2017 Health Law Symposium

Thursday, October 5, 2017

STATE BAR of NEW MEXICO
CENTER FOR LEGAL EDUCATION

CLE Information

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Presenter Biographies

2017 Health Law Symposium

Presenter Biographies

Stefan Chacon is from Taos, New Mexico, and a 2009 graduate of the George Washington University Law School. He is a shareholder at Montgomery & Andrews in Albuquerque, where he serves clients exclusively in the healthcare industry. The majority of Chacon's practice involves the Federal False Claims Act, State fraud statutes, and related compliance and government investigation matters. Chacon also represents his health care clients in employment, administrative, and commercial litigation matters.

Erica Chavez is a staff attorney for Presbyterian Healthcare Services in Albuquerque, New Mexico. Chavez's practice focuses primarily on health payers, plans, and managed care as well as health information and technology. She holds a B.S. in Psychology from Arizona State University and received her J.D. and M.P.H. from the University of Colorado. Upon graduation, Chavez worked in-house for the University of Colorado, where she furthered her interest in health law assisting on projects for the Anschutz Medical Campus. Chavez is a New Mexico native and moved back to Albuquerque in 2015, and prior to joining Presbyterian, she worked as in-house counsel for the University of New Mexico. She is currently the Health Law Section liaison for the Young Lawyers Division of the NM State Bar.

Bryan J. Davis is a partner at Davis & Gilchrist, P.C., in Albuquerque. He earned his B.A. in History, summa cum laude, in 1998, and J.D., cum laude, in 2002 from the University of New Mexico, where he served as Editor-in-Chief of the New Mexico Law Review. Davis is AV-rated by Martindale-Hubbell and a Southwest Super Lawyer in Healthcare law. He defends providers in Medicare/Medicaid fraud investigations and lawsuits by state and federal agencies as well as health plan and governmental overpayment audits. Davis also represents physicians and whistleblowers in disputes with hospitals and other healthcare facilities under the federal False Claims Act, New Mexico Fraud Against Taxpayers Act, and New Mexico Whistleblower Protection Act. He has successfully tried whistleblower and peer review cases in state and federal courts as well as administrative overpayment trials before the Fair Hearings Bureau of the Human Services Department.

Daniel Duhigg, D.O., M.B.A. is board-certified in General Psychiatry and Addiction Psychiatry, and holds an advanced credential in chronic pain management. He is the Medical Director for Addiction Services at Presbyterian Health Services in Albuquerque, New Mexico and Clinical Associate Professor at the University of New Mexico. Duhigg's clinical duties at Presbyterian focus exclusively on patients of all ages living with substance use disorders and he has a special affinity for treating adolescents with substance use disorders.

Jeff Dye is the President and Chief Executive Officer of the New Mexico Hospital Association, representing 45 member hospitals across the state. He is the Chairman of the Board of Directors of Hospital Services Corporation and is regularly involved in legislative and regulatory advocacy at both the federal and state level. Dye worked 26 years in small and rural hospital settings with broad experience in community health planning, hospital operations, legislative initiatives and state and national hospital association governance. He served 18 years as administrator of Socorro General Hospital, and has also filled administrative roles in Lovington and Alamogordo, New Mexico and Laramie, Wyoming. Duhigg holds an MBA from the University of New Mexico. He became a Fellow in the American College of Healthcare Executives in 2007 and achieved the Certified Association Executive (CAE) credential in 2008. Since joining the Association in 2004, Dye has served on numerous boards and taskforces promoting good policy for coverage, Medicaid, trauma care, donor services and workforce enhancement. Dye was honored to receive special recognition as a "Friend of Nursing" at the Nursing Excellence Awards in 2007.

William W. Horton maintains a national practice representing healthcare providers and other business enterprises in mergers, acquisitions and joint ventures, securities and corporate finance law, regulatory compliance, and corporate governance matters. Prior to joining Jones Walker, Horton was a practice group leader at two other Birmingham-based law firms and served as general counsel of one of the nation's largest publicly traded healthcare providers, and currently serves as head of the firm's Birmingham office. With substantial experience both in private practice and as senior legal officer for a large public company, Horton has been involved in complex corporate finance and acquisition transactions in almost all sectors of the healthcare services industry. His background includes representation of issuers in securities offerings and periodic reporting, representation of borrowers in complex financing transactions, counseling healthcare providers on regulatory compliance, and representation of healthcare enterprises, financial services businesses, and other business clients in corporate governance matters, acquisition and divestiture transactions, joint ventures, venture investments, and other business transactions. He also has extensive experience in government and internal investigations. In addition, Horton is a certified mediator for the American Health Lawyers Association Dispute Resolution Service and regularly serves as a hearing officer for medical staff peer review hearings. In addition to his practice, Horton serves as an adjunct professor at the University of Alabama School of Law and as a clinical associate professor at the School of Optometry at the University of Alabama at Birmingham. He has also served as a faculty panelist for George Washington University's Graduate Certificate in Healthcare Corporate Compliance Program since its inception in 2005. He is the founding president of the National Board of Health Lawyers, a specialty certification organization.

David H. Johnson is an attorney at Montgomery and Andrews Law firm. Previously, he was Vice-President and Shareholder at Bannerman & Johnson, P.A., where he represented healthcare providers throughout New Mexico. Prior to that, he was a director and chair of the healthcare business and regulatory group at Rodey, Dickason, Sloan, Akin & Robb. Johnson began his career as a health lawyer in litigation practice, focusing on medical malpractice defense and complex litigation involving ERISA and health care class action lawsuits. He has been a faculty member of the UNM School of Medicine and adjunct faculty at the UNM School of Law, UNM College of Nursing and the Stanford University Primary Care Associate Program. Johnson limits his practice to the representation of healthcare providers in regulatory, operational, transactional, fraud & abuse, and litigation matters. His clients include hospitals, medical groups, ASCs and imaging centers, home care and long term care organizations, as well as individual healthcare professionals.

Patricia Padrino has approximately fourteen years of both civil and criminal litigation experience. Prior to joining the Attorney General's Office in 2009, Padrino worked in the areas of civil litigation, including insurance defense and civil rights litigation. Prior to that, she was a prosecutor for the 13th Judicial District Attorney's Office, prosecuting all types of criminal cases, including sex crimes, property crimes, violent crimes and drug crimes. She has both civil and criminal trial experience, and brought that experience to her position at the Attorney General's Office. Starting out in 2009 as an Assistant Attorney General in the Medicaid Fraud Control Division, Padrino handled many of the Division's larger and more complicated civil and criminal cases. Padrino subsequently became the Director of the Division and has served in that capacity since 2015.

Mary Leto Pareja is an Associate Professor of Law at the University of New Mexico School of Law and has been teaching since 2005. Before joining the academy, she spent almost a decade in private practice, most recently as an equity partner at a large Denver law firm with offices around the world where she specialized in ERISA law. At UNM, Pareja teaches Tax, Health Law, and Torts, as well as supplementing the business law curriculum as needed. She spent five years as the Qualified Tax Expert in UNM's Low Income Taxpayer Clinic. In addition, she regularly travels to Madrid, Spain as part of UNM's Madrid Summer Law Institute, where she teaches Spanish law students about U.S. law and the common law legal system. Pareja's research interests focus on economic justice issues, including asset building, wealth preservation, and retirement and health security for low- and middle-income individuals and communities. She is a graduate of the Georgetown University Law Center and Smith College.

Gabriel Parra is in private practice with the Law Offices of Gabriel M. Parra, LLC, where he practices primarily in the areas of healthcare and business. Parra is a native New Mexican and a graduate of the University of New Mexico Anderson School of Management, 1992 (BBA, Accounting) and the University of New Mexico School of Law, 1995. He was an associate and then shareholder with the Albuquerque law firm of Sutin Thayer & Browne, PC where he practiced in firm's corporate and municipal finance departments. He also worked for nearly 15 years in the legal department at Presbyterian Healthcare Services where he gained significant health law experience, including particular expertise in the areas of insurance, managed care, the Affordable Care Act, the New Mexico Medicaid program and New Mexico's Health Insurance Exchange. He has served on the Board of Directors of the New Mexico Health Insurance Exchange and was a member of the initial Insurance Nominating Committee.

David Roddy, Health Policy Director New Mexico Primary Care Association, has over 40 years of experience in health care finance, administration, and technology. He recently stepped down from the Executive Director's position at NMPCA which he held for 20 years. He previously served as the CFO of a large New Mexico Community Health Center for 15 years, Director of Outpatient Clinics for a 380 bed hospital, and Director of the Health Center Finance Department for the National Association of Community Health Centers. Roddy has had extensive consulting experience primarily assisting community health centers in the areas of finance, operations, managed care, and network development.

Thomas Schripsema, DDS has been a lifelong resident of Albuquerque. After graduating from Manzano High School he went on to receive a B.A. in biology from Calvin College in Grand Rapids, MI and a D.D.S from Creighton University in Omaha, NE. He has maintained a private general practice here in Albuquerque since 1983, while spending some time working as a civilian at Kirtland AFB. He took over as executive director of the New Mexico Dental Association in June of 2016, but continues to practice on a limited part-time basis. Schripsema has been involved in organized dentistry throughout his career and served as president of the Albuquerque District Dental Society, the New Mexico Academy of General Dentistry and the New Mexico Dental Association. He served as that organization's chair of government affairs from 1999 to 2016. Schripsema served as a delegate to the American Dental Association for over 20 years and was a member of the ADA's Council on Dental Benefits Programs from 2002-2006 and the [CDT] Code Revision Committee from 2003-2009. He has authored a number of papers on dental practice and health policy.

Linda Sechovec is a graduate of Drake University who has served as the New Mexico Health Care Association Executive Director for 30 years. She serves on numerous state advisory boards and represents long term care providers before the legislature, regulators, and other collaborative organizations. Sechovec is a past president of the American Health Care Association's Affiliated State Health Care Association Executives group and remains active with her professional organization.

Stephen Stoddard is the Executive Director of the New Mexico Rural Hospital Network.

Howard Thomas is an Albuquerque native; he earned his B.A. at the University of New Mexico, and his J.D. from the UNM School of Law. Thomas has practiced law since 1980. He was in private practice for many years, primarily representing plaintiffs and defendants in civil litigation in areas such as personal injury, wrongful death, insurance bad faith, and engineering and construction. Since 1998, Thomas has been an Assistant U.S. Attorney. For nearly 19 years, he was the Affirmative Civil Enforcement Coordinator and Civil Health Care Fraud Coordinator at the U.S. Attorney's Office for the District of New Mexico. In that capacity, he led a number of healthcare fraud investigations. He has recently transferred to the criminal division, where he prosecutes a variety of Federal criminal cases. He is admitted to practice law in Colorado, the District of Columbia, New Mexico and Texas, as well as before the United States Supreme Court.

Jill Vogel, JD, RN is an attorney at Kreager Mitchell PLLC in San Antonio, Texas with over 30 years of experience in the healthcare industry as an attorney, administrator and registered nurse, including Chief Legal Officer and Interim Chief Nurse Officer of an acute care hospital, Associate General Counsel and Corporate Privacy Officer of a national healthcare system, and a 24-year career in the U.S. Army. Vogel is certified in Health Law by both the New Mexico Board of Legal Specialization and the Texas Board of Legal Specialization. She currently chairs the San Antonio Bar Association's Health Law Section and is the immediate past chair of the State Bar of New Mexico's Health Law Section. Additionally, Vogel is a Certified Information Privacy Professional and serves on UT Health San Antonio's Institutional Review Board.

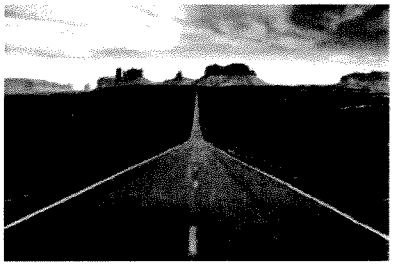
Analyzing and Responding to HIPAA Privacy Breaches, Even When No One is Watching

ANALYZING AND REPORTING HIPAA BREACHES, EVEN WHEN NO ONE IS WATCHING

JILL S. VOGEL, JD, RN

KreagerMitchell

OVERVIEW:



We will discuss:

- HIPAA Breach Notification Rule
- Definitions/Principles
- Risk Assessments
- Breach Notification Process
- Ethical considerations

Congratulations!

You have just been appointed General Hospital's General Counsel and Chief Privacy Officer.

Although the majority of your experience is in corporate law, you have some familiarity with HIPAA and medical records.

Your CEO informs you that one of your major performance goals will be ensuring all employees and contractors comply with HIPAA so the hospital does not experience the breach issues it had under your predecessor.

Your CEO also informs you that the hospital is purchasing a new location in the next few months and as project manager the new hospital will take up the vast majority of your time this year.

You review HIPAA regulations when time permits and learn more about the following:

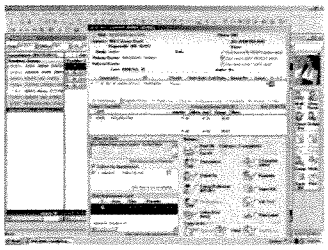
A Few HIPAA Definitions/Principles

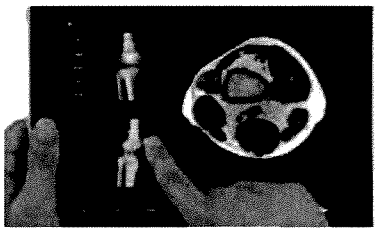
HIPAA Breach Notification Rule

- Requires HIPAA covered entities (CE) and their business associates (BA) to provide notification following a "breach" of "unsecured" Protected Health Information (PHI).

Protected Health Information (PHI)

"Individually identifiable health information" held or transmitted by a CE or its BA **in any form or media**, whether electronic, paper or oral.





Individually Identifiable Health Information

- Information, including demographic data, that relates to
  - The individual's past/present/future physical/mental health/condition
  - The provision of health care to the individual, or
  - The past/present/future payment for the provision of health care to the individual

and identifies the individual or can reasonably be used to identify the individual

De-Identified Health Information

- De-identified health information neither identifies nor provides a reasonable basis to identify an individual.
- No restrictions on the use or disclosure of de-identified health information.

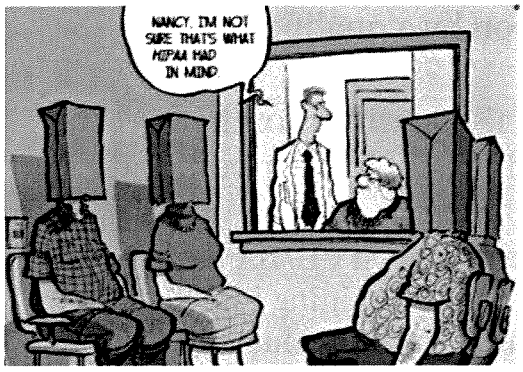
2 Ways to De-identify information

- A formal determination by a qualified statistician or
- Removal of specified 18 identifiers of the individual, relatives, household members and employers
  - This method is adequate only if CE/BA has no actual knowledge that the remaining information could be used to identify the individual.

18 Identifiers

1. Names
2. Geographic subdivision smaller than state
3. All elements of dates directly r/t an individual
4. Telephone numbers
5. Vehicle identification and serial numbers including license plate number
6. Fax numbers
7. Device identifiers and serial numbers
8. Email addresses
9. Web universal resource locators
10. SSN
11. Internet protocol (IP) addresses
12. Medical record number
13. Biometric identifiers including voice and fingerprints
14. Health plan beneficiary numbers
15. Full face photograph and comparable images
16. Account numbers
17. Certificate/license numbers
18. Any other unique identifying number, characteristic or code

De-Identified Health Information



- NOT proper de-identification!

Permitted Uses and Disclosures of PHI

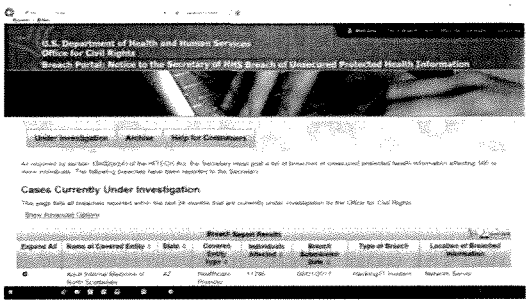
- To the individual;
- For treatment, payment, healthcare operations ("TPO");
- Uses/disclosures with opportunity to agree/object (e.g. facility directory, family/friends);
- Incidental use and disclosure (e.g., public areas)
- Public Interest and Benefit Activities (e.g., law enforcement purposes);
- Limited data set with data agreement (e.g. public health purposes)

Unsecured PHI

- PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary HHS.
  - Note: CE and BA must only provide the required notifications if the breach involves unsecured PHI.

HIPAA "Wall of Shame"

https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf

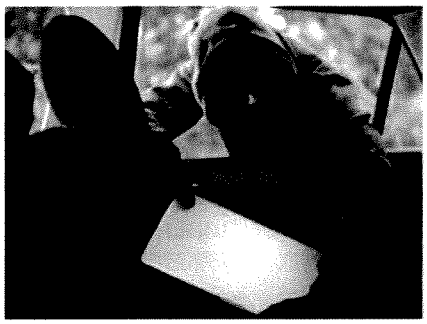


Three months later, a nurse case manager calls you and reports her hospital-issued laptop and a thumb drive were stolen from her car.

She believes the thumb drive contains approximately 500 patient records.

She also believes the thumb drive is password protected per hospital policy.

But she thinks she may have written the password on a sticky note taped to her laptop.



Analyzing and Reporting Suspected Breaches

- Is it a breach?
- Is it reportable?
- To whom?
- Reporting methods?
- Deadlines?

Definition of a Breach

- An impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of PHI.
- An impermissible use or disclosure of PHI is **PRESUMED to be a breach** unless the CE or BA demonstrates that there is a low probability that PHI has been "compromised" based on a four-factor risk assessment.

"Compromise" of Security/Privacy of PHI

Pre-Omnibus Standard	2013 Omnibus Standard
Use/disclosure that poses a **significant risk** of financial, reputational or other harm to the person whose rights were violated.	• Determining whether compromise exists requires a **good faith risk assessment** by the CE that documents consideration of relevant factors in determination. • Notification is **required** unless CE can demonstrate **low probability** that PHI is **compromised** based on risk assessment.

Discretionary Breach Notification

CE and BA have discretion to provide the required breach notifications following an impermissible use or disclosure without performing a risk assessment.

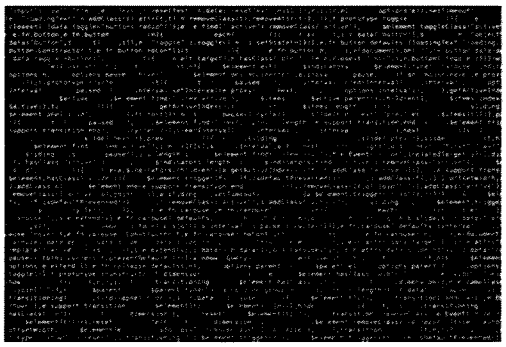
Ethical Considerations

Decision Process for Risk Assessments

1. Is the data PHI?
   - If the data is not PHI, stop here. No further action is needed from a HIPAA breach notification standpoint.
2. Is the data "unsecured PHI"?
   - If you can determine with **complete assurance** the PHI is secured and the method of securing PHI was enabled as of the breach, stop here. Document any remedial actions (training, revised policies, etc.).

Rendering Unsecured PHI Unusable, Unreadable or Indecipherable to Unauthorized Persons

- Encryption
- Destruction (shredding, sanitization)



PHI + unauthorized disclosure = violation

If PHI was acquired/accessed/used/disclosed in a manner not permitted under HIPAA a violation has occurred.

BUT is it a "breach"?

Next Step: Determine and document whether the incident is within one of the three statutory exceptions to the definition of "breach."

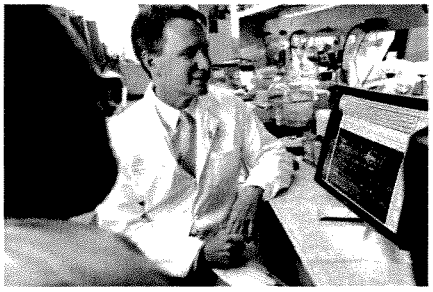
Exception 1:

A. Unintentional access/acquisition/use of PHI by workforce member of CE or BA;
B. In good faith;
C. In scope of work; and
D. No further HIPAA prohibited disclosure.

Exception 2:

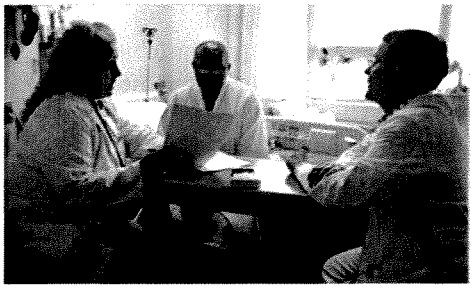
Inadvertent disclosure of PHI by:

A. One workforce member to another at same CE or BA;
B. Both authorized to access information, and
C. No further HIPAA prohibited disclosure.



Exception 3:

Unauthorized disclosure of PHI to an unauthorized person where there is good faith reason to believe recipient would not retain information.

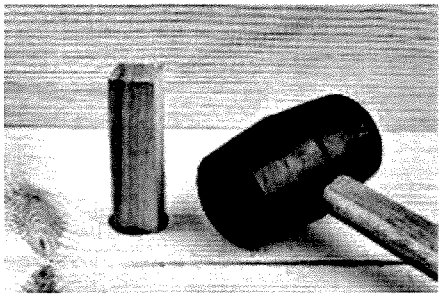


If an exception is met…

- If the event falls into one of these three exceptions, notification is not necessary.
- Document the exception determination and keep for your files.

BUT…

If you find yourself doing this…

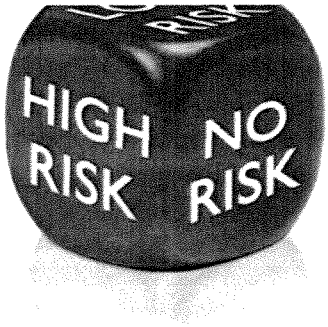


It is time for an integrity check!

Ethical Considerations

- Exceptions leave room for judgment calls
- Pressure to decrease breaches vs. patients' right to know

Risk Assessments



Determining Probability of Compromise

- Scoring Matrix (NIST)
  - **High**: The information more than likely could be impermissibly used or disclosed
  - **Medium**: The information may be impermissibly used or disclosed
  - **Low**: The information has a minimal, rare, or seldom probability of being impermissibly used or disclosed
- Impact Severity Scale (AHIMA)
  - **Severe**: The PHI in question easily identifies the patient and could be impermissibly used or disclosed
  - **Moderate**: The PHI in question has the potential of identifying the patient and the probability of improper use or disclosure is uncertain
  - **Minimal**: The PHI in question may or may not identify the patient; however, satisfactory assurances have been obtained that the information will not be impermissibly used or disclosed

Risk Assessment Factors

1. The **nature and extent** of the PHI involved, including the types of identifiers and likelihood of re-identification;
2. The **unauthorized person** who used the PHI or to whom the disclosure was made;
3. Whether PHI was **actually acquired or viewed**; and
4. The extent to which the risk to the PHI has been **mitigated**.

Risk Assessment Factor #1

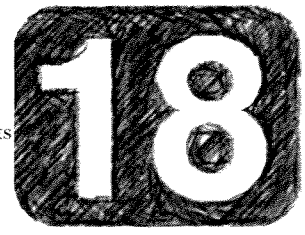
The **nature and extent** of the PHI involved, including the types of identifiers and likelihood of re-identification.

Consider:

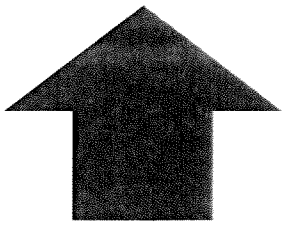
- the sensitivity of the identifiers involved
  - SSN
  - Sensitive diagnosis
- the likelihood of re-identification
- Linkage to other information.

18 Identifiers

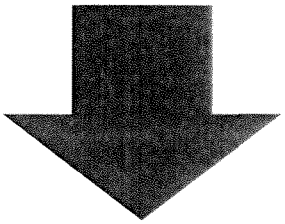
1. Names
2. Geographic subdivision smaller than state
3. All elements of dates directly r/t an individual
4. Telephone numbers
5. Vehicle identification and serial numbers including license plate number
6. Fax numbers
7. Device identifiers and serial numbers
8. Email addresses
9. Web universal resource locators
10. SSN
11. Internet protocol (IP) addresses
12. Medical record number
13. Biometric identifiers including voice and fingerprints
14. Health plan beneficiary numbers
15. Full face photograph and comparable images
16. Account numbers
17. Certificate/license numbers
18. Any other unique identifying number, characteristic or code



Risk Level?



Name
SSN
Diagnosis
Financial Information



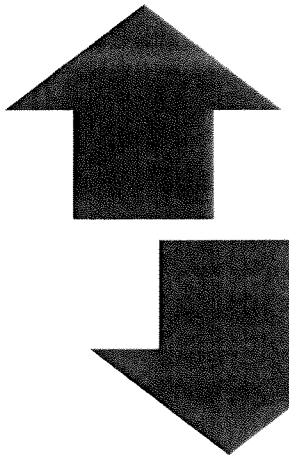
Initials
No SSN
No medical or financial information

Risk Assessment Factor #2

- The **unauthorized person** who used the PHI or to whom the disclosure was made.

- Consider:
  - Does the unauthorized recipient have an obligation to protect the privacy and security of the information?
  - Likelihood of re-identification by unauthorized recipient(s)
  - Motive
  - Demeanor
  - Unintended disclosure vs. seeking out PHI
  - Was PHI taken with intent to use or sell?

Risk Level?

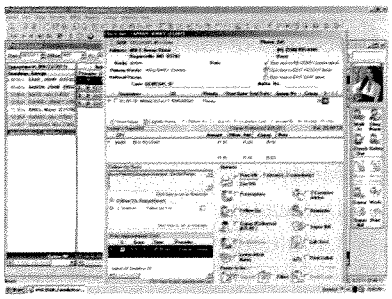


Not in CE or BA workforce
Targeted information
Threatened disclosure

CE/BA workforce
Unintended disclosure

Risk Assessment Factor #3

Whether PHI was **actually acquired or viewed**.



- Consider:
  - Distinction between **actual** acquisition/view of unsecured PHI vs. **opportunity** for acquisition/viewing
  - Can you demonstrate PHI was never accessed/viewed/acquired?

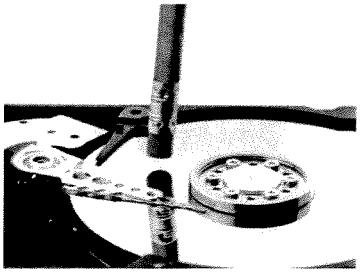
Risk Level?

PHI actually viewed

Can demonstrate PHI not actually viewed

Risk Assessment Factor #4

The extent to which the risk to the PHI has been **mitigated**.

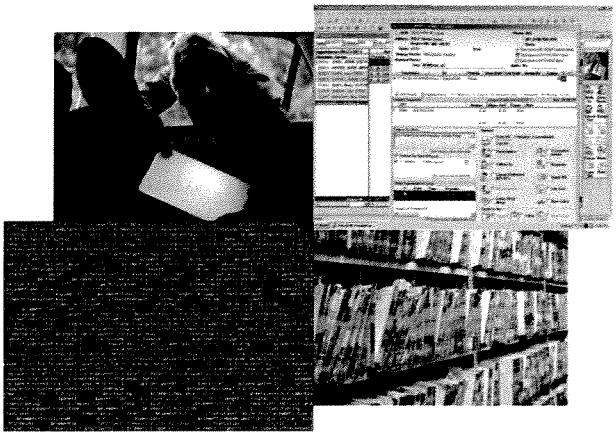


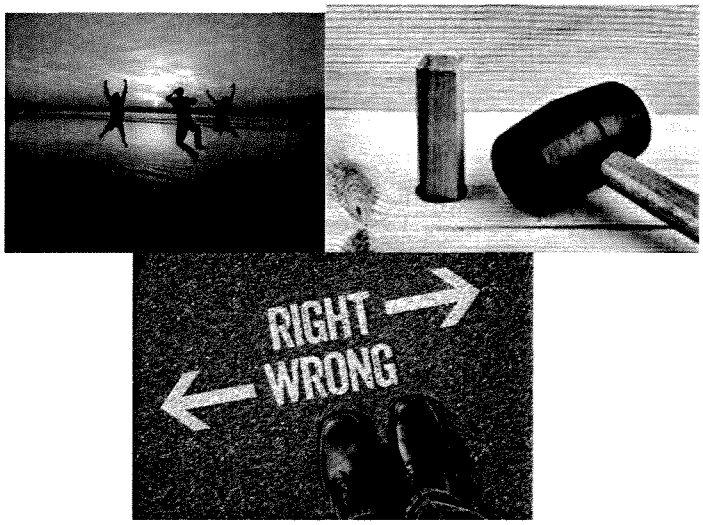
- Consider:
  - Extent and efficacy of the mitigation.
- Examples of mitigation:
  - Recipient's satisfactory assurances that the information will not be further used or disclosed or will be destroyed.

Risk Level?

PHI not returned
Recipient uncooperative

Recipient returns PHI
Recipient gives satisfactory assurances





Breach Notification Requirements

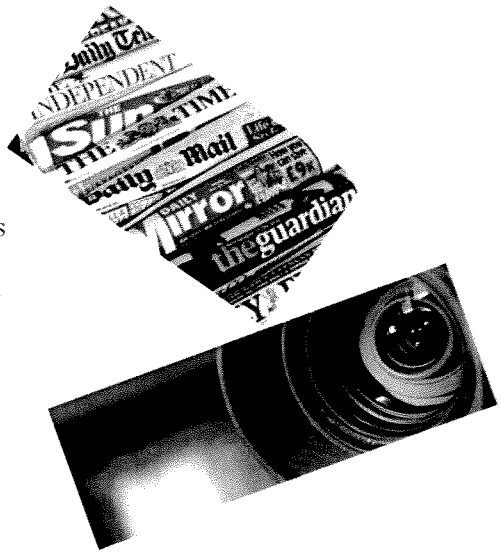
Individual(s)

- Methods
  - Mail
  - Email (if agreed)
  - Substitute Notice
    - Website
    - Media
    - Telephone

- Timing: Within 60 days after discovery
- Content: Describe-
  - Breach
  - Type of information involved
  - Steps individuals should take to protect themselves
  - Steps CE is taking to investigate/mitigate harm/prevent further breaches

Media

- 500+ residents of a state
- Via prominent media outlets
- Press release
- Without unreasonable delay
  - No later than 60 days after discovery
- Same content as individual notice



Secretary, HHS

499 or less

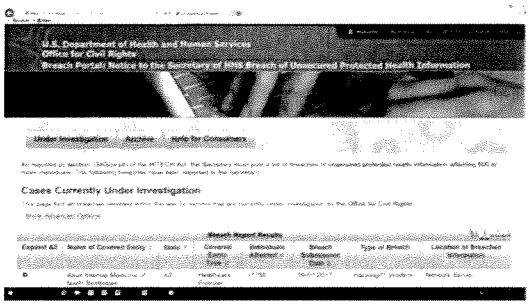
- via HHS web site annually.
  - no later than 60 days after end of calendar year breach discovered
  - May report all on same date
  - Must submit individual reports

500 or more

- via HHS web site
  - without unreasonable delay no later than 60 days after discovery

HIPAA "Wall of Shame"

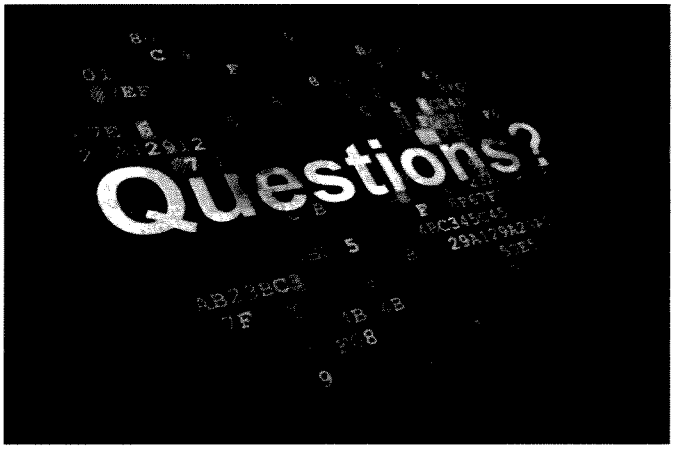
https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf



Ethical Considerations

In review:

- HIPAA Breaches Notification Rule
- Definitions/Principles
- Risk Assessments
- Breach Notification Process
- Ethical considerations



Thank you!

KreagerMitchell

NOTES

Update on the Affordable Care Act

NOTES

Fraud and Abuse: Trends, Developments and Strategy

NOTES

Medicaid: A Primer

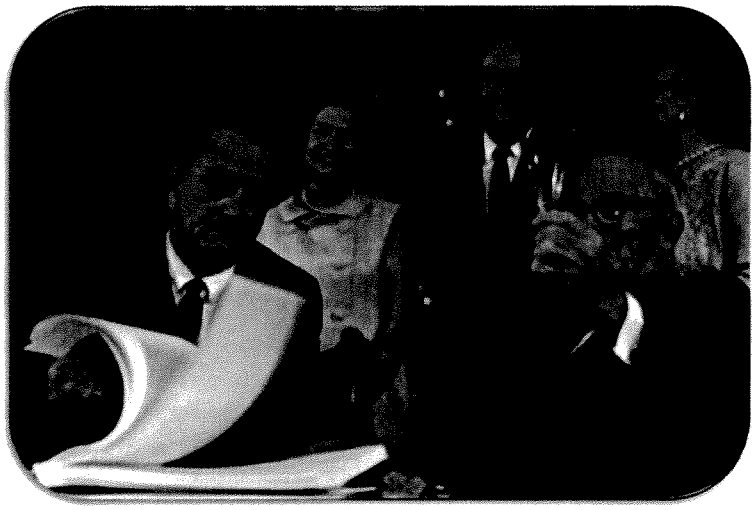
(Everything You Wanted to Know but Were Too Afraid to Ask)

A Primer: Everything you wanted to know, but were too afraid to ask

Erica Chavez, Presbyterian Healthcare Services
Gabe Parra, Law Offices of Gabriel M. Parra, LLC
October 5, 2017

DISCLAIMER: Any views or opinions expressed in this presentation are solely those of the presenters and do not represent the official policy or position of Presbyterian or its affiliates

Medicaid History



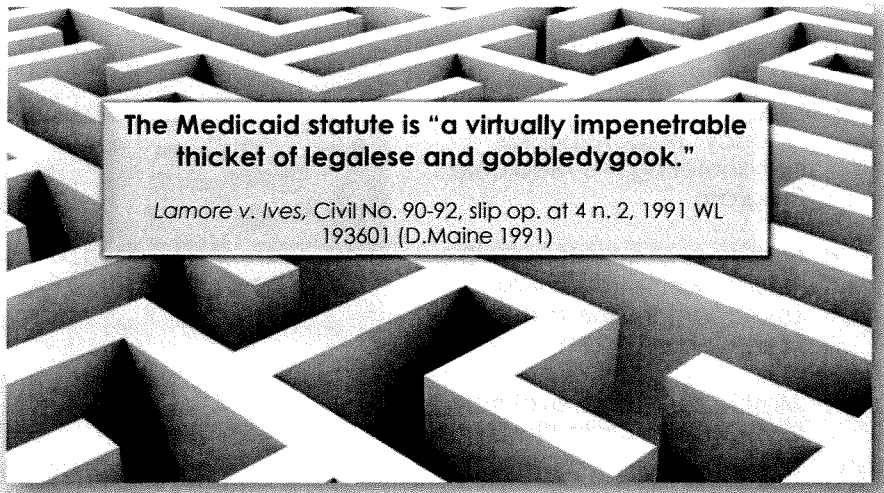
Medicaid History

- Title XIX of the Social Security Act
  - Created as a federal-state partnership
  - Federal government provided matching grants to states to finance care for:
    - Children from low-income families
    - Single parents with dependent children
    - Older adults, blind and/or disabled individuals
    - Individuals receiving federal income maintenance payments and assistance
  - States have guaranteed federal financial support for part of their Medicaid programs

Medicaid Today

- Covers 1 in 5 Americans
- Principal source of long-term care for Americans
- Nation's largest single insurer
- Finances over 16% of all personal health spending in the U.S.
- Covers half of all births in the U.S.
- Children's Health Insurance Program (CHIP)
  - For children in families with incomes too high for Medicaid but who can't afford private coverage

Legal Authority and Guidance



Legal Authority and Guidance

Federal

- Title XIX Social Security Act – 42 U.S.C. 1396a
- 42 C.F.R. Subchapter C, Part 430-456
- Case Law
- CMS Medicaid State Operations Manual
- CMS State Medicaid Director & Survey Letters
- OIG Audits and Investigations of Medicaid
- https://www.medicaid.gov/

New Mexico

- State Plan and State Plan Amendment (SPA)
- Statutes and the NMAC
- Case Law
- HSD Managed Care Contract
- HSD Managed Care Policy Manual
- HSD Letters of Direction (LODs)
- http://www.hsd.state.nm.us/Default.aspx

How is it funded?

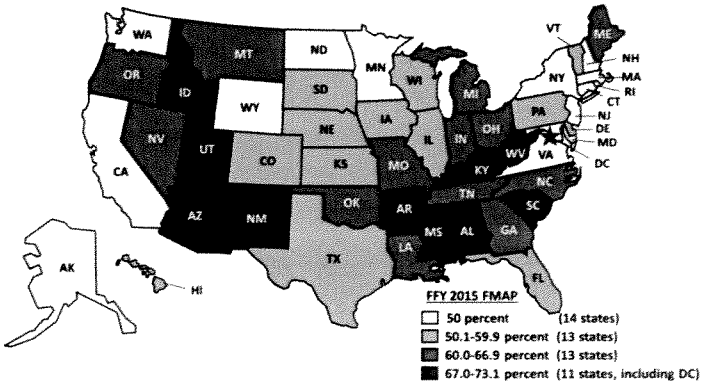
Federal Financial Participation

To qualify states **must**:

- Designate a "single-state agency" responsible for administering the Medicaid Program
- Create and submit to CMS a "State Plan" – governing document for the state's Medicaid program
- Must receive approval from CMS for their State Plans SPAs

Figure 1

Medicaid costs are shared by the states and the federal government.



NOTE: FMAP percentages are rounded to the nearest tenth of a percentage point. These rates are in effect Oct. 1, 2014-Sept. 30, 2015. These FMAPs reflect the state's regular FMAP; they do not reflect the FMAP for newly eligibles in states that adopted the ACA Medicaid expansion.
SOURCE: Federal Register, January 21, 2014 (Vol. 79, No. 13), pp 3385-3388, at http://www.gpo.gov/fdsys/pkg/FR-2014-01-21/pdf/2014-00931.pdf.

SOURCE: Medicaid Financing: How Does it Work and What are the Implications, The Henry J. Kaiser Family Foundation (May 2015)

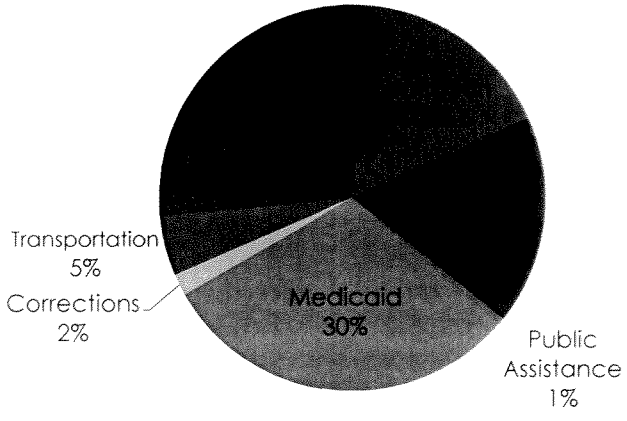
How much does it cost?

FY 2016

- United States - $553,453,647,756
- New Mexico - $5,364,140,357

SOURCE: State Health Facts: Total Medicaid Spending FY 2016, Henry J. Kaiser Family Foundation

New Mexico Spending Trends 2015



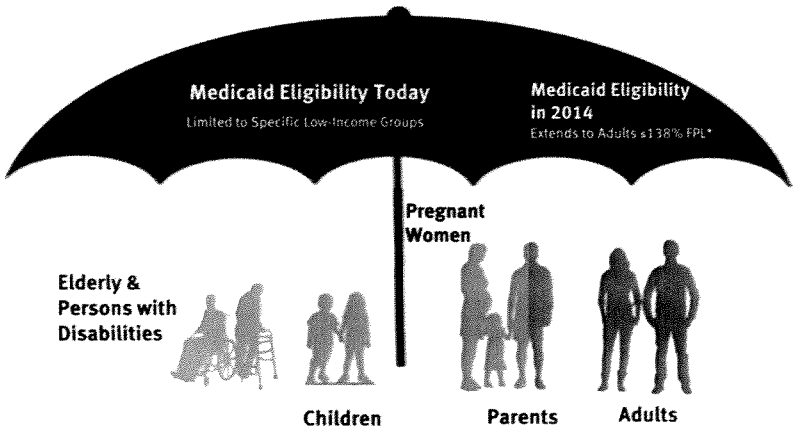
SOURCE: Data from National Association of State Budget Officers
*Other includes CHIP

Who is Covered?

- June 2017
  - United States – **74,424,652** individuals enrolled in Medicaid and CHIP
  - New Mexico – **777,519** individuals enrolled in Medicaid and CHIP (**out of ~ 2.08 million**)

SOURCE: https://www.medicaid.gov/medicaid/by-state/stateprofile.html?state=new-mexico

The ACA Medicaid Expansion Fills Current Gaps in Coverage



NOTE: The June 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius* maintained the Medicaid expansion, but limited the Secretary's authority to enforce it, effectively making the expansion optional for states. 138% FPL = $15,856 for an individual and $26,951 for a family of three in 2013.

SOURCE: The ACA Medicaid Expansion Fills Current Gaps in Coverage, The Henry J. Kaiser Family Foundation (March 2013)

What is Covered?

Mandatory

- Physician services
- Lab and x-ray services
- Inpatient hospital
- Outpatient hospital
- Early and Periodic Screening, Diagnosis, and Treatment (PSDT) for people under 21
- Family planning
- Rural and federally qualified health center (FQHC) services
- Nursing facility services for people 21 and over
- Home health for certain populations

Optional

- Prescription drugs
- Clinic services
- Dental services, dentures
- PT and rehab
- Prosthetic devices, glasses
- Primary care case management
- Intermediate care facilities for the mentally disabled
- Inpatient psychiatric care for individuals under 21
- Personal care services
- Hospice services
- Alcohol and drug treatment

Waivers

- The Department of Health and Human Services (HHS) has the authority to grant "waivers" of Medicaid requirements in certain circumstances
- Give states more flexibility to design coverage options

1915(b) Waiver

- "Freedom of choice" waiver
- HHS may approve waivers of certain SSA 1902 requirements for certain programs including Medicaid Managed Care

Section 1115 demonstration projects

- Waivers of requirements and authorized Medicaid expenditures under SSA 1903 if reforms are likely to promote the objectives of the Medicaid program
- Has to be budget neutral

Deficit Reduction Act of 2005

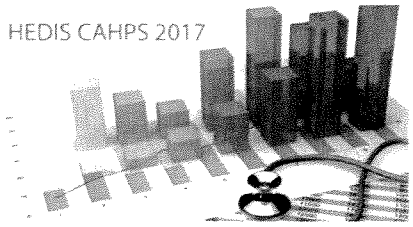
- More authority to states to design their programs

1915(c), (d), (e) Waivers

- "Home and Community Based services" waiver
- HHS may allow states to cover home-based services for certain Medicaid recipients who would otherwise require institutionalization if services aren't covered under the State Plan

How is Quality Monitored?

- States use data and payment strategies to improve quality in Medicaid
- Require Medicaid Managed Care Organizations (MCOs) to provide utilization and performance data
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)



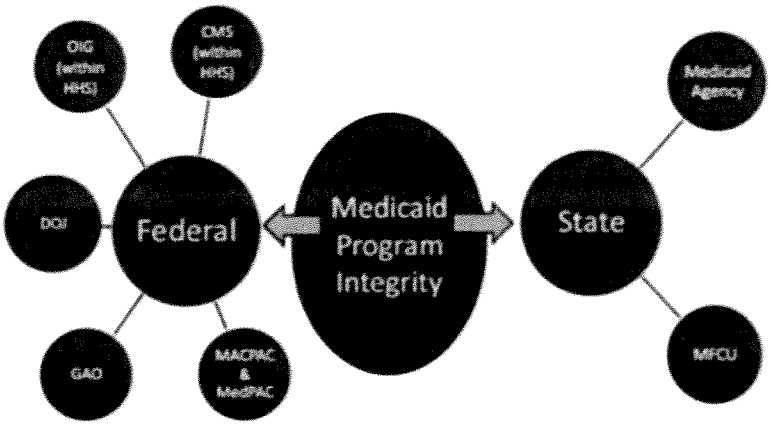
How is Quality Monitored?

- Federal law requires that all states with MCOs contract with an External Quality Review Organization (EQRO) to provide independent assessment of quality performance of Medicaid plans
- Health Information and Technology (HIT) initiatives to promote better coordination of care

Program Integrity

- Management of Medicaid to ensure quality and efficient care and appropriate use of funds with minimal waste
- Responsibility of both the federal government and the states
- Federal government
  - Monitors and enforces state compliance with the federal rules
  - Reviews state agency performance
  - Audits and investigates suspected fraud
  - Imposes sanctions
  - Provides guidance and training to the states
- State government
  - Responsible for daily management of Medicaid
  - Detect and address improper payment
  - Conduct audits
  - Monitor quality
  - Investigate and prosecute provider fraud and abuse

Agencies Involved in Medicaid Program Integrity



NOTES: CMS = Centers for Medicare & Medicaid Services, OIG = Office of Inspector General, DOJ = Department of Justice, GAO = Government Accountability Office, MACPAC = Medicaid and CHIP Payment Advisory Commission, MedPAC = Medicare Payment Advisory Commission. CMS and OIG are federal agencies within the Department of Health & Human Services, while GAO, MACPAC, and MedPAC are Congressional agencies.

SOURCE: Program Integrity in Medicaid: A Primer, The Henry J. Kaiser Family Foundation (July 2012)

Medicaid Reimbursement

- State Plan determines the state payment methodology for Medicaid services
- CMS verifies that state funding sources meet statutory and regulatory requirements before authorizing FFP
- States can establish their own provider payment rates within federal requirements
  - Generally pay for services through fee-for-service or managed care (or a combination of both)

Medicaid Reimbursement

Fee for Service

- State pays provider directly for services
- Based on volume of beneficiaries
- Payment rates based on:
  - Costs of providing the service
  - Review of what commercial payers pay in the market
  - Percentage of what Medicare pays for equivalent service

Managed Care

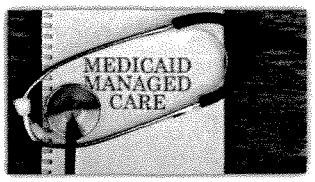
- State contracts with MCOs to deliver care through networks and pay providers
- MCOs are paid a monthly capitation payment rate

Managed Care

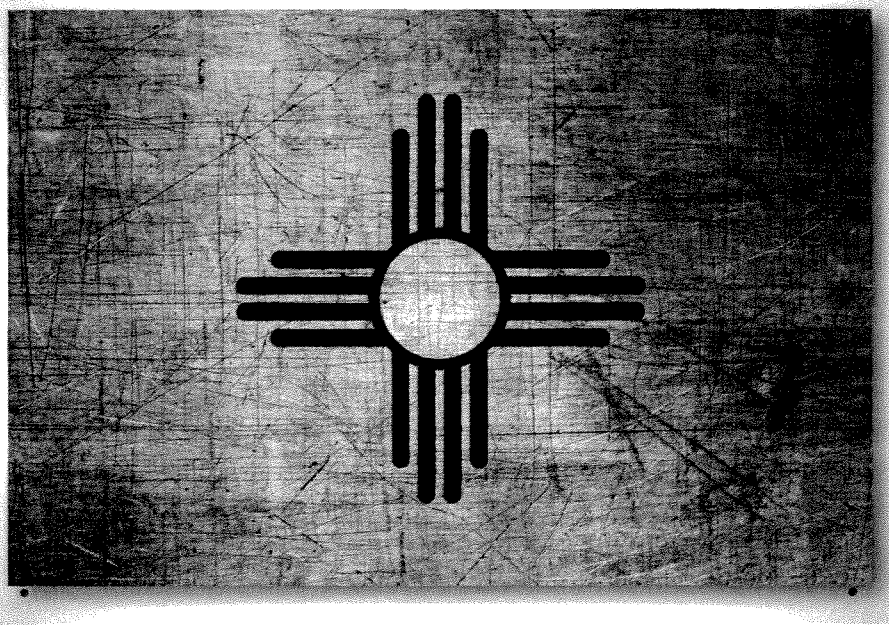
- Designed to manage cost, utilization, and quality
- Predominant form of service delivery – 70%
- Contracted arrangements between the state and MCOs
- MCOs accept a set per member per month (PMPM) capitation payment for these services
  - Get a flat fee for an individual enrolled in a managed care plan regardless of the cost of that persons' care
  - PMPM will vary based on what cohort the member is in

Managed Care

- Capitation rates are developed using local costs and average utilization of services
  - Can vary from one region of the country to another
- Medicaid and CHIP Managed Care Final Rule 2017
  - First major update to managed care regulations in over a decade



Centennial Care



Question #1

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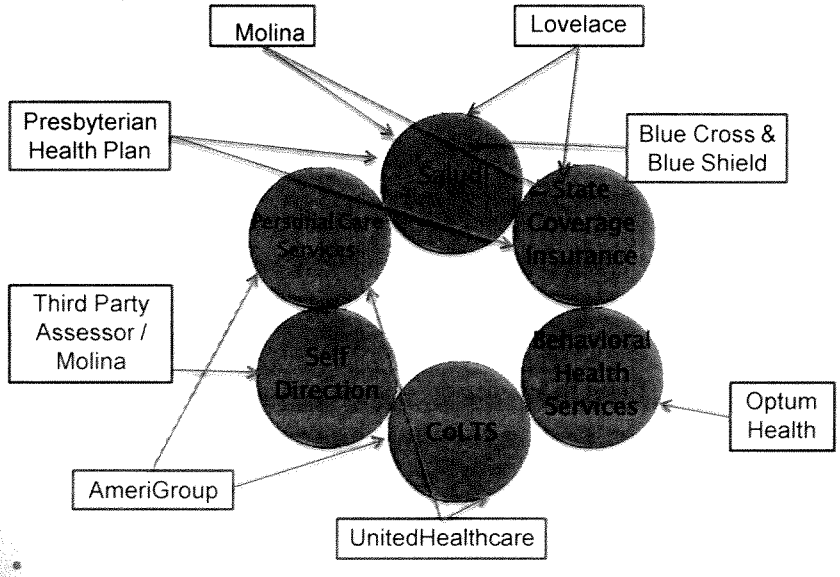
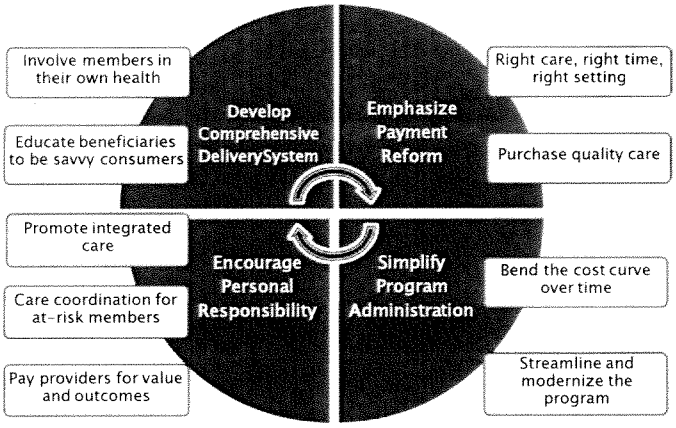
When did Centennial Care 1.0 begin?

Medicaid in 2013
Pre-Centennial Care



Centennial Care
Guiding Principles



HUMAN SERVICES DEPARTMENT

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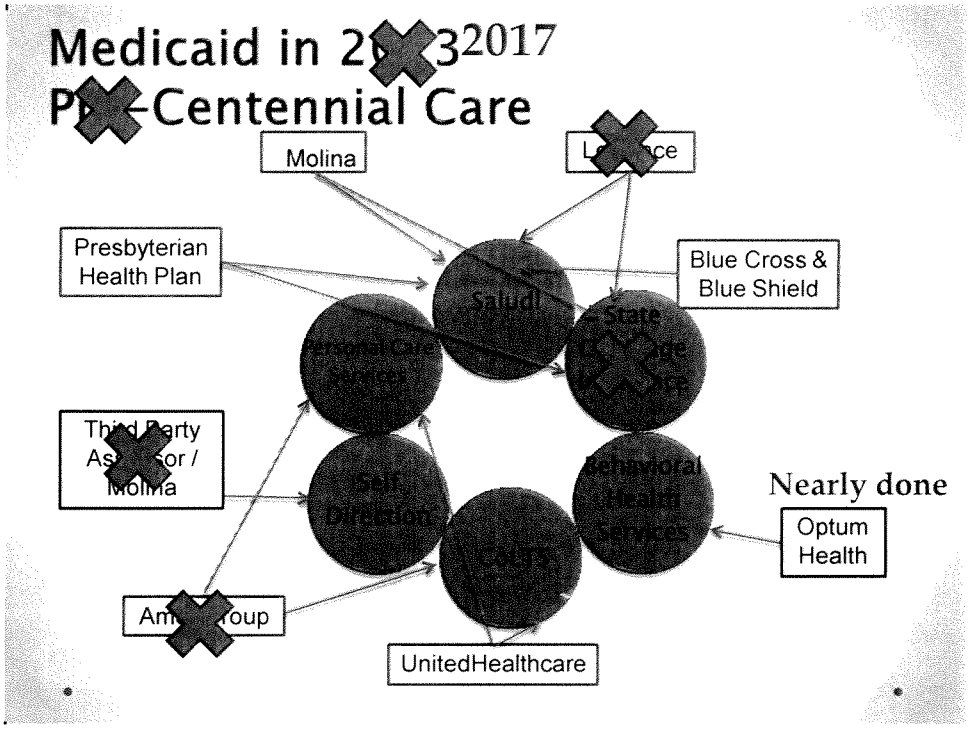
Question #2

• • •

Centennial Care today - How many MCOs are there?

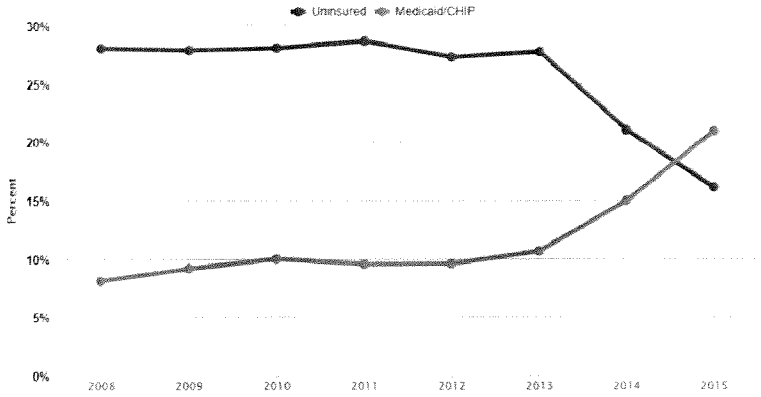


Question #3

. . .

How many people are covered by Centennial Care?

New Mexico Uninsured and Medicaid-Insured (19-64 population)



Source: SHADAC State Health Compare, University of Minnesota

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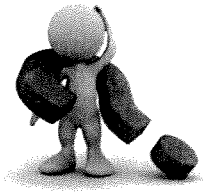
Current Landscape

Federal/State Impacts to Consider



Question #4

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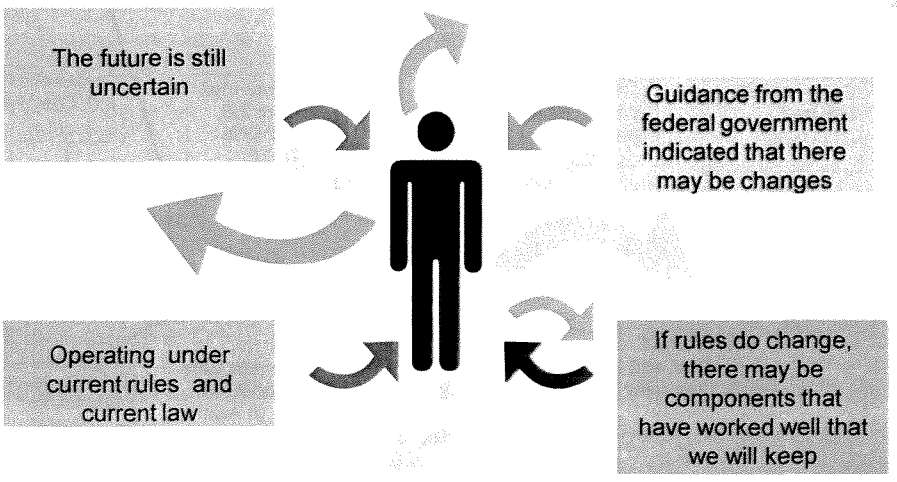
How much does New Mexico spend on its Medicaid program?

Federal Medicaid Changes



Question #5

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When does Centennial Care 2.0 begin?

Centennial Care Timeline

Centennial Care Initiated
(1/1/2014)

Centennial Care 2.0 Stakeholder Input
(10/2016-6/2017)
- Subcommittee of the MAC
- Tribal Consultation
- Concept Paper
- Public meetings

Centennial Care 2.0 RFP Released
(9/1/2017)

Centennial Care 2.0 RFP DUE DATE
(11/3/2017)

Centennial Care Readiness Period
(4/1/2018 to 12/31/2018)

Centennial Care 2.0 Effective
(1/1/2019)

2014 | 2015 | 2016 | 2017 | 2018 | 2019

Draft Waiver Application and Public Comment
(9/2017-11/2017)

Final Waiver Application, CMS Review and Approval
(11/2017-12/2018)

Centennial Care 2.0 Notice of Intent to Award
1/8/2018)

Centennial Care 2.0 Contract Award Date
3/15/2018)

HUMAN SERVICES DEPARTMENT

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What is HSD's Vision for the future of CC?

- Centennial Care 2.0 builds on successes achieved during the past four years
- Improvements and reforms will ensure sustainability of the program while preserving comprehensive services

Areas of Focus for CC 2.0

A. Care Coordination

B. Behavioral Health Integration

C. Long-Term Services and Supports (LTSS)

D. Payment Reform

E. Member Engagement and Personal Responsibility

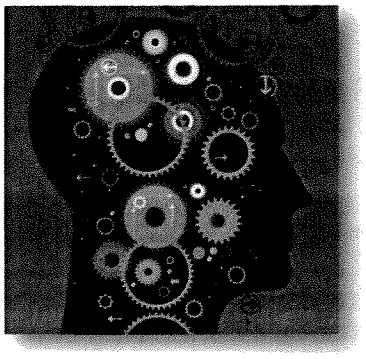
F. Administrative Simplification through refinements to benefits and eligibility

A. Care Coordination

1. Increase Care Coordination at the Provider Level
2. Improve Transitions of Care
3. Expand programs working with high needs populations
4. Initiate Care Coordination for Justice involved prior to release
5. Pilot a home-visiting program focused on pre-natal, post-partum and early childhood development
6. Obtain 100% federal funding for Native American members for services received through IHS

B. Behavioral Health Integration

1. Expanding Health Homes (CareLink NM)
2. Support workforce development
3. Support Peer-Delivered, Pre-Tenancy and Tenancy Support Housing Services

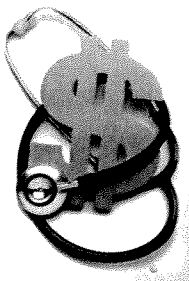


C. Long-term Services and Supports

1. Allow for one-time start-up goods for transitions when a member transitions from agency-based to self-directed care
2. Increase caregiver respite hours from 100 to 300
3. In order to continue to provide access to the Community Benefit services for all eligible members who are Nursing Facility Level of Care (NF LOC), establish some limits on costs for certain services in the SDCB model
4. Implement automatic NFLOC approval for members whose condition is not expected to change
5. Include Nursing facilities in Value Based Purchasing (VBP) arrangements and use Project ECHO to provide expert help for nursing home staff

D. Payment Reform

1. Pay for better quality and value by increasing percentage of providers payments that are risk-based
2. Use VBP to drive other CC 2.0 goals
3. Advance Safety-net care pool initiatives



E. Member Engagement and Personal Responsibility

1. Advance the Centennial Rewards Program
2. Allow providers to charge small fees for three or more missed appointments
3. Premiums for populations with incomes that exceed 100% of FPL
4. Require co-payments for certain populations
5. Modify tracking requirements for cost sharing
6. Expand opportunities for Native American members in CC

F. Administrative Simplification

1. Cover most adults under one comprehensive benefit plan
2. Develop buy-in premiums for dental and vision for adults
3. Eliminate the three month retroactive eligibility period for most CC members
4. Eliminate transitional Medicaid coverage that providers an additional 1 year that increased earnings can cause loss of eligibility
5. Incorporate eligibility requirements of the Family Planning program.

F. Administrative Simplification

6. Request waiver from limitations imposed on the use of IMD
7. Request waiver authority to cover former foster care individuals up to age 26 who are former resident of other states
8. Request waiver authority for enhanced administrative funding to expand availability of LARC for certain providers

Acronyms and Glossary of Terms

- **ABD** – Aged Blind and Disabled – a category of eligibility under Medicaid
- **(S)CHIP** – (State) Children's Health Insurance Program
- **CMS** – Centers for Medicare and Medicaid Services
- **CoLTS** – Coordination of Long-Term Services – former NM managed LTC program
- **Dual Eligible** (or "Duals") – individuals who are eligible for both Medicare and Medicaid
- **EPSDT** – Early Periodic Screening, Diagnosis, and Treatment – mandatory services for children
- **FFS** – Fee-for-Service
- **FMAP** – Federal Medical Assistance Percentage (Federal match)
- **FPL** – Federal Poverty Level. The standard for much of Medicaid eligibility.
- **HCBW/HCBS** – Home and Community-Based Waiver/Services
- **LTC** – Long-Term Care. Also **LTSS** – Long-Term Services and Supports
- **MCO** – Managed Care Organization
- **SPA** – State Plan Amendment
- **SSI** – Supplemental Security Income – automatically qualify for Medicaid
- **SSDI** – Social Security Disability Insurance. - may or may not be Medicaid eligible and have a 2-year waiting period for Medicare
- **Waivers** – a vehicle that allows States to waive statutory requirements and implement different kinds of programs and services – most common are 1915(b); 1915(c); and 1115

Helpful Resources

- Lots of data about Medicaid (and Medicare and the Uninsured), the Kaiser's State Health Facts site:
- http://kff.org/statedata/

- Another great source for a wide range of information about the program is from the Center for Health Care Strategies (CHCS):
- http://www.chcs.org/

- For the official CMS perspective:
- http://medicaid.gov/

- The Medicaid and CHIP Payment and Access Commission (MACPAC) was created in 2009 and their site has a plethora of data and information:
- http://www.macpac.gov

- NM HSD website has a lot of resources, including the Managed Care Policy manual and links to applicable regulations:
- http://www.hsd.state.nm.us/

- HSD's website on Centennial Care 2.0:
- http://www.hsd.state.nm.us/centennial-care-2-0.aspx

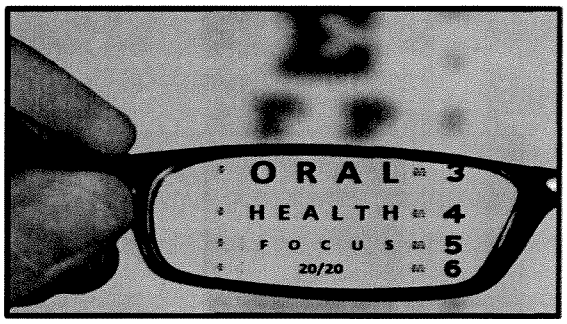
NOTES

Healthcare Trade Associations Panel: What Matters to Those on the Front Lines

New Mexico DENTAL ASSOCIATION | ADA | FOCUS2020 | Action for DENTALHEALTH ADA American Dental Association

As the trusted voice of oral health care in the state, the **New Mexico Dental Association** advocates for oral health policies that not only represent the interests of our 700 members, but also the general public. Established in 1908, the NMDA is a state constituent of the American Dental Association (ADA). The Associations function is to provide services that benefit our members and their practices. The NMDA provides leadership on all issues regarding oral health care and fosters an awareness of the obligation and responsibility of the dental profession to the community. We also seek to offer proactive and innovative solutions to the complex and wide-ranging issues facing oral health care. Our membership is divided into 6 geographic districts, with nearly half of our membership in the Albuquerque District.

ORAL HEALTH FOCUS 2020



Through our **"Oral Health Focus 2020"** plan, the Association has outlined a comprehensive seven-year initiative to address New Mexico's barriers to oral health in four areas: ***prevention, education, workforce and economic concerns***. The plan works in partnership with the ADA's Action for Dental Health program, and is a community-based movement created with the goal of improving the oral health of New Mexico residents.

PREVENTION

While so much of health care reform is focused on allowing people to access care, the best, most cost-effective way to improve people's health is to reduce the need for care.

- *Require all children to receive a checkup prior to starting elementary school to establish a "dental home."*
- *Establish that the state dental director be a dentist.*
- *Seek incentives to encourage communities to provide optimal levels of fluoride in their water supplies.*

ECONOMICS

Dentistry is quite different from medicine for many reasons. Unlike medicine, the vast majority of dollars spent on dental care still come from individuals, families and their employers through benefits plans. This means that the delivery of dental services is much more market-driven than medicine. Ultimately, practice viability is not determined by the need for services, but by the demand for services. Unmet need will only become demand when support programs are adequately funded or communities create a virtual demand by subsidizing local practices.

- *Reform and expand Medicaid to streamline claim submission, provide improved benefits for adults and seniors and claim reimbursement at reasonable market-justified rates. Currently, nearly 50% of New Mexican's are Medicaid-eligible. Benefits are limited, and coverage falls short of providing the amount and extent of dental care needed. Since Medicaid often pays less than the cost to provide a service, it doesn't effectively result in an "Ability to Purchase." This creates no demand in the marketplace.*
- *Create an Insurance Bill of Rights so patients may see the dentist they choose without inappropriate coercion or penalties.*
- *Eliminate Gross Receipts Tax on patient's out-of-pocket expenses that disproportionately burden families, the sick, the disabled and the elderly.*

EDUCATION

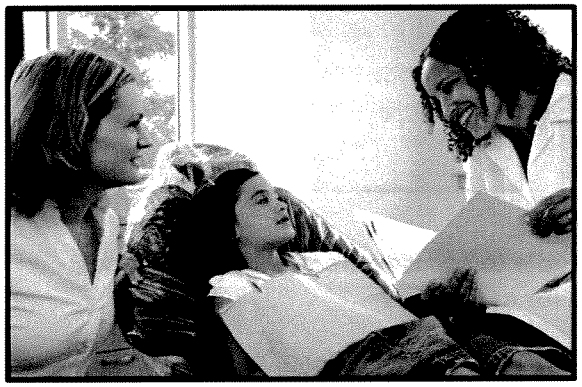
New Mexico does not have a dental school, thus all dentists in New Mexico received their dental education somewhere else. This is not a workforce issue. It is a matter of needing a steady supply of new dentists and providing an educational opportunity to qualified New Mexico students to ensure that our dentists represent the diversity of New Mexico's cultures and geography. Our vision is to work towards a dental school incrementally by:

Creating a "critical mass" of qualified applicants by:

- *Adequately funding the WICHE (Western Interstate Commission on Higher Education) program that allows New Mexico students to get their dental education by attending an out of state school.*
- *Establishing a BA/DDS program at the University of New Mexico that recruits students out of high school, nurtures them throughout their undergraduate education and assures them of a place in the medical school, if they remain qualified.*

While also:

- *Building the infrastructure for a public health model school that utilizes Federally-qualified Health Centers for clinical training in each quadrant of the state.*



WORKFORCE

New Mexico does not have a shortage of dentists. In fact, New Mexico had a SURPLUS of almost 340 dentists over the benchmark (1 dentist per 2,500 population) ...and that number is rising. There are local areas of need, but that too is improving. The focus should not be on creating more providers, but utilizing those we have, exploiting the full scope of practice of existing NM workforce models, and creating pathways to provide services, including:

- *Creating Public/private partnerships and improving loan repayment incentives.*
- *Expand utilization of Community Dental Health Coordinators (CDHC) to bridge the gap between the existing care resources and unmet need. The CDHC combines the skills of an expanded function assistant and a community health worker and has an established educational home at Central New Mexico Community College (CNM).*
- *Encourage the use Expanded Function Dental Assistants (EFDA), CDHC's, and certified dental hygienists in collaborative practices that extend existing resources to underserved populations utilizing teledentistry and other new communication tools. Working as a team, the dentist, EFDA, CDHC and dental hygienist can treat more patients with greater efficiency, while saving resources.*

PHILANTHROPY

The dentists of the New Mexico Dental Association play an active role in giving back to the community. Through our charitable arm, the New Mexico Dental Association Foundation, we hold Mission of Mercy free dental clinics across the state. Our six events since 2010 have resulted in $6 million in donated care to 8200 patients. The Foundation also oversees the Donated Dental Services program providing care to elderly, disabled or medically compromised patients in their home communities throughout New Mexico.

New Mexico DENTAL ASSOCIATION ADA

Learn more about the New Mexico Dental Association's proactive and innovative solutions to the complex and wide-ranging issues facing oral health care by visiting nmdental.org.

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Opioid Epidemic In New Mexico and Beyond

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