DUAL ELIGIBLE and ELDERLY

POPULATIONS IN NEW MEXICO:

Key Opportunities for Improved Access to Quality Health Care Under the Federal Patient Protection and Affordable Care Act

A BluePrint For Health New Mexico Paper

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INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 ("ACA") adopted important changes to Medicaid, Medicare, and other health-related programs, many of which provide opportunities for state-level implementation efforts. This paper discusses some of the most noteworthy of those changes that provide options for improving the access of two partly overlapping populations of New Mexico families and individuals to quality, person-centered health care and improved outcomes.

The two groups are "**Dual Eligibles**," and "**the elderly**" (for purposes of this paper, age 55 and older). The paper suggests opportunities for New Mexico's diverse communities -- as reflected by the BluePrint Counties of emphasis (Bernalillo, Dona Ana, McKinley, and San Juan) -- to consider regarding implementation efforts (*including during the state's current "Medicaid Redesign" process*). The opportunities are noted briefly in the Executive Summary and, following a more in-depth discussion of the ACA provisions, are detailed at pages 18-20.

EXECUTIVE SUMMARY

"Dual Eligibles" ["**Duals"**] are individuals age 65 and older, and persons with disabilities, who have coverage under both Medicare *and* Medicaid. They have Medicaid because their income and assets are low enough to meet the eligibility requirements for that program. There are more than 65,000 Duals in New Mexico; they are found in every racial and ethnic community and in every part of our state. Medicaid pays for their Medicare premiums (under a "**Buy-in**" program) and, for many of them, their Medicare cost-sharing. Medicare is their primary payer, resulting in considerable cost savings for the Medicaid program.

As a group, Duals have a disproportionately poor health status, and, as would be expected, incur program expenditures disproportionate to their numbers. Nearly half of them have at least one mental or cognitive impairment, and 60% have multiple chronic conditions. More than half have incomes under the federal poverty level. Because they must deal with two programs, which have many differing rules, they often encounter difficulty in optimally and appropriately accessing services. They are commonly unaware of their rights, and, in some cases, of their *eligibility* for coverage. **[Part I.A. and B.]**

The ACA devotes unprecedented attention to their plight; calling for greater access, continuity, coordination, integration, quality, and *beneficiary understanding* of the services for which they are eligible. Two new offices were established at the federal Centers for Medicare and Medicaid Services ("CMS") to develop best practices and policy revisions to achieve those ends, test new service delivery models, and provide states with more data and help. **[Part I.C.]**

While Duals face unique problems, as individuals who are elderly and/or persons with disabilities they will also be directly affected by ACA programs, policies, and issues discussed in Parts II and III that affect those population groups.

Opportunities for implementation include adopting best practices generated by federal studies; considering changes to the state's "Coordination of Long-Term Services"(CoLTS) program; improving the "Buy-in" program; and reinvigorating community education and outreach.

The ACA provides a broad expansion of Medicaid, and many options for expanding services for the elderly, persons with disabilities, and others. As the BluePrint Counties of emphasis and Advisory Network have stressed, while such changes are critical and welcome, other matters such as racial and ethnic disparities, cultural competence, gender concerns, and disability access problems create barriers to care access and quality, and *must* also be addressed, in consultation with diverse stakeholders, in implementing each program discussed herein.

The ACA *requires* states to add, *by January 1, 2014,* **new Medicaid coverage** for adults ages 19-64 who do not have Medicare or Medicaid, and have countable family income under 138% of the federal poverty level (states can set higher levels). As many as 200,000 New Mexicans could qualify. *Most of the funding for this coverage will be provided by federal funds: 100% for 2014-2016, declining in stages to 90% for 2020 and later years*. **[Part II.A.]**

The coverage will increase access to care, and support increased provider availability and medical transportation services (including for rural and underserved areas). However, it will use a new income eligibility formula that will require massive revisions to eligibility processing systems, and new training for eligibility workers; and it will require new community education and outreach, and increased provider and transportation services infrastructure. **[Part II.A.-A.1.]**

Opportunities for implementation include pre-1/1/14 phase-in of the coverage (to vet revised information technology systems and worker training, ensure timely community education and outreach efforts, and develop provider and transportation infrastructure); and, in consultation with diverse communities and stakeholders, ensure that procedures and materials are fully responsive to the needs of all racial and ethnic groups, and persons with disabilities.

Several ACA provisions involve new options for **home and community-based services** ("**HCBS"**) for the elderly and persons with disabilities. By stressing "person-centered,""whole person," and "consumer-directed" community-based care, they promote greater independence and well-being for families, and improved health outcomes.

The ACA establishes a new Medicaid HCBS service option -- "**Community First Choice**" ("**CFC**") -- which covers home-based *attendant* services and supports needed to assist beneficiaries with activities of daily living. Individuals must be eligible for Medicaid and have incomes under 150% of the federal poverty level (a higher level might be required). Services must be "self-directed." The state can also cover transition costs such as first month's rent and utilities. CFC could replace the current "**Personal Care Option**" ("**PCO**") services. *States get a 6 percentage point increase in federal matching funds for CFC services.* **[Part II.B.1.]**

The ACA extends a "**Money Follows the Person**" (MFP) program, under which persons receiving Medicaid-covered institutional care can receive funds to help transition to community

living. *New Mexico qualifies for a federal Medicaid matching rate of about 85% for MFP*, and has received funds to operate a small MFP program through 2016. **[Part II.B.2.]**

New Mexico has six HCBS Medicaid "waiver" programs, that serve about 7,000 individuals, but enrollments are capped due to limited state funding. There are multi-*year* waits for the largest of these programs. A special day center-oriented HCBS program in Albuquerque called "PACE" manages enrollees' Medicaid *and* Medicare benefits, serves about 385 people age 55 and older, and also has a waiting list. All these programs require applicants to have a nursing-home level of care need. **[Part II.B.3.a.]**

The ACA expands a "**Sec.1915(i)**" HCBS option that states can add to their Medicaid programs. Unlike the waiver programs, the number of persons served cannot be limited *per se*, and individuals will not have to demonstrate a nursing facility level of care. However, states can *target* the coverage to individuals with particular conditions and severity levels. The BluePrint Counties of emphasis have each indicated, for example, that obesity, mental illness, and diabetes are among their priority conditions for action, and those could be targeted. **[Part II.B.3.]**

Increasing the availability of information about health-related programs is an expressed priority in all the BluePrint Counties of emphasis. The ACA authorizes a substantial increase in funding for the state's "**Aging & Disability Resource Center**" ("**ADRC**"), in part to provide unbiased information on the range of long-term care services options, including HCBS options. **[Part II.B.4]**

The ACA establishes a new, premium-based *long term care insurance* program, called the "**CLASS"** program, to be operational on or after October 1, 2012. Benefits will be focused on home and community-based care. **[Part II.B.5]**

Opportunities for implementation include adoption of CFC (and replacing the state's similar PCO services); expansion of MFP; adoption of "1915(i)" programs for conditions determined as priorities by the BluePrint Counties of emphasis, diverse local communities, and other stakeholders; development of all such programs in consultation with affected populations and communities; community education on the CLASS insurance coverage when it is finalized; and cooperation with the ARDC to coordinate and improve access to information.

The ACA authorizes the adoption or testing of new medical **services delivery models**, all designed to promote more integrated and coordinated care, improved health *outcomes*, use of interdisciplinary teams and information technology, and "whole-person" and "person-centered" approaches to improve the experience of patients and their families. Since they can be organized on a local basis, communities will have the opportunity to support particular models, and work to ensure that they address local needs and concerns. Models include:

"**Health Home**" services, an optional Medicaid service for beneficiaries with *chronic conditions* including mental health, substance use disorder, asthma, diabetes, heart disease, and obesity. HIV/AIDS may be added in the future. States can limit the coverage to particular

conditions, particular severity levels, and particular geographic areas. *The federal matching rate for the first two years of implementation will be 90%.* **[Part II.C.1.a.]**

"**Medical Homes,"** long promoted especially for *primary care*. The ACA authorizes the testing of this model for population groups such as "*high-need*" individuals and women, and for chronic care management. The options are open ended, allowing for increased local variation. **[Part II.C.1.b.]**

"Accountable Care Organizations" (ACOs), larger provider organizations that can share in savings from reductions in beneficiaries' costs of care. One model being tested is for *Medicare* fee-for-service beneficiaries; others types are likely to be created. However, Federally Qualified Health Centers and rural health centers may not be able to act as ACOs. **[Part II.C.2]**

"**Health Teams,**" group practices designated by state and *Tribal organizations* to provide interdisciplinary primary care services in local areas, and support other primary care providers in their areas. The organizations must also provide Medicaid Health Home services. **[Part II.C.3.]**

Opportunities for implementation include ensuring that any providers adopting these service delivery models address racial, ethnic, language, gender, cultural competence, and disability access barriers; supporting Tribal organizations and other communities seeking to implement Health Teams; adopting Health Home services targeting high priority conditions identified by local communities and stakeholders; supporting local providers when appropriate and possible; and ensuring that affected patients are fully informed of their rights and responsibilities.

In regard to Duals and the elderly the ACA contains many other provisions of interest, but within the limits of this paper we note just three types: expansion of Medicaid and Medicare beneficiaries' access to preventive care and wellness services; requirements for physical accessibility of diagnostic equipment in medical care facilities; and changes to Medicare Advantage and Prescription Drug Plan rights. **[Part II.D.]**

Opportunities for implementation include enhanced local community education and outreach activities to make residents aware of these and other new ACA-authorized programs and benefits in a culturally competent manner.

New Mexico is currently pursuing a "**Medicaid Redesign**" plan to "reinvent and transform" the Medicaid program in ways not yet fully defined. Administration officials *have* stated they want federal permission to place the entire program under a single managed care format, while simultaneously reducing the current number of managed care companies and considering innovative service delivery models such as Health Homes and ACOs. **[Part III]**

Some or all the opportunities for implementation discussed in this paper involving Medicaid could, to the extent possible, be pursued within the Medicaid Redesign process as well any other appropriate venues.

PART I: IMPROVED COORDINATION OF BENEFITS FOR DUAL ELIGIBLES

A. Who Are the Dual Eligibles?

"Dual Eligibles" ("**Duals**") are individuals who have coverage under both Medicare *and* Medicaid at the same time. They have Medicare because they satisfy that program's mainly "categorical" requirements, *i.e.*, they are age 65 and older, or disabled (under Social Security criteria), and they have Medicaid because their income and assets are low enough to meet the requirements for a Medicaid eligibility group (Medicare is not means tested). When any of their health care services are coverable under both Medicare and Medicaid, *Medicare* is the primary payer, resulting in substantial cost savings for the Medicaid program.

Duals can be subdivided into two general groups: (1) those who qualify for a "*full-benefit*" Medicaid eligibility category (*i.e.*, one that covers all or most Medicaid services), and for whom Medicaid also pays Medicare premiums and cost-sharing; and (2) those who qualify only for "*limited-benefit"* Medicaid eligibility categories, the most familiar of which is "QMB," the benefits under which consist solely of payment for Medicare premiums (and, for QMB, cost-sharing).[1] The program of Medicaid payments for Medicare premiums is called the "**Buy-in.**" Even limited-benefit eligibility is extremely valuable. Beneficiaries can save $1,400 and more a year in their Medicare costs and have broader provider choice. Also, medical providers receive more reimbursements, and, as noted, the state saves Medicaid dollars.

The largest numbers of full-benefit Duals are Medicare beneficiaries whose income and resources are low enough to qualify for federal Supplemental Security Income ("SSI") benefits and who as a result automatically qualify for Medicaid. Medicare beneficiaries who receive Medicaid coverage for nursing home care, or home and community-based long term care services, account for the second largest number of full-benefit Duals. There are also some less familiar Medicaid eligibility groups that may include full-benefit Duals.[2] Limited-benefit Duals have "too much" income and assets to qualify for SSI, but are nonetheless very poor.

As a group, Duals have a more disproportionately poor health status than individuals with Medicare or Medicaid only, and incur program expenditures disproportionally large compared to their numbers. Forty-three percent of Duals have at least one mental or cognitive impairment, and 60% have multiple chronic conditions; two-thirds are age 65 and older (the remainder are younger persons with disabilities); and more than half have incomes under the poverty line.[3]

Because they must deal with two programs, which have many differing rules, full-benefit duals often encounter difficulty in optimally and appropriately accessing services, especially when going through coverage transitions, resulting in beneficiary and family confusion and poor health outcomes. These general facts were stressed in the major ACA initiatives discussed below. With respect to limited-benefit Duals, the situation is somewhat different. While some may not receive their full benefits, many individuals who *could* get the coverage don't know it.

This includes uninsured poor people who lack sufficient Social Security-covered work to qualify for premium-free Medicare Part A. QMB coverage would buy them into Medicare Part B *and* A, thus getting them reliable health coverage. However, getting that Medicare coverage involves a long and convoluted and process (involving "conditional" Medicare applications) that the state could simplify and accelerate by amending its Buy-in program.

B. The Dual Eligible Population In New Mexico

There are more than 65,000 Duals in New Mexico, an estimated half of whom reside in the BluePrint for Health New Mexico Counties of emphasis. About 71% are full-benefit Duals. About 71% are elderly (age 65 and older). Duals comprise roughly 13% of the state's Medicaid population, but account for about 26% of *state* Medicaid expenditures, about $256,360,000.

It should be noted that Medicaid beneficiaries who are elderly or persons with disabilities are *expected* to account for a "disproportionate" share of Medicaid expenditures. They are *as a group* far more likely to need ongoing services for chronic conditions, and higher cost services such as hospital and long term care services. In addition, persons with disabilities are *as a group* by definition more likely to need health care services, especially related to their disabilities and related conditions.

New Mexico Duals access their coverage in several ways. For example, about half are covered by the "CoLTS" managed care system [discussed in Part I.D. below]; many are enrolled in HMO-type "Medicare Advantage" plans (including "Special Needs Plans"); many are in programs for persons with developmental disabilities, and many (primarily limited-benefit Duals) access services on a fee-for-service basis.

C. ACA Provisions Directly Affecting Dual Eligibles

Two provisions of the ACA have increased *the opportunity* for improved coordination of services (and payments therefore) for Duals. Although placing dramatically increased focus on the problems confronting this population group, and holding out the promise for future steps to address those problems, the new provisions primarily call for studies, demonstration projects, and the gathering and sharing of data.

1. Promoting Improved Care Coordination and Integration

a. Medicare-Medicaid Coordination Office

The most far-reaching of the new ACA provisions is Section 2602 (codified as 42 USC 1315b),[4] which shines a bright light on the problems Duals have faced in adequately accessing care and sets forth several goals that must be pursued to eliminate those problems. Section 2602(a) established the creation of a new "Coordinated Health Care Office" in CMS -- the agency renamed it the "**Medicare-Medicaid Coordination Office**" (**MMCO**) -- with a mandate to "more effectively integrate" benefits under Medicare and Medicaid, and improve coordination

between the federal government and the states to ensure that Duals "get full access to the items and services to which they are entitled" under the two programs.

Section 2602(c) sets forth eight goals for the MMCO: (1) provide Duals full access to the benefits to which they are entitled; (2) simplify *processes* for Duals to access benefits; (3) improve the *quality* of health care and long-term services for Duals; (4) increase Duals' *understanding* of and *satisfaction* with their coverage; (5) eliminate *regulatory conflicts* between rules under Medicare and Medicaid; (6) improve *care continuity* and ensure safe and effective *care transitions* for Duals; (7) eliminate *cost-shifting* between Medicare and Medicaid and among related health care providers; and (8) improve the *quality of provider performance* under Medicare and Medicaid.

To help accomplish these goals the MMCO is charged with providing states, Medicare Advantage plans, physicians, and other relevant entities or individuals with the *education and tools* needed to develop programs that "align benefits" under Medicare and Medicaid for Duals; supporting state efforts to coordinate and align acute care and long-term care services for Duals with other Medicare services; and providing support for coordination of contracting and oversight by States and CMS regarding the integration of Medicare and Medicaid.

The MMCO was established in 2010, and quickly launched a 15-state "Demonstration to Integrate Care for Dual Eligible Individuals" (New Mexico was not one of them). On May 16, 2011, the office published a "request for information" seeking comments on some of the above-noted goals. The comments, which were due by July 11, 2011, may provide a valuable source of practical ideas and best practices to enhance Duals' coordinated, integrated, quality care. The MMCO also launched initiatives to make Medicare data and technical assistance available to states, and invited states to apply for grants to pursue two new managed care models that would combine and coordinate all of enrolled Duals' Medicare and Medicaid benefits.[5]

b. The Innovation Center

ACA Section 3021 (codified as 42 USC 1315a), authorizes the creation of the "**Center for Medicare and Medicaid Innovation**" (**CMI**) in CMS, with an exceptionally broad mandate to test "innovative payment and service delivery models." Preference is to be accorded to models that "improve the coordination, quality, and efficiency of health care services." Section 3021 specifies a non-exclusive list of 20 models that can be selected, at least three of which directly refer to Duals. For example, the 10th model is "to test and evaluate fully integrating care for dual eligibles…" The CMI's authority extends well beyond Duals, but the office regularly collaborates with the MMCO in establishing demonstration projects including those noted above.

While the above-noted provisions put unprecedented focus on problems affecting Duals as a group, and clearly *encourage* state action and coordination efforts, nothing *requires* New Mexico to undertake any actions. Nonetheless these provisions provide considerable support for stakeholders to encourage the state to promptly adopt best practices and beneficial policies

generated by the studies and demonstrations. Moreover, although saying virtually nothing about *limited*-benefit Duals, they serve as a reminder of the value of outreach to potential Duals.

D. Current Activity in New Mexico

New Mexico *has* acted to coordinate services for some Duals, most notably through the adoption of the "**Coordination of Long-Term Services**" ("**CoLTS**") program. Under CoLTS, which was implemented between August 2008 and April 2009, most *full-benefit* Duals -- as well as Medicaid beneficiaries who receive nursing facility care, "Personal Care Option" ["PCO"] services [*see* Part II.B.1.a., below], and care under two home and community-based "waiver services" programs -- have most of their services provided and coordinated through one of two private contractors.[6] There are about 38,400 New Mexicans under CoLTS, of whom about 85% are Duals and about half of whom reside in the BluePrint Counties of emphasis. About 6,770 are Native Americans, who, while unable to opt out of CoLTS, can utilize Indian Health Service and Tribal providers without CoLTS referrals.

The stated goals of CoLTS are similar to those articulated under ACA Section 2602, and the nature of, and duties under, the program are described in a detailed set of state regulations.[7] One of the stated goals of the program is to *use best practices from other states*. At the center of CoLTS' coordination efforts are a set of "Service Coordinators" employed by each contractor, who must address not only coordination of enrollee services *within* their company's provider network, but with New Mexico's separate behavioral health care coordinating entity as well. They establish service plans for enrollees, and must visit them at least once each quarter. This, contrasts with beneficiaries' health care providers (especially the potential service providers discussed in Part II.C., below), who may have contact with them at least every few days.

The CoLTS program's performance has recently come under fire from state officials, including in a Legislative Finance Committee report.[8] That report, while seeing potential promise in managed care efforts, and crediting some of the contractors' activities, was unable to determine whether CoLTS added any value to prior case management models. It also criticized CoLTS for its purported failure to control costs, primarily for PCO services. Moreover, CoLTS was established to coordinate *long-term care services*, not the care needs of Duals per se. It is uncertain whether CoLTS will be continued under New Mexico's Medicaid Redesign plan.

Meanwhile, New Mexico's Medicaid agency has periodically participated in education and outreach efforts to reach potentially eligible limited-benefit Duals, and has been made aware of problems QMB beneficiaries often experience in having cost-sharing protections implemented in, for example, Medicare Advantage plans. Reinvigorated education and outreach efforts are warranted, especially in collaboration with diverse local communities and stakeholders, to ensure those efforts take into consideration racial, ethnic, cultural competence, disability access, and other barriers. Monitoring the implementation of Duals' cost-sharing coverage rights is also warranted, as is revisiting the state's Buy-in program.

PART II: EXPANDED COVERAGE AND SERVICE PROVISIONS AFFECTING THE ELDERLY

A large number of ACA provisions give states -- and, in some cases, local medical providers -- the opportunity to expand or improve coverage for "the elderly" (and persons with disabilities, among others). This paper highlights only some of the most noteworthy. Although most of the provisions establish state *options*, one authorizing a major expansion of Medicaid coverage is *mandatory*. We turn to this ACA provision first.

A. Expanded Medicaid Eligibility for Low Income Adults

ACA Section 2001 amends the Medicaid Act to *require* states to add, *effective January 1, 2014*, new eligibility for a broad class of individuals between the ages of 19 and 64, who don't have Medicare, who are not covered under an existing eligibility group, and who have countable *family* income under 133% of the federal poverty level (effectively 138% due to a 5% income disregard). There will be no assets test. An estimated 200,000 or more New Mexicans will be eligible for this coverage. Moreover, the lion's share of funding will be provided by the federal government: *100%* for 2014-2016, declining in stages to 90% for 2020 and later years.

There will be a new scope of services coverage for this new group, but mental health parity will be required, and ***transportation*** to and from medical appointments will have to be covered. There will also be a new income-eligibility calculation methodology that will be used, which will require what a state official described as "*massive*" changes to the state's eligibility-processing computer systems, as well as significant worker training. For a more detailed discussion of the new coverage, *see* the paper *"**Medicaid and Healthcare Reform in New Mexico: Opportunities and Recommendations*** (2010), appended to the SJM 1 Health Care Reform Working Group Report (hereinafter cited as "The SJM 1 Report").

The new group will include elderly individuals age 55-64 who are not sick enough, or have income or assets "too high," to qualify for SSI and therefore qualify for Medicaid under current rules. They face unaffordably high insurance premiums, if they can get health insurance at all. The coverage will be vital for their access to health care and improved health outcomes, as it will be for tens of thousands of other poor, uninsured New Mexicans. The resulting increase in Medicaid-covered medical *transportation* services will be extremely important, especially in rural communities, to accessing services. One stumbling block involves the paucity of medical providers in rural and underserved communities. While the influx of newly-insured people may help attract increased provider numbers, additional workforce initiatives may be indispensible.

1. Current New Mexico Coverage

New Mexico has a program called "**State Coverage Insurance**" ("**SCI**"), which provides limited health coverage to a capped enrollment of about 43,000 individuals ages 19-64. There is

a closed-off waiting list of about 30,000. SCI was promoted as a "public-private partnership" to encourage small employers to help fund health insurance for their workers, but other individuals can also qualify, and constitute over half the membership. About 80% of SCI enrollees have family incomes under 100% of the federal poverty level. The scope of ACA Section 2001 services coverage is considerably broader; it could largely replace SCI, and enable SCI to focus on its original employment-based intent.

B. New Home and Community-Based Long Term Care Options

The ACA enacted an array of home and community-based services ("HCBS") coverage, services, and service-delivery options. Although many are only authorizations for grants and "demonstration projects" -- traditionally limited in geographic and population scope --; two new Medicaid services options were created, HCBS program expansion was authorized, and a new long-term care insurance program was established. While these options will be of interest to many persons eligible for Medicaid, they will definitely be of interest to the elderly.[9]

1. Community First Choice

ACA Section 2401 (codified as 42 USC 1396n(k)) established, effective October 1, 2010, a new Medicaid service coverage option called "**Community First Choice**" ("**CFC"**) under which Medicaid-eligible individuals *at risk* of institutionalization will be able to receive home-based attendant services and related supports to accomplish their "activities of daily living" ("ADLs") and "*instrumental* activities of daily living" ("IADLs").[10] CFC's income eligibility level is at least up to150% of the federal poverty level. Services must be provided in accordance with an individualized "**person-centered plan of service.**" The state's federal matching funds rate will be *increased* by 6 *percentage points* for CFC services.

Under CFC states are *required* to cover: (1) assistance with ADLs, IADLs, and "health-related tasks" through hands-on assistance, supervision, or cueing; (2) acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs and health-related tasks; (3) back-up systems (electronic devices like pagers, personal emergency response systems and mobile devices) to ensure continuity of services and supports; and (4) voluntary training on how to select, manage, and dismiss attendants. States have the *option* to include coverage of (1) **transition costs,** including rent and utility deposits, first month's rent and utilities, bedding, kitchen supplies, and other necessities; (2) expenditures related to a need identified in the individual's plan of *service*" that increase independence or substitute for human assistance; and (3) other services and supports; provided all these services and supports are linked to an assessed need in the individual's service plan.

States can use a variety of service-delivery models, but all must be based on "self-*directed*" services, which have been found to improve health outcomes and independence.[11] CMS may conclude that states must use the higher income eligibility level used for Medicaid nursing facility eligibility. If so, individuals with incomes *over* 150% of the poverty level will have to show they have a current institutional level of care need. Use of the higher level would

not cover many other people, since individuals must be eligible for Medicaid to receive CFC services, and income eligibility for almost all pertinent Medicaid eligibility groups is under 150% of the federal poverty level. The state must develop and implement CFC coverage in collaboration with a state-established "Development & Implementation Council," whose majority must consist of persons with disabilities, elderly individuals, and their representatives.

a. Current New Mexico Coverage

New Mexico's Medicaid program includes "personal care option services" ("PCO"), the central feature of which also involves the provision of attendant care services.[12] The PCO program currently covers about 15,000 individuals, virtually all of whom would qualify for CFC coverage. The CFC services package is broader than that available under PCO, and most individuals would not have to demonstrate a current nursing home level of care need, so more people could be covered. Recently, concerns have been expressed about the size and costs of PCO services, so it is reasonable to assume that there will be similar objections to adopting CFC. However, the increased federal payment share could mitigate those cost concerns. Adoption of the CFS option was recommended in the SJM 1 Report.

2. Money Follows the Person

"**Money Follows the Person**" ("**MFP"**) is a demonstration project originally authorized in 2006. Under MFP, persons receiving Medicaid-covered institutional care, but who want to transition to community living, can receive a pot of money to use for up to a year, on a self-directed basis, to meet their transition costs. Each individual must have a person-centered plan for using their funds**.** The state must assure that Medicaid-covered HCBS are available for the individual. *States receive an enhanced federal Medicaid matching rate for MFP services, which for New Mexico will be about 85%.* ACA Section 2403 extended the project through 2016, and reduced the maximum length of institutional residency for MFP eligibility to 90 days.

a. Current New Mexico Coverage

The New Mexico Human Services Department received a MFP services grant this year in the amount of $23,724,360 for five years, $595,839 of which is for the current fiscal year. HSD expects to provide MFP funding to 670 individuals over a 5 year period; 600 of them will be individuals age 65 and older, 70 of them will be individuals with mental illness. The state's minimum institutional residency requirement is only *30 days*. Specified agencies and facilities will be referring people to the program, but anyone can apply, through the "Aging & Disability Resource Center" ("ARDC") discussed in Part II.B.4. Although the amount of the money, and the numbers to be served, are modest, MFP is an important tool in ongoing efforts to transition elderly (and disabled) individuals to community-based care and could merit expansion.

3. Expansion of Home and Community-based Services [HCBS] options

In addition to CFC and MFP, the ACA authorizes other new options for promoting expanded Medicaid HCBS programs. The most noteworthy one applicable to New Mexico is

Section 2402(b) (amending 42 USC 1396n(i), [k/a/ **"1915(i)"**]), that broadens the ability of states to adopt a HCBS program as part of their regular Medicaid plans (as opposed to applying for waivers). Individuals would not have to demonstrate a nursing facility level of care need to qualify. Coverage would have to be available statewide, without limits on the *numbers* of people served, though the state could target it to individuals with particular conditions. CMS has noted that *mental illness* and *substance abuse disorders*, among the priorities for some BluePrint Counties of emphasis, could be among such targeted conditions.[13] Adoption of targeted 1915(i) programs, in consultation with stakeholders, was recommended in the SJM 1 Report.

a. New Mexico's HCBS programs

New Mexico operates six HCBS waiver programs, some of which have been in existence for over 25 years. The programs are: the **"CoLTS c"** (formerly "D&E") waiver, that serves about 2,525 people; the **"Developmentally Disabled" (DD)** waiver, that serves about 3,800 people; the **"Mi Via,"** waiver, that is based exclusively on a self-direction model, and that serves about 820 people; the **"Medically Fragile"** waiver, which serves about 210 people; the **"AIDS"** waiver, which serves 16 people; and the **"BI"** waiver for individuals with traumatic brain injury, that serves about 330 people (pertinent data sources are inconsistent on some of these individual figures). The Mi Via population is drawn from the other waivers, and *includes* the BI group. Because of limited funding, there are waiting lists for each of these programs, several *years* long in the case of the CoLTS c and DD waivers.

Each of these waiver programs has a cap on the number of individuals who can be served based on the waiver authorizations and the amount of funds appropriated. By comparison, the "PCO" services discussed in Part II.B.1.a. -- also a HCBS program -- for which enrollment is not capped serves about 15,000 individuals, more than twice the number served under the waivers. In addition, it is important to be aware that there is a special, day center-oriented HCBS program called "PACE" located in Albuquerque that manages its enrollees' Medicare and Medicaid services. It serves about 385 individuals *age 55 and older*, and also has a waiting list.

Since the state has not appropriated funding to significantly increase waiver program enrollment, it is not likely to adopt an open-ended state plan option *per se*. However, targeting one or more 1915(i) programs to narrowly defined conditions and, perhaps, on a pilot project basis might be more feasible and could be of interest to the BluePrint Counties of emphasis, each of which have listed particular conditions as high priorities.

4. Expanded Funding for Resource Centers

ACA Section 2405 provides a substantial increase in funding for "State Aging & Disability Resource Centers," to assist individuals and their families in understanding, among other things, the range of long-term care options -- including HCBS options -- available in their states. New Mexico has maintained an Aging & Disability Resource Center ("**ARDC**") for many years, within the state's Aging & Long Term Services Department. The ARDC provides one-on-one information, counseling, and problem-solving assistance on a broad range of public

and private benefits and resources, on a telephone, walk-in, and web-based basis. It is important for members of local communities throughout the state to be aware of this service; the ARDC can be reached at 1-800-432-2080, Monday thru Friday, 8:00 AM-5:00 PM.

5. The CLASS Act

ACA Sections 8001-8002 (codified as 42 USC 300*ll*-300*ll*-7) enact a new, nationwide *long term care insurance* program, called "CLASS" (for "**Community Living Assistance Services and Supports Act**"), which will begin after October 1, 2012, and be funded through premiums. It will primarily target employee groups. To receive benefits enrollees will have had to have paid premiums for at least 60 months and have earned at least a minimum amount. Premiums for people with incomes under the poverty level will be kept very low, to encourage broad participation. Eligibility for benefits will be based on a finding of *functional limitations*. Most specifics are left to a federal agency, in consultation with an Advisory Council, so we won't know many details for well over a year The agency will fund each state's "Protection & Advocacy System" to provide information and assistance services.[14] CLASS insurance will provide another tool for funding HCBS and, if successful, will help defray potential Medicaid spending. Upon its launch, promotional and community education efforts can be considered.

C. New Service Delivery Models

The ACA has several provisions designed to test or utilize **new services delivery models** under Medicaid and Medicare. The models are designed to improve access to quality care and health *outcomes*; through easier access to providers, increased coordination and integration of services, and use of information and communications technology and interdisciplinary (*i.e.*, not just doctors) teams. They must follow a "person-centered" and "whole-person" approach to improve the experience of patients and their families, while reducing costs. "Whole person" means addressing the patient's physical *and mental* health needs, as well as *social needs*.

This paper highlights four models: "Health Homes," "Medical Homes," "Accountable Care Organizations," and "Health Teams." Despite the differences in names all share the above-noted design, but they are authorized by the ACA in different ways. Health Teams, for example, involve a special program available to *e.g.*, Native American health systems. All demonstrate the potential range of service delivery and care coordination models that can be developed in cooperation with local communities rather than imposed entirely from the top down by state or federal agencies. While the models show great promise, experience has shown that patients are often unaware of their status and rights,[15] a concern that will have to be addressed.

1. When a Home is not a Home: Health Homes and Medical Homes

The ACA authorizes funding for two similar models: "Health Homes" and a few specified types of "Medical Homes." The use of the word "home" is misleading; both models refer to groups of medical providers and other workers who coordinate a broad spectrum of services for particular groups of patients. CMS has noted that the Health Home model arose out

of the Medical Home model, and the names are often used interchangeably. We turn first to Health Homes, because the ACA authorizes a specific Medicaid service option using that name.

a. Health Homes

ACA Section 2703 (codified as 42 USC 1396w-4), effective January 1, 2011, authorized Health Home services as a new Medicaid option. Under this option, beneficiaries with *chronic conditions* can select a "designated provider," a "team of health professionals," or a "health team" to provide them with a comprehensive set of *care management and coordination services.* Services include health promotion; transitional care (including follow-up) from inpatient to other settings; patient and family support; referrals to community and social support services; and use of health information technology to link services and report on the outcomes of the services. The payment for these services is *in addition* to the payments for medical care provided by the Health Home. *To encourage states to adopt Health Home services, the federal matching payment rate for them during the first two years of implementation will be 90%*.

Beneficiaries must have at least: two chronic conditions; one chronic condition and be at risk for a second; or one serious and persistent *mental health* condition. "Chronic condition" means mental health, substance use disorder, asthma, diabetes, heart disease, and overweight with a body mass index over 25. CMS has indicated that HIV/AIDS might be added.[16] The service does not have to be provided statewide and can be limited to particular chronic conditions or numbers or severity levels of particular conditions.

"Designated providers" include individual practitioners, groups, Federally Qualified Health Centers ("FQHCs"), community and mental health centers, and home health agencies determined *by the state* to be qualified. "Team of Health Care Professionals" means teams *described by the state* that include physicians and other professionals (*e.g.*, nurse coordinators, nutritionists, social workers, behavioral health workers) that *the state deems* appropriate and which can be based in a wide variety of settings. The term "Health Team," refers to a new type of interdisciplinary organization described in ACA Section 3502, discussed in Part II.C.3 below.

States have considerable flexibility in Health Home program design, including in limiting the communities they can serve, and the particular chronic conditions that will be targeted. This increases the ability of local communities and stakeholders to work with the state and local providers to establish Health Home programs that address local priorities, and incorporate cultural competence requirements and the other program design elements important for optimal access. New Mexico received a federal matching funds grant in the amount of $500,000 for Health Home planning activities. *Moreover, the state's Medicaid Redesign plan indicates that Health Home services are being considered for inclusion.*

b. Medical Homes

The medical home model has been discussed and promoted for at least 45 years, most prominently by provider organizations stressing *primary care.* It has come to be referred to as

the "**person-centered medical home**" model. Although the concept of the Health Home is said to have drawn heavily on the Medical Home model, the ACA does not include a specific Medicaid or Medicare "Medical Home" option, nor, except in the "Health Teams" provision discussed below, any *definition* of the model. The 2009 New Mexico Legislature, however, enacted a Medicaid Medical Home law[17] that can serve as an excellent source of requirements for Medical Homes as well as the other service delivery models discussed in this paper.

The list of preferred models listed for testing by the CMS Center for Innovation [*see* Part I.C.1.b.] includes: patient-centered medical home models for "*high-need applicable individuals;*" medical homes that address *women's unique health care needs*; and community-based "health teams" supporting "*small-practice **medical homes**"* by assisting primary care practitioners in chronic care management, including patient self-management activities. It is reasonable to assume that Medical Homes and Health Homes will operate similarly and can thus be the subject of similar community and stakeholder implementation efforts.

2. Accountable Care Organizations (ACOs)

The Accountable Care Organization (ACO) is another new, albeit similar coordinated care model, which can involve considerably larger provider organizations. The ACO model has received an exceptional amount of attention as a coordinated care model applicable to diverse patient populations, and the Medicaid Redesign plan is considering its use. The BluePrint for Health New Mexico paper *"**Accountable Care Organizations and Federal HealthCare Reform**"* discusses ACOs in depth; this paper comments briefly only on an ACA provision authorizing ACOs for *Medicare* fee-for-service beneficiaries.

ACA Section 3022 (codified as 42 USC 1395jjj), *requires* CMS to operate a *Medicare* "Shared Savings Program," by 2012. "Shared Savings" means that ACOs will be able to keep a portion of the "savings" from reductions in the costs of care for beneficiaries "*assigned*" to them. The manner in which ACO's earn shared savings is unusual. Beneficiaries are *not* required to obtain services from "their" ACO! "Assignment" is solely a technical means for identifying which beneficiaries that make some use of an ACO's providers will have their health care usage tracked to assess the ACO's care coordination efforts and shared savings entitlement. And CMS has stated that *beneficiaries can even opt out of those usages.* Beneficiaries are likely to find all this confusing, and thus may fail to obtain optimal health outcomes -- a concern that must be addressed. Furthermore, CMS has stated that FQHCs and rural health centers, which are commonly preferred by rural and underserved communities, cannot serve as *Medicare* ACOs. This will not prevent their participation as *Medicaid* ACOs, but this policy should be changed.

3. Community Health Teams

Health Teams are authorized as an important component of new health care *systems*. ACA Section 3502 (codified as 42 USC 256a-1) requires CMS to fund certain "entities" to establish community-based, interdisciplinary, inter-professional **Health Teams**, to both provide coordinated services to patients, and support other primary care providers in the entity's hospital

service areas. The entities that can receive the funds are: (1) states or state-designated entities; and (2) *Indian tribes or tribal organizations*. The entity must create a plan for its area that incorporates prevention, patient education, and care management in health care that is integrated with other community-based resources; and establish the Health Team and ensure its broadly interdisciplinary and inter-professional composition. The entity must also provide funding to local primary care providers, and must also provide *Health Home services.*

The Health Team's obligation to support and assist other primary care providers in its area (including "patient-centered **medical homes**," as defined in Section 3502[18]) is extensive. Section 3502 authorizes an exceptionally broad primary, preventive, and disease management program that is worthy of serious consideration by eligible entities and their communities. It is not, however, without stumbling blocks. For example, Indian Health Service and Tribal health programs continue, despite ACA-authorized funding increases, to be severely under-funded. As sovereign nations each Tribe and Pueblo has the sole right to decide whether the Section 3502 is applicable to their circumstances, and feasible. These decisions should be fully supported.

4. Additional Models Being Tested

The ACA also authorizes small-scale tests of two other *Medicare* service delivery models worthy of mention. They could provide useful guides to possible *Medicaid* models. Section 3024 (codified as 42 USC1395cc-5) establishes the "**Independence at Home Medical Practice Demonstration Program**" under which multidisciplinary physician-, *nurse practitioner-, or physician assistant*-directed teams provide "comprehensive, coordinated, and accessible" care to certain "high need"[19] patients ***at the patient's home***. Teams get extra payments depending on improving outcomes, beneficiary and family caregiver satisfaction, and reducing care costs.

Section 3026 creates a "**Community-Based Care Transitions Program**" that will fund enhanced hospital discharge planning and post-discharge services coordination for "high-risk" hospitalized beneficiaries.[20] Inadequacies in this area are harmful to beneficiaries and their families and preventable hospital readmissions are extremely costly to Medicare. Eligible entities include community-based organizations that furnish care transition services; their governing body must include "sufficient" numbers of consumers. Preference will be given to entities serving medically underserved populations, small communities, and rural areas.

D. Other ACA Provisions of Note -- Community Education

The ACA contains a large number of other provisions of interest, but for purposes of this paper we note three sets: several Sections that expand Medicaid and Medicare beneficiaries' access to preventive care and wellness services;[21] Section 4203, that will, possibly by late 2012, require minimum physical accessibility requirements for diagnostic equipment in most medical care settings; and several Sections that effected changes to Medicare beneficiaries' Medicare Advantage plan and Prescription Drug Plan rights.[22] The BluePrint for Health New Mexico Counties of emphasis have already been engaged in such activities regarding the first topic, and the BluePrint Advisory Network has expressed specific interest in the second.

PART III: MEDICAID REDESIGN

The state has embarked on an ambitious plan to redesign the Medicaid program, and in May hired Alicia Smith & Associates to lead the effort. The Administration has concluded that current Medicaid expenditures are "unsustainable." Although we know of few specifics yet, the state has outlined some broad Redesign elements. One is to place the entire Medicaid program under a single managed care organization (MCO), reduce the number of MCOs currently involved in the program, and negotiate an overall funding agreement with CMS. Another is to incorporate more "personal responsibility" elements, most notably co-payments, but also incentives for healthy behaviors. Another is to use revised provider payments and service delivery models (such as Health Homes and ACOs) to promote more coordinated, primary care.

Administration officials often refer to the Redesign plan as Medicaid *Modernization.* Yet MCOs have been used in Medicaid for *decades*, without clear proof, as noted by Ms. Smith, that they necessarily improve care quality. Co-pays have also been used by Medicaid programs for decades, despite evidence that they can *reduce medically necessary care*. Use of Health Home, Medical Home, and ACO services *would* be modernization, as would adoption of the other new services options discussed in this paper. One of the most prominent Medicaid modernization examples is the new Section 2001 *eligibility expansion*, that eliminates some of the "categorical" eligibility requirements that have long artificially limited Medicaid coverage.

Some of the ideas in Ms. Smith's application to draft the Redesign plan are clearly innovative but, to date, there has been little public information on the details of the plan. And, while Ms. Smith (and HSD Secretary Squier) commendably stressed the importance of *input* from Native Americans and other stakeholders in developing the plan, and said the plan *must "*recognize [New Mexico's] cultural and geographical diversity," there has been little to date against which those commitments can be measured. It is vital that comprehensive public input be fully accommodated *before* the plan is in the form of a "first draft," and also well *before* the submission of an "1115" waiver application to CMS, a prerequisite to implementation of the final Redesign plan.

Native Americans, members of other affected communities, and all other stakeholders need to know the tentatively proposed *details* of the plan in order to provide meaningful input, and to know the answer to basic questions like: Which of New Mexico's current Medicaid services will be included, or, if altered, in what way? Which of the new ACA coverage and services options will be included? How will an "overall funding agreement" with CMS incorporate the ACA's federal matching rate enhancements, and deter cost-shifting harmful to patient needs? How exactly will racial disparities, cultural competence, and related access barriers be addressed?

Most of the opportunities for implementation suggested in this paper refer to efforts vis a vis "the state." All or most of those opportunities can also be pursued within the Medicaid Redesign process, and, if deemed appropriate, with CMS.

OPPORTUNITIES FOR IMPLEMENTATION

Opportunities Regarding Dual Eligibles

1. Adopt the best practices and policy revisions for improving coordinated and integrated care for Duals generated by federal initiatives. Representatives and members of local communities and stakeholders could do this, and could work cooperatively with the state and medical providers to implement them through revised policies and practices in New Mexico.

2. Determine whether the state's "CoLTS" case management program should be retained, replaced, reorganized, or transformed. The state could do this, in consultation with affected beneficiaries and families, and with representatives and members of local communities and stakeholders.

3. Ensure that Duals' coverage rights are being implemented. Representatives and members of local communities and stakeholders could do this, in cooperation with the state and medical providers.

4. Amend the state's "Buy-in" program for paying for individuals' Medicare Part A premiums. The state could do this, so that low-income individuals age 65 and older who don't automatically qualify for Medicare can obtain it more simply and quickly.

5. Reinvigorate outreach efforts with appropriate racial, ethnic, gender, cultural, language, and disability status accommodations, to increase access to Medicare for potential Duals unaware of their buy-in eligibility. The state and representatives and members of local communities and stakeholders could do this cooperatively.

Opportunities Regarding the New Medicaid Expansion

1. Phase-in the new coverage, at least 9 months to a year *before* 2014. The state could do this, to get desperately needed health coverage to New Mexicans as soon as possible, and to have time to develop new information technology systems and worker training; avoid January 1, 2014 chaos; promote community education and outreach; and develop provider and transportation services infrastructure before full-scale implementation takes place.

2. Ensure, prior to any coverage roll-out, that the language and processes used in educational materials, eligibility-processing, Q&A services, and notices are fully responsive to the needs of all racial and ethnic groups, and persons with disabilities. The state should do this, in consultation with representatives and members of local communities and stakeholders. The recommendations of the SJM 1 Report Consumer Protection & Consumer Education Advisory Group could provide an excellent guide.

Opportunities Regarding Home and Community based Services Expansions

1. Adopt the Community First Choice option. The state could do this, to expand the number of persons who obtain critically needed attendant-based care; promote independent, community-based living; help avert deterioration of individuals' health to the point of their needing institutional care; and increase federal revenue.

2. Make the availability of the Money Follows the Person (MFP) benefit more widely known. The state could so this -- in consultation with representatives and members of local communities and stakeholders -- to give members of all New Mexico's diverse communities equal access to it.

3. Increase the funding for the Money Follows the Person program substantially. The state could do this, to expand the numbers of persons helped with moving from institutional to community care including persons with disabilities under age 65.

4. Adopt one or more targeted "1915(i)" Medicaid community-based care programs. The state could do this, and could target conditions determined as priorities by representatives and members of local communities and stakeholders.

5. Establish additional PACE programs, to provide Dual Eligibles with another option for community-based long term care. The state could do this, in cooperation with interested local organizations and communities and CMS.

6. Develop any home and community-based care programs in consultation with representatives and members of affected populations, local communities and stakeholders and include requirements that address racial, ethnic, language, gender, cultural competence, and disability access barriers. The state should do this.

7. Coordinate local community education and informational efforts with those of the state "Aging & Disability Resource Center" ("ARDC)." Representatives and members of local communities and stakeholders could do this, and could work cooperatively with the ARDC on ways to make its services more accessible to their racial and ethnic populations and persons with disabilities.

8. Conduct community education activities regarding the "CLASS Act" long-term care insurance program when it is launched. Representatives of local communities and stakeholders could do this.

Opportunities Regarding New Service Delivery Models

1. Adopt Medicaid Health Home services targeting conditions determined by local communities to be the highest priorities in their areas. The state could do this, in consultation with affected populations and representatives and members of local

communities and stakeholders, who could also support local providers willing to provide the services.

2. Establish Section 3502 local, primary care-focused, "entities" that will establish community Health Teams to provide and support primary care services. Indian tribes or tribal organizations could do this, as could other local entities approved by the state. Representatives of other communities and stakeholders could work cooperatively with the state, medical providers, and other organizations to establish such entities.

3. Support Tribal organizations and other local entities that choose to adopt the Section 3502 entity/Health Team model. Representatives and members of local communities and stakeholders could do this.

4. Ensure that any Health Homes, Medical homes, Accountable Care Organizations or Health Teams that operate in any community adopt requirements that address racial, ethnic, language, gender, cultural competence, and disability access barriers to access and quality care pertinent to that community. The state and the organizations should do this, in consultation with representatives and members of affected local communities and stakeholders

5. Support the proposals of Health Homes, Medical Homes, and Accountable Care Organizations that welcome community and stakeholder involvement, and are committed to addressing the access barriers referred to in #4. Representatives and members of local communities and stakeholders could do this.

6. Ensure that beneficiaries are fully aware of their relationship to, and rights and responsibilities under, Health Homes, Medical Homes, Accountable Care Organizations, and Health Teams. Representatives of local communities and stakeholders could do this, through education, counseling, and monitoring.

Opportunities Regarding Other ACA provisions of Note – Community Education

1. Conduct community education activities to make consumers better aware of the enhanced preventive care services, future diagnostic equipment disability access requirements, and changes to Medicare Advantage and Prescription Drug Plan rights. Representatives of local communities and stakeholders could do this.

Opportunities Regarding Medicaid Redesign

1. Provide input in the Medicaid Redesign plan process. Representatives and members of local communities and stakeholders could do this, working collaboratively, and could as part of that input use the Opportunities for implementation listed above.

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[1] The eligibility categories are "QMB" (*see* 8 NMAC 240.400 ff), "SLMB" (*see* 8 NMAC 245.400 ff.), "QI" (*see* 8 NMAC 250.400 ff), and "Qualified Working Disabled Individuals" (QD) (*see* Medical Assistance Division Eligibility Manual). QMB pays for individuals' Medicare Part B *and A* premiums, deductibles and co-insurance; SLMB and QI pay only for Medicare Part B premiums; QD pays for Medicare Part A premiums.

[2] Examples are "Working Disabled Individuals" (*see* 8 NMAC 243.400 ff) and "Breast and Cervical Cancer Program" (*see* 8 NMAC 252.400 ff) coverage.

[3] 76 *Federal Register* 28196-197 (May 16, 2011). These figures were drawn from several studies.

[4] The legislative process of enacting the ACA was complicated. The final Bill passed on March 23, 2010, "The Patient Protection and Affordable Health Care Act," Pub. L. No. 111-148, included most of the law, but a number of its sections were amended or repealed by some of its other sections! In addition, the "Health Care and Education Reconciliation Act of 2010," Pub. L. No. 111-152 (March 30, 2010), in part amended or repealed some sections as well. In this paper we cite ACA Sections in the form they assumed after any such amendments and/or repeals.

[5] CMS, Dear State Medicaid Director Letter SMDL# 11-008, ACA# 18, *Re: Financial models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*. The two models would be: (1) capitation, using blended Medicare and Medicaid rates; and (2) managed fee-for-service, under which *the state* could share in savings.

[6] Note that both CoLTS contractors pay "provider taxes" that help fund the state's Medical Insurance Pool.

[7] *See* 8 NMAC Chapters 307.1 ff.

[8] *See, e.g.,* the February 14, 2011 Report to the Legislative Finance Committee, *HSD, Program Evaluation: Medicaid Coordination of Long-Term Services Program.*

[9] For an excellent discussion of most of the provisions discussed in this sub-Part see the National Senior Citizens' Law Center article listed in the References section.

[10] ADLs are defined as "basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring." IADLs are defined as "activities related to living independently in the community, including but is not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community."

[11] Beneficiary advocates in New Mexico have worked for years to successfully have self-direction incorporated into HCBS programs.

[12] The rules for New Mexico's PCO coverage are set forth at 8 NMAC 315.1 ff.

[13] CMS, *Improving Access to Home and Community-Based Services* (August 6, 2010), "Dear State Medicaid Director" Letter, SMDL# 10-013, ACA# 4.

[14] Unfortunately, the *funding* that is supposed to be provided for those advocacy services is expected to be delayed for a considerable time. July 5, 2011 Email exchange with Jim Jackson, Executive Director of New Mexico's P&A agency (called "Disability Rights New Mexico").

[15] *See, e.g., Patient-Centered Medical Homes*, Health Affairs (September 14, 2010), at p. 9.

[16] CMS, *Health Homes for Enrollees With Chronic Conditions* (November 16, 2010), "Dear State Medicaid Director, Dear State Health Official" Letter, SMDL# 10-024, ACA# 12, at p. 5.

[17] NM Laws 2009, Ch. 143, codified as NMSA 1978, 27-2-12.15.

[18] The Sec. 3502(c)(2) definition: "a mode of care that includes personal physicians or other primary care providers; whole person orientation; coordinated and integrated care; safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements; expanded access to care; and payment that recognizes added value from additional components of person-centered care."

[19] "High need" individuals are those with two or more chronic illnesses (including Alzheimer's and others designated by CMS), who have had a non-elective hospital admission and acute or sub-acute rehabilitation services in the past year, and have two or more "functional dependencies." Some analysts have suggested that this model would be especially useful for individuals with severe mental illness.

[20] The definition of "high-risk" involves an arcane formula that CMS will establish, but includes factors like multiple chronic conditions and risk factors associated with hospital readmissions such as cognitive impairments.

[21] *See, e.g.,* ACA Sections 3202, 3111, 4004, 4102-03, and 4108 (if the state obtains a grant under this section).

[22] *See, e.g.,* ACA Sections 3202, 3204, 3304, 3305, 3311, and 3312. *See also* Section 1101 of the "Health Care and Education Reconciliation Act of 2010," cited in note 4.