Section 1115 Demonstrations: New Mexico Centennial Care

Public Comments

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<tr><td>CENTENNIAL CARE WILL ELIMINATE TRUE CONSUMER DIRECTED CHOICE</td><td>Consumers who are currently receiving Consumer directed personal care services would only have two choices when Centennial Care is implemented on January 1, 2014. They would have the option to go with a delegated based personal care agency through the Agency Based Community Benefit or go into a Mi Via type self-direction program called the Self-Directed Community Benefit. Listed below are many of the concerns that the agency has that their consumers would be facing if Centennial Care is put into place in its current model.
If the state eliminates the Consumer-Directed model of PCO, it will unnecessarily harm New Mexico consumers, workers and businesses.
This decision forces consumers to either move to a service that requires them to do more complex and difficult things to direct their own care (such as manage a budget) or give up the ability to direct their own care and allow an agency to take more control of their lives and services. The Self-Directed Community Benefit requires them to do things that they are not interested in doing, or may not be capable of doing safely.
If they wanted or needed Mi Via type program or traditional agency-based services they would already be enrolled. Consumers have selected and been successful in the Consumer-Directed PCO model that allows them to direct their care without the level of responsibility and liability that exists in a Mi Via type program.
Many agencies that currently provide directed services will be forced to stop providing PCO services all together, especially those that provide services using the FEA model. People employed in management and administrative positions in local communities will lose their jobs as a result.
Many of the caregivers who are supporting consumers in the current Consumer Directed Option will be forced to take significant cuts in pay as a result of the shift of consumers to the delegated option. Some of these caregivers will leave the workforce as a result of lower pay. This once again increases unemployment both locally and throughout the state.
Many Consumer-Directed PCO agencies provide services in rural areas. Consumers living in rural areas of the state may have less access to services as a result of the loss of the directed option. Due to the training requirements that require monthly travel to come in to an agency's office, traditional agencies have difficulty recruiting and retaining a sufficient number of workers in these rural to maintain consumers in their homes. This is especially true on the Pueblos and Navajo Nation.
Problems with access to home care will lead to unnecessary, more costly out of home placements, including nursing homes and hospitalizations.
The move to Centennial Care is complicated and stressful enough without adding this additional change.
By using Xerox as the only fiscal agent to assist with self-directed services, NM money is going to a large out of state provider and there has been no bid process to be in this role that we are aware of.</td><td>2013-07-15 09:30</td></tr>
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	• • Summing it up: Vulnerable Consumers are being forced to move from a service model that they have chosen because they want it, they like it, it meets their needs and it is provided by agencies that they know and trust, into new services that have not asked for and that may not be appropriate for them. The decision to force them to change service models will negatively impact not only these consumers but the workers who help them and the local businesses that support both the consumers and their workers.	
EPSDT data and monitoring would benefit children	The waiver application only mentions EPSDT in the glossary, yet it's emphasized that having a care coordination system is one of the state's main goals. Good EPSDT monitoring and data by the state and ensuring that EPSDT treatment will be part of the MCO's care coordination duties could help achieve this goal for children.	2012-10-12 07:53
How will savings be achieved for children and others already in managed care?	New Mexico's waiver application does not contain sufficient information to truly understand the budget projections and calculations. Moving to managed care would not generate savings among beneficiaries already covered by managed care without other program changes, yet the state's waiver application predicts savings from populations already in managed care, including children insured through Medicaid and CHIP.	2012-10-12 07:14
NM Voices for Children strongly objects to New Mexico's proposal to eliminate the retroactive eligibility for new Medicaid enrollees. This u	NM Voices for Children strongly objects to New Mexico's proposal to eliminate the retroactive eligibility for new Medicaid enrollees. This unfortunate proposal penalizes every Medicaid-eligible individual and family who runs up medical bills before getting enrolled in Medicaid, or who don't stay enrolled, no matter what the reason might be, including people who don't know about Medicaid or that they might be eligible, or who have trouble enrolling because of red tape or because they don't speak English or live in a remote area. Similar to the New Mexico's proposal to adopt new co-pays, there is no indication that this proposal is intended to do anything but save the state money. There is no indication it can satisfy the demonstration or research requirements of a Section 1115 waiver and it is not consistent with the goals of the Medicaid Act. 90-day retroactive coverage was put into the Social Security Act for good reasons, and it should not be waived. Without retroactive coverage, just one hospitalization could turn into crushing medical debt for a low-income family. Retroactive coverage not only ensures that low-income patients receive medical care without facing horrible debt and collection agencies, it also reduces the uncompensated care on hospitals and other providers. The New Mexico Hospital Association has said that retroactive coverage generates $48 million in payments to the three largest hospitals in the Albuquerque area, and hundreds of millions statewide. Loss of these payments will significantly increase uncompensated care in New Mexico—already a huge problem. We do not see what research or demonstration purpose can be served from this proposal. HSD has not evaluated the impact that eliminating retroactive coverage will have on Medicaid recipients, nor has the state included a plan to study the effects of this proposal in the future in the evaluation plan that is included in the final waiver application.	2012-10-05 13:20

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	HSD argues that this will not hurt people because most Medicaid beneficiaries will have health insurance by July 2014 due to the Affordable Care Act. This is not going to prove true. Native Americans are not subject to the individual mandate. Anyone who is below the income tax filing threshold will not be subject to tax penalties for failure to have coverage. Many low-income families may not enroll in Medicaid immediately because they are unaware that they are eligible. HSD has stopped most outreach for the Medicaid program in the last two years, and has no plans to resume it. Nearly 50,000 children in New Mexico are eligible for Medicaid now but are not enrolled, partly because HSD has suspended efforts to reach out to their families. 90% or more of these unenrolled children live in Native American and Hispanic families, who face unique burdens in learning about Medicaid and getting enrolled. Families at this income level also face financial instability – they may move addresses frequently and have difficulties with staying enrolled in Medicaid. Families face numerous barriers in New Mexico when attempting to enroll in Medicaid. It would be unfair to penalize them for the state's failure to enroll them. Many New Mexico newborns on Medicaid fail to be transferred to children's Medicaid on their first birthday, in large part because the state requires parents to provide documents re-verifying the citizenship and identity of these children. The state continues to practice "autoclosure" whereby a computer automatically closes cases that have not been processed in a given time period, even when the failure to process the case was due to the fault of the Department and not the individual. HSD seems to assume that eliminating 90-day retroactive coverage will put pressure on both patients and providers to get eligible patients enrolled in Medicaid. This proposal—so harmful to the people affected--is not necessary as a motivator. Both patients and providers still have every incentive to nail down enrollment well before expiration of the 90-day period because if the patient fails to do so he/she will be stuck with a big bill which the provider will probably not be able to collect. Eliminating retroactive coverage will have serious consequences for New Mexicans. Although the state hopes to save money, this proposal will merely shift the costs to healthcare providers and low income patients. It will penalize low-income New Mexicans for longstanding administrative barriers to Medicaid outreach and enrollment that our state still has not addressed. We strongly urge the Secretary to disapprove this proposal.	
Centennial care will surely jeopardize the success of the Mi Via Self-firected Waiver. We have worked long and hard for this waiver.		2012-10-05 12:55
Protect Self-directed Services	The Arc of New Mexico disagrees with the application statement on page 1 that the state has been buying quantity not quality. This is not true in the Mi Via self-directed HCBS Medicaid Waiver. The budget for services provided and goods purchased is intensely scrutinized with multiple steps for approving the plan and budget.	2012-10-05 09:48

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	One of the most important things to keep in mind when reviewing this waiver is that individual programs cannot be standardized across all populations. For example: individuals with spinal cord injuries are completely different from individuals with dementia. The services provided are different the ability to self-direct is different; the ability to live independently in the community is different. Those differences must be taken into account for the "right services to be delivered at the right time". The definition for Home-Health Aides as written sounds like a Medicare definition and doesn't meet the needs of individuals using the Personal Care Option and the Mi Via Self-Directed Waiver. Implementing this definition could lead to higher costs for the program because not all services need to be supervised by a nurse and not all attendants need to be certified as home health aides. The basic premise of self-direction is that individuals know what services they need when and where and who can provide those services. Finally, the elimination of "Community Direct Support" is especially troubling. The rational for elimination (only used by people with developmental disabilities and they are not part of the waiver) given by the state is discriminatory as individuals with all types of disabilities use community direct support and almost all adults with developmental disabilities who are not on the Developmental Disabilities HCBS waiver will be in the Centennial Care waiver and this waiver should support those needs as well.	
6. Self-Direction and Home and Community-Based Services	QUOTE: "MCOs will also be required to provide coordination/support broker services by either providing the services themselves or contracting out to individuals or agencies that have demonstrated experience with self-direction. These coordination/support brokerage services include but are not limited to: assistance with building budgets, conflict resolution, development of worker agreements and other non-financial services." COMMENT: The MiVia Consultant should be retained as currently implemented. A consultant that is chosen by and acts on the behalf of the recipient should be retained and not performed by an MCO or a individual or company contracted with an MCO. A recipient should be confident that the Consultant is actin on their behalf and not the MCO. QUOTE: "In order to determine the appropriate level of support and interventions necessary to increase a recipient's change of success, recipients will complete a self-assessment tool. For example, the outcome of the self-assessment tool can help an MCO determine if a recipient needs to appoint a representative to assume the self-direction functions on their behalf or if additional support services are warranted." COMMENT: A poor idea as expressed. It should be further defined. Recipierns may not be able to complete or perform a self-assessment "tool". These statements are grossly unclear as to meaning. For example the recipient may be paralyzed, senile etc. and cannot "use" the tool. Further Comment: Current assessments are performed by an independent Healthcare agency and not the MCO. This implies a greater likelihood an accurate assessment.	2012-10-05 09:47

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	Additional Comment: Changes of this magnitude are likely to be "full" of mistakes and beneficaries are extremly likely to be the victim of mistakes, inaccuracies inherent in large changes.	
the best I can read the proposed waiver, there will be no more transportation, as well as many of the other things going away that enable pe	is non-medical transportation going away with so many other benefits that enable folks with disability to remain in their rural NM communities? Cutting this low cost necessity will cause decline in health and safety creating much higher cost at a greatly compromised quality.	2012-10-04 20:32
Include Mi Via features in Centennial Care	New Mexico currently has a self-directed waiver for people who meet nursing facility LOC, called Mi Via, that is working well and has saved the state money. This waiver will be ended with the advent of Centennial Care, the 1115 waiver. There will be the option to self-direct long-term services in the Centennial Care program, but some of the best features of Mi Via will be eliminated. The drastic changes to and elimination of many of the services available today in Mi Via will defeat the purposes of self-direction. Self-direction is based on the notion that a person knows best about what will help them meet their needs related to their disability and their choices will improve service quality. Additionally, given the flexibility to pay for unconventional services and goods, self-directed participants will find ways to meet their needs that are effective and save money. Without a structure that supports these basic purposes of self-direction, the benefits that can be accrued from self-direction, for individuals and for the health care system, will not be achieved. The Centennial Care waiver does not support the purposes of self-direction and therefore diminishes the concept of self-direction. A better alternative is to maintain all of the rules and requirements of the Mi Via program as, it is today, in the Centennial Care program, including all service codes. Here are some examples of important features of Mi Via that will be drastically changed or eliminated: 1) There will be a cap of $500 on related goods in the 1115 waiver. Currently, the only limitation on related goods is the budget amount the participant receives. There is an unwarranted perception by the state that Mi Via participants want to spend their budgets on “things” and not on the essential medical, functional, clinical and/or habilitative services they need to meet their need. As a Mi Via consultant, by far the majority of participants know what their needs are and want services and goods will help them meet their needs. These are examples of items that Mi Via participants purchase: • exercise equipment for in home use • diapers • iPad for adapted communication, learning, information • equipment and supplies to manage self-directed services • noise canceling headphones to reduce sounds that trigger seizures • non-prescription health remedies and supplements • blender to puree food • air quality products to help with asthma, allergies, dryness • water pick for person with limited mobility as an aide to dental hygiene	2012-10-04 12:10

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	• portable ramp • blood pressure monitor • magnetic fall alarm • audio/video monitors The purchase of these related goods increases independence, improves health and/or reduces the needed units of care-giving services. The cap on related goods defeats the purpose of self-direction, driving participants back into more costly services or even institutionalization. There should be no cap on related goods. 2) In the current Mi Via program, there are service codes for "health related services and equipment" and "fees and memberships." These are services, not related goods. They have been eliminated in the 1115 waiver application. These service codes allow participants to purchase such things as: • Cell phone service for safety • Internet service for managing their Mi Via program, finding resources, communication and community connections • Gym memberships for fitness and weight loss • Swimming lessons • Emergency response service • Memberships to zoos, museums, state parks • Weaving classes • Gun range membership • Zumba class These services enhance safety at home and in the community, improve fitness and health, increase communication, help find resources, and are critical for opportunities to participate in the community. Again, by making it possible to purchase unconventional health and safety related services, participants find effective ways to meet their needs that also saves money. 3) An important Mi Via service, Community Direct Support, is totally eliminated in the Centennial Care waiver. It is a service that "helps you participate in community life in order to enhance relationships with others, work or participate in meaningful activities." The reason the state gave for not including Community Direct Support in the 1115 demonstration waiver is that it is primarily used by people with developmental disabilities and this population is not included in the 1115 demonstration waiver. As a Mi Via consultant, 50% of the participants enrolled in my organization have chosen to purchase Community Direct Support services. This includes many of the participants with brain injury, which will be a population participating in the 1115 demonstration waiver. Also, we work with participants who are aging or physically disabled who are receiving this service. The importance of the support for community membership is that, over and over again, we see that people with strong family and/or community support have better quality services, often need fewer services than those without natural support and often cost less to serve. With limited assistance for community membership, which is what the 1115 demonstration waiver will provide, people will be isolated in their homes resulting in all of the negative effects associated with this kind of isolation – increased dependence, poor health, increased mental health issues, higher mortality.	

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Discrimiates against people w/ severe disabilities	New Mexico's 1115 waiver will discriminate against people with more severe disabilities and those that need a higher intensity of service. The Centennial Care plan will not provide in-home, community-based services to people whose long-term services will cost more than a nursing home. Persons who fall into this category will not be able to remain in the community, but will have to be institutionalized, or receive fewer services then they need to be healthy and safe. A better alternative is to require long-term services in the aggregate to cost no more than nursing facilities. In a managed care system, payment for services is based on a per member/per month capitated amount. The MCO provides services for all its members from the aggregate of the per member/per month fees. Some will cost more, some will cost less. It should be up to the MCOs to manage the cost of long-term services within the capitated payments it receives and these services should meet the needs of each member and be provided in their homes and communities. In any population of people receiving long-term services, there will be a small number whose needs are extensive and will require a greater intensity of services at a greater cost. This can be and should be manageable in a managed care environment.	2012-10-04 12:07
Dont try to fix anything that needs no fixing. I think this upcoming new waiver is a terrible idea, Which will cause program centered supwel	Dont try to fix what doesnt need fixing. Youll send us back to the horiffic institutionalized/ dark ages methodology. Our current waiver gives indiduals an actual life. It is life which brings on the problems. Our current waiver is person centered and will improve. Give us a chance to prove that weve moved foward so-much. Do not start tieing up a noose on our best ideal waiver. Just let us be please! I understand our country's deficit has much to do with this disasterous change of waiver. but dont take it out on us, giver us less budget alotment, but please dont cut us. Pleople will die from a program centered environment. Ohh, have you tested this on chimps ,or lab ratys? Bet they didnt survive long, did they?	2012-10-02 16:17
Don't force people to change providers if their present ones are helping a lot! The uncertainty of all this change is horrible for us.	We need to know now if our daughter's present providers will continue under this new system. Otherwise we are thrown into turmoil yet again and it is terrible for a person with autism, o/cd, anxiety, depression, mr, bipolar disorder etc. The State is playing with fire but it is families and individuals who will pay the price	2012-09-30 08:50
PROTECT DUAL ELIGIBLES FROM CENTENNIAL CARE	Dual Eligibles ["Duals"] are beneficiaries who have both Medicare and Medicaid coverage. As a group they have disproportionately greater, and more chronic, impairments than Medicare or Medicaid beneficiaries generally. Section 2602 of the Affordable Care Act specifically and specially called for improving Duals' access to services, care integration, continuity, transitions, and understanding of coverage rights. Yet rather than honor that provision HSD has insisted on lumping 40,000 New Mexico Duals into Centennial Care, where they will comprise less than 10% of the enrollee population. The Mandy Pino Center believes Duals should not be required to enroll in Centennial Care. There are significant differences between their needs and rights. and those of other proposed Centennial Care enrollees, regarding critical matters including care coordination, enrollment and disenrollment, opt-out, free choice of providers, services coverage, co-pays, providers, transitions care, educational needs, and enrollment assistance. Regarding	2012-09-25 17:10

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	care coordination --- said to be a central pillar of Centennial Care --- the needs of Duals will be both quantitatively greater (as HSD has acknowledged); and qualitatively different, since it involves coordinating benefits under two separate programs. Because of Duals' comparatively small numbers, the large overall caseloads care coordinators will have, and the broad educational campaigns promised for Centennial Care generally, there is a likelihood of diminished implementation of Duals' special rights and interests, a drowning out of the separate information they need, and possible cost shifting (including of Medicare dollars) to in effect subsidize the services, care coordination, and educational activities for other enrollees. Moreover, having a single system in which different beneficiaries have different rights, procedures, and needs for information is a recipe for confusion for beneficiaries, caregivers, MCOs, care coordinators, and providers alike. HSD's original and revised §1115Applications for Centennial Care have said virtually nothing about how the rights and interests of Duals will be specially protected. Yet in the agency's separate Proposal to participate in the CMS Financial Alignment Initiative which focuses on Duals --- which was subsequently abandoned --- HSD itself expressed concern that absent that Proposal they would not be doing enough to address the special needs of Duals even under Centennial Care! Rather than include any special protections for Duals, HSD's revised Application cryptically asserts --- for the first time, without prior notice, explanation, or opportunity for comment --- that it plans to require all Centennial Care MCOs to be or become statewide Medicare "Special Needs Plans (SNPs)" or "Medicare Advantage" plans! Apart from failing to provide any clarity for this new approach, HSD's has inexplicably decided that the more than 90% of Centennial Care enrollees who don't have Medicare will have to join MCOs governed in significant part by Medicare rules and policies. This new approach fails to address any of the problems discussed above, but may cause new confusion for everyone else. It should be rejected. Special protections for Duals are indispensable, and can be best provided in a system established specifically for Duals (such as enhancing HSD's current CoLTS system).	
Protect Behavioral Health Care Dollars	Youth Development, Inc. (YDI) supports specific language to protect behavioral health care dollars. We believe that language should be inserted to ensure that behavioral health funding is not "subsumed" by primary health. We agree with concerns that emerged in 2011 by the New Mexico Behavioral Health Expert Panel, including 50 behavioral health state experts, that "behavioral health funding and accountability for this funding must be tracked separately and not co-mingled with funding for physical health." The panel said that we must "maximize dollars to consumers (services) and minimize dollars for administration." Finally, "dollars saved through efficiencies need to go back into the system to build additional services for consumers and families." (See "white paper" at http://www.cbhtr.org/bhept) Under the "carve in" envisioned by Centennial Care, funds for physical and behavioral health care will be managed together. If a change must occur in	2012-09-19 14:50

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	the current “carve out” program, our preference is for what the panel termed a "hybrid-carve in" that it says would provide for the following: • “MCO(s) manage both behavioral health and physical health funds, with special condition in place to protect and promote the development of behavioral healthcare and the integration of behavioral healthcare and physical healthcare • A more permeable line that allows tracked funds to flow between BH and PC to support health needs of people with mental illness and BH needs of people with medical conditions • Funds for behavioral health services would be tracked and accounted for separately from funding for physical health • Could have multiple MCOs, as well as regional components • The Behavioral Health Collaborative would still sign the contract and have oversight of the implementation of the Behavioral Health components of the contract(s), as well as track outcomes, integration, efficiencies, etc.” • Under the “hybrid-carve in,” the panel said that the following would occur: • “Separate per member per month rate for behavioral health • Requirement that MCO(s) contract directly with New Mexico providers/provider networks • Requirement that behavioral health savings be tracked and reinvested into BH system.” In a recent presentation of the panel’s recommendations before the New Mexico Legislature’s Behavioral Health Subcommittee, Dr. Steven Adelsheim spoke to the issue of how to build an integrated care model that supports a strong behavioral health system (http://www.nmlegis.gov/lcs/handouts/BHS%20090712%20Four%20Quadrant%20Model%20for%20Behavioral%20Health%20Integration.pdf). He presented important information on the relationship between mental and physical health, noting that there are higher medical costs, for example, for people who have chronic illnesses and untreated depression. Our position is that a “hybrid-carve in” model will further the goal of creating an integrated care model that would better link behavioral health with primary care. Dr. Adelsheim’s presentation included that the strongest protection for behavioral health care dollars is through the “carve-out” model and that under “carve in,” as proposed under Centennial Care, behavioral health care dollars would be difficult to track and manage. Our belief is that the “hybrid-carve in” model will allow for behavioral health care dollars to be tracked separately while fulfilling the goal of an integrated care model. YDI, founded in 1971 and based in Albuquerque, is a nationally recognized youth service organization that provides educational, developmental and humanitarian assistance to children, youth and families in central, northern and southern New Mexico. YDI’s Prevention, Intervention and Treatment Division (PIT) provides services for children, youth, adults and families to stay healthy, to teach them life skills and to have a safe living environment. Program activities are delivered in a variety of settings, including school classrooms, community centers and churches, in the family home, group	

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	homes, on the streets and out in the community. Services are available to both Medicaid and non-Medicaid clients. In addition, YDI is implementing the Elev8 full-service community schools' initiative. Four of Elev8 New Mexico's five schools have school-based health centers that provide primary and behavioral health care. More than 50% of visits to the centers are for behavioral health care, which is a strong need in all of New Mexico's schools.	
Expand access to long term services but don't put an arbitrary cap on benefits	Disability Rights New Mexico (DRNM) supports the proposed expansion of access to long term services without having to be in a waiver slot, but we believe that limiting community-based services to no more than the cost of nursing home placement violates the Americans with Disabilities Act (ADA). The state's proposal allows all income-eligible Medicaid participants who meet the nursing home level of care to access a wide variety of community-based services, most of which are now available only to those in the Disabled and Elderly (CoLTS) waiver program. These services include assisted living, employment supports, emergency response, environmental modifications, skilled maintenance therapy and many others that enable people with disabilities to live independent and integrated lives in their communities. There are around 17,000 people on the current waiting list for these services, and many of them are (or will be) income eligible for Medicaid and will gain access to these "waiver" services. The state's proposal will greatly expand access to these needed services and DRNM supports this plan. However, the proposal limits the amount that can be spent on community-based services for an individual to the cost of nursing home care. This is a change from the state's current approach that allows some individuals to receive higher cost services so long as the waiver program as a whole remains cost effective. The proposed approach discriminates against persons who have more severe disabilities and need more extensive services; it provides no option for them to benefit from the program and to be served in the most integrated setting. As a result they are likely to be placed in a nursing home. Failure to modify program policies as needed on an individual basis to assure equal opportunity to benefit and to receive services in the most integrated setting appears to be a violation of the ADA. "Centennial Care" will be a capitated managed care system, in which each Managed Care Organization will receive a certain payment amount each month for each member. The cost of services for most Medicaid recipients will be less than the monthly payment, and for some it will be more, but the MCO must provide the Medicaid services that each person needs. The state pays the same amount whether the person is served in a nursing home or in the community, so the state does not need to impose a spending cap that will exclude certain individuals from community-based services. CMS should approve the expansion of access to community-based services but reject the across-the-board spending limitation, or at least require the state to provide an exception process so that those who need a higher level of service have an opportunity to receive the level of services that they need in the community.	2012-09-18 17:17
Fees for emergency room use harm low income families	The New Mexico Center on Law and Poverty remains very concerned with the state's plan to impose fees on Medicaid beneficiaries for non-	2012-09-14 12:37

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	emergency use of the ER. This proposal fails to satisfy either the legal or policy goals of a Section 1115 waiver. First, the state intends to seek a waiver that exceeds federally permissible limits for children and adults between 100% and 150% FPL. Second, the state's proposal fails to meet the requirements of Section 1916(f) of Title XIX of the Social Security Act, which permits exemptions to Medicaid cost-sharing protections for individuals over 100% FPL only if they demonstrate a unique and untested use of co-payments; are limited to two years or less; will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients; and are voluntary or make provisions for assumption of liability for preventable damage to the health of beneficiaries resulting from involuntary participation. New Mexico's request on its face clearly does not meet any of these requirements. This is not a unique and untested proposal. Over 35 years of research has proven that the imposition of co-pays cause beneficiaries to delay or forsake access to both necessary and unnecessary care. The state has recognized the harms of imposing cost-sharing in the past and actually chose not to implement a state law in 2009 that would have these very same co-pays on non-emergency uses of the emergency room. Also, nothing in the state's waiver application limits this part of the demonstration to two years, indicates that these fees are voluntary, or offers a remedy for beneficiaries who were deterred from care and suffered adverse health consequences due to these mandatory fees. Furthermore, HSD has failed to provide any information about the causes of emergency room use, severity of the problem, or costs to justify this proposal in New Mexico. Without more specific data to understand the reasons why people use emergency rooms for non-emergent situations, HSD cannot identify a problem or show that implementing these fees will solve the problem. Therefore, the risks to recipients from this proposal have been clearly demonstrated without any evidence of medical benefit. This proposal fails to meet the legal standards required by Section 1916(f) and must be denied on these grounds. Third, New Mexico's proposal for cost-sharing likely violates federal law which requires that before an individual can be charged co-pays, a provider must "inform the individual of the name and location of an actually available and accessible alternative non-emergency services provider that charges only a nominal copayment." Accessible and available alternative sources of non-emergency sources do not exist in most of New Mexico, particularly in rural and frontier areas. The State of New Mexico Health Policy Commission reported in January 2011 that 32 of 33 NM counties have been federally designated as Health Professions Shortage Areas, Medically Underserved Areas or Populations. New Mexico ranks 49th out of 50 states for dentists per capita, and we are short 400 to 600 full time primary care physicians. Our current nursing shortage of 1,000 is expected to triple to 2,800 by 2015. In conclusion, we see no research or demonstration value in assessing fees for non-emergency use of the emergency room when alternatives are clearly not available. The application fails to meet the legal requirements of the SSA, and is contrary to the objectives of the Medicaid Act to serve the best interests of recipients and ensure access to care. Using waiver authority to fund emergency room diversion programs and to enhance	

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	transportation services is a far wiser choice than penalizing New Mexicans for lack of access to providers. We respectfully ask your agency to reject this proposal.	
New Mexico families and children with autism are faced with a lack of timely diagnosis.	The State needs to fund autism providers outside of UNM who are qualified to conduct diagnostic evaluations. Families are currently waiting from 9 months to over a year to get a diagnosis.	2012-09-12 17:54
Develop, Implement, and Expand services for persons with autism spectrum disorder	Expand applied behavioral analysis benefits to children with autism from ages 0-8. Develop services within behavioral health to meet the needs of older children with autism Develop services within behavioral health to meet the needs of adults who are not eligible for the DD Waiver Expand Comprehensive Community Support Services to include children and adults with autism Develop health homes for individuals with autism and challenging behaviors	2012-09-11 10:39
Consistency in administrative processes	The New Mexico Youth Provider Alliance (NMYPA) is the largest organization of behavioral health agencies in the State. The NMYPA is a non-profit advocacy organization, comprised of 37 member agencies across New Mexico, serving over sixty thousand children and families a year. Our organization advocates on behalf of our members, and thousands of New Mexican children and families. Our member agencies serve many of the most vulnerable children and families in the State, including families dealing with mental health, substance abuse, and the effects of physical abuse and neglect. Our member agencies collectively employ five thousand (5000) New Mexicans each year, in providing critical behavioral health and social services to our clients. The combined budgets of our member agencies represent two hundred million dollars/annually ($200M), a significant and important piece of the New Mexican economy the vast majority of which is spent or re-invested in our local communities. The NMYPA has been a vocal advocate since its founding, and has been an especially critical component of the Behavioral Health system over the past five years. In the State's dealings with Value Options and Optumhealth, the NMYPA's input has had significant influence. In the State's endeavors to transform our behavioral health system, the NMYPA is a crucial player, as our members are the agencies providing the bulk of the behavioral health services in our state. The NMYPA's members and leaders serve on the New Mexico Behavioral Health Planning Council, the Optumhealth Provider Council, and almost every other governing or advisory body related to behavioral health in New Mexico. The members of the NMYPA, and the children, families and adults we serve, have weathered multiple significant transitions and changes to our system of care. Across these multiple transitions, we have garnered significant information about the problems and pitfalls that can occur during such transitions. We offer this information and recommendations with the intent of ensuring that services to our clients remain stable, reliable and	2012-09-07 15:10

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	reimbursed, in order to prevent the chances of disruption that might significantly impact the lives of these individuals. As the State of New Mexico moves forward with intent to again redesign the New Mexico Medicaid system, submitting an 1115 waiver to CMS, the members and Board of Directors of the NMYPA respectfully submit the following recommendations: • Elimination of retroactive eligibility The NMYPA strongly opposes this component of the Waiver application. It is viewed as having a significant negative impact consumers in ease of accessing needed services and on providers in terms of receiving reimbursement for services legitimately provided to Medicaid-eligible clients in need; • Administrative consistency across MCOs The NMYPA requests that the MCO's contracted by the State should have consistency in administrative processes, to reduce administrative burden on service providers. This consistency should require uniformity in contracting processes, authorization forms and processes, appeals and grievance processes and credentialing processes. • MCO subcontracting with local provider networks The NMYPA requests that the State be required to issue clarification and specific definition of 1115 waiver application language for "qualified core service provider networks." This concept is not clear, and poses significant potential for dramatic change and disruption of services of services if implemented differently between MCO's, or if implemented by the State without clear definitions and expectations. • Payment options such as capitation, case rates, PMPM The NMYPA requests that the State be required to make public specific information on the forms of payment to providers that are being considered by the State or MCOs, and to participate in such discussions before final determinations are made. • Tribal Choice The NMYPA strongly supports that Native Americans should continue to be offered choice in their participation in managed Medicaid. • Value Added Service For the duration of the BH Collaborative process, and the previous Medicaid waiver issued to the State, significant services within the behavioral health system of care have been supported through contractually-required "Value-Added Services," funded by the contracted Statewide Entity. As the State moves forward in Centennial Care, there is no information regarding this funding stream, and the services it supports. The NMYPA requests that the State be required to provide definitive clarification on the status of Value Added Services prior to implementation of Centennial Care, with a transparent, adequate planning process to address the changes to these services and the clients who receive them. • Appeals Process The NMYPA requests that the State be required to standardize the behavioral health appeals process in the contracted MCO's. Throughout the past decade, NMYPA members have experienced tremendous administrative burden and reimbursement obstacles as they attempt to navigate an arbitrary and ineffective appeals and grievance process	

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	around negative authorization decisions. As administrative burden has increased since 2005, and there has been an increase in the management of authorization of intensive behavioral services, the appeals and grievance process has become increasingly critical. Requested changes to this process would include specific, contractually-determined appeals and grievances processes that are uniform across MCO's and that cannot be changed without a clear due process. Additional changes would include specific roles and protections of the rights of providers in the appeals process, as well as the rights of members; clear separation of the authorizing entity/individual from the appeals entity/individual; and enforcement and monitoring of timely appeals resolution. • External Monitors The State should be required by CMS to have an external contractor monitoring the readiness review process and the implementation period. We have substantial evidence of weaknesses in the readiness review process, and in contract compliance/implementation monitoring. Both managed care and State are understandably invested in seeing this process as ready and working, and thus may be naturally resistant to recognizing/acknowledging problems. With both Value Options and Optum, the State had to bring in external monitors (Parker Dennison and Alicia Smith) on multiple occasions, to verify providers' reports of payment problems. We request that the State be required to have such external monitoring in place in advance, to prevent extended periods of payment problems and to monitor the administrative reconciliation process during implementation. The contracted external monitors should also be tasked with monitoring the appeals and grievance process for a period of not less than six months from the beginning of Centennial Care. • Data Transparency From 1999 to 2005, the State was required to post "Early Warning System" data publicly, regarding the health of the BH system under managed care. This data included quarterly reports on BH utilization, authorizations, denials and critical incidents. This data was a way in which the community and external groups could assess and monitor the health of the BH system, based on objective data, across the managed care organizations. Such data is currently reported to the BH Collaborative, but has not been made publicly available. Frequent and repeated requests for data by providers, consumer advocates and even legislators transparency have been unsuccessful. As part of the transition to Centennial Care, the State should renew publication of data and information about the functioning of the BH system. • Hold Harmless Period The State should again require a "hold-harmless" period on the BH system, as they did in the Value Options (2005) transition. Such a requirement would restrict MCO's from making precipitous changes to codes, processes, rates, etc. during the transition/implementation period. During previous transitions, this hold-harmless period was successful in mitigating very serious and damaging changes to the fragile BH system. Respectfully submitted, on the behalf of the NMYPA ,	

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	____________________________ ____________________________ Nancy Jo Archer Margaret McCowen Co-Chair Co-Chair	

Section 1115 Demonstrations: New Mexico Centennial Care - New 1115 Demonstration Request

Public Comments

Title	Description	Created At
Mi Via EBT Card	Managed Care Organizations do little but take money out of the state and create problems for individuals on the waivers. There should be an Mi Via EBT card developed for Mi Via participants to access their annual budgets. This would help Mi Via participants (especially brain injured people) to have better control of their budgets and create the self-direction Mi Via is suppose to be. This would cut down and stress and anxiety for Mi Via participants with brain injuries and help them become more responsible for themselves. Under the current model there is no way the participant can direct their services because of the process participants must go through after their budget is approved. Once participant's budgets are approved the MI Via EBT card would have their annual budget items on it to access their goods and services. This would cut out one of the major problems people with brain injuries encounter with their budgets: Xerox! This would save money and the headaches people with brain injuries face on a regular basis on the Mi Via waiver.	2012-06-05 13:42
SAVE WAIVER AS IS – NO CHANGES It greatly helps my child with disabilities and thousands of others. Proposed changes would destroy its abi	SAVE WAIVER AS IS – NO CHANGES It greatly helps my child with disabilities and thousands of others. Proposed changes would destroy its ability to provide the nursing home level of 24/7 individualized care that my son and others require in their safe homes and families. Family members caring for the disabled are much cheaper and more effective than expensive, abusive institutions. Protect our loved ones and save money	2012-06-05 12:57
SAVE WAIVER AS IS – NO CHANGES It greatly helps my child with disabilities and thousands of others. Proposed changes would destroy its abi	SAVE WAIVER AS IS – NO CHANGES It greatly helps my child with disabilities and thousands of others. Proposed changes would destroy its ability to provide the extreme, Level 5, 24/7 individualized care that my son and others require in their safe homes and families. Family members caring for the disabled are much cheaper and more effective than expensive, abusive institutions. Protect our loved ones and save money!	2012-06-05 12:44
Correction about "don't approve waiver for self-direction"	The comment titled: Don't approve waiver for self-direction" can be easily miss-understood. It means that I am asking CMS to not allow NM to be able to waive the rules for self-direction. If the state is allowed to waive self-direction, it means that the MCOs do not have to offer self-direction or if they do provide self-direction, the MCOs would not have to abide by the CMS rules for self-directed programs. Without these rules, self-direction could be anything the MCOs want it to be.	2012-06-05 10:39
It is essential for behavioral health dollars to be clearly delineated	New Mexico's behavioral health system is close to collapse. CMS must require any new system to dedicate specified amounts of money for behavioral health care. The current proposal will allow HSD's chosen contractors to bleed off dollars needed for behavioral health services into medical/surgical services.	2012-06-05 07:53
Don't approve waiver for self-direction	The Centennial Care waiver requests a waiver for self-direction. At the same time, the state maintains that it will provide the opportunity for self-direction. New Mexico needs the protection of CMS's self-direction requirements. We need to make sure that self-direction in Centennial Care provides person centered planning and a system of assistance in support of self-direction. Please don't approve a waiver of self-direction.	2012-06-05 06:42

Title	Description	Created At
Comparatively low cost for the giant steps of health afforded each participant	On NM Mi Via needs of the client are met and paid at the lowest cost when written by client who understands their challenges and disabilities from a lifetime of experience a corporate employee can never fathom. This allows an individualized treatment program that can pinpoint a client's problems in the most cost and behaviorally effective way. The proposed "Centennial" waver would change the focus from individual service to the greatest number served and eventually result in huge sums of money going to the corporations and nursing homes, thus providing substandard care. Once again cut off from Society, our most vulnerable population of depressed, disabled people will flood nursing homes, and increased medical costs will overtax an already overburdened system at the expense of the people New Mexico claims it wants to "help". number served wi	2012-06-05 02:56
Please do not include MiVia in Centennial Care...	Please leave MiVia, New Mexico's Self Directed Waiver program out of Centennial Care. My son is a participant in MiVia and it has increased his happiness, his safety, his health, and his general well-being in the following ways: allows him to live in his family home, allows caregivers who know him (parents and a caregiver of 13 years) to monitor his health and special medical needs, allows freedom from institutional schedules that dictate mealtime, bedtime, and leisure activities. Self-Direction may not be for everyone, but, it definitely fits certain conditions in our society where traditional delivery methods do not work. The use of consultants and natural community supports are already in place with MiVia. Participants are allowed and encouraged to rely on self, family, and friends, when appropriate.	2012-06-04 22:36
MANAGED CARE IS NEVER PERSON CENTERED AND ALWAYS MISMANAGED !	Out families idea is to continue and strengthen the supports provided by the Mi-Via program. We need to continue to allow individuals and families to work to provide supports that allow us to individualize for the unique circumstances of each person. NO managed care can do this, it is at best cookie cutter nonsense that supports easy facilitation for the staff and expensive layers of management that encourages "cover you ***" services and "oversight" that stifles creativity and self management. We strongly object to ending Mi-Via as we have seen tremendous progress for our three children who are medically fragile.	2012-06-04 16:41
One size does NOT fit all	"Each of the new MCOs would be responsible for administering the full range of Medicaid services – physical health, behavioral health, and long-term services and supports – for everyone from newborns to seniors." I suspect this will be difficult to maintain efficiently, and in an individualized way. Currently, the method of assessing necessary hours is inadequate for many who require full care. Be VERY careful or expensive hospital and nursing home admissions are inevitable.	2012-06-04 15:37
Our family believes self-direction is a crucial civil right for people with disabilities	Please maintain and strengthen Mi Via as an effective self-directed services delivery system for eligible New Mexicans. Exempt it from the 1115 Waiver. We believe that it the civil right of people with disabilities to direct their own services. The creation and implementation of Mi Via in NM represented the best coming-together of a wide range of organizations in	2012-06-04 13:02

Title	Description	Created At
	support of people with disabilities. Our son benefits greatly from Mi Via, and is learning to be more responsible for and independent in his own care decisions. He is able to receive services and equipment that keeps him healthy and out of the hospital. For example, this year he bought an adapted tricycle which has greatly increased his range of motion, leg and trunk stability and head control, as well as expanded his social connections because he joined a bike team. This self-directed equipment choice has eliminated the need for expensive, painful surgery to alleviate contractions, reduced his need for laxative medications and increased his connections to his community. Even under the current Mi Via, we had to appeal the denial of the trike. Under an MCO, we could not have purchased it. Please do not force us to return to the huge, managed-care warehouse model we created Mi Via to escape!!!	
TBI's need the Mi Via Waiver to continue self planning personal and effective medical and cognitive therapies for improved quality of life.	Self directing, while at times difficult and frustrating, is finally working for me. I have multiple traumatic brain injuries and need some help to utilize the Mi Via Waiver Program; however, I do manage my own program and have a much improved quality of life since being accepted into Mi Via a few years ago. When I can tell my family and friends that, "Life is Good", it seems no less than a miracle to us all. Mi Via Self Directed Waiver is finally working for all involved == and now you want to eliminate it. Please keep Mi Via intact. It is actually working for the participants now.	2012-06-04 11:44
Centennial Care will end self direction in New Mexico	I have worked in Mi Via, New Mexico's Self Directed Waiver in one way or other since it began. New Mexico's current 1115 Waiver applicaiton will effectively end self direction for New Mexican and replace it with a managed care system that will not meet their needs. New Mexico has been doing "managed care" for several years, which has saved money by not providing services. Coordinators are not available, there are long waits on "hold", there are not "call-backs." How will "robust coordination" be better? While the application professes support of self-determination, it ask for a waiver of CMS rules for Self-Determination. Are we to believe that MCOs will provide self-determination without direction from CMS? In fact the goal of this application is to effectively end participant deligated services and replace them with a system where decisions about care and support will be made without participant input or consent. This will result in a system that will be cheap, only marginally meet the needs of its members (if at all) and only enrich large corporate interests (MCOs).	2012-06-04 11:24
Innovation and self direction are victims of NM Centennial Care program	Support innovation by keeping Mi Via the way it is. Don't include it in the Centennial Care waiver.	2012-06-04 06:19
MCOs can't self-direct I am a Mi Via consultant for New Mexico's self-directed waiver program, known as Mi Via. My comments will address t	MCOs can't self-direct I am a Mi Via consultant for New Mexico's self-directed waiver program, known as Mi Via. My comments will address the state's plans for self-direction in its 1115 waiver application. Mi Via was developed using the best thinking and best practices in self-direction. As such, it is to be expected that the outcomes of Mi Via are similar to the findings from program evaluations of self-directed projects that were funded by the Robert Wood Johnson Foundation in the 1990's and early 2000's. The findings from these initial program evaluations include: • Participants experience better quality services;	2012-06-03 15:40

Title	Description	Created At
	• Participants were more satisfied with their services and their lives; • Self-directed services were cost effectiveness; • Traditional case managers and service coordinators were a barrier to self-direction; • Assistance to support self-direction is best when independent from traditional long-term care programs; New Mexico has never done a program evaluation of Mi Via to determine if the outcomes of self-direction are comparable to the findings of the evaluation of the initial self-directed projects. Without any data to the contrary, it can be expected that Mi Via outcomes would be similar to those of these initial self-direction projects. The state is proposing to eliminate one of the Mi Via waivers without any idea if Mi Via is effective in meeting the state's proclaimed objectives. The Centennial Care plan proposes to offer self-direction. However, the state's proposal will eliminate some of the services that participants can self-direct in Mi Via; put arbitrary caps on the purchase of related goods; use service coordinators to assist those who choose self-direction; and restrict self-direction to those it deems capable of self-directing. I am asking CMS to either require New Mexico to continue the nursing facility Mi Via waiver as a separate program or require the current Mi Via regulations, standards, policies and practices be incorporated in the MCO Centennial Care programs. I am asking CMS to not allow caps on any goods or services that can be purchased through self-direction. The state is proposing a $500 limit on related goods. This is a totally arbitrary number and has no basis in any data about utilization or the relationship between the purchase of related goods to improving service quality. I am asking CMS to require the state to establish an independent system of assistance to support self-direction. Traditional service coordinators and case managers in New Mexico discourage people from Mi Via and don't understand self-direction. I am asking CMS to require the state to explain how self-direction will be based on person centered planning. I am asking CMS to assure that the state will provide access to self-direction for all otherwise eligible Medicaid recipients and to assure that the state does not use intellectual or cognitive impairments as a basis for denying self-direction.	
I am a Mi Via consultant for New Mexico's self-directed waiver program, known as Mi Via. My comments will address the state's plans for sel	I have a story to tell about self-direction by MCOs. My mother and uncle live in AZ, ages 88 and 86, and both are receiving self-directed attendant care through the state's 1115 waiver. They chose to self-direct so they could hire the caregivers they wanted. Both have a degree of dementia. Our family has a strong commitment to making sure they live at home and enjoy a good quality of life. The self-directed attendant care services are working nicely. They are both assisted in self-direction by the family. AZ has restrictive criteria for self-direction. MCO members must be oriented, demonstrate logical reasoning and be able to direct their care to be eligible to self-direct. Even though my mother and uncle have dementia, they meet the criteria, supported by statements from their PCPs.	2012-06-03 15:37

Title	Description	Created At
	The Case Manager from the MCO recently denied both of them the self-directed option because, "You are not able to hire and train your own attendant. You are not able to set their time and keep track of it. You are not able to send in their time sheets. Your family is doing this for you. We will pay for an attendant (from an agency) to help you with all of the same tasks that your attendant is now doing for you." The CM and her supervisor claimed that a member must be able to do everything without any assistance from anyone or they aren't capable of self-directing. AZ regulations, standards and the self-direction handbook never say that a member must do everything themselves without any assistance from anyone. When I asked the CM for the regulations, standards, policies and/or procedures that support her decision to deny my mother and my uncle the option to self-direct, she said the information was "proprietary." The family filed appeals of these denials with the MCO. The MCO reviewed the appeals and denied them within 5 business days of receiving our request for appeals. The CM who made the denial, her supervisor who helped make the decision to deny and the CM manager for the MCO were the ones who reviewed our appeals. AZ administration code requires that the MCOs provide an appeals process that includes: • The person(s) making the decision to deny cannot be part of the review of the appeal; • The member appealing can request documents from the MCO; • The member appealing can present evidence on their behalf. None of these things happened. The MCO flagrantly abused their power. Even though we pointed this out to the state, the state did nothing. We did request documents from the MCO according to the MCO's instructions. The documents came a week after the MCO made its decision to denial our appeals. When we received the documents, we discovered that the CM contacted the PCPs for my mother and uncle, gave the doctors a questionnaire to complete asking if they could perform certain tasks without assistance from anyone. This little questionnaire was not sanctioned in any way by the state and the CM did not get permission from my mother or uncle to ask their PCPs to complete the questionnaire. This is how self-direction by an MCO works. As regards New Mexico's 1115 waiver application, it is imperative that CMS: • Not allow New Mexico to establish any criteria restricting otherwise eligible Medicaid recipients to choose to self-direct; • Make sure New Mexico has a robust system of assistance in support of self-direction that is independent of the MCO; • Make sure that all MCO service coordinators, even though they won't be assisting people to self-direct, are educated about self-direction and that Mi Via stakeholders assist in educating them; • Make sure that MCO service coordinators provide information about the option to self-direct to all recipients of long-term care services on an annual basis and that they do so in a neutral way; • Make sure that MCO service coordinators never discourage anyone from choosing to self-direct;	

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	• Make sure that the MCOs have an appeals process that: o Doesn't allow the person(s) who made the decision that is being appealed to review the appeal; o Provides the person appealing with a timeframe for requesting documentation from the MOC and for presenting evidence to support their appeal; • Allow the recipient of services to appeal directly to the state for a fair hearing; • Assure the transparency of all MCO's policies and procedures that guide its service delivery and decision-making and that MCOs provide this information upon request by a recipient.	
It isn't clear that people will autism will be included in Centennial Care , that "cost neutrality," could be achieved by creating appropria		2012-06-02 06:23
Create a system of care for individuals with autism spectrum disorders	Individuals with autism spectrum disorders haven't gotten appropriate services in the current NM Medicaid system. 1 in 88 New Mexicans are challenged by a diagnosis of ASD. In order for Centennial Care to meet the needs of this growing population, planning must occur through NM Medicaid for: accessible and reliable diagnosis for people of all ages; appropriate evidence based interventions - including Applied Behavior Analysis as an EPSDT benefit for children, and comprehensive community support services based on level of care for individuals across the life span; Transparent process of substantiating higher levels of care and options for individuals with challenging behavior; In state short term residential placement by facilities who meet established criteria for autism specific expertise; appropriate behavioral health services and supports for families who are challenged by their loved one's autism; Capacity building through the establishment of health homes and person centered wraparound services for individuals with autism and challenging behaviors. The state should specifically name ASD as a diagnosis in the request for proposals from managed care organizations and work to establish physical and behavioral services that meet medical necessity for this unique population.	2012-06-01 11:20
Oppose these proposals that harm low income families	The NM Center on Law and Poverty submits the following comments on the Centennial Care waiver request. While we are pleased with some aspects of the waiver application, we are also seriously concerned about several proposals and respectfully request that they be rejected. 1. Additional co-pays and fees We are very concerned with the state's plan to impose fees on beneficiaries for non emergency use of the ER. This proposal does not promote the objectives of the Medicaid Act-to provide medical assistance to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to increase access to independence and self-care. 35 years of research has demonstrated that co-pays cause people to delay or forsake access to needed care. Beneficiaries made clear to HSD	2012-05-30 14:38

Title	Description	Created At
	at every turn that they can't afford additional cost sharing or co-pays. Individuals who seek care in the ER often truly believe they have emergencies, and shouldn't be deterred from accessing care for fear of having to pay fees that they cannot afford. These fees will be administratively burdensome for the state, and additional cost-sharing could violate federal law requiring that before an individual can be charged co-pays, a provider must "inform the individual of the name and location of an actually available and accessible alternative non-emergency services provider that charges only a nominal copayment." Accessible and available alternative sources of non-emergency sources do not exist in most of NM, particularly in rural and frontier areas. The NM Health Policy Commission reported in January 2011 that 32 of 33 NM counties have been federally designated as Health Professions Shortage Areas, Medically Underserved Areas or Populations. We rank 49th out of 50 states for dentists per capita, and are short 400 to 600 primary care physicians. We see no research or demonstration value in assessing fees when alternatives are clearly not available, and ask your agency to reject this proposal. 2. Elimination of retroactive coverage We are also concerned about the proposal to eliminate the retroactive eligibility for beneficiaries required by the Medicaid Act. There is no indication that this proposal will satisfy the demonstration or research requirements of a Section 1115 waiver or promote the purpose of the Medicaid Act to serve the best interests of recipients. Without this coverage, just one hospitalization could turn into crushing medical debt for a low-income family. Uninsured adults are three times as likely as the insured to have been unable to pay for basic necessities such as housing or food due to medical bills. Furthermore, hospitals frequently charge uninsured patients two to four times what health insurers and public programs pay for hospital services. We do not see what purpose can be served from this proposal aside from saving money in the face of Medicaid expansion under the ACA. When asked why the state had decided to pursue the waiver, HSD responded that since every Medicaid beneficiary will have health insurance in 2014 due to the ACA's individual mandate, retroactive coverage will no longer be necessary. This assumption is flawed because many individuals who will become newly eligible for Medicaid under the ACA may not get coverage immediately. Retroactive coverage also serves as a bridge program for families who frequently "churn" in and out of Medicaid coverage due to administrative barriers and errors that leave them without coverage while an address change has failed to be processed or required paperwork is being gathered and submitted. Eliminating retroactive coverage will have serious consequences, shifting costs to hospitals and low income patients and penalizing low-income New Mexicans for administrative barriers and other errors in the enrollment process that our state still has not addressed. We strongly urge your agency to disapprove this proposal. 3. Lack of Tribal Consultation We urge CMS to consult directly with tribal leadership in NM about this application and provide deference to them when making decisions about approval. ARRA mandates that state plans for Medicaid must involve extensive consultation with tribes and tribal organizations and NM's State-	

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	Tribal Collaboration Act mandates the state to "make a reasonable effort to collaborate with Indian nations, tribes or pueblos in the development and implementation of policies, agreements and programs of the state agency that directly affect American Indians..." As noted by tribal leadership during a meeting with HHS last month, the requirement to "collaborate" implies something more than consultation; HSD should have worked in closer partnership with tribes and pueblos to find areas for mutual agreement and to address any concerns. Native Americans were first informed of the state's intention to seek a waiver of the protections against mandatory managed care at the February 21 presentation of the concept paper- two short months before the final application was submitted. If NM had consulted with tribes before the decision to redesign the Medicaid program was made or had given deference to what input they have received so far, they wouldn't be moving forward with this proposal. Throughout the waiver process, Native American communities have expressed negative experiences with and almost uniform opposition to mandatory managed care and have objected to the elimination of the fee-for-service option. CMS issued guidance to states in July 2001 specifying that "we are encouraging States to be as responsive as possible to the issues and concerns expressed by the Tribes during the consultation process." NM has failed to do so. We stand in agreement with many of our tribes, nations, and pueblos in asking your agency to reject the state's request. Thank you for your time and attention to this important matter.	
Oppose cost sharing and mandatory managed care for Native Americans	The NM Center on Law and Poverty submits the following comments on the Centennial Care waiver request. While we are pleased with some aspects of the waiver application, we are also seriously concerned about several proposals and respectfully request that they be rejected. 1. Additional co-pays and fees We are very concerned with the state's plan to impose fees on beneficiaries for non emergency use of the ER. This proposal does not promote the objectives of the Medicaid Act-to provide medical assistance to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to increase access to independence and self-care. 35 years of research has demonstrated that co-pays cause people to delay or forsake access to needed care. Beneficiaries made clear to HSD at every turn that they can't afford additional cost sharing or co-pays. Individuals who seek care in the ER often truly believe they have emergencies, and shouldn't be deterred from accessing care for fear of having to pay fees that they cannot afford. These fees will be administratively burdensome for the state, and additional cost-sharing could violate federal law requiring that before an individual can be charged co-pays, a provider must "inform the individual of the name and location of an actually available and accessible alternative non-emergency services provider that charges only a nominal copayment." Accessible and available alternative sources of non-emergency sources do not exist in most of NM, particularly in rural and frontier areas. The NM Health Policy Commission reported in January 2011 that 32 of 33 NM counties have been federally designated as Health Professions Shortage	2012-05-29 14:33

Title	Description	Created At
	Areas, Medically Underserved Areas or Populations. We rank 49th out of 50 states for dentists per capita, and are short 400 to 600 primary care physicians. We see no research or demonstration value in assessing fees when alternatives are clearly not available, and ask your agency to reject this proposal. 2. Elimination of retroactive coverage We are also concerned about the proposal to eliminate the retroactive eligibility for beneficiaries required by the Medicaid Act. There is no indication that this proposal will satisfy the demonstration or research requirements of a Section 1115 waiver or promote the purpose of the Medicaid Act to serve the best interests of recipients. Without this coverage, just one hospitalization could turn into crushing medical debt for a low-income family. Uninsured adults are three times as likely as the insured to have been unable to pay for basic necessities such as housing or food due to medical bills. Furthermore, hospitals frequently charge uninsured patients two to four times what health insurers and public programs pay for hospital services. We do not see what purpose can be served from this proposal aside from saving money in the face of Medicaid expansion under the ACA. When asked why the state had decided to pursue the waiver, HSD responded that since every Medicaid beneficiary will have health insurance in 2014 due to the ACA's individual mandate, retroactive coverage will no longer be necessary. This assumption is flawed because many individuals who will become newly eligible for Medicaid under the ACA may not get coverage immediately. Retroactive coverage also serves as a bridge program for families who frequently "churn" in and out of Medicaid coverage due to administrative barriers and errors that leave them without coverage while an address change has failed to be processed or required paperwork is being gathered and submitted. Eliminating retroactive coverage will have serious consequences, shifting costs to hospitals and low income patients and penalizing low-income New Mexicans for administrative barriers and other errors in the enrollment process that our state still has not addressed. We strongly urge your agency to disapprove this proposal. 3. Lack of Tribal Consultation We urge CMS to consult directly with tribal leadership in NM about this application and provide deference to them when making decisions about approval. ARRA mandates that state plans for Medicaid must involve extensive consultation with tribes and tribal organizations and NM's State-Tribal Collaboration Act mandates the state to "make a reasonable effort to collaborate with Indian nations, tribes or pueblos in the development and implementation of policies, agreements and programs of the state agency that directly affect American Indians..." As noted by tribal leadership during a meeting with HHS last month, the requirement to "collaborate" implies something more than consultation; HSD should have worked in closer partnership with tribes and pueblos to	

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	find areas for mutual agreement and to address any concerns. Native Americans were first informed of the state's intention to seek a waiver of the protections against mandatory managed care at the February 21 presentation of the concept paper- two short months before the final application was submitted. If NM had consulted with tribes before the decision to redesign the Medicaid program was made or had given deference to what input they have received so far, they wouldn't be moving forward with this proposal. Throughout the waiver process, Native American communities have expressed negative experiences with and almost uniform opposition to mandatory managed care and have objected to the elimination of the fee-for-service option. CMS issued guidance to states in July 2001 specifying that "we are encouraging States to be as responsive as possible to the issues and concerns expressed by the Tribes during the consultation process." NM has failed to do so. We stand in agreement with many of our tribes, nations, and pueblos in asking your agency to reject the state's request. Thank you for your time and attention to this important matter.	
Family planning post-2014	Planned Parenthood of New Mexico (PPNM) is pleased to submit these comments on the state of New Mexico's request for an 1115 waiver for its Centennial Care program. PPNM is the state's largest provider of reproductive health care services, serving nearly 20,000 women, men, and teens annually at our five health centers throughout the state. Approximately half of PPNM's patient visits are supported by Medicaid, underscoring the crucial role it plays in the lives of our patients. A significant part of the Medicaid safety net for our patients has been the family planning-only expansion that first happened through the 1115 waiver process and has since been converted into a State Plan Amendment (SPA). This expansion allows women and men who do not qualify for full Medicaid benefits to receive a family planning-only benefit package if their income is up to 185% FPL. While the state is not asking for waiver authority – and does not need to do so – to drop the income eligibility level for this benefit package (and other Medicaid limited benefit packages) to 138% FPL in 2014, they are making budget neutrality projections based on this fact (pp. 46-47 of the state's application). PPNM wishes to express our concern to both CMS and the state about the potential implications of this decision, particularly for two populations. The first is women who will receive affordability waivers and be exempt from purchasing coverage in the Exchange. By definition, these women are unable to afford the coverage that is available to them, even with the subsidies for which they are eligible. In a low-income state like NM, unfortunately, there are too many women who will likely fall into this category. Finding a way to maintain some sort of family planning-only benefit for those who are unable to otherwise access affordable coverage is not an ideal solution for all their medical needs, but at least maintains the status quo for those between 139% FPL and 185% FPL who could currently access family planning-only coverage.	2012-05-25 12:31

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	The other group of concern to us is adolescents who are currently able to access confidential family planning-only services under the SPA. This allows for increased access for adolescents to confidential and no-cost family planning services, which is particularly important in NM, a state that has consistently had one of the highest teen pregnancy rates in the country. Against this backdrop, maintaining a family planning-only benefit that adolescents can continue to access confidentially would help assure continuing access to family planning for this vulnerable group. We appreciate the difficult choices that states need to make in this challenging fiscal environment, but we also know that Medicaid family planning expansions are a proven, cost-effective investment, as summarized in an extensive report recently issued by the Guttmacher Institute in December 2011, Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future. We hope that the state and CMS will keep these considerations in mind when making decisions about the Centennial Care waiver and the future of Medicaid and health care reform implementation in the state. Thank you for the opportunity to comment on this important issue.	