSD (subject to the number of slots available) to continue making Community Transition Services available to those individuals who have been in nursing homes for 30 days or more rather than increasing the minimum stay requirement to 90 days as the state proposes. (Application, p.211) We find this requested change particularly ironic and disturbing since a 90-day nursing home stay requirement was cited by HSD just a few months ago as the principal reason for its decision to withdraw from the federal Money Follows the Person program. The department claimed that this alleged "mandate" in the federal program would cause personal hardship and create a financial burden on the state by forcing people to remain longer in facilities, yet the state now is seeking to impose the very requirement it rejected. We do not think CMS should become a partner in this deceptive change in approach.

### Behavioral Health Services

***Integrated service model:*** We support the integrated model for physical and behavioral health proposed in Centennial Care. The goal is a "holistic" approach that coordinates treatment for medical and behavioral health. However, the proposal allows the MCOs to subcontract with partner organizations to coordinate and deliver behavioral health services (so long as the MCO remains the risk-bearing entity), and requires the MCOs to delegate much of their behavioral health service delivery to local or regional Core Service Agencies (CSAs). It is not clear how subcontracting the management of behavioral health, and delegating service delivery to the CSAs, will assure that this integration occurs. We request that CMS require more clarity and detail from the state about how the integration will be promoted and incentivized.

***Preserving behavioral health funding:*** Another significant concern related to the change from the current “carve-out” model to the new integrated approach is maintenance of fiscal effort. New Mexico’s mental health service system is already under-funded, so it is critical that dollars currently spent on behavioral health are not inadvertently siphoned off to other uses. HSD has promised that this funding will not be diminished, but the waiver application appears to specifically allow any and all costs associated with integrating physical and behavioral health to come out of existing behavioral health funding, which casts doubt on the state’s assurances. We therefore support a requirement for an “early warning system” that would identify significant changes in funding levels for behavioral health service delivery. This can and should be a part of the Quality Monitoring portion of the application (Section 6). An objective and transparent data collection and reporting system, reflecting the type, level and cost of services being delivered, would let all interested parties monitor changes from year to year and from the old system to the new one.

***Performance reporting:*** From 1999 to 2005, the State was required to post "Early Warning System" data publicly, regarding the “health” of the behavioral health system under managed care. This included quarterly reports on utilization, authorizations, denials and critical incidents. This information was a way in which the community and external groups could assess and monitor the performance of the behavioral health system, based on objective data, across the managed care organizations. Such data are currently reported to the state Behavioral Health Purchasing collaborative, but have not been made publicly available. Frequent and repeated requests for the information by providers, consumer advocates and even legislators have been unsuccessful. As part of the transition to Centennial Care, the State should be required to renew publication of data and information about the performance of the behavioral health system.

***New services:*** The state’s application proposes three new behavioral health services that would 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. We welcome the addition of these services. However, we note that a family support program can raise issues of confidentiality of information regarding the family member with the behavioral health issue. Implementation of such a program must be done in a way that stresses voluntary participation and protects confidentiality.

***Screening for behavioral health needs:*** 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. We support the intent of the proposal to identify participants with behavioral health needs and assure that they receive the scope and intensity of services that they need. However, we are concerned that the assessment process appears to rely heavily upon telephone contacts and self-reporting.

Many individuals with behavioral health issues will not “engage” in telephonic assessment processes and therefore may not be identified as potentially in need of assistance. Some individuals may be hesitant to report a need for services in an attempt to avoid stigma or unwanted interventions. CMS should require the state to clearly explain how the needs



assessment process will be conducted so as to be comprehensive and effective, especially for this population.

### Co-pays

HSD has identified “personal responsibility” as one of the four major principles underlying its Centennial Care proposal, and describes its goal as “engaging recipients more in the process of staying and/or getting healthy and in using the health care system more efficiently” (Application, p.32). Co-pays are a major component of this aspect of the program, with co-pays proposed in two circumstances: use of the emergency room in non-emergency situations and use of brand-name prescription medications when a generic equivalent is available.

There is a considerable body of research that establishes that co-pays and other forms of cost-sharing are a barrier to receiving needed health care services. This is especially so in the case of low-income populations such as Medicaid beneficiaries. Co-pays are particularly problematic for people with disabilities and chronic conditions who must use services on a more regular and frequent basis. Because HSD emphasized cost-sharing from the time it initially raised the idea of redesigning the Medicaid program, we were very concerned about this part of the redesign and we are pleased that the waiver proposal submitted to CMS calls for co-pays in only those two situations and not more broadly throughout the program. However, concerns remain as to the measures included in the waiver application.

***Emergency room co-pays:*** The proposal calls for co-pays as high as \$50 to be imposed on individuals with income above the poverty level who go to the emergency room (ER) in a situation that is eventually determined by a medical professional not to be an emergency. There is no “reasonable layperson” exemption to cover cases where the person reasonably believed the situation required emergency attention.

The co-pays are provided for in a state statute, §27-2-12.16 NMSA 1978, that was enacted in 2009 but has not previously been implemented. HSD itself expressed concerns about the bill when it was under consideration by the state Legislature. Summarized in the legislative analysis of the measure, those included concerns that cost-sharing:

- “can have negative consequences for recipients, causing individuals to delay or forgo needed care” and “can be a barrier to access”,
- “could lead to higher costs overall”,
- “can lead to poorer health outcomes for recipients”,
- “could increase the rate of uninsured individuals”,
- “would create additional administrative burden for providers” to determine which individuals would need to pay and what amount they should pay, and would impose burdens on HSD “to track income and other client data to determine who would need to pay and how much, track client out-of-pocket expenditures, and enforce the cost-sharing requirements”, and
- would require changes to the HSD computer systems.

HSD also noted that some of the co-pay amounts in the bill exceeded maximum amounts allowed under federal law. (Legislative Finance Committee, Fiscal Impact Report on House Bill

438, 3/6/2009, at pp.2-3.) We agree with these positions put forth by HSD and believe that the co-pays are poor policy that will burden recipients, providers and the department itself .

Beyond the policy considerations, we note that §1916A(e) of the Social Security Act, 42 U.S.C. §1396o(e), authorizes co-pays for non-emergency ER care but limits the amounts that can be charged. To the extent that the proposed co-pays exceed what is authorized by federal law, the state must obtain a waiver authorizing them. HSD seeks such a waiver under §1115 of the Social Security Act. However, §1115 does not authorize the Secretary to waive provisions of §1916A. (See §1115(a), 42 U.S.C. §1315(a).) In order to waive provisions of that section, the provisions of §1916(f) of the Act must be met. That section bars a waiver unless the Secretary finds that it is for a demonstration project that:

“(1) will test a unique and previously untested use of copayments,

“(2) is limited to a period of not more than two years,

“(3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,

“(4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and

“(5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.”

HSD has made no such showings. There is no indication that the proposed co-pays are “unique and previously untested”. HSD seeks authority to impose them for the full five years of the requested waiver, not just two. There has been no attempt to show that the co-pays will benefit recipients sufficiently to overcome the risk of harm imposed, or to design a methodologically sound test that uses control groups or any other meaningful measure. And there certainly is no stated intention to make the co-pays voluntary.

Since HSD has not even tried to meet the conditions imposed by §1916(f), CMS should reject the proposed co-pays insofar as they exceed those authorized by §1916A(e).

We note also that §1916(A) and implementing federal regulations impose a number of pre-conditions that must be satisfied before the co-pay may be charged. These include requirements that the hospital staff identify another provider that can provide the needed care “contemporaneously” with the ER (§1916A(e)(4)(B)), and assist in arranging an appointment with that alternative provider. We are concerned that staff in many instances will not have an accurate understanding of these requirements and will impose the fee in situations where it is not properly authorized by federal and state law. In these cases, Medicaid recipients will be improperly charged a co-pay or will forgo timely services because they are unable to pay.

The proposed co-pays are apparently based on a belief that Medicaid beneficiaries choose to go to emergency rooms when they could get services through other providers at a lower cost to the Medicaid program, and that the threat of having to pay a co-pay will cause them to make better choices. However, the state has presented no evidence that Medicaid recipients are misusing emergency rooms. To the contrary, the state’s waiver application and its RFP for MCOs for the program recognize that there is a shortage of alternative sources of care, call for

development of such alternatives, and indicate that one of the tasks expected of the MCOs is developing them. It is difficult to reconcile the state's view that Medicaid beneficiaries are making poor choices for which they should be punished with its acknowledgment that they lack alternatives for those choices.

***Prescription drug co-pays:*** HSD is proposing a co-pay of \$3.00 when a person insists on a brand-name drug when a generic equivalent is available. Psychotropic medications for behavioral health conditions would be exempt from the co-pay, in recognition of the fact that these drugs are particularly individualized and that generics often are less effective or otherwise inappropriate for a particular person. HSD has indicated that an exceptions process will be available for other types of medication when an individual needs the brand-name version and the generic is not an acceptable substitute.

We are pleased that HSD has exempted psychotropic drugs from the co-pay. And we do not object to the fee in cases where there is a true generic equivalent that is equally as effective for the individual as the brand-name drug, and the individual is aware of that fact and has a true choice of medication.

However, we note that prescription drugs are prescribed by providers and are not available simply on the patient's "demand", as described in the waiver application (p.33). The individual should not be punished through imposition of a co-pay where the decision to prescribe the brand-name drug has been made by the physician or other prescribing provider.

We are pleased that HSD has decided that there will be an exceptions process to ensure access to brand-name drugs other than psychotropics when needed by a particular patient because the generic version is less effective, poorly tolerated or otherwise an inadequate substitute. However, the department has provided no detail about what that exception process will be. The waiver application does not address this issue. The draft contract incorporated as an appendix to the RFP for MCOs includes a provision, clause 4.5.12.1, that would require each MCO to develop its own exception process. The contract provides that HSD would have to approve each MCO's process but sets out no criteria or standards to guide that decision.

In order to be meaningful, the process should be easy to navigate and should result in a prompt decision, so that individuals with a legitimate need for the brand-name drug rather than a generic can get their medications without undue burden or delay. We urge CMS to require that HSD provide specifics about the exceptions process that ensures that these standards are met across all the Centennial Care MCOs.

#### Retroactive eligibility

It is long-standing Medicaid law that a state Medicaid program must cover expenses incurred by an eligible individuals in the three months prior to an application for Medicaid. Social Security Act §1902(a)(34), 42 U.S.C. §1396a(a)(34). The state now proposes to eliminate this coverage.

HSD has proffered a variety of justifications for this change. Initially, the department said that it planned to move as much as possible of the Medicaid program into MCOs and simply did not wish to have a continuing fee-for-service component. Later, it claimed that it would be unfair to require the MCOs to cover costs incurred before they had an opportunity to manage the individual's care. In the waiver application, the justification given is that signing up for medical coverage before getting sick is a matter of personal responsibility. (Application, pp. 26, 44) The first of these reasons is a matter of agency convenience, which is completely inadequate to justify the imposition of burdensome medical costs on Medicaid-eligible individuals (and the health care providers who will inevitably bear much of the burden through unpaid bills when the person cannot afford to pay). The second is implausible. The final justification given in the formal waiver application makes clear that the state's real intention is merely punitive. HSD's position appears to be that a person who hasn't enrolled in Medicaid must be punished for that failure, regardless of the circumstances that led to it.

For a state agency charged with addressing the needs of low-income New Mexicans, the department displays a disappointing lack of awareness of the life circumstances of the people it serves. There are many pressing needs that may occupy the minds and the time of low-income individuals and families that take priority over undergoing the arduous process of signing up for Medicaid. Many of these people won't even be aware that they might be eligible for Medicaid coverage and may learn that fact from a provider when they seek care. The state has not indicated, in its waiver application or elsewhere, that it intends to pursue any types of outreach or educational activity to ensure that eligible New Mexicans are aware of their eligibility for the Medicaid program, and the state's past record on outreach is not reassuring. Nor does HSD state any intention to eliminate barriers to enrollment that often make it hard even for those who wish to enroll to do so.

HSD expresses a belief that it is an individual's duty to obtain health coverage from the Health Insurance Exchange or from Medicaid. However, Governor Martinez so far has refused to commit to adopting the Medicaid expansion to cover New Mexicans with incomes up to 138% FPL and her administration has now indicated that it does not expect the individual Exchange to be operational by January 2014 as required by the ACA. (Statements of Milton Sanchez, Deputy Director, New Mexico Office of Health Care Reform, October 2, 2012.) It seems that the state is not carrying *its* burden of responsibility in connection with ensuring that coverage options are available and accessible, so its proposal to punish low-income New Mexicans who are seen as lacking in responsibility rings hollow.

The state has not shown that waiving the requirement for retroactive eligibility will promote the objectives of the Medicaid program. It has offered no plan for measuring the impacts of this change on either individuals or health care providers, who will be the collateral damage if this change goes into effect.

Aside from being a poor choice on policy grounds, elimination of retroactive eligibility appears to violate the maintenance of effort (MOE) provisions of the ACA by implementing more restrictive eligibility rules than were in place on the date of enactment of that law. The MOE requirements remain in effect until the state has a functioning insurance exchange in place through which individuals may obtain health coverage. ACA §2001(b), Social Security Act

§1902(gg). Until New Mexico has satisfied that requirement, the ACA's MOE provisions bar the waiver sought by New Mexico here. The state has not requested a waiver of the MOE provisions. (See Application, p.68.)

The state acknowledges that public comment on this aspect of its application was "strongly negative" (Application, p.26), but insists on proceeding with it, although HSD now proposes to delay implementation for six months to give people more time to enroll in Medicaid. This concession is commendable, but inadequate to remedy the significant problems with this proposal. We urge CMS to reject it.

Thank you for your consideration of these comments.

Sincerely,

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