Summary
The State of New Mexico is proposing to create a new, capitated managed long-term care program entitled Coordinated Long-Term Services (CLTS). The program will provide primary, acute, and long-term care services to beneficiaries in one seamless, coordinated, and integrated program.

An estimated 38,000 individuals will be enrolled in CLTS. The program will be phased in by geographic regions in the state. The populations that will be eligible to participate are:

- Individuals eligible for both Medicare and Medicaid (“healthy duals”), but not requiring nursing facility level of care [income up to 74% of the federal poverty level (FPL)]
- Individuals currently eligible for long-term care services based on assessed need for nursing facility level of care:
  - Nursing facility residents (income up to 225% FPL)
  - Participants in New Mexico’s disabled and elderly (D&E) home- and community-based services waiver program (income up to 225% FPL)
  - Individuals 21 years of age and older who are receiving Medicaid state plan personal care option (PCO) services (income up to 74% FPL)
  - Certain persons with a brain injury not previously enrolled in a waiver

CLTS is predicated on participants receiving supports and services in the most suitable integrated setting. Participants are expected to benefit from improved health status, satisfaction, and quality of life. Specifically, CLTS will:

- Coordinate Medicare and Medicaid funding streams and services.
- Promote home- and community-based services.
- Decrease dependency on nursing facility utilization.
- Provide a broader range of supports and services in a coordinated managed care environment.
- Provide a framework for an aggressive program of quality management and data sharing.
- By applying the principles of community integration, enable the State to more effectively manage public resources and serve more eligible people.

New Mexico intends to contract with at least two managed care organizations (MCOs) to deliver the CLTS program. Participating MCOs will be required to be approved as Medicare Advantage Special Needs Plans (MA/SNP). This will allow dual-eligible participants who choose to join
their Medicaid plan’s Medicare SNP to benefit from a seamless and coordinated program of acute care, pharmacy, and long-term supports and services.

CLTS participants with behavioral health needs will receive behavioral health services through New Mexico’s Behavioral Health Collaborative. Services will be provided under a capitated managed care arrangement between the CLTS MCO and the behavioral health statewide entity.

**Background**

Like most states, New Mexico’s long-term care services system consists of a fragmented mix of institutional, state plan, and home- and community-based waiver services. In State Fiscal Year 2006, New Mexico served approximately 6,600 individuals in four home- and community-based services waiver programs serving the Disabled and Elderly (D&E), HIV/AIDS, Medically Fragile, and Developmentally Disabled (DD) populations. *Mi Via*, a fifth waiver program offering self-directed services, became operational in Fiscal Year 2007. More than 6,400 individuals receive Medicaid funding for nursing facilities services, and over 10,400 receive state plan personal care services, requiring assessed need at nursing facility level of care. Approximately 14,500 dually-eligible individuals receive most of their acute care services through Medicare fee-for-service, with Medicaid providing certain non-Medicare-covered acute care benefits. Most individuals who are not dually-eligible receive acute care services through *SALUD!* , New Mexico’s Medicaid managed care program. In Fiscal Year 2006, total Medicaid spending (state and federal) for acute and long-term care services for the CLTS target population, excluding dually eligible individuals, was approximately $675 million.

There is limited effective coordination and integration between and among the various programs serving individuals who will be eligible for CLTS. This fragmentation of services leads to duplication, over- and under-utilization, missed opportunities to reduce dependency on institutional services, inappropriate emergency room visits and in-patient hospitalizations, and no effective means to monitor health status and quality of life.

New Mexico, like other states, maintains a central registry of individuals seeking a slot in the existing home- and community-based services waiver programs. Dually-eligible individuals who do not meet nursing facility level of care receive Medicare cost sharing from Medicaid and other Medicaid state plan services not covered by Medicare. Since these dual eligibles are exempt from *SALUD!* , they access what services they require from Medicaid through fee-for-service providers. Yet these “healthy duals” represent a vulnerable population who can, and often do, become eligible for nursing facility level-of-care when a catastrophic event occurs (e.g., a stroke, debilitating fall, heart attack), or when a stable living arrangement or natural support environment is compromised or lost.

Healthy duals and individuals on the central registry comprise a significant cohort of people who will benefit from CLTS. A wider array of coordinated long-term supports and services will help to reduce hospitalizations (Medicare savings for dual eligibles) and institutional care (savings for both Medicare and Medicaid). Effective care coordination and quality management will promote improved health status, satisfaction, and quality of life—in the community. CLTS will create needed flexibility to offer more cost-effective services in the least restrictive, most integrated environment to a larger number of Medicaid beneficiaries.
Currently, Medicaid-eligible adults receiving state plan personal care services have the option to self-direct those services. Participants enrolled in CLTS who would like to self-direct their community-based supports and services will be given the choice of either (1) Mi Via, New Mexico’s recently approved 1915(c) self-directed waiver that provides beneficiaries with an individual budget, or (2) a self-directed option under CLTS in which self-directed community-based supports and services are offered by the MCO. Individuals choosing Mi Via will receive benefits other than community-based long-term supports and services through CLTS. Individuals not choosing Mi Via will receive all their covered benefits through CLTS.

New Mexico is in the process of implementing the Money Follows the Person (MFP) in New Mexico Act of 2006, which mandates the State’s Aging and Long Term Services Department to identify elderly individuals and people with disabilities who are eligible for community-based living and offer them the opportunity to choose the type of service that best meets their needs from among all available service options. When CLTS is ready for implementation, the MFP program will be incorporated into CLTS.

Presently, there are no effective incentives in New Mexico’s fragmented system of long-term care services to achieve a balanced and flexible system focused on an individual’s needs. This can result in inappropriate utilization of nursing facility services, or the inability of nursing facility residents, when possible, to return to the community. As noted in the summary section of this concept paper, New Mexico is committed, through CLTS, to promoting home- and community-based services and decreasing dependency on nursing facility services. Therefore, the CLTS rate-setting methodology will be designed to provide incentives to MCOs to reduce nursing facility utilization, when appropriate to individual needs, both by diverting placement in a nursing facility and by helping nursing facility residents who can—and wish to—return to home- and community living.

While New Mexico invests heavily in care coordination services for home- and community-based services waiver participants, there is no opportunity to extend such services to individuals who are not eligible for waiver services. The coordinated and integrated CLTS service delivery system will enable participants and their families to more effectively navigate the myriad services available for linking primary and acute care, long-term care, and community-based supports and services, consistent with self direction.

Finally, the current fragmented service delivery system does not provide for integrated, relational databases, particularly with respect to assessment data and level-of-care determination data. The State will reconfigure underlying data systems to both standardize data elements and reporting requirements and enable communication and sharing of data among relevant data sources within state government. This will enable the State to track the experience of CLTS participants longitudinally to: (1) maintain baseline demographic, diagnostic, and functional characteristics of the target population; (2) provide the basis for eligibility and level-of-care determinations; (3) contribute to the information needed for care planning and care coordination; (4) establish, over time, a database sufficient to generate risk-adjusted Medicaid capitation rates; and (5) provide needed performance and satisfaction data to aid in program evaluation and the identification of opportunities for quality improvement.
The CLTS Program
The following discussion provides more detail on the CLTS program, including the organizational structure; enrollment, assessment, and care coordination; the benefit package; financing and rate setting methodology; program phase-in and transition planning for beneficiaries; participant rights; and quality assessment and performance improvement.

Organizational Structure
The State anticipates contracting with at least two risk-bearing, long-term care MCOs to manage CLTS. The MCOs will be required to be approved as Medicare Advantage SNPs. The MCOs will be at risk for all acute care and community-based supports and services for Medicaid-only participants (with the exception of those who choose to participate in Mi Via). The MCOs will be at risk for Medicare Advantage SNP enrollees’ acute care services, as well as Medicaid community-based supports and services. The MCOs will be at risk for the care of duals and non-duals living in nursing facilities. For those CLTS participants who choose not to join their MCO’s Medicare Advantage SNP, MCOs will be responsible for coordinating Medicaid services with other Medicare Advantage SNPs, with other Medicare Advantage plans that do not have SNPs, or with Medicare fee-for-service providers. MCOs will be at risk for Medicare cost-sharing for those individuals who choose to remain in Medicare fee-for-service. MCOs will not be at risk for the State’s contribution to the Medicare prescription drug program (Part D) for those individuals who are not participating in the MCO’s SNP (which CMS requires to offer a prescription drug plan).

Enrollment
Dually-eligible individuals, D&E waiver participants, persons 21 years and older receiving state plan personal care services, and nursing facility residents will be mandatorily enrolled in CLTS for all their Medicaid services. Initially, persons enrolled in the Developmentally Disabled, HIV, and Medically Fragile waivers and persons residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MRs) will not be included in CLTS. The State will consider including these populations at a later date. The state legislature has provided additional funds to enroll more persons with brain injury (as defined by the State) in CLTS. These individuals are not currently enrolled in the D&E waiver, but must meet the D&E waiver eligibility requirements.

Assessment
The State is developing a universal assessment tool that will be used with all participants in CLTS. This tool will facilitate collection of a core assessment dataset that will provide the basis for following participants longitudinally over time, capturing critical aspects of individual needs, experiences, services, demographic and diagnostic shifts, and measures of satisfaction and outcomes. The State will coordinate with the MCOs to ensure that the core assessment data elements are the same as or map-able from proprietary assessment elements that MCOs use internally to manage the care of their enrollees. Where applicable, the State will use the same measures required by Medicare to assess MA/SNP enrollees (e.g., Health Outcomes Survey [HOS], Health Plan Employer Data and Information Set [HEDIS], and the Consumer Assessment Health Plans Survey [CAHPS]) to minimize duplication or conflicts among reporting requirements.
**Care Coordination**

Care coordination services provided by MCOs to all CLTS participants will provide the critical hub from which all services will emanate, especially community-based supports and services. With the direct participation of the CLTS participant—and family members or significant others if needed and available—the care coordinator will provide the coordination and integration required to help individuals access the supports and services they need to remain in the community or, where possible, to return to the community from a nursing facility.

**Benefit Package**

The State will provide CLTS participants with the same acute care benefits provided to SALUD! enrollees. Behavioral health services will be coordinated by the State’s Behavioral Health Collaborative through a capitated managed care arrangement between the CLTS MCO and the behavioral health statewide entity. The State will provide community-based supports and services similar to the home- and community-based services currently provided under existing waiver programs. However, under one monthly payment, the MCOs will have the flexibility to construct individualized care plans that respond to each enrollee’s needs with creative and flexible supports and services, consistent with federal requirements, that may be substitutes for, or variations of, currently available services. For example, creative environmental adaptations may obviate the need for personal care services. Payment for unconventional items or informal services may be substituted for more expensive, structured services. At the same time, if an enrollee needs a more traditional service like personal care, it would be provided.

The State expects that through creative, care coordination-driven, self-directed, and carefully monitored service delivery, MCOs will be able to provide healthy duals with increased prevention and wellness services, as well as health status monitoring and assistance with natural and informal supports. Services such as these will help ensure that individuals remain in the community as long as possible. Longitudinal assessment data described above will enable the State and MCOs to target healthy duals whose diagnostic and natural supports indicators suggest risk of deterioration and possible institutionalization. These individuals would be the focus of aggressive efforts to maintain or improve health status and/or prevent institutionalization.

**Financing and Rate Setting**

The State is committed to realigning the financial incentives currently driving Medicaid long-term care costs in New Mexico. The State proposes to develop a “single blended rate” approach to capitation, with annual targets for decreases in utilization of nursing facility services. A single blended rate will provide incentives for MCOs to invest in aggressive management of health status and community-based supports and services to prevent institutionalization, as well as incentives to move individuals from nursing facilities back into the community. Such a rate structure will also encourage MCOs to invest in aggressive care-coordination of nursing facility residents. It will encourage placement of care coordinators in nursing facilities or making care coordinators available on a 24-hour, 7-day-a-week basis to respond to individual need, help prevent or delay an individual’s rapid deterioration and hospitalization, and therefore reduce costs. A single blended rate will encourage MCOs to hit reduction targets for nursing facility utilization, both to gain a bonus reward and to avoid possible penalties. CLTS is also expected to help reduce emergency room visits and inpatient hospitalizations, although the rate structure will not be explicitly designed to impact utilization in these settings.
The State is considering several tiers of the single blended rate that would eventually be based on assessment and utilization data. This would yield risk-adjusted rate cells based not on location of service, but rather on the severity/complexity status of the individual enrollee regardless of setting. In other words, it would be possible for a community-dwelling individual to receive a higher capitation rate than a “low level” nursing facility resident. The data to support this methodology is not expected to be available in the early years of program implementation, so the rate setting methodology will be based initially on historical fee-for-service or SALUD! capitation expenditure experience.

**Program Phase-In and Transition Planning**

A geographic phase-in will ease the transition from traditional fee-for-service state plan and waiver services to capitated managed long-term care. The State anticipates including Bernalillo County, the most populous county in the state, in the first phase of implementation in order to build the infrastructure required for delivery of all services in all counties. The State will require the MCOs to maintain existing care plans and services for 60 days. During this transition period, MCOs will reassess each participant and work with the individual to redesign (or in some instances simply confirm) his/her care program to reflect greater flexibility and self direction.

**Participant Rights**

The State will afford participants in CLTS the same rights and protections afforded all other participants in Medicaid managed care, as required by the June 14, 2002, managed care regulations stemming from the Balanced Budget Act of 1997. For those dual eligibles also enrolled in the MCO’s Medicare Advantage SNP, the State will ensure that where there are differences in grievance and appeal procedures, every effort will be made to steer the issue to the proper agency (e.g., if the service at issue is Medicare-related, the grievance or appeal will be filed with the appropriate Medicare system, and for a Medicaid related issue, the appeal or grievance will be directed to the Medicaid agency).

**Quality Assessment and Performance Improvement (QAPI)**

In New Mexico, the Human Services Department, the Aging and Long Term Services Department, and the Department of Health have collaborated closely on the development of CLTS as well as other waiver programs. As part of these joint efforts, the three agencies have already begun work on development of an “umbrella” QAPI initiative for all of the State’s long-term supports and services programs. This will include development of a comprehensive quality management strategy for the Medicaid portion of CLTS that will be in conformance with the final Medicaid managed care regulations, nursing facility quality requirements, and home- and community-based services waiver requirements. Working with MCOs and stakeholders, the State will establish New Mexico-specific performance measures that will be integrated into a pay-for-performance program. The State will also work towards developing a single, all encompassing QAPI program that seamlessly incorporates not only Medicaid services, but Medicare services as well.

In developing and implementing its QAPI process, the State will develop a strategy for using all available data sets (e.g., HEDIS, HOS, CAHPS, Minimum Data Set [MDS], and OASIS) and, if available, the Participant Experience Survey (for Medicaid community-based supports and
services), encounter data (both Medicare and Medicaid), Part D drug data from the MCOs’ Medicare SNPs, and data from the core assessment dataset. This will enable the State to continuously track the performance of MCOs and the experiences of CLTS participants.

MCOs will be required to use this data as well to identify opportunities for improvement and to implement targeted quality improvement programs to achieve specific desired state goals and to address areas of needed improvement. The State will require that MCOs establish credentialing standards for network providers that meet Medicaid standards and incorporate the use of quality measures in network management, enrollment within the provider network, and continuous improvement. The State views the QAPI process as central to its principal goal in CLTS to manage long-term care resources more effectively so that more individuals can be served in a way that improves health status and quality of life and diminishes dependency on nursing facility services.

Stakeholder Input Process
The State is committed to working in partnership with all stakeholders and has been convening meetings of a CLTS Advisory Group since December 2005. The Advisory Group is comprised of representatives from all relevant stakeholder groups, including elderly persons, individuals with disabilities, and their families; advocates; service providers; and other interested parties. Stakeholders participating in the Advisory Group share their expertise and offer advice. The State will continue these meetings as planning for CLTS proceeds. Workgroups appointed from the larger Advisory Group have been assigned specific issues to investigate. The State has begun discussions with nursing facility representatives to consider a number of State and nursing facility options, such as conversion of nursing home beds, bed-banking, and offering home- and community-based services as an alternative to nursing facility services. In addition, focus groups with future participants and their families are planned. As the CLTS waiver application is developed, stakeholder review and comment will continue to be solicited and encouraged.

The State will continue meetings with representatives from the Native American tribes to seek their input and encourage their participation on the CLTS Advisory Group. The State recognizes that many Native American tribes have elder care services; their experience and programmatic suggestions will be vital in developing and implementing CLTS.

Conclusion
At the conceptual heart of New Mexico’s proposal is the firm belief that it is possible—as well as desirable and necessary—to organize the State’s long-term care system into a more integrated, coordinated system of primary care, acute care, institutional services, and community-based supports and services. It must be available not just to persons meeting the nursing facility level of care, but to healthy duals as well. The State intends to develop and implement a fiscally responsible managed care environment in which MCOs are at risk for achieving the desired outcomes set by the State—that is, promotion of home- and community-based services, reduced dependency on institutional care, participants’ improved health status and quality of life, and participants’ greater satisfaction with the array and provision of long-term supports and services.