State of New Mexico
Human Services Department

Centennial Care 2.0 1115 Waiver Amendment Request

to

The Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services

Dr. David R. Scrase, M.D., Cabinet Secretary
New Mexico Human Services Department

Nicole Comeaux J.D., M.P.H., Director
Medical Assistance Division

JANUARY 1,2021 – DRAFT PROPOSAL

TABLE OF CONTENTS

SECTION 1: PURPOSE, GOALS AND OBJECTIVES 3
A. Statement of Purpose 3
B. Centennial Care 2.0 Goals and Objectives 3
C. Public Process 4

SECTION 2: AMENDMENT PROPOSALS 5

SECTION 3: CURRENT PROGRAM DESIGN 15
A. Current Populations Covered 15
B. Current Demonstration Benefits 16

SECTION 4: WAIVER LIST 17
A. Expenditure Authority Requests 17
B. Waiver Authority Requests 17

SECTION 5: COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS 11

SECTION 6: APPROACH TO BUDGET NEUTRALITY 19
A. Budget Neutrality Overview 19
B. CHIP Allotment Neutrality 19
C. Budget Neutrality Summary 19

SECTION 7: EVALUATION DESIGN AND QUALITY STRATEGY 23

SECTION 8: STATE PUBLIC NOTICE 24

APPENDICES 25
Appendix A: Glossary 25
Appendix B: Final Evaluation Report 26
Appendix C: State Public Notices 27
Appendix D: Summary of Stakeholder Feedback (including Feedback from Federally Recognized Tribal Nations) and State Response 28
Appendix E: Documents Demonstrating Quality 29
Appendix F: Centennial Care 2.0 Eligibility Groups 30
Appendix G: Centennial Care 2.0 Benefits 41
Appendix H: Currently Approved Benefit Definitions and Limits 47
Appendix I: Attachments 56

SECTION 1: PURPOSE, GOALS AND OBJECTIVES

A. Statement of Purpose

The New Mexico Human Services Department (HSD) Medical Assistance Division (MAD) is seeking federal authority to amend the 1115 Centennial Care 2.0 Waiver (Project Number 11W-00285/6) to make the following changes:

- Expand the Medicaid program toward a more integrated model of behavioral health care delivery by providing Medicaid reimbursement for extended Institution for Medical Disease (IMD) stays for individuals with Serious Mental Illness (SMI)/Serious Emotional Disorder (SED).
- Establish High-Fidelity Wraparound (HFW) as an intensive care coordination approach for children and youth who have high intensity needs.
- Establish a Primary Care Graduate Medical Education (GME) expansion funding mechanism designed to develop new and/or expanded GME programs focusing on the specialties of General Psychiatry, Family Medicine, General Pediatrics, and General Internal Medicine.
- Expand coverage of the Coronavirus (COVID-19) vaccine, to the extent not covered by the federal government during the period of Centennial Care 2.0 demonstration and its administration to individuals who have limited benefit plan coverage including Family Planning Category of Eligibility (COE), Emergency Medical Services for Aliens (EMSA), individuals covered under the COVID-19 uninsured population (FFCRA) and also those receiving only Pregnancy-related services.

The requested changes will impact the currently approved waiver authorities, expenditure authorities and Special Terms and Conditions (STCs) for the period between July 1, 2021 and December 31, 2023. Please visit the following link to see the current approved waiver authorities, expenditure authorities and STCs.

http://www.hsd.state.nm.us/approvals.aspx

B. Centennial Care 2.0 Goals and Objectives

The state's demonstration's goals for New Mexico's Medicaid managed care program, known as Centennial Care 2.0, include providing the most effective, efficient health care possible for covered New Mexicans and to continue the healthcare delivery reforms that were initiated during the previous demonstration period. Specifically, the state's goals are to:

- Assure that Centennial Care members receive the right amount of care, delivered at the right time, and in the right setting;
- Ensure that the care and services being provided are measured in terms of their quality and not solely by quantity;
- Slow the growth rate of costs or "bend the cost curve" over time without inappropriate reductions in benefits, eligibility or provider rates; and
- Streamline and modernize the Medicaid program in the state.

Today, Centennial Care 2.0 features an integrated, comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care, pharmacy, behavioral health services, institutional services and home and community-based services (HCBS).

The waiver provides an opportunity for the state to continue advancing successful initiatives while implementing new, targeted strategies to address specific gaps in care and improve healthcare outcomes for its most vulnerable members. Key initiatives of the Centennial Care 2.0 waiver include:

- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continue to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through value-based purchasing arrangements to achieve improved quality and better health outcomes;
- Continue the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative; and
- Further simplify administrative complexities and implement refinements in program and benefit design.

As part of the demonstration amendment, the state seeks to strengthen its support to cover New Mexicans through an integrated and comprehensive Medicaid delivery system.

C. Public Process

The state has fully complied with Centennial Care 2.0 STCs #6, #7 and #9 in submitting this amendment request to CMS.

The state must comply with the state notice procedures as required in 42 CFR §431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

In addition, the state must apply with tribal and Indian Health Program/Urban Indian Organization consultation requirements in section 1902(a) (73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, or contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC #6 or extension, are proposed by the state.

Please refer to Section 8 for details about the proposed timeline, public input and Tribal Consultation process for this amendment application.

SECTION 2: AMENDMENT PROPOSALS

Amendment Proposal #1: Expand the Medicaid program toward a more integrated model of behavioral health care delivery by providing expanded Medicaid reimbursement for individuals with Serious Mental Illness (SMI)/Serious Emotional Disorder (SED) receiving care in an IMD.

Summary

HSD is requesting an amendment to the 1115 Research and Demonstration Waiver to seek a waiver of the Institution for Mental Disease (IMD) exclusion for all Medicaid beneficiaries aged 21-64, regardless of delivery system. The objective of this waiver is to maintain and enhance beneficiary access to behavioral health services in appropriate settings and ensure that individuals receive care in the facility most appropriate to their needs in line with the first goal of the demonstration. This waiver will fill a critical gap in the of continuum of care, and provide better support for individuals who may require longer stays at a residential treatment facility.

The waiver of the IMD exclusion would allow psychiatric facilities (i.e. hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services) to be able to provide reimbursable services to Medicaid recipients with SMI/SED for stays in excess of fifteen (15) days. In addition, HSD is seeking expenditure authority, notwithstanding the IMD limitations in 42 CFR 438.6(e), for capitation payments to managed care entities under contracts that permit those entities to provide enrollees aged 21-64 inpatient services in an IMD regardless of the length of stay. HSD would also seek this expenditure authority for members who participate in the fee for service program to ensure equal access to care in IMDs for all Medicaid enrollees.

Behavioral Health Context, Network and Gaps in New Mexico

New Mexico's Behavioral Health services are delivered through agencies that are licensed and/or certified as hospitals, community mental health clinics, core service agencies, federally qualified health centers, and behavioral health agencies. HSD's Behavioral Health Services Division (BHSD) serves as the monitor and subject matter expert for the NM Behavioral Health System.

New Mexico's Federally Qualified Health Centers (FQHCs), Community Mental Health Clinics (CMHCs) and state certified behavioral health agencies (BHAs) serve as the state's behavioral healthcare delivery backbone despite facing ongoing provider shortage with limited inpatient and intensive outpatient options. Inpatient facilities are few and geographically located in the most populous regions of the state. Specifically, New Mexico has only five Institutes for Mental Disease (IMDs), which are primarily located in urban communities in the center and southwestern portions of the state. Further, there are no residential treatment facilities that qualify as IMDs.

While the state has a robust Critical Access Hospital presence, none have inpatient psychiatric care available. Similarly, the state has highly limited options for outpatient and partial treatment. New Mexico has a total of 109 intensive outpatient providers for a ratio of 1:546 and there are no residential mental health treatment facilities for adults. Finally, New Mexico faces a behavioral health provider shortage; for example, our most populous county (Bernalillo) has a 1:90 ratio of Medicaid beneficiaries to psychiatrists/prescribers.

In New Mexico, an average of 10% of the Medicaid population had an SMI diagnosis and 6% had an SED designation in August 2019. Thus, 8% of the NM Medicaid population was experiencing SMI/SED at the start of the demonstration. These percentages and prevalence exceed the SAMHSA estimate of 5.4% average of SMI across the U.S.'s civilian population. With 23.5% of New Mexican children living in poverty, SAMHSA classifies NM in the highest poverty tier with estimates for SED in New Mexico range from 7-13%. Similarly, for August 2019, the range of SMI/SED within the NM Medicaid population and across NM counties is 4-15% (SMI) and 3-24% (SED). New Mexico is a highly rural state, with 1/3 of those with SMI/SED living in a rural county. The counties with the highest percent of Medicaid beneficiaries with SMI and SED are in rural communities; for example, 14% of the Medicaid beneficiaries in Los Alamos County are diagnosed with SMI and 24% of the children in De Baca County are diagnosed with SED. With a shortage of behavioral health providers in NM, it is likely under-diagnosis is present, particularly in the smaller, rural communities with limited access to clinicians.

New Mexico has an ongoing need for additional inpatient capacity and intermediate levels of care. The statewide ratio is 1-to-546 for intensive outpatient/partial hospitalization with a ratio of 1-to-1231 for our most populous county (Bernalillo). At this time, there are no partial hospitalization programs that serve Medicaid beneficiaries. Access to a psychiatric hospital and/or IMD is very limited, with a ratio of 1-to-11,900 and 1-to-78 for Medicaid beneficiaries to psychiatric beds. For adolescent residential treatment facilities (RTF), the ratio is 1:2433. These limitations in inpatient and intermediate levels of care drive barriers in access to treatment and place undue strain on the outpatient system including the FQHCs and BHAs.

There are other gaps in mental health network capacity. Residential treatment facilities (RTFs) in New Mexico are only available to treat those with SED/SMI under the age of 21. There are no adult RTFs (over 21 years) for mental health. Further, there are gaps in behavioral health care coordination with care coordination services not available in the Medicaid FFS arrangement at this time. Lastly, the state has begun standing up community-based crisis intervention services. These are immediate, crisis-oriented services designed to ameliorate or minimize an acute crisis episode or to prevent inpatient psychiatric hospitalization or medical detoxification. These include crisis triage centers which provide voluntary stabilization of behavioral health crises including emergency mental health evaluation and care for those aged 14 and older. Crisis stabilization services are outpatient services for up to 24-hour stabilization of crisis conditions including withdrawal management and as an alternative to the emergency department or police department. There are now three licensed Crisis Triage Centers, and services at both the crisis triage centers and crisis stabilization providers are expected to increase overtime.

Current Services and Initiatives

HSD offers a broad array of behavioral health services in the New Mexico Medicaid program. For example, Community Mental Health Clinics (CMHC) provide five core services, including: professional consultation; community-based crisis intervention; therapeutic interventions; medication services; and psychosocial interventions. In addition, most CMHCs provide Comprehensive Community Support Services (CCSS), allowing Medicaid recipients access to an array of psychosocial services. HSD also launched Health Homes, CareLink NM (CLNM), with a designated population of adults with SMI and children/adolescents with SED. HSD is in the process of adding SUD to the eligibility criteria for Health Homes, which will enable CLNM providers to provide services to this vulnerable population. The CLNM model is in eight counties and all sites provide enhanced care coordination and integration of primary, acute, behavioral health, long term care

services and social supports.

On December 18, 2018, CMS approved the Substance Use Disorder (SUD) program to allow New Mexico to better address opioid use disorders and other SUDs, which are a serious public health concern in New Mexico. In 2019, New Mexico implemented a comprehensive continuum of services. The continuum of services includes screening, assessment, and treatment of SUD. Several new services were added that are based on the American Society of Addiction Medicine's levels of care (ASAM LOC) including placement criteria, staffing, and standards. These services are designed for an individual's restoration to a functional level within his or her life and community and include, but are not limited to:

- Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a community-based practice designed to identify, reduce, and prevent problematic substance use or misuse or co-occurring mental health disorders as an early intervention.
- Peer support services are an evidence-based mental health model of care which consists of a certified peer support worker who assists individuals with their recovery from mental illness and substance use disorders.
- Intensive outpatient programs (IOPs) for SUD is a time limited service utilizing a multi-faceted approach to treatment for an eligible recipient who requires structure and support to achieve and sustain recovery.
- Adult Accredited Residential Treatment Centers (AARTCs) are facilities for adult recipients who have been diagnosed as having a SUD and meet the appropriate ASAM criteria for this level of care.
- Crisis Stabilization is a service providing up to 24-hour stabilization of crisis conditions, including withdrawal management. Crisis Stabilization includes services that are designed to ameliorate or minimize an acute crisis episode and to prevent incarceration, emergency department visits, inpatient psychiatric hospitalization, or medical detoxification.
- Crisis Triage Centers (CTCs) are community-based alternatives to hospitalization or incarceration. The facilities are either for providing crisis stabilization as indicated above, or residential, with stays of 3 to 14 days. CTCs have more than 16 beds. They serve youth and adults to provide voluntary stabilization of behavioral health crises including emergency mental health evaluation, withdrawal management, and transition planning for continued care post-discharge.

Inpatient and Residential Services in an IMD

New Mexico currently reimburses for stays at an inpatient IMD level of care for adults aged 22 through 64 who have a SUD diagnosis and meet ASAM admission criteria. The services covered include withdrawal management (detoxification) and rehabilitation. In 2019, 4,256 beneficiaries received either residential or inpatient treatment for SUD in an IMD in New Mexico. The annual average length of stays for this set of beneficiaries in was 19.2 days, well under the aim of the statewide average length of stay of 30 days in residential treatment settings.

However, CMS's regulation (Federal Rule 42 C.F.R. 438.6(e) as amended) currently prohibits federal funding to MCOs when members aged 21-64 with SMI or SED are in IMDs for more than 15 days during a calendar month. This results in a serious gap in the continuum of care for one of our most vulnerable populations. Many people can receive treatment in the community safely and effectively, but when a crisis occurs that

requires a higher level of care these patients often end up in emergency departments and acute care hospitals, which are often neither the most effective nor the most efficient place of service. Through this Waiver, New Mexico will expand access to these critical services by reimbursing longer stays in an IMD for Medicaid beneficiaries with SMI/SED and/or SUD.

SMI/SED Goals and Milestones

In addition to the state's current demonstration goals, New Mexico supports the SMI/SED goals for the demonstration, as outlined by CMS in its SMI/SED Guidance (SMD #18-011), as described below:

- Reduce utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Reduce preventable readmissions to acute care hospitals and residential settings;
- Improve availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
- Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

New Mexico will provide detailed information on its strategies and state actions for meeting the demonstration milestones (as identified in the guidance from CMS) in its Implementation Plan. New Mexico will finalize and submit its Implementation Plan as soon as possible following submission of this application to CMS. SMI/SED Waiver Milestones include:

- Ensuring quality of care in psychiatric hospitals and residential settings;
- Improving care coordination and transition to community-based care;
- Increasing access to continuum of care, including crisis stabilization services; and
- Earlier identification and engagement in treatment through increased integration.

In addition to the Implementation Plan, New Mexico will submit a Health IT Plan (HIT Plan) that will describe the state's ability to leverage health IT, advance health information exchange, and ensure health IT interoperability in support of the Waiver's goals. New Mexico will work closely with its Medicaid and behavioral health divisions, external stakeholders, and CMS in the development of the formal Implementation Plan and HIT Plan. Both documents will outline the specific timelines and state action items that will need to occur to meet each of the above-listed milestones.

Maintenance of Effort (MOE)

In accordance with the SMI/SED Guidance (SMD #18-011), New Mexico understands that this Waiver is subject to a maintenance of effort (MOE) requirement to ensure the authority for more flexible inpatient and residential treatment does not reduce the availability of outpatient community-based behavioral health treatment options.

The implementation of SMI/SED is budget neutral. The state is gathering data to establish the base years cost for outpatient community-based behavioral health treatment options and will be included on the waiver application.

Amendment Proposal #2: Establish High Fidelity Wraparound (HFW) as an intensive care coordination approach for children and youth who have high intensity needs.

HSD proposes to cover a HFW service model for children who meet the criteria of SED, including functional impairment and behavioral health and mental health disorders**.** Wraparound delivers the outcomes youth/families, systems, and providers seek. In addition, Wraparound delivers these outcomes while reducing costs. HFW is youth-driven, family-centered, community-based, and strengths-based and includes an individualized planning process and Action Plan to support the young person and their family in the Wraparound process. HFW will identify, access, obtain, and monitor mental health, social services, educational services, other formal services, and natural and community supports that will assist the young person and their family in meeting their needs and achieving their vision.

High Fidelity Wraparound addresses:

- Eliciting a personal or family vision of a future
- Building a safe and trusting relationship
- Recognizing, listening for, and being responsive to the level of past trauma and its current effects
- Building a strengths-based personal/family narrative to create new perspective
- Listening and building upon functional strengths
- Listening for needs vs. problems
- Providing real help in a real way
- Assisting families in rediscovering a dependable, community-centered support system
- Encouraging self-care of Wraparound facilitators

General eligibility criteria for NM:

- Children or youth with a SED diagnosis;
- Functional impairment in two or more domains identified by the Child & Adolescent Needs and Strengths (CANS) tool;
- Involved in two or more systems (special education, behavioral health, protective services, juvenile justice), or at risk for such involvement in the case of children aged 0 to 5; and
- At risk or in an out of home placement.

Structured Referral System/ Process Development Plan:

Enhancements to New Mexico's Children, Youth & Families Department's (CYFD's) information system, currently under development, will allow for direct referrals when eligibility criteria are met. This will ensure equity and consistency to access services. The Child & Adolescent Needs and Strengths (CANS) Tool will be an essential component of a screening system for Protective Services to refer automatically to HFW. Screening criteria based on a CANS score, and other assessment tools need to be developed. CYFD will also develop a procedure and a system of accountability to ensure referrals occur in all instances in which they are indicated. CYFD and HSD, through an Interagency Council, will develop internal protocols as well as guidance for external referral sources to understand when and how to refer children and youth to HFW.

New Mexico will be implementing a phased in approach:

- Phase One: Given that children in protective services custody are most at risk, the 2,132 New Mexican children in CYFD custody will be phase one of the implementation. To reach the goal of serving all children in CYFD custody we would need 101 facilitators in 17 counties.
- Phase two: Will include all children in New Mexico in need of HFW.

Providers: New Mexico is proposing to utilize the Behavioral Health Agencies (BHA) 432 as the primary service provider type. Providers with documented experience working with SED children and families, as well as care coordination, case management, care coordination, or resource management will be allowed to apply for enrollment and training as a Medicaid HFW provider.

Providers will send a letter of interest to CYFD's contractor, New Mexico State University's (NMSU's) Center of Innovation (COI). COI will request information and if the agency meets criteria, the process flows through an Interagency Council consisting of CYFD, HSD/Behavioral Health Services Division (BHSD), and Medicaid representatives will review and determine if a provider may proceed with the next steps to enroll as a Medicaid provider and contract with the Managed Care Organizations (MCOs). The COI will employ coaches and trainers to continue to seed the system of care with high quality subject matter experts.

HSD is currently considering requirements for provider payments, care coordination, ensuring and monitoring access, assessment of medical necessity, overseeing quality of services, data collection, paying for start-up or training costs.

Billing Methodology: Submission of the HFW service model via an 1115 waiver will allow HSD to address current provider limitations by which providers can provide HFW, provide payment for services not otherwise billable, and continue to expand the population of children served over time. Specific coding and billing practices should be followed for a HFW team, based on the expected or actual number of encounters necessary to ensure the safety, improved functioning, and recovery of the youth.

A monthly case rate will simplify billing and permit HSD to set a rate that encompasses all key elements of HFW. The rate should include indirect cost reimbursement for the delivery of the HFW model, taking into consideration the factors that contribute to under-compensation through traditional payment models. This approach includes compensation for:

- Small caseloads;
- Team staffing, including unlicensed practitioners;
- Extraordinary training, supervision, and certification costs; and
- Lost productivity due to collateral contacts, travel associated with community-based services, daily team meetings, outreach, telephone calls, and documentation.

HFW delivers the outcomes youth/families, systems, and providers seek. In addition, HFW delivers these outcomes while reducing costs.

There are also increasing data on ROI from the many states and communities that have implemented Wraparound. States and communities that have implemented the system of care approach (driven through the implementation of HFW have reported changes in service utilization patterns. Such changes have resulted in cost savings for the public systems that serve children with serious mental health conditions and their families (Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C., 2014).

Amendment Proposal #3: GME expansion funding mechanism designed to develop new and/or expanded GME programs focusing on the specialties of General Psychiatry, Family Medicine, General Pediatrics, and General Internal Medicine.

The need for primary care physicians in New Mexico and nationally is well documented. NM has the oldest physician population, and an on-going need for 100 –200 primary care physicians and a similar number of psychiatrists. The ability to serve Medicaid customers and others in a comprehensive, cost-effective primary care system is significantly hampered by this provider shortage.

Investment in the primary care physician workforce yields significant returns for both local economies and population health. For example, each physician supports $3,166,901 in output, an average of 17.07 jobs, approximately $1.4 million in total wages and benefits, and $126,000 in state and local tax revenues. Finally, the availability of a primary care physician in a rural area leads to better health outcomes such as those relating to mortality and heart disease as well as a reduction in emergency room visits.

There is significant drive and energy among New Mexicans to expand primary care GME programs. (GME is the physician training period after medical school and before independent practice; research illustrates 50-75% of residents will stay within 100 miles of their residency program). In 2020, HSD (in collaboration with community stakeholders) released a 5-year strategic plan for primary care GME expansion. The strategic plan outlines that over a 5-year period, starting in 2019, the anticipated GME primary care programs would grow from 8 to 13 (63% increase). In 2020, two additional programs were added for a 25% increase. Further, the number of primary care residents in training is expected to grow from 142 to 297 (a 109% increase). The number of graduates each year would grow from 48 to 93 (starting in 2025), representing a 94% increase.

To make this expansion possible, GME programs require funding support from the State. Thus, HSD requests expenditure authority for federal match of $500,000 state general fund per year to establish a Primary Care GME expansion funding mechanism designed to develop new and/or expanded GME programs focusing on the primary care specialties of General Psychiatry, Family Medicine, General Pediatrics, and General Internal Medicine.

The GME expansion program provides grant funding and technical assistance to new and/or expanded primary care medical residency programs in community-based primary care settings, such as Federally Qualified Health Centers, rural health clinics, and tribal health centers. HSD requests federal match for the GME expansion funding. HSD will prioritize funding applications that emphasize the following: (1) developing new or expanded programs with specialties of General Psychiatry, Family Medicine, General Pediatrics, and General Internal Medicine; (2) increasing positions for medical specialties having shortages within the state; and (3) increasing positions in medically underserved areas. Any of the entities below may apply for GME Expansion funding:

- a NM Sponsoring Institution;
- a NM licensed hospital;
- an academic medical education institution;
- a new or proposed freestanding GME program;
- an established or new GME training consortium; or,
- an FQHC or Rural Health Clinic.

An eligible GME program must meet the criteria below. The program must:

- be an existing, new or planned, nationally accredited non-military residency (post-medical school GME) program;
- be a Sponsoring Institution;
- have, or intend to have, first-year residency positions; and,
- intend to create new first-year positions through expansion of an existing program or establishment of a new GME program.

Preferences for funding include:

- Federally Qualified Health Center (FQHC) applicants;
- Applicants providing services in rural or frontier communities;
- Applicants providing services in underserved populations (e.g. disparate access to primary care, poor health status, addressing health disparities, and other locally determined concerns);
- Programs demonstrating commitment to recruit diverse New Mexican residents; and,
- Programs demonstrating commitment to retain residents in New Mexico post-residency.

Funding Criteria

HSD will solicit applications from eligible Graduate Medical Education (GME) programs that intend to create new First-Year Residency Positions in the state by establishing a new- or expanding an existing- GME program. Program funds may be used to:

1) Plan for and develop new- or expand existing- Accreditation Council of Graduate Medical Education (ACGME) programs within the specified primary care specialties;
2) Cover staff, technical assistance, and other related costs associated with ACGME application development for new programs; and/or,
3) Fund start-up operating costs prior to launch of a new program.

Programs are prohibited from expending funds on the following:

- Resident salaries.
- Salaries/stipends and benefits payments for residents subsidized by the military, Public Health Service, or other federal agencies.
- Salaries/stipends and benefits that are calculated at a higher pay rate than that which an individual (or similar position) normally receives at the Sponsoring Institution or participating site.
- Professional liability insurance for professional activities outside the participating residency program.

Application Criteria

Applications must include the following four requirements:

Requirement 1: An Abstract that will serve as a summary of key information. Applicants are encouraged to use the Abstract.

Requirement 2: A narrative of not more than 20 total pages (Times New Roman font, 12-point, double-spaced and one-inch margins) that captures the information requested from the sections to be described within this RFA. Each section should be clearly labeled, and pages beyond the 20-page limit will <u>not</u> be considered. Appendices and attachments do not count towards the 20-page limit.

Requirement 3: A budget indicating the uses of grant funds for residency development purposes. Applicants may use the template provided or submit in a different format so long as information requested is provided.

Requirement 4: A project workplan reflecting the program stage of development and goals and objectives identified in the abstract, budget, and narrative. Workplan should cover a minimum of twelve months, and-supplementing the organizational chart-include a diagram that illustrates the structure for implementing, coordinating, overseeing and reporting on the different components of the plan and activities for the project. Applicants may use the sample project workplan or submit in a different format so long as information requested is provided.

Applicants may apply for any or all levels of program development from initial assessments through pre-start-up operating support. (A summary of the stages is provided below followed by more comprehensive descriptions). Grant applications can be for support at any level of development.

Summary of ACGME-accredited program development stages:

A. *Stage 1: Planning for a Residency Program – Needs & Assets Assessment*
    - Partnerships vs Independent Programs
    - Collaborators / Stakeholders Involved
    - Developing a new Sponsoring Institution or
    - Working with an Existing Sponsoring Institution
    - The degree to which the community, organization or consortium has assessed its capacity to develop an ACGME accredited physician training program in one of the priority specialties
    - To what degree has an initial financial assessment been completed
    - Whether the RFA Applicant has organizational (CEO/Board/GME Committee, if applicable) approval to proceed with residency development
    - Budgeting and Preparing a Proforma

B. *Stage 2: ACGME Application Development*
    - The degree to which staff and financial resources have been allocated to program development
    - Development and Submitting of a Sponsoring Institution Application, if applicable
    - Developing and Submitting a Program Application (for the Specialty Program chosen)
    - Documentation and Site Visit Preparation
    - Program Letters of Agreement

C. *Stage 3: Pre-Operations (time between program approval and beginning of residency training)*
    - ACGME Initial Accreditation Letter
    - Pre-Operation Support
        - Recruitment Costs
        - Faculty and Administrative Costs
        - Addressing Citations

Establish a funding pool or other approvable mechanism to support workforce development

HSD proposes a funding pool or other approvable mechanism for federal Medicaid support for graduate medical education to support workforce development, with the goal of improving access to care in rural and frontier regions of New Mexico by increasing the number of primary care, family medicine, and psychiatric residents in community-based clinic settings. Under the proposed methodology, HSD will fund the total cost of up to ten residencies statewide in community-based provider settings with high numbers of attributed Medicaid patients. The community-based clinic will be required to meet HSD established criteria to be eligible for the alternative payment. The criteria may include to type of residency program offered, numbers and types of Medicaid clients served, and other categories of residency programs. HSD will work with the New Mexico Primary Care Association and the New Mexico Primary Care Training Consortium to develop the specific criteria for funding these residencies and the terms of agreement among the community-based clinics, hospitals and HSD.

Amendment Proposal #4: Expand COVID-19 vaccine coverage to individuals who have limited benefits like Family Planning Category of Eligibility (COE), Emergency Medical Services for Aliens (EMSA), Uninsured Individuals – COVID-19 testing and related services (FFCRA), and Pregnancy related services.

HSD proposes to add coverage of the Coronavirus (COVID –19) vaccine and its administration for all populations covered under this demonstration waiver. While the initial cost of the vaccine will be paid for through federal funding authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act, HSD proposes to reimburse providers for the cost of the vaccine at such time when federal funding to purchase the vaccine is no longer available to States. HSD also proposes to cover administration of the vaccine by a provider for individuals with limited benefit plan coverage including those who are covered under Family Planning Category of Eligibility (COE), Emergency Medical Services for Aliens (EMSA), Uninsured Individuals –COVID-19 testing and related services (FFCRA), and Pregnancy related services COE (301).

SECTION 3: CURRENT PROGRAM DESIGN

A. Current Populations Covered

Table 1 represents the eligibility groups currently served in Centennial Care 2.0. At the end of 2020, New Mexico's Medicaid program covered approximately 900,000 individuals, with 752,000 enrolled in Centennial Care. Since the end of 2018, HSD has enrolled more than 52,000 new individuals into the program, with the largest growth attributed to the Medicaid adult expansion program.

Table 1 – Eligibility Groups Covered in Centennial Care 2.0

Population Group	Populations
TANF and Related	Newborns, infants, and children Children's Health Insurance Program (CHIP) Foster children Adopted children Pregnant women Low-income parent(s)/caretaker(s) and families Breast and cervical cancer Refugees Transitional medical assistance
SSI Medicaid	Aged, blind and disabled Working disabled
SSI Dual Eligible	Aged, blind and disabled Working disabled
Medicaid Expansion	Adults between 19-64 years old up to 133% of MAGI

The following populations are excluded from Centennial Care:

- Qualified Medicare Beneficiaries;
- Specified Low-Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency medical services;
- Program of All-Inclusive Care for the Elderly;
- Individuals residing in Intermediate Care Facilities for Individuals with an Intellectual Disability;
- Individuals eligible for family planning services only.

The following services are excluded from Centennial Care:

- Medically Fragile 1915(c) waiver HCBS;
- Developmentally Disabled 1915(c) HCBS;
- Mi Via 1915(c) HCBS; and
- Supports Waiver 1915(c) waiver HCBS.

Appendix F provides the complete table of mandatory and optional populations covered in the current waiver and outlined in the approved STCs. Appendix F also includes a table of Individuals whose coverage is limited under section 42 CFR 435.214 and is expanded to include COVID-19 vaccine and vaccine administration whose coverage is limited under section 6008 of the Family First Coronavirus Response Act (FFCRA).

B. Current Demonstration Benefits

Centennial Care provides a comprehensive package of services that include behavioral health, physical health, and long-term care services and supports. Members meeting NF LOC are able to access LTSS through CB services (i.e., home and community-based services) without a waiver slot. The CB is available through agency-based community benefit services (ABCB) (services provided by a provider agency) and self-directed community benefit services (SDCB) (services that a participant can control and direct).

Centennial Care also includes services only available for individuals enrolled in Centennial Care, including the Community Interveners for deaf and blind individuals. A Community Intervener is a trained professional who works one-on-one with deaf-blind individuals who are older than four years of age to provide critical connections to other people and the community.

Appendix H provides the comprehensive benefits currently available to Centennial Care members and outlined in the approved STCs.

SECTION 4: WAIVER LIST

A. Expenditure Authority Requests

Under the authority of section 1115(a)(2) of the SSA, expenditures made by HSD for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration, be regarded as expenditures under the Medicaid State Plan but are further limited by the special terms and conditions for the section 1115 demonstration.

1. Expenditures for members in managed care and FFS to receive expanded services provided through an IMD. Expanded services will be available to eligible adults with SMI and children with SED in the event they meet the diagnostic criteria mandated by the included assessment (Attachment A) so long as the cost of care is the same as, or more cost effective than, a setting that is not an IMD.

2. Expenditure authority to provide grant funding and technical assistance to new and/or expanded primary care medical residency programs in community-based primary care settings, such as Federally Qualified Health Centers, rural health clinics, and tribal health centers.

3. Expenditure authority to provide reimbursement for the cost of the COVID-19 vaccine, to the extent not covered by the federal government during the period of the Centennial Care 2.0 demonstration, and its administration to all populations covered under this demonstration waiver and to extend such coverage and reimbursement to the following limited benefit plan populations:

   - Family Planning;
   - COVID-19 Uninsured Group;
   - Emergency Medical Services for Aliens; and
   - Pregnancy-related services.

4. Expenditure authority to provide coverage and reimbursement for HFW services for children and youth with high intensity needs.

B. Waiver Authority Requests

Under the authority of section 1115(a)(1) of the SSA, waivers of applicable provisions of section 1902 of the SSA to support the following initiatives:

1. Waiver of any requirement in section 1902 of the SSA required to implement coverage and reimbursement for HFW services for children and youth with high intensity needs.

SECTION 5: COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS

The current waiver, including STCs, was approved in December 2018, and is effective for the five-year period between January 1, 2019, to December 31, 2023. As currently approved, New Mexico is compliant with the requirements of the approved Centennial Care waiver.

SECTION 6: APPROACH TO BUDGET NEUTRALITY

A. Budget Neutrality Overview

The proposed waiver amendment proposals will have a minimal impact to the budget neutrality.

B. CHIP Allotment Neutrality

The amendment proposals will not impact allotment neutrality.

C. Budget Neutrality Summary

The federal share of the combined Medicaid expenditures for the populations included in this demonstration, excluding those covered under the Title XXI Allotment Neutrality, will not exceed the federal share of Medicaid expenditures without the demonstration.

HSD makes the following assumptions with regard to budget neutrality:

- HSD proposes a per capita budget neutrality model for the populations covered under the demonstration and outline the per capita limit by Medicaid Eligibility Group (MEG) and proposes an aggregate cap, trended annually for uncompensated care and Hospital Quality Improvement Incentive expenditures;
- State administrative costs are not subject to the budget neutrality calculations;
- The projected savings is the difference between the without and with waiver projections;
- Nothing in this demonstration application precludes HSD from applying for enhanced Medicaid funding as CMS issues new opportunities or policies; and
- The budget neutrality agreement is in terms of total computable so that HSD is adversely affected by future changes to federal medical assistance percentages.

Table 2 – Current Approved Without Waiver and With Waiver Projected Medicaid Expenditures (Total Computable)

Waiver Period Description	Current Approved	Amendment Proposals
Total 5 Year Member Months (Without Waiver)	49,499,763	49,576,615
Total 5 Year Member Months (With Waiver)	49,499,793	49,576,615
Current Waiver Variance (DY1-DY5)	$3,762,696,140	$3,762,696,140
Renewal Waiver (DY6-DY10)		
Without Waiver	$40,386,951,910	$40,412,589,964
With Waiver	$34,313,721,693	$34,434,661,132
Savings (Without Less With Waiver)	$6,073,230,217	$5,977,928,832
Savings after Phasedown of Savings	$4,156,379,601	$4,101,403,392
Savings with D1-DY5 Carryover and DY6-DY10 Phase-down	**$7,919,075,741**	**$7,864,099,532**

	New Mexico Budget Neutrality Status By Calendar Year					
Without Waiver	DY1 - 2014 Actual	DY2 - 2015 Actual	DY3 - 2016 Actual	DY4 - 2017 Actual	DY5 - 2018 ***Projected	5-Year Total DY1-DY5
Member Months - Actual						
MEG 1 - TANF and Related	4,517,149	4,454,290	4,621,656	4,620,724	4,794,344	**23,008,163**
MEG 2 - SSI Medicaid Only	497,958	494,529	493,577	487,965	493,777	**2,467,806**
MEG 3 - SSI Dual	428,025	435,140	447,801	441,565	454,413	**2,206,944**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	2,799	2,382	2,987	3,830	3,957	**15,955**
MEG 5 - 217-Like group Dual	26,895	27,063	31,866	40,287	41,859	**167,970**
MEG 6 - VIII Group (Medicaid Expansion)	1,887,728	2,748,632	3,078,074	3,140,843	3,219,148	**14,074,425**
Total Member Months	**7,360,554**	**8,162,036**	**8,675,961**	**8,735,214**	**9,007,497**	**41,941,262**
Without Waiver PMPMs						
MEG 1 - TANF and Related	$ 385.80	$ 400.77	$ 416.32	$ 432.47	$ 449.25	**$ 417.43**
MEG 2 - SSI Medicaid Only	$ 1,763.90	$ 1,842.83	$ 1,925.21	$ 2,008.00	$ 2,094.34	**$ 1,926.36**
MEG 3 - SSI Dual	$ 1,780.77	$ 1,857.34	$ 1,937.21	$ 2,020.51	$ 2,107.39	**$ 1,942.83**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 4,936.92	$ 5,090.46	$ 5,248.77	$ 5,412.01	$ 5,580.32	**$ 5,291.83**
MEG 5 - 217-Like group Dual	$ 1,776.90	$ 1,853.31	$ 1,933.00	$ 2,016.12	$ 2,102.81	**$ 1,957.42**
MEG 6 - VIII Group (Medicaid Expansion)	$ 577.87	$ 607.34	$ 638.31	$ 670.87	$ 705.08	**$ 646.69**
Total PMPM	**$ 616.22**	**$ 641.55**	**$ 666.65**	**$ 695.96**	**$ 724.45**	**$ 671.44**
Without Waiver Expenditures						
MEG 1 - TANF and Related	$ 1,742,724,978	$ 1,785,150,637	$ 1,924,092,463	$ 1,998,344,184	$ 2,153,879,288	**$ 9,604,191,550**
MEG 2 - SSI Medicaid Only	$ 878,350,269	$ 911,332,022	$ 950,239,887	$ 979,831,334	$ 1,034,137,005	**$ 4,753,890,517**
MEG 3 - SSI Dual	$ 762,214,336	$ 808,204,553	$ 867,484,358	$ 892,186,288	$ 957,625,947	**$ 4,287,715,482**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 13,818,444	$ 12,125,476	$ 15,678,086	$ 20,727,999	$ 22,078,742	**$ 84,428,746**
MEG 5 - 217-Like group Dual	$ 47,789,749	$ 50,156,064	$ 61,596,973	$ 81,223,380	$ 88,022,421	**$ 328,788,588**
MEG 6 - VIII Group (Medicaid Expansion)	$ 1,090,856,222	$ 1,669,350,032	$ 1,964,773,916	$ 2,107,087,019	$ 2,269,759,489	**$ 9,101,826,677**
Safety Net Care Pool						
Uncompensated Care	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 68,889,323	**$ 344,446,615**
HQII	$ -	$ 2,824,462	$ 5,764,727	$ 8,825,544	$ 12,011,853	**$ 29,426,586**
Total Expenditures	**$ 4,604,643,320**	**$ 5,308,032,569**	**$ 5,858,519,734**	**$ 6,157,115,071**	**$ 6,606,404,068**	**$ 28,534,714,762**

	New Mexico Budget Neutrality Status By Calendar Year					
With Waiver	DY1 - 2014 Actual	DY2 - 2015 Actual	DY3 - 2016 Actual	DY4 - 2017 Actual	DY5 - 2018 ***Projected	5-Year Total DY 01-DY 05
With Waiver PMPMs						
MEG 1 - TANF and Related	$ 329.56	$ 344.71	$ 339.89	$ 320.25	$ 331.34	**$ 333.07**
MEG 2 - SSI Medicaid Only	$ 1,656.46	$ 1,785.14	$ 1,753.81	$ 1,729.49	$ 1,797.09	**$ 1,744.30**
MEG 3 - SSI Dual	$ 1,333.20	$ 1,342.69	$ 1,353.24	$ 1,264.02	$ 1,312.01	**$ 1,320.93**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 2,380.17	$ 2,347.27	$ 2,539.53	$ 3,276.11	$ 3,378.05	**$ 2,867.63**
MEG 5 - 217-Like group Dual	$ 3,226.87	$ 3,143.68	$ 2,879.63	$ 2,792.74	$ 2,912.94	**$ 2,965.23**
MEG 6 - VIII Group (Medicaid Expansion)	$ 454.02	$ 477.23	$ 452.76	$ 452.41	$ 475.48	**$ 462.83**
Total PMPM	**$ 520.98**	**$ 539.68**	**$ 522.76**	**$ 506.90**	**$ 526.01**	**$ 523.14**
With Waiver Expenditures						
MEG 1 - TANF and Related	$ 1,488,667,702	$ 1,535,460,173	$ 1,570,847,385	$ 1,479,771,354	$ 1,588,545,862	**$ 7,663,292,476**
MEG 2 - SSI Medicaid Only	$ 824,848,758	$ 882,801,472	$ 865,639,419	$ 843,930,022	$ 887,363,765	**$ 4,304,583,436**
MEG 3 - SSI Dual	$ 570,641,057	$ 584,259,220	$ 605,981,392	$ 558,147,336	$ 596,196,493	**$ 2,915,225,498**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 6,662,084	$ 5,591,208	$ 7,585,577	$ 12,547,497	$ 13,365,365	**$ 45,751,731**
MEG 5 - 217-Like group Dual	$ 86,786,741	$ 85,077,407	$ 91,762,281	$ 112,511,133	$ 121,933,866	**$ 498,071,428**
MEG 6 - VIII Group (Medicaid Expansion)	$ 857,072,658	$ 1,311,717,799	$ 1,393,624,749	$ 1,420,952,207	$ 1,530,653,327	**$ 6,514,020,740**
Safety Net Care Pool						
Uncompensated Care	$ 68,889,323	$ 67,294,973	$ 68,889,323	$ 68,889,324	$ 68,889,323	**$ 342,852,266**
HQII	$ -	$ 2,824,462	$ 7,359,077	$ -	$ 12,011,853	**$ 22,195,392**
Total Expenditures	**$ 3,903,568,323**	**$ 4,475,026,714**	**$ 4,611,689,203**	**$ 4,496,748,873**	**$ 4,818,959,853**	**$ 22,305,992,966**

Budget Neutrality Variance	New Mexico Budget Neutrality Status By Calendar Year					
	DY1 - 2014 Actual	DY2 - 2015 Actual	DY3 - 2016 Actual	DY4 - 2017 Actual	DY5 - 2018 ***Projected	5-Year Total DY 01-DY 05
Without Less With Waiver Expenditures	**$ 499,132,065**	**$ 502,166,347**	**$ 699,348,513**	**$ 988,513,095**	**$ 1,073,536,120**	**$ 3,762,696,140**
Cumulative Variance	**$ 499,132,065**	**$ 1,001,298,412**	**$ 1,700,646,925**	**$ 2,689,160,020**	**$ 3,762,696,140**	**$ 3,762,696,140**

** Variance excludes Hypothetical Groups and Safety Net Care Pool Expenditures*

Expenditure Variance By Waiver Group						
MEG 1 - TANF and Related	$ 254,057,276	$ 249,690,464	$ 353,245,078	$ 518,572,830	$ 565,333,426	**$ 1,940,899,075**
MEG 2 - SSI Medicaid Only	$ 53,501,511	$ 28,530,550	$ 84,600,468	$ 135,901,312	$ 146,773,240	**$ 449,307,081**
MEG 3 - SSI Dual	$ 191,573,279	$ 223,945,333	$ 261,502,966	$ 334,038,952	$ 361,429,453	**$ 1,372,489,984**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 7,156,360	$ 6,534,268	$ 8,092,509	$ 8,180,502	$ 8,713,377	**$ 38,677,015**
MEG 5 - 217-Like group Dual	$ (38,996,992)	$ (34,921,343)	$ (30,165,308)	$ (31,287,753)	$ (33,911,445)	**$ (169,282,840)**
MEG 6 - VIII Group (Medicaid Expansion)	$ 233,783,564	$ 357,632,233	$ 571,149,167	$ 686,134,812	$ 739,106,162	**$ 2,587,805,937**
Safety Net Care Pool						
Uncompensated Care	$ -	$ 1,594,350	$ -	$ (1)	$ -	**$ 1,594,349**
HQII	$ -	$ 0	$ (1,594,350)	$ 8,825,544	$ -	**$ 7,231,194**
Total Variance	**$ 701,074,997**	**$ 833,005,855**	**$ 1,246,830,531**	**$ 1,660,366,198**	**$ 1,787,444,214**	**$ 6,228,721,795**

Without Waiver	Annualized Trend	New Mexico Budget Neutrality Status By Calendar Year						
		Adjustments to DY5	DY6 - 2019 Projected	DY7 - 2020 Projected	DY8 - 2021 Projected	DY9 - 2022 Projected	DY10 - 2023 Projected	5-Year Total DY6-DY10
Member Months								
MEG 1 - TANF and Related	3.8%	-	4,974,487	5,161,399	5,355,334	5,556,556	5,765,338	**26,813,113**
MEG 2 - SSI Medicaid Only	1.2%	-	499,659	505,610	511,633	517,727	523,894	**2,558,523**
MEG 3 - SSI Dual	2.9%	-	467,635	481,241	495,244	509,653	524,482	**2,478,255**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	9.0%	-	4,373	4,802	5,244	5,698	6,166	**26,283**
MEG 5 - 217-Like group Dual	9.6%	-	46,535	51,395	56,446	61,696	67,152	**283,226**
MEG 6 - VIII Group (Medicaid Expansion)	2.5%	-	3,299,404	3,381,662	3,465,970	3,552,381	3,640,945	**17,340,362**
Hypothetical Services only MEGs								
MEG 10 - Covid-19 Vaccine Coverage For Partial Benefit Populations	0.0%	-	-	-	-	-	-	-
MEG 11 - High Fidelity Wrap Coverage For Fee-For-Service Members	0.0%	-	-	-	-	-	-	-
Total Member Months	**3.2%**	-	**9,292,093**	**9,586,110**	**9,889,870**	**10,203,711**	**10,527,979**	**49,499,763**
Without Waiver PMPM								
MEG 1 - TANF and Related	3.8%	$ (6.10)	$ 460.00	$ 477.48	$ 495.62	$ 514.45	$ 534.00	**$ 497.68**
MEG 2 - SSI Medicaid Only	4.1%	$ (20.59)	$ 2,158.77	$ 2,247.28	$ 2,339.42	$ 2,435.34	$ 2,535.19	**$ 2,345.43**
MEG 3 - SSI Dual	4.1%	$ (130.82)	$ 2,057.62	$ 2,141.98	$ 2,229.80	$ 2,321.22	$ 2,416.39	**$ 2,238.54**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.1%	$ (6.38)	$ 5,747.30	$ 5,926.04	$ 6,110.34	$ 6,300.37	$ 6,496.31	**$ 6,148.01**
MEG 5 - 217-Like group Dual	4.1%	$ 1,414.18	$ 3,661.18	$ 3,811.29	$ 3,967.56	$ 4,130.23	$ 4,299.57	**$ 4,003.02**
MEG 6 - VIII Group (Medicaid Expansion)	4.7%	$ -	$ 738.22	$ 772.92	$ 809.24	$ 847.28	$ 887.10	**$ 812.78**
Hypothetical Services only MEGs								
MEG 10 - Covid-19 Vaccine Coverage For	0.0%	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
MEG 11 - High Fidelity Wrap Coverage For Fee-For-Service Members	0.0%	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Total PMPM	**4.0%**	**$ (4.40)**	**$ 749.06**	**$ 779.21**	**$ 810.55**	**$ 843.13**	**$ 876.99**	**$ 813.78**
Without Waiver Expenditure								
MEG 1 - TANF and Related		$ (29,231,764)	$ 2,288,249,485	$ 2,464,449,112	$ 2,654,216,451	$ 2,858,596,241	$ 3,078,713,669	**$ 13,344,224,957**
MEG 2 - SSI Medicaid Only		$ (10,166,391)	$ 1,078,650,304	$ 1,136,249,871	$ 1,196,925,236	$ 1,260,840,644	$ 1,328,169,115	**$ 6,000,835,170**
MEG 3 - SSI Dual		$ (59,444,427)	$ 962,212,283	$ 1,030,807,756	$ 1,104,293,355	$ 1,183,017,693	$ 1,267,354,237	**$ 5,547,685,323**
Hypothetical Group								
MEG 4 - 217-Like Medicaid		$ (25,230)	$ 25,133,717	$ 28,456,808	$ 32,039,692	$ 35,900,401	$ 40,058,175	**$ 161,588,792**
MEG 5 - 217-Like group Dual		$ 59,196,558	$ 170,374,456	$ 195,882,517	$ 223,954,368	$ 254,819,251	$ 288,725,944	**$ 1,133,756,535**
MEG 6 - VIII Group (Medicaid Expansion)		$ -	$ 2,435,685,299	$ 2,613,740,753	$ 2,804,812,563	$ 3,009,852,259	$ 3,229,880,935	**$ 14,093,971,810**
Hypothetical Services only MEGs								
MEG 10 - Covid-19 Vaccine Coverage For Partial Benefit Populations		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
MEG 11 - High Fidelity Wrap Coverage For Fee-		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Safety Net Care Pool								
Uncompensated Care Pool		$ -	$ 68,889,323	$ -	$ -	$ -	$ -	**$ 68,889,323**
HQII		$ -	$ 12,000,000	$ 12,000,000	$ 12,000,000	$ -	$ -	**$ 36,000,000**
Graduate Medical Education		$ -	$ -	$ -	$ 2,457,089	$ 2,457,089	$ 2,457,089	**$ 7,371,267**
Total Expenditures		**$ (39,671,254)**	**$ 7,041,194,866**	**$ 7,481,586,817**	**$ 8,030,698,752**	**$ 8,605,483,578**	**$ 9,235,359,163**	**$ 40,394,323,177**

With Waiver	Annualized Trend	Adjustments to DY5	New Mexico Budget Neutrality Status By Calendar Year DY 06 - 2019 Projected	DY 07 - 2020 Projected	DY 08 - 2021 Projected	DY 09 - 2022 Projected	DY 10 - 2023 Projected	5-Year Total DY 06-DY 10
Member Months								
MEG 1 - TANF and Related	3.8%	-	4,974,487	5,161,399	5,355,334	5,556,556	5,765,338	**26,813,113**
MEG 2 - SSI Medicaid Only	1.2%	-	499,659	505,610	511,633	517,727	523,894	**2,558,523**
MEG 3 - SSI Dual	2.9%	-	467,635	481,241	495,244	509,653	524,482	**2,478,255**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	9.0%	-	4,373	4,802	5,244	5,698	6,166	**26,283**
MEG 5 - 217-Like group Dual	9.6%	-	46,535	51,395	56,446	61,696	67,152	**283,226**
MEG 6 - VIII Group (Medicaid Expansion)	2.5%	-	3,299,404	3,381,662	3,465,970	3,552,381	3,640,945	**17,340,362**
Hypothetical Services only MEGs								
MEG 10 - Covid-19 Vaccine Coverage For Partial Benefit Populations	0.0%	-	-	-	-	-	-	-
MEG 11 - High Fidelity Wrap Coverage For Fee-For-Service Members	0.0%	-	-	-	-	-	-	-
Total Member Months	**3.2%**	-	**9,292,093**	**9,586,110**	**9,889,870**	**10,203,711**	**10,527,979**	**49,499,763**
With Waiver PMPMs								
MEG 1 - TANF and Related	3.9%	$ -	$ 344.61	$ 356.54	$ 372.25	$ 388.37	$ 401.82	**$ 373.80**
MEG 2 - SSI Medicaid Only	3.9%	$ -	$ 1,881.37	$ 1,954.91	$ 2,031.33	$ 2,110.73	$ 2,193.24	**$ 2,036.16**
MEG 3 - SSI Dual	3.8%	$ -	$ 1,374.39	$ 1,426.57	$ 1,480.74	$ 1,536.96	$ 1,595.32	**$ 1,485.96**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.1%	$ -	$ 5,747.30	$ 5,926.04	$ 6,110.34	$ 6,300.37	$ 6,496.31	**$ 6,148.01**
MEG 5 - 217-Like group Dual	4.1%	$ -	$ 3,661.18	$ 3,811.29	$ 3,967.56	$ 4,130.23	$ 4,299.57	**$ 4,003.02**
MEG 6 - VIII Group (Medicaid Expansion)	4.7%	$ -	$ 738.22	$ 772.92	$ 809.24	$ 847.28	$ 887.10	**$ 812.78**
Hypothetical Services only MEGs								
MEG 10 - Covid-19 Vaccine Coverage For	0.0%	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
MEG 11 - High Fidelity Wrap Coverage For Fee-For-Service Members	0.0%	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Total PMPM	**3.9%**	**$ -**	**$ 639.90**	**$ 662.76**	**$ 693.93**	**$ 722.35**	**$ 746.68**	**$ 694.83**
With Waiver Expenditures								
MEG 1 - TANF and Related		$ -	$ 1,714,233,973	$ 1,840,243,276	$ 1,993,498,540	$ 2,158,019,237	$ 2,316,650,150	**$ 10,022,645,175**
MEG 2 - SSI Medicaid Only		$ -	$ 940,044,519	$ 988,424,895	$ 1,039,295,218	$ 1,092,783,635	$ 1,149,024,890	**$ 5,209,573,157**
MEG 3 - SSI Dual		$ -	$ 642,711,733	$ 686,525,684	$ 733,326,452	$ 783,317,649	$ 836,716,769	**$ 3,682,598,286**
Hypothetical Group								
MEG 4 - 217-Like Medicaid		$ -	$ 25,133,717	$ 28,456,808	$ 32,039,692	$ 35,900,401	$ 40,058,175	**$ 161,588,792**
MEG 5 - 217-Like group Dual		$ -	$ 170,374,456	$ 195,882,517	$ 223,954,368	$ 254,819,251	$ 288,725,944	**$ 1,133,756,535**
MEG 6 - VIII Group (Medicaid Expansion)		$ -	$ 2,435,685,299	$ 2,613,740,753	$ 2,804,812,563	$ 3,009,852,259	$ 3,229,880,935	**$ 14,093,971,810**
Hypothetical Services only MEGs								
MEG 10 - Covid-19 Vaccine Coverage For		$ -	$ 8,917,845	$ -	$ 17,983,314	$ 17,983,314	$ -	**$ 44,884,473**
MEG 11 - High Fidelity Wrap Coverage For Fee-		$ -	$ 8,917,845	$ -	$ 17,983,314	$ 17,983,314	$ -	**$ 44,884,473**
Safety Net Care Pool								
Uncompensated Care Pool		$ -	$ 68,889,323	$ -	$ -	$ -	$ -	**$ 68,889,323**
HQII		$ -	$ 12,000,000	$ 12,000,000	$ 12,000,000	$ -	$ -	**$ 36,000,000**
Graduate Medical Education		$ -	$ -	$ -	$ 2,457,089	$ 2,457,089	$ 2,457,089	**$ 7,371,267**
Total Expenditures		**$ -**	**$ 6,026,908,710**	**$ 6,365,273,933**	**$ 6,877,350,549**	**$ 7,373,116,149**	**$ 7,863,513,951**	**$ 34,506,163,292**

Budget Neutrality Variance	DY1 - DY5 Savings	Adjustments to DY5	New Mexico Budget Neutrality Status By Calendar Year DY 06 - 2019 Projected	DY 07 - 2020 Projected	DY 08 - 2021 Projected	DY 09 - 2022 Projected	DY 10 - 2023 Projected	5-Year Total DY 06-DY 10
Expenditure Variance By Waiver Group								
MEG 1 - TANF and Related			$ 574,015,512	$ 624,205,836	$ 660,717,911	$ 700,577,003	$ 762,063,519	**$ 3,321,579,781**
MEG 2 - SSI Medicaid Only			$ 138,605,785	$ 147,824,976	$ 157,630,018	$ 168,057,009	$ 179,144,225	**$ 791,262,013**
MEG 3 - SSI Dual			$ 319,500,549	$ 344,282,072	$ 370,966,903	$ 399,700,044	$ 430,637,469	**$ 1,865,087,037**
Hypothetical Group								
MEG 4 - 217-Like Medicaid			$ -	$ -	$ -	$ -	$ -	**$ -**
MEG 5 - 217-Like group Dual			$ -	$ -	$ -	$ -	$ -	**$ -**
MEG 6 - VIII Group (Medicaid Expansion)			$ -	$ -	$ -	$ -	$ -	**$ -**
Hypothetical Services only MEGs								
MEG 10 - Covid-19 Vaccine Coverage For			$ (8,917,845)	$ -	$ (17,983,314)	$ (17,983,314)	$ -	**$ (44,884,473)**
MEG 11 - High Fidelity Wrap Coverage For Fee-For-Service Members			$ (8,917,845)	$ -	$ (17,983,314)	$ (17,983,314)	$ -	**$ (44,884,473)**
Safety Net Care Pool								
Uncompensated Care Pool			$ -	$ -	$ -	$ -	$ -	**$ -**
HQII			$ -	$ -	$ -	$ -	$ -	**$ -**
Graduate Medical Education			$ -	$ -	$ -	$ -	$ (0)	**$ (0)**
Total Variance			**$ 1,014,286,156**	**$ 1,116,312,884**	**$ 1,153,348,204**	**$ 1,232,367,429**	**$ 1,371,845,212**	**$ 5,888,159,885**
Expenditure Variance, Carry-over and Phase Down								
DY1 - DY5 Variance Carry-over	**$3,762,696,140**							
DY6 - DY10 Variance								
Savings by DY			$ 1,032,121,847	$ 1,116,312,884	$ 1,189,314,832	$ 1,268,334,057	$ 1,371,845,212	
Phase Down %			90.0%	80.0%	70.0%	60.0%	50.0%	
Savings after phase-down			$ 928,909,661.91	$ 893,050,307	$ 832,520,382	$ 761,000,434	$ 685,922,606	**$ 4,101,403,392**
Cumulative Savings			**$ 4,691,605,802**	**$ 5,584,656,109**	**$ 6,417,176,491**	**$ 7,178,176,925**	**$ 7,864,099,532**	**$ 7,864,099,532**

SECTION 7: EVALUATION DESIGN AND QUALITY STRATEGY

The current waiver includes STCs that were approved in December 2018 and are effective for the five-year period between January 1, 2019 to December 31, 2023. The current approval provided New Mexico up to 180 days from January 1, 2019 to develop the evaluation design and quality strategy. HSD received approval for the CMS for the Medicaid 1115 Demonstration and Substance Use Disorder Waiver Evaluation Design Plan on March 25, 2020. The document can be located on HSD website: https://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx

SECTION 8: STATE PUBLIC NOTICE

Draft Waiver Amendment Application

This draft waiver amendment application and all related documents can be found at HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. The website also provides information about scheduled public input sessions including meeting dates, times and locations.

HSD published the draft waiver amendment application on January 1, 2021. Table 3 outlines the scheduled public hearings scheduled by HSD.

Table 3 –Public Notice Timeline

Event	Dates
Public Comment Period	January 1, 2021 – January 31, 2021
Publish Date – Draft 1115 Waiver Amendment Application	January 1, 2021
Gather Feedback – Draft Waiver Amendment Application Public Hearings will be conducted virtually as a result of COVID-19:	
• **Public meeting: GoToMeeting (MAC Meeting)** **1:00 p.m. – 4:00 p.m.** https://global.gotomeeting.com/join/444460373 You can also dial in using your phone. United States: +1 (669) 224-3412 Access Code: 444-460-373 Join from a video-conferencing room or system. Dial in or type: 67.217.95.2 or inroomlink.goto.com Meeting ID: 444 460 373 Or dial directly: 444460373@67.217.95.2 or 67.217.95.2##444460373	January 19, 2021
• **Public meeting: GoToMeeting** **9:30 a.m. – 10:30 a.m.** Please join from your computer, tablet or smartphone. https://global.gotomeeting.com/join/335397581 You can also dial in using your phone. (For supported devices, tap a one-touch number below to join instantly.) United States: +1 (646) 749-3112 - One-touch: tel:+16467493112,,335397581# Access Code: 335-397-581	January 28, 2021
Final Waiver Application Submission to CMS	March 1, 2021

APPENDICES

Appendix A: Glossary

Acronym	Term
ABCB	Agency-Based Community Benefit
ABP	Alternative Benefit Plan
CB	Community Benefit
CFR	Code of Federal Regulations
CHV	Centennial Home Visiting
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
ED	Emergency Department
FPL	Federal Poverty Limit
GME	Graduate Medical Education
HCBS	Home and Community-Based Services
HSD	New Mexico's Human Services Department
LTSS	Long Term Services and Supports
MAGI	Modified adjusted gross income
MCO	Managed Care Organization
MEG	Medicaid Eligibility Group
NF	Nursing Facility
NFP	Nurse Family Partnership
NF LOC	Nursing Facility Level of Care
NM	New Mexico
NMAC	New Mexico Administrative Code
PAT	Parents as Teachers
SDCB	Self-Directed Community Benefit
SMI/SED	Serious Mental Illness/Serious Emotional Disturbance
STC	Special Terms and Conditions
SUD	Substance Use Disorder

Appendix B: Final Evaluation Report

The final evaluation report is available on HSD's website at:
https://www.hsd.state.nm.us/LookingForInformation/centennial-care-final-evaluation-report.pdf

Appendix C: State Public Notices

RESERVED – IN PROGRESS

Appendix D: Summary of Stakeholder Feedback (including Feedback from Federally Recognized Tribal Nations) and State Response

RESERVED – IN PROGRESS

Appendix E: Documents Demonstrating Quality

Attached are the following documents that provide strong evidence of HSD commitment to quality currently and ongoing:

1. Quality Strategy is available on HSD's website at: http://www.hsd.state.nm.us/providers/2017-nm-quality-strategy-final.pdf
2. EQRO Summary Reports are available on HSD's website at: http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Final%20Waiver%20Documents/Appendix%20E_2%20-%20EQRO%20Summary%20Report.pdf

Appendix F: Centennial Care 2.0 Eligibility Groups

Mandatory and optional state plan groups described below derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived and as described in the current 1115 Waiver Standard Terms and Conditions.

- Table 4 describes the mandatory State Plan populations included in Centennial Care;
- Table 5 describes the optional State Plan populations included in Centennial Care; and
- Table 6 below, describes the beneficiary eligibility groups who are made eligible for benefits by virtue of the expenditure authorities expressly granted in this demonstration (i.e. the 217-like group).

Table 4 – Mandatory State Plan Populations

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
Parents/Caretaker Relatives	Low Income Families (1931) 42 CFR 435.110	No	TANF and Related
Transitional Medical Assistance	Families with 12 month extension due to earnings • §408(a)(11)(A) • §1931(c)(2) • §1925 • §1902(a)(52) and 1902(e)(1)	No	TANF and Related
Extension due to Spousal Support	Families with 4 month extension due to increased collection of spousal support • §408(a)(11)(B) • §1931(c)(1) 42 CFR 435.115	No	TANF and Related
Pregnant Women	Consolidated group for pregnant women • §§1902(a)(10)(A)(i)(III) and (IV) • §§1902(a)(10)(A)(ii)(I), (IV) and (IX) • §1931(b) and (d) 42 CFR 435.116	No	TANF and Related
Children under Age 19	Consolidated group for children under age 19 • §§1902(a)(10)(A)(i)(III), (IV), (VI) and (VII) • §§1902(a)(10)(A)(ii)(IV) and (IX) • §1931(b) and (d) 42 CFR 435.118	No	TANF and Related
Continuous Eligibility for Hospitalized Children	Children eligible under 42 CFR 435.118 receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay §1902(e)(7) 42 CFR 435.172	No	TANF and Related
Deemed Newborns	Newborns deemed eligible for one year §1902(e)(4) 42 CFR 435.117	No	TANF and Related

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
Adoption Assistance and Foster Care Children	Children receiving IV-E foster care or guardianship maintenance payments or with IV-E adoption assistance agreements • §1902(a)(10)(i)(I) • §473(b)(3) 42 CFR 435.145	No	TANF and Related
Former Foster Care Children	Former foster care children under age 26 not eligible for another mandatory group 1902(a)(10)(A)(i)(IX) 42 CFR 435.150	No	TANF and Related
Adult group	Non-pregnant individuals age 19 through 64 with income at or below 133% FPL 1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	No	VIII Group
Aged, Blind, and Disabled	Individuals receiving SSI cash benefits 1902(a)(10)(A)(i)(II) Disabled children no longer eligible for SSI benefits because of a change in the definition of disability	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals under age 21 eligible for Medicaid in the month they apply for SSI 1902(a)(10(A)(i)(II)(cc)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Disabled individual whose earning exceed SSI substantial gainful activity level 1902(a)(10)(A)(i)(II) 1619(a)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
Aged, Blind, and Disabled	Individuals receiving mandatory state supplements 42 CFR 435.130	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Institutionalized individuals continuously eligible for SSI in December 1973 42 CFR 435.132 Blind and disabled individuals eligible for SSI in December 1973 42 CFR 435.133	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals who would be eligible for SSI except for the increase in OASDI benefits under Public Law 92-336 42 CFR 435.134	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals ineligible for SSI because of requirements inapplicable in Medicaid 42 CFR 435.122	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Disabled widows and widowers Early widows/widowers 1634(b) 42 CFR 435.138	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals who become ineligible for SSI as a result of OASDI cost-of- living increases received after April 1977 42 CFR 435.135	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
Aged, Blind, and Disabled	1939(a)(5)(E) Disabled adult children 1634(c)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Disabled individuals whose earnings are too high to receive SSI cash 1619(b)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard 1902(a)(10)(A)(ii)(V) 1905(a) 42 CFR 435.236	NF LOC: Included PACE: Excluded ICFMR: Excluded	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 5. Optional State Plan Populations

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on Centennial Care 2.0?	D. MEG for Budget Neutrality
Optional Targeted Low Income Children	Optional group for uninsured children under age 6 1902(a)(10)(A)(ii)(XIV) 42 CFR 435.229 Note: If sufficient Title XXI allotment is available as described under STC 84, uninsured individuals in this eligibility group are funded through the Title XXI allotment. Insured individuals in this eligibility group are funded through Title XIX, and if Title XXI funds are exhausted as described in STC 85, then all individuals in this eligibility group are funded through Title XIX.	No	If Title XIX: TANF and Related If Title XXI: MCHIP Children
Optional Reasonable Classification of Children	Optional group for children under age 19 not eligible for a mandatory group §§1902(a)(10)(A)(ii)(I) and (IV) 42 CFR 435.222	No	TANF and Related
Independent Foster Care Adolescents	Individuals under age 21 who were in foster care on their 18th birthday 1902(a)(10)(A)(ii)(XVII) 42 CFR 435.226	No	TANF and Related
Out-of-State Former Foster Care Children	Individuals under age 26 who were in foster care in a state other than New Mexico or tribe in such other state when they aged out of foster care 1902(a)(10)(A)(ii)(XX) 42 CFR 435.218	No	TANF and Related

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on Centennial Care 2.0?	D. MEG for Budget Neutrality
Aged, Blind, and Disabled	Working disabled Individuals 1902(A)(10)(A)(ii)(XIII)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Institutionalized Individuals	Individuals who would be eligible for SSI cash if not in an institution 1902(a)(10)(A)(ii)(IV) 1905(a) 42 CFR 435.211	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Breast and Cervical Cancer Program	Uninsured individuals under 65 screened and found to need treatment for breast or cervical cancer 1902(a)(10)(A)(ii)(XVIII) 42 CFR 435.213	No	TANF and Related
Home and Community Based 1915(c) Waivers that are continuing outside the demonstration (217 group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Act, through the state's 1915(c) Developmentally Disabled waiver	1915(c) waiver services are not provided through Centennial Care 2.0	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Home and Community Based 1915(c) Waivers that are continuing outside the demonstration (217 group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Act, through the state's 1915(c) Medically Fragile waiver.	1915(c) waiver services are not provided through Centennial Care 2.0	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Home and Community Based 1915(c) Waivers that are continuing outside the demonstration (217 group	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Act, through the state's 1915(c) Supports waiver.	1915(c) waiver services are not provided through Centennial Care 2.0	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Home and Community Based 1915(c) Waivers that are continuing outside the demonstration (217 group	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Act, through the state's 1915(c) Mi Via waiver.	1915(c) waiver services are not provided through Centennial Care 2.0	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on Centennial Care 2.0?	D. MEG for Budget Neutrality
Home and Community Based 1915(c) Waivers that were transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who would only be eligible in an institution in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Social Security Act, if the state had not eliminated its 1915(c) AIDS, Colts, and Mi Via-NF waivers	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Home and Community Based 1915(c) Waivers that are continuing outside of the demonstration (217 group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.2276 and section 1924 of the Act	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 6. Demonstration Expansion Populations

A. Expansion Medicaid Eligibility Group	B. Description Statutory/ Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care 2.0?	E. MEG for Budget Neutrality
Home and Community Based 1915(c) Waivers that were transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who would only be eligible in an institution in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Social Security Act, if the state had not eliminated its 1915(c) AIDS, Colts, and Mi Via-NF waivers	<u>Income test</u>: 300% of Federal Benefit Rate with Nursing Facility Level of Care determination. <u>Resource test</u>: $2000	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.2276 and section 1924 of the Act	<u>Income test</u>: 300% of Federal Benefit Rate with Nursing Facility Level of Care determination. <u>Resource test</u>: $2000	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 7: Limited Benefit Group Enrollees

A. Limited Benefit Medicaid Eligibility Group	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?
Individuals eligible for family planning services only (category 029)	Individuals whose coverage is limited under section 42 CFR 435.214 is expanded to include COVID-19 vaccine and vaccine administration whose coverage is limited under section 6008 of the Family First Coronavirus Response Act (FFCRA)	These are FFS individuals with limited benefits
Pregnancy Related Services (category 301)	Individuals whose coverage is limited under section 42 CFR 435.4 is expanded to include COVID-19 vaccine and vaccine administration whose coverage is limited under section 6008 of the Family First Coronavirus Response Act (FFCRA)	Yes, in CC 2.0 with limited benefits.
COVID-19 Testing Group (category 085;Federal Match 8)	Individuals whose coverage is limited/authorized through the Families First Coronavirus Response Act (FFCRA) is expanded to include COVID-19 vaccine and vaccine administration whose coverage is limited under section 6008 of the Family First Coronavirus Response Act (FFCRA)	These are FFS individuals with limited benefits
Emergency Medical Services for aliens (EMSA) (category 085;Federal Match 4)	Individuals whose coverage is limited under section 42 CFR 440.255 is expanded to include COVID-19 vaccine and vaccine administration whose coverage is limited under section 6008 of the Family First Coronavirus Response Act (FFCRA)	These are FFS individuals with limited benefits

Appendix G: Centennial Care 2.0 Benefits

Table 8 describes the current non-CB services, including services available under the Alternative Benefit Plan (ABP). Table 8 lists the CB services. Table 9 lists the services available only through Centennial Care including the three new BH services

Table 8 – Centennial Care Non-Community Benefit Services

Service	Medicaid State Plan	ABP Services
Accredited Residential Treatment Center Services	X	X Age limited
Applied Behavior Analysis (ABA)	X	X Age Limited
Adult Psychological Rehabilitation Services	X	X
Ambulatory Surgical Center Services	X	X
Anesthesia Services	X	X
Assertive Community Treatment Services	X	X
Bariatric Surgery	X	X Lifetime limit
Behavior Management Skills Development Services	X	X Age Limited
Behavioral Health Professional Services: outpatient behavioral health and substance abuse services	X	X
Cancer Clinical Trials	X	X
Case Management	X	
Comprehensive Community Support Services	X	X
Day Treatment Services	X	X Age limited
Dental Services	X	X
Diagnostic Imaging and Therapeutic Radiology Services	X	X
Dialysis Services	X	X
Durable Medical Equipment and Supplies	X	X Limits apply
Emergency Services (including emergency department visits, psychiatric ER, and ground/air ambulance services)	X	X
Experimental or Investigational Procedures, Technology or Non-Drug Therapies[1]	X	X

[1] Experimental and investigational procedures, technologies or therapies are only available to the extent specified in MAD 8.325.6.9 or its successor regulation.

Service	Medicaid State Plan	ABP Services
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	X	X Age Limited
EPSDT Personal Care Services	X	X Age Limited
EPSDT Private Duty Nursing	X	X Age Limited
EPSDT Rehabilitation Services	X	X Age Limited
Family Planning	X	X
Federally Qualified Health Center Services	X	X
Hearing Aids and Related Evaluations	X	
Home Health Services	X	X Limits apply
Hospice Services	X	X
Hospital Inpatient (including Detoxification services and medical/surgical care)	X	X
Hospital Outpatient	X	X
Inpatient Hospitalization in Freestanding Psychiatric Hospitals	X	X
Inpatient Rehabilitative Facilities	X	X Skilled nursing or acute rehab facility only
Intensive Outpatient Program Services	X	X
Immunizations	X	X
IV Outpatient Services	X	X
Diagnostic Labs, X-Ray and Pathology	X	X
Labor/Delivery and Inpatient Maternity Services	X	X
Medication Assisted Treatment for Opioid Dependence	X	X
Midwife Services	X	X
Multi-Systemic Therapy Services	X	
Non-Accredited Residential Treatment Centers and Group Homes	X	X Age limited
Nursing Facility Services	X	X
Nutritional Services	X	

Service	Medicaid State Plan	ABP Services
Occupational Therapy Services	X	X Limits apply
Outpatient Hospital based Psychiatric Services and Partial Hospitalization	X	X
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital	X	X
Outpatient Health Care Professional Services	X	X
Outpatient Surgery	X	X
Prescription Drugs	X	X
Primary Care Services	X	X
Physical Therapy	X	X Limits apply
Physician Visits	X	X
Podiatry Services	X	X Limits apply
Pre- and Post-Natal Care	X	X
Pregnancy Termination Procedures	X State-funded	X State-funded
Preventive Services	X	X
Prosthetics and Orthotics	X	X Limits apply
Psychosocial Rehabilitation Services	X	X
Radiation Therapy and Chemotherapy	X	X
Radiology Facilities	X	X
Rehabilitation Option Services (Psycho social rehab)	X	X Limits apply
Rehabilitation Services Providers	X	X Limits apply
Reproductive Health Services	X	X
Rural Health Clinics Services	X	X
School-Based Health Center Services	X	X
Smoking Cessation Services	X	X
Specialist Visits	X	X
Speech and Language Therapy	X	X

Service	Medicaid State Plan	ABP Services
		Limits apply
Swing Bed Hospital Services	X	X
Telemedicine Services	X	X
Tot-to-Teen Health Checks	X	X Age Limited
Organ and Tissue Transplant Services	X	X Lifetime limit
Transportation Services (medical)	X	X
Treatment Foster Care	X	X Age Limited
Treatment Foster Care II	X	X Age Limited
Treatment of Diabetes	X	X
Urgent Care Services/Facilities	X	X
Vision Care Services	X	X Only for eye injury or disease; routine vision care not covered

Table 9 – Centennial Care Current Community Benefit Services

Service Description	ABCB	SDCB
Adult Day Health	X	
Assisted Living	X	
Behavioral Support Consultation	X	X
Community Transition *(community reintegration members only)*	X	
Customized Community Supports		X
Emergency Response	X	X
Employment Supports	X	X
Environmental Modifications *($5,000 every 5 years)*	X	X
Home Health Aide	X	X
Homemaker		X
Nutritional Counseling		X
Personal Care Services *(Consumer Directed and Consumer Delegated)*	X	X
Private Duty Nursing Services for Adults (RN or LPN)	X	X
Related Goods *(phone, internet, printer etc...)*		X
Respite	X	X
Skilled Maintenance Therapy Services *(occupational, physical and speech therapy)*	X	X
Specialized Therapies *(acupuncture, biofeedback, chiropractic, cognitive rehabilitation therapy, Hippotherapy, massage therapy, Naprapathy, Native American Healers)*		X
Non-Medical Transportation		X

Refer to Appendix H for additional details about each community benefit including benefit limitations.

Table 10 – Services Available to Centennial Care Members Only

Service Description
Family Support
Behavioral Health Respite
Recovery Services
Community Interveners for the Deaf and Blind
Institutional for Mental Disorder with SUD diagnosis *Subject to Waiver Requirements/Limits*
Home Visiting *Subject to Waiver Requirements/Limits*
Pre-Tenancy *Subject to Waiver Requirements/Limits*

Appendix H: Currently Approved Benefit Definitions and Limits

I. Adult Day Health (ABCB)

Adult Day Health services provide structured therapeutic, social and rehabilitative services designed to meet the specific needs and interests of members by the care plans incorporated into the care plan.

Adult Day Health Services are provided by a licensed adult day-care, community-based facility that offers health and social services to assist members to achieve optimal functioning. Private Duty nursing services and skilled maintenance therapies (physical, occupational and speech) may be provided within the Adult Day Health setting and in conjunction with the Adult Day Health services but would be reimbursed separately from reimbursement for Adult Day Health services.

II. Assisted Living (ABCB)

Assisted Living is a residential service that provides a homelike environment which may be in a group setting, with individualized services designed to respond to the individual needs as identified by and incorporated in the care plan.

Core services provide assistance to the member in meeting a broad range of activities of daily living including; personal support services (homemaker, chore, attendant services, meal preparation), and companion services; medication oversight (to the extent permitted under State law), 24-hour, on-site response capability to meet scheduled or unpredictable member’s needs and to provide supervision, safety, and security. Services also include social and recreational programming. Coverage does not include 24-hour skilled care or supervision or the cost of room or board. Nursing and skilled therapy services are incidental, rather than integral to, the provision of assisted living services. Services provided by third parties must be coordinated with the assisted living provider.

> **Limits or Exclusions:** The following services will not be provided to members in Assisted Living facilities: Personal Care, Respite, Environmental Modifications, Emergency Response or Adult Day Health. The Assisted Living Program is responsible for all of these services at the Assisted Living Facility.

III. Behavior Support Consultation (ABCB and SDCB)

Behavior Support Consultation is the provision of assessment, treatment, evaluation and follow-up services to assist the member, parents, family enrollees and/or primary caregivers with coping skills which promote maintaining the member in a home environment.

Behavior Support Consultation: 1) informs and guides the member’s providers with the services and supports as they relate to the member’s behavior and his/her medically fragile condition; 2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s); 3) supports effective implementation based on a functional assessment; 4) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the member and his/her service and support providers. Based on the member’s care plan, services are delivered in an integrated/natural setting or in a clinical setting.

IV. Community Transition Services (ABCB)
Community Transition Services are one-time set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement (excluding assisted living facilities) to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are determined by the MCO based on the state's criteria outlined in these STCs and in 8.308.12.13.D. NMAC, and are monitored by the state to ensure the expenses are reasonable. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- Services necessary for the individual's health and safety such as but not limited to, pest eradication and one-time cleaning prior to occupancy; and
- Moving expenses.

Limits or Exclusions: Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services are limited to $3,500 per person every five years. Deposits for Assisted Living Facilities are limited to a maximum of $500. In order to be eligible for this service, the person must have a nursing facility stay of at least 90 days prior to transition to the community.

V. Customized Community Supports (SDCB)
Customized Community Supports include participation in community congregate day programs and centers that offer functional meaningful activities that assist with acquisition, retention or improvement in self-help, socialization and adaptive skills. Customized Community Supports may include day support models. Customized Community Supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings.

VI. Emergency Response (ABCB and SDCB)
Emergency Response services provide an electronic device that enables a member to secure help in an emergency at home and avoid institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when a "help" button is activated. The response center is staffed by trained professionals. Emergency response services include: installing, testing and maintaining equipment; training members, caregivers and first responders on use of the equipment; twenty-four (24) hour monitoring for alarms; checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.; and reporting member emergencies and changes in the member's condition that may affect service delivery. Emergency categories consist of emergency response and emergency response high need.

VII. Employment Supports (ABCB and SDCB)
Employment Supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted. The job coach provides training, skill development, and employer consultation that a member may require while learning to perform specific work tasks on the job; co-worker training; job site analysis; situational and/or vocational assessments and profiles; education of the member and co-workers on rights and responsibilities; and benefits counseling. The service must be tied to a specific goal specified in the member's care plan.

Job development is a service provided to members by skilled staff. The service has five components: 1) job identification and development activities; 2) employer negotiations; 3) job restructuring; 4) job sampling; and 5) job placement.

Employment Supports will be provided by staff at current or potential work sites. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by members receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

> **Limits or Exclusions:** Payment shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program. FFP cannot be claimed to defray expenses associated with starting up or operating a business.

VIII. Environmental Modifications (ABCB and SDCB)

Environmental Modification services include the purchase and/or installation of equipment and/or making physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance his/her level of independence.
Adaptations include the installation of ramps and grab-bars; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing); turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light- activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating/cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems and/or signaling devices.

All services shall be provided in accordance with applicable federal, state, and local building codes. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction/remodeling services, provide administrative and technical oversight of construction projects, provide consultation to family enrollees, providers and contractors concerning environmental modification projects to the member's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

> **Limits or Exclusions:** Environmental Modification services are limited to five thousand dollars ($5,000) every five (5) years. Additional services may be requested if a member's health and safety needs exceed the specified limit.

IX. Home Health Aide (ABCB and SDCB)

Home Health Aide services provide total care or assist a member in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampoo (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake. The Home Health Aide services assist the member in a manner that promotes an improved quality of life and a safe environment for the member. Home Health Aide services can be provided outside the member's home. State plan Home Health Aide services are intermittent and provided primarily on a short-term basis; whereas, Home Health Aide services are provided hourly, for members who need this service for a long term basis. Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home Health Aides perform an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulation and exercise, household services essential to health care at home, assisting with medications that are normally self-administered, reporting changes in patient conditions and needs, and completing appropriate records. Home health aide services must be provided under the supervision of a registered nurse or other appropriate professional staff. Must make a supervisory visit to the member's residence at least every two weeks to observe and determine whether goals are being met. Home Health Aide Services must be provided by a state licensed Home Health Agency under the supervision of a registered nurse.

X. Non-Medical Transportation (SDCB)

Non-Medical Transportation services enable SDCB members to travel to and from community services, activities and resources as specified in the SDCB care plan.

> **Limits or Exclusions**: Limited to 75 miles radius of the member's home. Non-Medical Transportation is limited to $1,000 per year. Not a covered service for minors.

XI. Nutritional Counseling (ABCB and SDCB)

Nutritional Counseling services include assessment of the member's nutritional needs, development and/or revision of the member's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan. Nutritional counseling must be provided by a state licensed dietician.

XII. Personal Care Services (ABCB and SDCB)

Personal Care Services (PCS) provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). There are two delivery models for ABCB and one for SDCB as follows:

Agency-Based Community Benefit:

1. Consumer delegated PCS allows the member to select the PCS agency to perform all PCS employer related tasks. The agency is responsible for ensuring PCS is delivered to the member in accordance with the care plan.
2. Consumer directed PCS allows the member to oversee his or her own PCS delivery, and requires the member to work with his or her PCS agency who then acts as a fiscal intermediary agency.

Self-Directed Community Benefit:

1. The member has employer authority and directly hires PCS caregivers or contracts with an agency.

XIII. Private Duty Nursing for Adults (ABCB and SDCB)
Private Duty Nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for members who are twenty-one (21) years of age or older with intermittent or extended direct nursing care in the member's home. Services include medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self- care assistance.

> **Limits or Exclusions**: All services provided under Private Duty nursing require the skills of a Licensed Registered Nurse or a Licensed Practical Nurse under written physician's order in accordance with the New Mexico Nurse Practice Act, Code of federal Regulation for Skilled Nursing.

XIV. Related Goods (SDCB)
Related goods are equipment, supplies or fees and memberships, not otherwise provided through under Medicaid. Related goods must address a need identified in the member's care plan (including improving and maintaining the member's opportunities for full membership in the community) and meet the following requirements: be responsive to the member's qualifying condition or disability; and/or accommodate the member in managing his/her household; and/or facilitate activities of daily living; and/or promote personal safety and health; and afford the member an accommodation for greater independence; and advance the desired outcomes in the member's care plan; and decrease the need for other Medicaid services. Related goods will be carefully monitored by health plans to avoid abuses or inappropriate use of the benefit.

The member receiving this service does not have the funds to purchase the related good(s) or the related good(s) is/are not available through another source. These items are purchased from the member's individual budget.

> **Limits or Exclusions:** Experimental or prohibited treatments and goods are excluded. Related goods are limited to $2,000 per person per care plan year.

XV. Respite (ABCB and SDCB)
Respite services are provided to members unable to care for themselves that are furnished on a short-term basis to allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite care is furnished at home, in a private residence of a respite care provider, in a specialized foster care home, in a hospital or nursing facility or an ICF/IDD meeting the qualifications for provider certification. When respite care services are provided to a member by an institution, that individual will not be considered a resident of the institution for purposes of demonstration eligibility. Respite care services include: medical and non-medical health care; personal care bathing; showering; skin care; grooming; oral hygiene; bowel and bladder car; catheter and supra-pubic catheter care; preparing or assisting in preparation of meals and eating; as appropriate, administering enteral feedings; providing home management skills; changing linens; making beds; washing dishes; shopping; errands; calls for maintenance; assisting with enhancing self-help skills; promoting use of appropriate interpersonal communication skills and language; working independently without constant supervision/observation; providing body positioning, ambulation and transfer skills; arranging for transportation to medical or therapy services; assisting in arranging health care needs and follow-up as directed by primary care giver, physician, and case manager, ensuring the health and safety of the member at all times.

Limits or Exclusions: Respite services are limited to a maximum of 300 hours annually per care plan year.

XVI. Skilled Maintenance Therapy Services (ABCB and SDCB)

Skilled maintenance therapy services include Physical Therapy (PT), Occupational Therapy (OT) or Speech and Language Therapy (SLT) for individuals twenty-one years and older. These services are an extension of therapy services provided for acute and temporary conditions that are provided with the expectation that the individual will improve significantly in a reasonable and generally predictable period of time. Skilled Maintenance Therapy services are provided to adults with a focus on maintenance, community integration, socialization and exercise, or enhance support and normalization of family relationships. Services in this category include:

Physical Therapy

Physical Therapy services promote gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include: professional assessment(s), evaluation(s) and monitoring for therapeutic purposes; physical therapy treatments and interventions; training regarding PT activities, use of equipment and technologies or any other aspect of the individual's physical therapy services; designing, modifying or monitoring use of related environmental modifications; designing, modifying, and monitoring use of related activities supportive to the care plan goals and objectives; and consulting or collaborating with other service providers or family enrollees, as directed by the member. Physical Therapy services must be provided by a state licensed physical therapist.

Occupational Therapy Services

OT services promote fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. Specific services may include: teaching of daily living skills; development of perceptual motor skills and sensory integrative functioning; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment; use of specifically designed crafts and exercise to enhance function; training regarding OT activities; and consulting or collaborating with other service providers or family enrollees, as directed by the member. Occupational Therapy services must be provided by a state licensed occupational therapist.

Speech Language Therapy

SLT services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology, and/or prevent progressive disabilities. Specific services may include: identification of communicative or oropharyngeal disorders and delays in the development of communication skills; prevention of communicative or oropharyngeal disorders and delays in the development of communication skills; development of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the member's environment to meet his/her needs; training regarding SLT activities; and consulting or collaborating with other service providers or family enrollees, as directed by the member. Speech Language Therapy services must be provided by a state licensed speech and language pathologist.

Limits or Exclusions: A signed therapy referral for treatment must be obtained from the member's primary care physician. The referral must include frequency, estimated duration of therapy, and treatment/procedures to be rendered.

XVII. Specialized Therapies (SDCB)

Specialized Therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A member may include specialized therapies in his/her care plan when the services enhance opportunities to achieve inclusion in community activities and avoid institutionalization. Services must be related to the member's disability or condition, ensure the member's health and welfare in the community, supplement rather than replace the member's natural supports and other community services for which the member may be eligible, and prevent the member's admission to institutional services. Experimental or investigational procedures, technologies or therapies and those services covered as a Medicaid state plan benefit are excluded. Services in this category include:

Acupuncture

Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits. Acupuncture services providers must be licensed by the NM Board of Acupuncture and Oriental Medicine.

Biofeedback

Biofeedback uses visual, auditory or other monitors to feed back to members' physiological information of which they are normally unaware. This technique enables a member to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health and performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback therapy is also useful for muscle re- education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

Chiropractic

Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis, for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health. Chiropractic services providers must be licensed by the NM Board of Chiropractic Examiners.

Cognitive Rehabilitation Therapy

Cognitive rehabilitation therapy services are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome specific cognitive problems. Cognitive Rehabilitation

Therapy providers must have a license or certification with the appropriate specialized training, clinical experience and supervision, and their scope of practice must include Cognitive Rehabilitation Therapy.

Hippotherapy

Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for members with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the member use cognitive functioning, especially for sequencing and memory. Members with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and for individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production. Hippotherapy providers must have a state license in physical therapy, occupational therapy, or speech therapy, and their scope of practice must include Hippotherapy.

Massage Therapy

Massage therapy is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a member's ability to be more independent in the performance of ADL living; thereby, decreasing dependency upon others to perform or assist with basic daily activities.

Naprapathy

Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function. Naprapathy providers must have a state license in Naprapathy.

Native American Healers

Native American Healers are a covered benefit under the self-directed community benefit. These services are subject to the $2000 annual specialized therapies limits. These services may also be a value added service provided by the MCO, for which the MCO does not receive FFP for these services. There are twenty-two sovereign Tribes, Nations and Pueblos in New Mexico, as well as numerous Native American individuals who come from many other tribal backgrounds. Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support members in their communities by addressing their physical and emotional health. Treatments may include dance, song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel. This form of therapy may be provided by community- recognized medicine men and women and others as healers, mentors and advisors to members, and provides

opportunities for members to remain connected with their communities. The communal support provided by this type of healing can reduce pain and stress and improve quality of life.

Limits and Exclusions: Specialized therapies are limited to $2,000 annually.

Appendix I: Attachments

Attachment A: Assessment of the Availability of Mental Health Services