State of New Mexico
Human Services Department

DRAFT - Application for Renewal of Section 1115 Demonstration Waiver
Centennial Care Program: Centennial Care 2.0

to

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

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EXECUTIVE SUMMARY

The New Mexico Human Services Department (HSD) is pleased to submit this Section 1115 Demonstration Waiver renewal application for New Mexico's Medicaid managed care program known as Centennial Care. Centennial Care was initially approved for a five year period, from January 1, 2014 through December 31, 2018.

Prior to Centennial Care, the Medicaid system in New Mexico was fragmented. In 2013, some 520,000 individuals, more than a quarter of the state's population, received health care through the Medicaid program. The challenges included:

- An expensive program, consuming about 16% of the State budget, up from 12% the previous year;
- An administratively complex program operating under 12 separate federal waivers in addition to a fee-for-service (FFS) program for those who either opted out of or were exempt from managed care;
- A fragmented program with seven different health plans administering different benefit packages for defined populations making it difficult for individuals, providers, and managed care organizations (MCOs) to manage complex medical and behavioral conditions; and
- A system that paid for the quantity of services delivered without emphasis on the quality of care that was being delivered.

The State's goals in implementing Centennial Care, as specified in the special terms and conditions (STCs), were to:

- Assure that Medicaid beneficiaries in the program 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 reductions in benefits, eligibility or provider rates; and
- Streamline and modernize the Medicaid program in the State.

Today, New Mexico's Medicaid managed care program features an integrated, comprehensive Medicaid delivery system in which the member's MCO is responsible for coordinating his/her full array of services, including acute care (including pharmacy), behavioral health services, institutional services and home and-community-based services (HCBS). Centennial Care's accomplishments during the past four years are listed below.

Centennial Care Accomplishments
• *Streamlining administration of the program* by consolidating a myriad of federal waivers that siloed care by populations. Today, four MCOs administer the full array of services in an integrated model of care. • *Building a care coordination infrastructure* that promotes a person-centered approach to care. Lower costs associated with inpatient stays and increased utilization of primary care office visits, preventive care and behavioral health services is evidence of the success. • *Increasing access to long-term services and supports (LTSS)* for people who previously needed a waiver slot to receive such services. Today, more than 29,750 individuals are receiving HCBS, which is an increase of 11.4% per year between 2014 and 2016. • *Continuing to lead the nation* in spending more of its LTSS dollars to keep members in their homes and in community settings rather than institutional settings. • *Demonstrating both cost-effectiveness and improved utilization of health care services.* Enrollment in the Medicaid program has grown by 8.5% per year while per capita costs have decreased by 1.5% between 2014 and 2016.

This renewal application builds on the program's accomplishments and identifies opportunities for targeted improvements and other modifications in the following key areas: care coordination, LTSS, physical and behavioral health integration, payment reform, member responsibility and engagement, refinements to benefits and eligibility, and administrative simplification. Details of the program modifications for the waiver renewal are described in Section 3--Concepts for Renewal. In summary, the improvements and modifications include:

- Refining care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continuing to expand access to LTSS and maintain the progress achieved in rebalancing efforts;
- Improving the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expanding payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Building upon and incorporating policies that seek to enhance beneficiaries' ability to become more active, responsible and involved participants in their own health care, including the introduction of modest premiums for higher income populations; and
- Further simplifying administrative complexities and implementing refinements in program and benefit design, some of which will be achieved with the replacement of the Medicaid Management Information System, including advanced data analytics capability.

Over the course of Centennial Care 2.0, New Mexico will continue to introduce progressive quality goals focused on improving health outcomes, implement pilot projects (based on both geography and specific populations) to advance program goals, and challenge its MCO partners to work cooperatively with the provider community to achieve a health care delivery system that is efficient and value-driven, while reducing health disparities across all populations.

The renewal application is organized according to the following sections:

- A review of the program as designed under the 1115 waiver, including innovative features;
- A summary of initiatives to be implemented in Centennial Care 2.0;
- A description of the requested waiver and expenditure authorities;
- An overview of the planned budget neutrality methodology;
- A summary of quality evaluation for waiver and quality activities for demonstration; and
- A description of HSD's comprehensive public input process.

SECTION 1: CURRENT PROGRAM DESIGN AND INNOVATIVE FEATURES

Centennial Care provides a comprehensive benefit package to eligible populations through an integrated, managed care model that includes a number of innovations. The following is a description of the current eligible populations and covered benefits and what makes Centennial Care unique from other Medicaid programs.

A. Current Populations Covered

Table 1 represents the eligibility groups currently served in Centennial Care. At the end of 2016, New Mexico's Medicaid program covered approximately 900,000 individuals, with 700,000 enrolled in Centennial Care. Since the end of 2013, HSD has enrolled more than 390,000 new individuals into the program, with the largest growth attributed to the Medicaid adult expansion program.

Table 1 – Eligibly Groups Covered in Centennial Care

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 ICF/IIDs;
- Medically Fragile 1915(c) waiver participants for HCBS;
- Developmentally Disabled 1915(c) waiver participants for HCBS; and
- Individuals eligible for family planning services only.

Appendix G illustrates the complete table of mandatory and optional populations covered in the current waiver.

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 a nursing facility level of care (NF LOC) are able to access LTSS through Community Benefit (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 included 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.

The comprehensive benefits currently available to Centennial Care members are listed in Appendix H.

C. Unique Features of the Current Program Design

Centennial Care transformed how Medicaid services are delivered to the most vulnerable populations in New Mexico. The current delivery system delivers the right amount of care, at the right time, and in the right setting. To achieve this goal, the program design includes the following key features and innovative elements.

1. Care Coordination

Fundamental to Centennial Care is a robust care coordination system that requires coordination at a level appropriate to each member's needs and risk stratification. The care coordination program creates a person-centered environment in which members receive the care they need in the most efficient and appropriate manner while advancing the integration of physical health, behavioral health and LTSS.

The approach to care coordination in Centennial Care includes:

- Assessing each member's physical, behavioral, functional, and psychosocial needs;
- Identifying the specific medical, behavioral and LTSS and other social support services (e.g., housing, transportation or income assistance) necessary to meet a member's needs;
- Ensuring timely access and provision of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence; and
- Facilitating access to other social support services and assistance needed in order to promote each member's health, safety, and welfare.

Centennial Care establishes levels of care coordination support that range from a low level of care coordination for members requiring a "light touch" (i.e., periodic service utilization monitoring) to higher levels of care coordination for members with the highest needs (i.e., members with chronic conditions and high utilizers) who require more intensive, hands on

care coordination. The intent is for members to receive the care coordination level of support that is most appropriate to meet their needs. In the event a member's needs should change, MCOs are required to make the corresponding change in the member's care coordination level.

Each member in Centennial Care receives a standardized health risk assessment (HRA) to determine if he or she requires a comprehensive needs assessment (CNA) and/or a higher level of care coordination. The CNA identifies members requiring level 2 or 3 care coordination and is followed by the development of a comprehensive care plan (CCP), which establishes the necessary services based on needs identified in the CNA. Members designated to care coordination level 2 or level 3 are assigned to a care coordinator who is responsible for coordinating their total care. MCOs routinely monitor claims and utilization data for all members to identify changes in health status and high-risk members in need of a higher level of care coordination.

Centennial Care transformed New Mexico's Medicaid managed care program with its focus on integrated, person-centered care and a robust care coordination program. HSD procured new MCOs capable of providing the entire suite of covered Medicaid services and included prescriptive contractual requirements regarding the care coordination activities to be conducted by the MCOs. The program requirements include:

- Timeframes for when the HRAs and CNAs must be completed;
- Clear expectations of care coordination tasks for each care coordination level;
- Specific CCP criteria;
- Qualifications for care coordinators;
- Frequency of touch points between care coordinator and members; and
- Specific care coordination requirements for members participating in a Health Home model.

Furthermore, MCOs are encouraged to build care coordination systems that maximize local community supports, such as Community Health Workers (CHWs). In the past four years, MCOs have been increasing their use of CHWs in care coordination roles as well as using CHWs to educate members about appropriate use of the delivery system.

MCOs have also effectively used PCMHs as an additional tool for delivery of care coordination. PCMHs have long been a part of the New Mexico Medicaid program landscape. However, with the implementation of Centennial Care, the four MCOs have increased the availability and use of in Patient Centered Medical Homes (PCMHs). Currently, more than 300,000 members are receiving care PCMHs.

As a result of these care coordination efforts and other innovations in Centennial Care, the average cost associated with inpatient hospital stays has decreased, while the use of more appropriate services such as primary care office visits and preventative care services increased.

2. Physical Health and Behavioral Health Integration

Centennial Care changed how members access benefits and how benefits are managed. Prior to Centennial Care, a member's care was managed and delivered by multiple MCOs. Members were enrolled with a physical health or a LTSS MCO, as well as with the statewide behavioral health MCO for mental health and substance abuse services (MH/SA). This fragmentation created barriers for treating the whole-person. Centennial Care changed the delivery of care by creating a person-centric model and placing the responsibility of the member's holistic care with a single MCO.

Three new behavioral health services were added in Centennial Care for eligible participants: family support, behavioral health respite, and recovery services. Prior to Centennial Care, these services were not otherwise available in the Medicaid program.

- Family Support — This service is a community-based, face-to-face interaction with the eligible beneficiaries and family members/significant others to identify the recovery and resiliency service needs within a recovery plan to enhance their strengths, capacities, and resources so as to promote their ability to reach the recovery and resiliency behavioral health goals they consider most important.
- Behavioral Health Respite — This service provides supervision and/or care of children and youth (up to 21 years of age diagnosed with a serious emotional or behavioral health disorder as defined by the DSM V) residing at home in order to provide an interval of rest and/or relief to the person and/or their primary care givers. The service may include a range of activities to meet the social, emotional, and physical needs of the caregiver(s) during the respite period. These services may be provided on a short-term basis (i.e., few hours during the day) or for longer periods of time involving overnight stays.
- Recovery Services — These services are peer-to-peer individual and group services that assist individuals with serious mental illness, severe emotional disturbance and substance use disorders to develop the skills they need to maximize their potential for a successful recovery.

HSD also implemented the "Treat First" model of care as an innovative approach to BH clinical practice improvement. It began with a six month trial within six provider organizations. The organizing principle has been to ensure a timely and effective response to a person's needs as a first priority in the approach. It has been structured as a way to achieve immediate meaningful engagement while gathering needed historical, assessment and treatment planning information over the course of four therapeutic encounters as opposed to the expectation that these functions be completed within the first encounter. The results of this trial achieved significant improvements in patient and provider satisfaction including the quality of treatment planning, early resolution of presenting problems and the reduction of subsequent "no show" appointments. As a result, HSD has implemented this approach as standard BH practice.

3. LTSS

A central goal of the Centennial Care program is assuring that members receive the right amount of care, at the right time, and in the most cost effective or "right" setting. Since 2008, HSD has administered its LTSS program through a managed care model designed to serve members in the most appropriate setting. New Mexico continues to lead the nation in spending more of its LTSS dollars to keep members residing in their homes and in the community rather than institutional settings. The American Association of Retired Persons' historical reporting contained in *The State Scorecard on LTSS for Older Adults, People with Physical Disabilities and Family Caregivers* has demonstrated that between the years of 2014 and 2017, New Mexico has ranked in the top five of states spending more of their LTSS dollars on CB services rather than institutional care. Centennial Care significantly advanced this trend. Today, more than 29,750 members are receiving LTSS in their homes or in the community.

Prior to Centennial Care, the state's LTSS program, known as the Coordination of Long-Term Services (CoLTS) program, restricted members who met the NF LOC criteria to receiving only Personal Care Services (PCS). It required members who needed additional CB services to place their name on a central registry list and wait for a waiver allocation.

Centennial Care expanded the availability of CB services to individuals who qualify for full Medicaid coverage and meet a NF LOC by eliminating the requirement for a waiver allocation in order to access the full suite of CB services. As part of this change, HSD removed the PCS benefit from the State Plan and included it as one of many services available in the CB service array, which resulted in increased access to PCS for eligible members. HSD continued to provide access to HCBS for those members who did not meet standard Medicaid financial eligibility due to having household income that is higher than program guidelines by establishing 4,289 slots as allocations to the Centennial Care waiver.

While such efforts result in improved member outcomes, they also result in reduced occupancy rates for nursing facilities and higher average costs to care for those who are residing in nursing facilities. According to a report by the New Mexico Legislative Finance Committee released in October 2016 , *Cost, Quality and Financial Performance of Nursing Homes in New Mexico* (report #16-10), the number of individuals living in New Mexico nursing homes declined by 12% between 2011 and 2015 as options for home and-community-based care have expanded under Centennial Care. "As such, nursing homes are caring for residents who are gradually becoming more dependent on others for activities of daily living, leading to higher costs of care. This has considerable implications in New Mexico, where 64 percent of nursing home residents rely on Medicaid to pay for their care." HSD will continue to work with the New Mexico Health Care Association, which represents the nursing home industry in New Mexico, to address the impact of the changing environment for how members prefer to receive LTSS and to advance quality and performance for nursing home care.

Additionally, HSD created an independent system that links together resources throughout the state to assist LTSS members. The New Mexico Independent Consumer Support System (NMICSS) provides Centennial Care beneficiaries, their advocates and counselors with information and referral resources in the following areas:

- Centennial Care health plan choice counseling;
- Grievance, appeals rights and fair hearings; and
- Understanding care coordination and levels of care.

The NMICSS provides informational brochures to inform beneficiaries and advocates on how to access the NMICSS and which participating organizations can help with specific topics. HSD partners with the NMICSS advisory team in planning and hosting semi-annual regional roundtable discussion groups with a focus on LTSS. The purpose of these meetings is to offer an environment conducive to open discussion regarding LTSS for Centennial Care members. These discussions have led to increased MCO trainings for care coordination; process improvements between the MCOs, HSD and LTSS providers; and trust building at the community level with MCOs, members and provider advocates.

4. Native American Members in Centennial Care

Several protections were implemented in Centennial Care to ensure that Native Americans continued to have access to Indian Health Service, Tribal health providers, and Urban Indian providers (I/T/Us) and to facilitate access to timely, quality care. The following protections are addressed in the Special Terms and Conditions (STCs) of the 1115 waiver and in the MCO contracts:

- Each MCO must have a full-time staff person to work directly with I/T/Us and be proficient in at least one New Mexican Native American/pueblo language;
- MCOs are encouraged to use local resources, such as I/T/Us, PCMHs, Health Homes, Core Service Agencies (CSAs) and tribal services to perform care coordination activities;
- The MCO cannot impose cost sharing on Native Americans;
- Members can chose I/T/Us to serve as their primary care provider;
- At least one FQHC shall be an Urban Indian FQHC in Bernalillo County;
- MCOs must allow members to seek care from any I/T/U whether or not the I/T/U is a contract provider;
- MCOs must track and report quarterly reimbursement and utilization data related to I/T/Us;
- MCOs must reimburse I/T/Us at least 100% of the rate currently established for IHS facilities (with a few exceptions);
- Services provided within I/T/Us are not subject to prior authorization requirements;
- Native American members accessing the pharmacy benefit at I/T/Us are exempt from the MCO's preferred drug list; and
- Native Americans may self-refer to an I/T/U for services.

Additionally, the STCs of the waiver required that HSD form an advisory group, the Native American Technical Advisory Committee (NATAC), comprised of representatives from New Mexico's tribal organizations and Indian Health Services. The group has been meeting quarterly since the planning phase of Centennial Care in 2013 and, more recently, held meetings dedicated to reviewing concepts and developing recommendations for the waiver renewal application. HSD plans to continue the NATAC group and maintain all of the current protections for Native Americans in Centennial Care 2.0.

HSD collaborates with the NATAC to better understand and improve the member experience for Native Americans in Centennial Care. As of April 2017, there are 44,426 Native American enrolled in Centennial Care with about 12,000 members enrolled in the Medicaid adult expansion. While not all Native Americans who are eligible for Medicaid are required to enroll in Centennial Care, those in need of LTSS are required to participate in the managed care program. Consistent with the non-Native American Medicaid population, PCS continues to be the most utilized CB service by Native Americans. Native American members are able to seek care from IHS and/or tribal providers regardless of whether those providers are contracted with a MCO.

In response to the NATAC's recommendation that the MCOs better utilize Community Health Representatives (CHRs) working with Tribal organizations, HSD included specific contractual requirements to increase the use of CHRs as part of the initiative to expand the work of CHWs. Additionally, the MCOs have implemented a variety of programs in Native American communities throughout New Mexico including a resource center in Shiprock, New Mexico and Tribal opportunities to perform specified care coordination activities.

In addition to the NATAC, HSD and the MCOs receive ongoing input from the Native American Advisory Boards (NAAB). The NAAB meets quarterly in tribal communities that have high enrollment in Centennial Care to discuss issues related to service delivery and operations. And, each of the MCOs is required to employ a full-time Native American liaison that works directly with IHS, Tribal 638 providers and HSD's Native American liaison.

5. Personal Responsibility and Member Engagement

One of the core principles of the Centennial Care program is to encourage greater personal responsibility of members to facilitate their active participation and engagement in their own health so they can become more efficient users of the health care system. Centennial Care required the MCOs to provide a member rewards program that offers incentives to members to become more actively engaged in managing their health.

a) Centennial Rewards

Centennial Care established a member-based rewards program known as Centennial Rewards, which was designed to encourage members to actively participate in their health care and drive improvements in health outcomes. It required the MCOs to collaborate and procure a vendor to implement a member rewards program. The MCOs selected the company Finity to administer the program, which was launched in the spring of 2014.

Any Centennial Care member enrolled in a MCO may participate in the Centennial Rewards program and receive points for engaging in and completing healthy activities and behaviors, including:

- Healthy Smiles, which rewards annual dental visits for adults and children;
- The Step-Up Challenge, which rewards completion of a three-week or nine-week walking challenge;
- Asthma Management, which rewards refills of asthma controller medications for children;

- Healthy Pregnancy, which rewards members who join their MCO's prenatal program;
- Diabetes Management, which rewards members who complete tests and exams to better manage their diabetes;
- Schizophrenia and/or Bipolar Disorder Management, which rewards members who refill their medications; and
- Bone Density Testing, which rewards women age 65 or older who complete a bone density test during the year.

Members who complete these activities earn credits, which may be redeemed for items in a Centennial Rewards catalog.

In 2016, approximately 70% of Centennial Care members participated in the Centennial Rewards program. Some of the demonstrated health outcomes for these members have been:

- Inpatient admissions have decreased among participants in the rewards program, resulting in a cost-savings of approximately $23 million in 2015;
- The average redemption rate of earned rewards is 24%, with the notable exception of the Step-Up Challenge, which has a redemption rate of 85%. This suggests that the proactive enrollment required for the Step-Up Challenge has had a substantial positive impact on member use of their rewards;
- Overall cost-savings attributed to the Centennial Rewards program increased by one-third from 2014 to 2015. Reduced inpatient admissions and costs per admission have been the dominant driver behind cost-savings across conditions;
- Participants across all conditions had higher compliance with Healthcare Effectiveness Data and Information Set measures and other quality outcomes than non-participants; and
- A comparison of risk scores indicates that higher risk members tend to participate in the Centennial Rewards program.

b) Member Engagement

In addition to Centennial Rewards, the MCOs continue to increase member engagement through implementation of the care coordination program, disease management programs, member advisory committees and Ombudsman programs that assist members with understanding MCO processes and address concerns not resolved through standard appeals and grievance procedures. MCO care coordinators remain critical in educating members about appropriate use of the delivery system and helping them to navigate the system. For example, CHWs employed by the MCOs engage members who frequently use the emergency department and connect them with primary care physicians. In addition, members in need of LTSS are able to review and discuss available CB services with their care coordinators who utilize a Community Benefit Services Questionnaire to determine which CB services members may be interested in receiving. Members who receive LTSS through the SDCB are actively engaged in developing their care plans, hiring their own caregivers and developing their payment rates. These members are responsible for completing employer-related tasks, such as approving and submitting employee timesheets to the fiscal management agency for payment.

In addition, the MCOs continue to develop strategies that promote member engagement through:

- Diabetes self-management programs and other disease-specific education classes;
- Wellness programs;
- Communication coaching;
- Physician video visits;
- Wellness benefits offering up to $50 per year in health/wellness purchases;
- Care coordination targeting specific chronic conditions;
- Targeted education and self-help materials; and
- Use of CHWs to engage members in meeting their care needs and addressing social determinants of health.

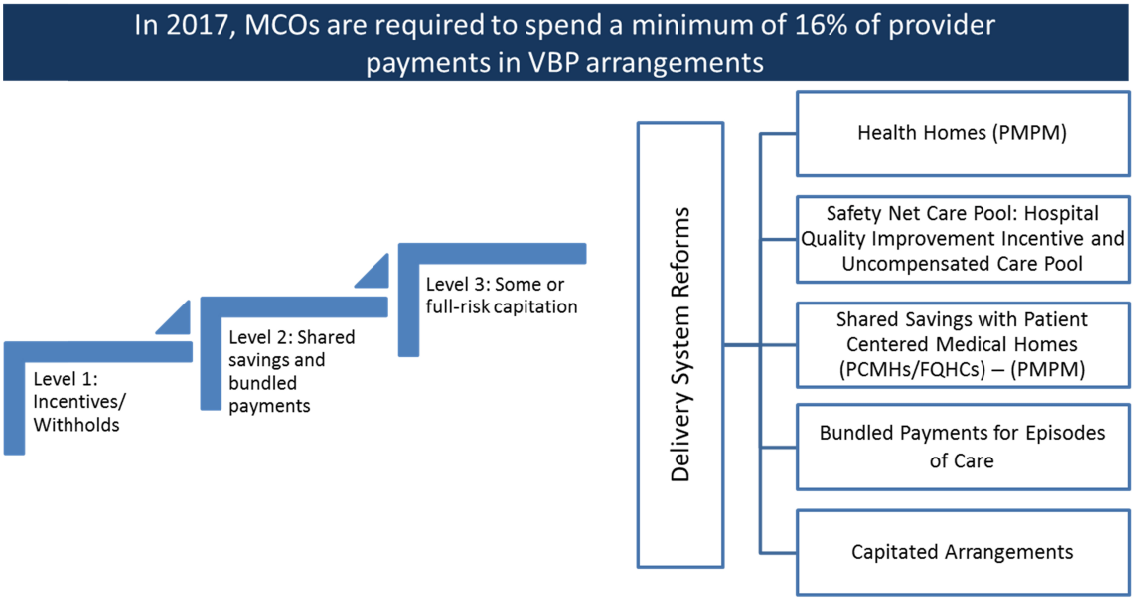
6. Payment Reform

A key program goal of Centennial Care has been to pay for value and not solely for volume of services rendered by rewarding providers for achievement in quality of care and improved member health outcomes. In 2015, HSD implemented payment reforms through a variety of pilot projects to test their effectiveness and to begin to engage providers in changing reimbursement methodologies to more effectively align with quality outcomes.

a) Value Based Purchasing

After testing a variety of payment reforms through multiple pilot projects implemented by the MCOs, HSD required, through specific contractual provisions, that the MCOs have a prescribed percentage of all provider payments in one of three levels of VBP payment arrangements. For Centennial Care 2.0, HSD will continue to increase the overall percentage of provider payments covered under a VBP arrangement and expand the types of providers covered in various models while also focusing on arrangements for behavioral health, long term care and nursing home providers. In Calendar Year 2017, the MCOs are required to have 16% of provider payments in value-based arrangements across three different levels, with level one at the lower end of the risk continuum and level three at the higher end as illustrated in Figure 1.

Figure 1 – Value Based Purchasing



MCOs are permitted to tailor their program to their covered population.

b) Safety Net Care Pool

As part of its delivery system reform initiatives, HSD has implemented other payment reforms through Health Homes and the Safety Net Care Pool (SNCP) Hospital Quality Incentive Initiative (HQII) pool. It has also required the MCOs to increase the number of members receiving care in PCMHs.

The SNCP is comprised of two programs: the Uncompensated Care (UC) pool and the HQII pool. Today, the UC pool provides funding to 29 eligible hospitals (formerly known as sole community provider program hospitals) for their uncompensated care. The payments are structured to provide funding to the smallest hospitals first, and then to medium-sized and lastly to largest hospitals, based on available funding.

The HQII Program incentivizes participating hospitals to meaningfully improve the health and quality of care of the individuals they serve who are Medicaid eligible or are uninsured. Beginning in 2015, the HQII Program evaluated and rewarded hospitals based upon essential quality measures for urgent improvements in care including:

- All cause readmissions;
- Obstetrical adverse events (without instrument);
- Postoperative deep vein-thrombosis or pulmonary embolism;
- Surgical site infections;
- Ventilator associated events;
- Adverse drug events;
- Catheter-associated urinary tract infections;
- Central line associated blood stream infections;

- Injury from falls and immobility; and
- Obstetrical adverse events (with instrument) and pressure ulcers.

Each hospital's HQII activities are consistent with the State's quality goals, as well as CMS' overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities).

As HQII advances into the final years of the current Centennial Care waiver, measures are evolving toward population-focused improvements including diabetes short-term and long-term complication rate, adults with asthma admission rate, heart failure admission rate and bacterial pneumonia admission rate.

In 2018, the percentage of funding available to the UC pool is 85%, or $68.9 million of the total available funding of $80.9 million, leaving $12.0 million or 15% available for HQII pool. Notable achievements include:

- From 2014 to 2016 there was a 41% decrease in requests for UC funding by the 29 SNCP hospitals participating in the UC program; and
- For 2015, the defined need for UC funding was fulfilled, with $1.6 million subsequently flowing from the UC pool to the HQII pool.

7. Telehealth

As part of Centennial Care, HSD focused on improvements in the utilization of telehealth for both physical and behavioral health care. MCOs were required to implement telemedicine initiatives for the convenience of members and to improve access to care in rural areas. The efforts of HSD and the MCOs have resulted in annual increases in behavioral health telemedicine utilization; active recruitment initiatives to pursue qualified telehealth providers; recruitment of behavioral health medication management providers; and the purchase of block time services of BH medication management providers through an external vendor.

8. Community Health Workers

CHWs are trusted members of the community who work within the local health care system in rural, frontier, tribal and urban areas. CHWs have been referred to as community health advisors, lay health advocates, Promotoras, outreach educators, community health representatives, peer health promoters, peer educators, and community connectors. They are in a unique position to provide interpretation and translation services, culturally appropriate health education, and, informal counseling and guidance on health behaviors, while encouraging self-efficacy. CHWs also serve as liaisons between the member and the health care system by assisting them in obtaining needed care.

Centennial Care MCOs have been required to increase the use of CHWs by 10% annually and have effectively been employing and contracting with more than 100 CHWs. New Mexico's

Medicaid program has been featured in several recent articles about advancing the use of CHWs, which can be found at the links below:

- https://west.stanford.edu/news/blogs/and-the-west-blog/2017/community-health-workers
- http://healthaffairs.org/blog/2017/07/25/diffusion-of-community-health-workers-within-medicaid-managed-care-a-strategy-to-address-social-determinants-of-health/

SECTION 2: CONCEPTS FOR RENEWAL

The Centennial Care waiver renewal provides opportunities for HSD to build upon the accomplishments achieved since implementation of Centennial Care. At the same time, HSD has identified opportunities for continued progress in transforming its Medicaid program into an integrated, person-centered, value-based delivery system. Based on feedback received over the past three years at the annual Centennial Care public forums and through recent input sessions with advocacy groups and stakeholders, HSD has identified key areas of refinement for Centennial Care 2.0.

The following list is a summary of program modifications for Centennial Care 2.0 that leverage successful elements of the existing program design, expand initiatives that directly benefit members, and ensure the financial viability and sustainability of the program over the long term.

- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions of settings of care.
- Continue to expand access to CB in the LTSS program and maintain the progress achieved in rebalancing efforts while collaborating with the nursing home industry to advance quality initiatives and performance.
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health.
- Continue to expand payment reform through VBP arrangements to achieve improved quality and better health outcomes.
- Build upon and incorporate policies that seek to enhance beneficiaries' ability to become more active, responsible and involved participants in their own health care.
- Further simplify administrative complexities and implement refinements in program design and benefit design, some of which will be implemented with the replacement of the Medicaid Management Information System. A summary of this project may be found at the following link: http://www.hsd.state.nm.us/uploads/files/The%20MMIS%20Replacement%20Project%20Overview.pdf.

This section of the renewal application outlines the program design proposals for Centennial Care 2.0.

1. Care Coordination Proposals

Care coordination remains a main focus for the Centennial Care program. Through continued evaluation of the care coordination program and feedback from advocates and members, HSD modified its approach to Care Coordination in 2016 to place greater emphasis on members with the highest needs– those assigned to Level 2 and Level 3 care coordination -- while minimizing Level 1 requirements. This change made sense at the three year mark, since most members had received a HRA and were designated to a specific care coordination level.

For Centennial Care 2.0, HSD aims to further refine care coordination by maximizing resources to target members with the highest needs and those experiencing transitions in settings of care. Additionally, HSD plans to transition more care coordination activities from the MCOs to providers with the capacity to manage subsets of the population and enter into VBP arrangements. The following modifications are proposed:

- Increase care coordination at the provider level;
- Strengthen transitions of care;
- Expand successful programs that target high-need populations;
- Initiate care coordination for justice-involved individuals prior to release;
- Pilot a home visiting program that focuses on pre-natal and post-partum care; and
- Obtain 100% federal funding for covered services delivered to Native Americans in Centennial Care that are "received through" IHS or Tribal facilities per the federal guidance.

Care Coordination Proposal #1: Increase care coordination at the provider level
HSD will continue to move forward with the expansion of its health home initiative, CareLink NM. At the same time, the PCMH model remains a viable and important model of care. Centennial Care has increased the number of members participating in PCMHs from 180,000 at the end of 2014 to more than 300,000 in 2017. PCMH models emphasize quality, access to care, appropriate use of health care that avoids unnecessary utilization (non-emergent emergency room visits etc.) and leads to better outcomes and cost savings. National studies suggest that patients served by PCMHs are more satisfied than those served in traditional primary care practices and that physician practice staff are happier in PCMHs. One group health study found that only 10% of staff in PCMH pilot programs felt high levels of exhaustion compared to 30% in control practices. The same study also found better retention and satisfaction among primary care physicians compared to non-PCMH practices (Grumbach & Grundy, 2010). For a state such as New Mexico with a shortage of providers, this is a particularly important outcome. PCMH providers play a critical role as they engage directly with their members and have the most frequent opportunity to build trusting relationships, which has a high impact on successful integration of physical and behavioral health. As part of the expansion of the PCMH model, the MCOs are engaging PCMH providers to conduct care coordination activities for their attributed members through VBP arrangements.

Centennial Care 2.0 seeks to expand on this initiative by continuing to transition care coordination functions from the MCOs to the provider level through delegated arrangements. As providers become more willing to accept risk for a subset of members, delegation of care coordination is critical to successful management of members. Under Centennial Care 2.0, HSD proposes to leverage opportunities to build on these successful models by supporting providers with the capacity to conduct care coordination activities and allowing MCOs to delegate care coordination functions.

Two approaches for care coordination delegation will be available – a Full Delegation Model and a Shared Functions Model. In the Full Delegation Model, the MCO delegates the full set of care coordination functions to the provider/health system (the delegate) for an attributable membership and retains oversight and monitoring functions. This model is only permitted when included as part of a VBP arrangement with the provider that outlines the payment

arrangement for the full delegation of care coordination as well as other requirements associated with improving quality and healthcare outcomes. In the Shared Functions Model, the MCO retains some care coordination functions and allows other care coordination activities to be conducted by a provider or partner, such as a local/community agency, CHW, Community Health Representative (CHR) working with a tribal organization, school-based health center (SBHC), paramedicine program, and/or personal care service agency. In this model, the partner may or may not have a VBP arrangement with the MCO.

Care Coordination Proposal #2: Improve transitions of care
Care coordination, when implemented timely and effectively, assists members through transitions of care by connecting them to local providers and stabilizing them in the new setting so that they are able to improve and thrive. Well-planned care coordination provides a variety of supports during transitions, including but not limited to: assistance with eligibility; addressing safety concerns in their home environment; and assistance with addressing housing issues. Transitional needs are identified and addressed in a transition of care plan developed by the care coordinator and the member. HSD intends to improve transitions of care by implementing measures that enhance the MCOs' ability to identify and provide situation-specific assistance for short-term transition periods, including, but not limited to:

- Discharge from an inpatient or nursing home stay;
- Frequent emergency department visits within a short period of time;
- Release from Crisis Triage Centers (a new NM service);
- Release from incarceration or detention facilities among justice-involved individuals;
- Community placement from a residential or institutional facility; and
- Children returning home from a foster care placement.

This initiative includes requirements for the MCO to conduct in-home assessments for members in need of CB services after transitions from facilities. In addition, HSD proposes to work with the MCOs to construct VBP initiatives and other member incentives that support positive outcomes of a successful discharge, such as:

- Continuing reductions in unnecessary emergency department visits post discharge for 30 days;
- Continuing reductions in preventable readmissions post discharge for 30 days;
- Ensuring timely follow-up primary care physician or behavioral health visits; and
- Encouraging timely medication reconciliation and prescription fulfillment.

Care Coordination Proposal #3: Leverage partnerships to expand successful programs that target high-need populations
With a focus on directing resources in areas where the most potential for impact exists, Centennial Care 2.0 will continue to expand and initiate successful programs that target high-need populations. HSD proposes to advance key initiatives through supporting collaborations and expanding programs that have demonstrated quality results in phase one of Centennial Care, and by leveraging successful community-based programs to initiate new opportunities in Centennial Care 2.0. These proposals include:

- Continuing to incentivize innovative collaborations between the MCOs and community agencies, such as paramedicine providers, wellness centers, PCS agencies and Project ECHO;
- Continuing efforts to build capacity and provide flexibility for the use of Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists, to provide care coordination functions;
- Continuing to promote use of CHWs and CHRs as extenders of care coordination to educate members about using the health care system;
- Implementing the full functionality of the Emergency Department Information Exchange (EDIE) to improve care coordination at the community level between EDs and community providers;
- Expanding the Health Home program, which serves children and adults with complex behavioral health needs, to other counties; and
- Piloting a wraparound approach (intensive care coordination) for youth involved with the CYFD to improve health outcomes and reduce stays in residential treatment centers.

Finally, as MCOs continue to demonstrate a thorough understanding of the requirements for basic care coordination activities, such as conducting needs assessments, face-to-face visits with members and regular updates to plans of care, HSD will shift its resources from compliance and monitoring of care coordination activities to focus on measurement of quality and healthcare outcomes. For example, evaluating the success of full delegation care coordination models will occur by monitoring outcome based performance measures established by MCOs.

Begun in 2017, the replacement of the Medicaid Management Information System (MMIS) will change many of HSD's business processes and provide new opportunities to improve the program. MCOs under contract during that time must exhibit flexibility and nimbleness in working with evolving systems. Opportunities will develop to capture and analyze data relevant to member-specific and population health outcomes (physical, behavioral, and social), quality metrics, and total cost of care. With such capability, HSD will be able to implement continued improvements in the care coordination program that are informed by meaningful data.

Care Coordination Proposal #4: Initiate care coordination for justice-involved individuals prior to their release from incarceration

HSD has developed and implemented the IT systems, policies and processes to facilitate eligibility "suspensions" for individuals who are involved in the criminal or juvenile justice system, and to ensure timely and automated eligibility reactivations upon the release of these individuals from custody.

HSD proposes to expand its engagement of individuals being released from correctional facilities to improve health care outcomes and, potentially, reduce recidivism. HSD requests approval to allow MCO care coordinators to work with justice-involved individuals to establish appointments, referrals and pharmacy services before these individuals are released to ensure continuity of care. The pilot may also include:

- Allowing for MCO delegation of care coordination to the county or facility for activities that occur prior to release; and

- Strengthening MCO contract requirements regarding after-hour transitions to address spontaneous or unplanned discharge from custody, often occurring during evening or weekend hours. HSD will require the MCOs to have a dedicated staff position to serve as a liaison to the participating facilities in order to address this complex issue.

Care Coordination Proposal #5: Pilot a home visiting program that focuses on pre-natal care, post-partum care and early childhood development with the Department of Health and the Early Childhood Services Program within CYFD
HSD proposes to implement an evidence-based home visiting pilot project in designated counties to provide Medicaid-reimbursable prenatal and post-natal care services to eligible pregnant women. The proposed home visiting pilot will be implemented in two to four New Mexico counties with poor performance for prenatal/postpartum care, poor birth outcomes, such as high rate of preterm births and high rate of low birth weight infants, or other risk factors.

New Mexico has an extensive home visiting network throughout the State. The MCOs will be required to contract with the high-fidelity HV models that are established in the designated counties to deliver a defined set of Medicaid-reimbursable services. They will also work collaboratively with the DOH and CYFD to implement the program, develop workforce and provider capacity to serve the members participating in the program, and improve prenatal and postnatal outcomes in the identified counties.

Care Coordination Proposal #6: Obtain 100% federal funding for covered services delivered to Native American members in Centennial Care that are received through IHS or Tribal Facilities
HSD proposes that when Centennial Care 2.0 MCOs enter into a care coordination agreement with Indian Health Services (IHS) and/or Tribal health providers (I/T/Us) for its Native American members, the Centennial Care MCO shall maintain the referrals, care plans and member records for all covered Medicaid services that are referred and provided by the MCO's provider network. The MCOs will share the records with the IHS/ITUs but remain the responsible party for record custody. Those services and referrals included in the member's record and care plan shall be eligible for the 100% Federal Medical Assistance Percentage (FMAP) rate per the federal guidance for services "received through" an IHS or Tribal facility (SHO #16-002).

2. LTSS Proposals

Essential to Centennial Care is the availability of CB services for members who require LTSS and wish to remain in the community or in their own home. As program utilization continues to increase, HSD's proposal for modifications to the CB services are focused on the long-term sustainability of the program without jeopardizing the gains achieved in improved access to care and health care outcomes derived from the program's innovative policy. HSD proposes the following modifications to the program in the Centennial Care 2.0 Waiver renewal:

- Add Nutritional Counseling as an option under ABCB to better align CB packages;
- Establish a one-time allowance for the cost of start-up goods when a member transitions from ABCB to SDCB;
- Address the need for additional respite hours for caregivers of Community Benefit members by increasing the number of hours available;

- Establish limitations on costs for certain services in the SDCB model;
- Implement an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change, which reduces administrative burden for both members and the State; and
- Require inclusion of nursing facilities in VBP arrangements and leverage the University of New Mexico's Project Extension for Community Healthcare Outcomes (Project ECHO) to provide expert consultation to nursing home staff working with members with complex conditions to improve quality of care and healthcare outcomes for such members. In addition, work with Project ECHO and UNM Section of Geriatrics to improve quality of care (and quality ratings) in participating New Mexico nursing facilities, as well as working to reduce avoidable readmissions from nursing facilities to hospitals.

LTSS Proposal #1: Align Services between ABCB and SDCB Models
HSD proposes to align the CB service packages by adding Nutritional Counseling to the ABCB benefit package. In addition, HSD proposes to change the name of the self-directed Homemaker service to self-directed PCS to lessen confusion and better align with ABCB. See Appendix I for comprehensive proposed CB benefits.

LTSS Proposal #2: Allow for one-time start-up goods when a member transitions from ABCB to SDCB
HSD proposes to establish a one-time funding amount of up to $2,000 for members who are transitioning from ABCB to SDCB to allow for necessary items such as a computer and printer. This change will result in maintaining the member in the community by accommodating for a one-time cost of goods and services necessary to successfully self-direct. For periods after transition, the annual budget will be reduced for the one-time costs and an annual limit established for continued purchase of goods and services as described in LTSS proposal #4. See Appendix I for comprehensive proposed CB benefits.

LTSS Proposal #3: Address the need for additional caregiver respite
Currently, respite services available under the CB are limited to 100 hours in most circumstances. HSD is proposing to increase the limit from 100 to 300 hours. This increase will allow members to access over 30 days of respite per annual period. See Appendix I for comprehensive proposed CB benefits.

LTSS Proposal #4: Establish limitations on costs for certain services in the SDCB model
HSD proposes to establish annual budget limitations for the following services for members in the SDCB model (see Table 2 below): related goods and services, non-medical transportation and specialized therapies. As this program continues to experience increased enrollment, the limitations will help to ensure long-term sustainability of the program and continue to allow HSD to offer access to the community benefit to all eligible Medicaid members who meet a NF LOC without needing a waiver allocation for such services. As part of implementation, HSD intends to impose these limits on all members enrolled in self-direction, both current and future members. To ease the transition to these new limits, HSD will establish a grace period of up to one year for members who would be impacted by the proposed limitations. See Appendix I for comprehensive proposed CB benefits.

Table 2 – SDCB Annual Service Limitations

SDCB Service	Description	Annual Limit
Related goods and services	Separate from the one-time funding for start-up goods and for members who transition from ABCD to SDCB. HSD proposes that for periods after transition an annual limit be established for continued purchase of goods and services.	$2,000
Non-medical transportation	HSD proposes an annual limit for non-medical transportation (carrier passes and/or mileage).	$1,000
Specialized therapies	HSD proposes to include an overall annual limit for the following specialized therapies such as: • Acupuncture • Chiropractic • Hippotherapy • Massage therapy	$2,000

LTSS Proposal #5: Implement an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change

This proposed change would result in reducing annual assessments for certain members, increasing administrative simplification and possibly achieve cost savings. Under this approach MCOs would still be required to complete an annual CNA and develop an annual CCP. Individuals must meet all financial eligibility criteria to qualify for ongoing coverage. This policy change is particularly relevant for members with certain conditions such as renal failure, quadriplegia, etc.

LTSS Proposal #6: Require inclusion of nursing facilities in VBP arrangements and leverage Project ECHO and the UNM Section of Geriatrics to provide expert consultation to nursing home staff working with members with complex conditions, systematic improvements in nursing home quality of care, and reductions in avoidable readmissions from Nursing Facilities to hospitals

As New Mexico continues to increase the number of members receiving LTSS in home and community settings, nursing facility occupancy rates continue to decline resulting in higher average costs to care for those who are residing in nursing facilities. HSD proposes, as funding permits, to continue to work with the New Mexico Health Care Association to explore alternative reimbursement methodologies and to mandate inclusion of nursing homes in MCO VBP arrangements. Additionally, HSD plans to expand upon its work with the University of New Mexico's Project ECHO program to provide consultation services to nursing facility staff working with members with complex conditions, particularly behavioral health issues. Project ECHO is a collaborative model that provides medical education and care management to primary care and other physicians in order to help them treat complex medical and behavioral health conditions. While Project ECHO does not provide direct care to patients, it expands access to specialty treatment for front-line clinicians treating complex conditions, such as Hepatitis C, HIV, tuberculosis, chronic pain, endocrinology, diabetes, and behavioral health disorders. HSD will establish expectations for the MCOs to expand Project ECHO consultations for nursing home staff working with members with complex conditions. In addition, given that 64 percent of

nursing facility patients are Centennial Care members, there are significant opportunities to develop statewide efforts to identify key opportunities for improvement of quality of care across the entire state, and to develop a system to evaluate all readmissions from Nursing Facilities to hospitals and substantially reduce the number of avoidable readmissions.

3. Physical Health and Behavioral Health Integration Proposals

While HSD has sufficient authority to continue advancement of physical and behavioral health integration, it has identified several strategies aimed at improving existing practices in Centennial Care that reduce the fragmentation of care through patient-centered practices. HSD may opt for waiver authority or alternatively choose another method such as a State Plan Amendment to implement the following opportunities:

- Expanding the Health Home model; and
- Establishing an alternative payment methodology to support workforce development.

Additionally, HSD seeks waiver authority for the following initiative as part of improving behavioral and physical health integration:

- Developing a housing support service to provide some peer-delivered, pre-tenancy and tenancy support services to active adults who are Seriously Mentally Ill (SMI).

Physical and Behavioral Health Integration Proposal #1: Expand the Health Home model
New Mexico's Health Home model, known as CareLink NM, provides a comprehensive system of care coordination for members with chronic behavioral health conditions. The model provides intensive and coordinated care for adults with a serious mental illness and children with severe emotional disturbance. In 2016, HSD implemented the model with two sites that are enrolling both FFS and managed care members, serving a total of 400 members. HSD is currently developing an expansion of the CareLink NM model to additional sites, including a Native American Health Home site, beginning in calendar year 2018. In Centennial Care 2.0, HSD intends to continue to expand the CareLink NM model through State Plan Authority, evaluating outcomes from existing sites and tailoring new sites to populations and conditions suited for the Health Home model. The Centennial Care 2.0 MCOs will be expected to continue to collaborate with HSD in the expansion of this program.

Physical and Behavioral Health Integration Proposal #2: Establish an alternative payment methodology to support workforce development
HSD proposes an alternative payment methodology for graduate medical education to enhance current payment rates, with the goal of increasing and improving access to care in rural and frontier regions of New Mexico by moving primary care and psychiatric residents from hospitals to community-based clinic settings. Under the proposed methodology, HSD will fund 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 the type of residency program offered, numbers and types of Medicaid clients served, and other categories of residency programs.

Physical and Behavioral Health Integration Proposal #3: Develop Peer-Delivered Pre-Tenancy and Tenancy Support Housing Services

HSD proposes to create a supportive housing service that provides some peer-delivered, pre-tenancy and tenancy support services to active participants with Serious Mental Illness (SMI). The pre-tenancy and tenancy support services would be delivered by peers in supportive housing programs associated with Linkages and Lead Agencies. These additional services do not include tenancy assistance in the form of rent or subsidized housing; instead they expand on the basic housing support provided today through comprehensive community support services (CCSS). HSD expects that the addition of this service will have a beneficial impact for the member by improving the integration of BH/PH services, improving treatment participation and outcomes and reducing unnecessary hospitalizations and use of emergency room for non-emergent issues.

4. Payment Reform Proposals

HSD has implemented requirements for MCOs to increase the portion of provider payments in VBP arrangements in CY17 and CY18. With Centennial Care 2.0, HSD has included a long-term and expanded VBP strategy that outlines incremental increases in the percentage of provider payments that must operate under a VBP arrangement. For Centennial Care 2.0, HSD proposes the following initiatives related to payment reform:

- Continue to drive value by improving provider readiness to participate in risk-based payment arrangements and increasing the percentage requirement of managed care provider payments that are risk-based;
- Leverage VBP arrangements that drive key program goals in the areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes; and
- Advance the SNCP program to additional providers with the goal of improving quality outcomes and include requirements for providers that participate in SNCP initiatives to be contracted network providers with each Centennial Care MCO.

Payment Reform Proposal #1: Pay for value versus volume and increase the share of provider payment arrangements that are risk-based

As HSD continues to expand requirements for MCOs to shift payments from volume of services to paying for quality and improved outcomes, HSD recognizes that it must continue to develop requirements for the MCOs, identify areas for providing technical assistance to interested health care providers and promote aligned quality metrics. As part of this opportunity, HSD proposes to:

- Increase the total percentage of MCO provider payments that are in VBP level 2 (shared savings and bundled payments) and level 3 (partial or full risk) arrangements;
- Improve provider readiness to participate in risk-based payment arrangements;
- Require that VBP arrangements incrementally increase for behavioral health providers, LTSS providers and smaller volume providers, including options for small providers to build collaborative partnerships;
- Reduce administrative burden and complexity wherever possible;

- Eliminate barriers to data sharing and improve the availability of actionable and reliable data for providers participating in VBP strategies;
- Align quality metrics and technical specifications across MCOs and health care payers (noting that in many instances Medicare and commercial insurance quality measures do not necessarily align with Medicaid populations); and
- Identify best practices to evaluate and quantify the success of VBP strategies.

Payment Reform Proposal #2: Leverage VBP to incentivize and drive key program goals in areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes, including avoidable emergency department utilization

HSD understands the importance of aligning programmatic goals with its VBP initiatives so that incentives remain aligned among payers, providers and members. It intends to leverage VBP arrangements to drive certain initiatives, including:

- Expanding the CareLink NM Health Home model to additional counties and evaluating other types of Health Homes that may align with Centennial Care initiatives to improve specific healthcare outcomes in certain populations;
- Pursuing options to expand Health Homes to tribal organizations through VBP strategies that support their ability to provide enhanced care coordination interventions;
- Broadening MCO VBP requirements to test strategies that target key program goal areas; and
- Exploring VBP strategies to improve provider shortage issues, particularly within primary care.

Payment Reform Proposal #3: Advance SNCP Initiatives

HSD proposes that funding in future periods for the Uncompensated Care (UC) pool grows at the level of annual cost trend as factored in the waiver, and that funding in future periods for the HQII pool grows by three times the level of annual cost trend as factored in the waiver. In addition, it plans to incrementally shift the funding ratio between the two pools so that 43% of the funding is allocated for the UC pool and 57% for the HQII. This ratio aligns with Centennial Care's goal to prioritize paying for quality versus volume. The HQII Program will continue to evaluate urgent improvements in care and continue to evolve toward the evaluation of population focused improvements. Areas of increasing importance are obstetrical adverse events, all cause readmissions and uncontrolled diabetes admission rates.

In addition to the revised allocation of funding, HSD proposes:

- Flexibility to modify or update measures that factor into funding of the HQII pool;
- Expand participation of the SNCP to all willing hospitals and other providers, such as nursing facilities; and
- Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network for the Centennial Care MCOs.

5. *Proposals to Advance Member Engagement and Personal Responsibility*

For Centennial Care 2.0, HSD seeks to build upon and incorporate policies that enhance members' ability to make informed decisions about their health and health care, and to become more active and involved participants in the health care system. In addition, HSD is proposing initiatives to increase the financial responsibility of individuals in higher-income Medicaid categories, including the Adult Expansion, Children's Health Insurance Program (CHIP) and Working Disabled Individuals (WDI). Native Americans would be exempt from any cost-sharing requirements. Proposals include:

- Advancing Centennial Rewards;
- Implementing premiums for certain populations with income that exceeds 100% of the federal poverty level (FPL);
- Requiring co-payments for certain populations;
- Allowing providers to charge nominal fees for three or more missed appointments; and
- Expand opportunities for Native American members in Centennial Care.

Member Engagement and Personal Responsibility Proposal #1: Advance the Centennial Rewards Program
To advance Centennial Rewards, HSD proposes to restructure rewards to focus on new conditions and to promote more proactive engagement. HSD proposes modifications that include:

- Designing rewards criteria to promote proactive participation, such as lowering blood pressure, meeting weight loss goals or smoking cessation;
- Utilizing earned rewards to apply toward monthly premium payments;
- Leveraging the Centennial Rewards vendor to assist with collection of proposed premiums; and
- Improving the promotion of Centennial Rewards by requiring targeted outreach, including mobile app technology to expand member engagement and participation.

Member Engagement and Cost Sharing Proposal #2: Implement premiums for populations with income that exceeds 100% FPL
The ACA expanded Medicaid eligibility to adults with income up to 138% FPL. In 2012, the U.S. Supreme Court issued a ruling that effectively made Medicaid expansion optional for states. As of January 1, 2017, a total of 32 states — including New Mexico — have expanded Medicaid. The expansion of Medicaid to the newly eligible has resulted in significant enrollment growth compared to enrollment of low-income adults before the Adult Expansion. Additionally, enrollment in CHIP has increased by 85% since early 2014. Compared to other states, New Mexico has generous eligibility thresholds for both children and adults, with the CHIP program extending to 300% FPL for children age 0–5 and to 240% FPL for children age 6–18. Under today's Centennial Care program, Medicaid Expansion Adults are not subject to any form of cost-sharing, and co-payments for CHIP recipients are minimal. In New Mexico, there are also minimal co-payments for WDI, which provides coverage for individuals up to 250% FPL.

For Centennial Care 2.0, HSD is proposing policies to implement premiums and cost sharing for individuals in higher-income Medicaid categories, populations above 100% FPL in the Adult Expansion, CHIP and WDI eligibility categories. The premium amount in the initial year is set at approximately one percent (1.0%) of income for individuals at the lowest end of the income bracket in each premium tier, and HSD is seeking the flexibility to implement premiums on an incremental basis up to two percent (2.0%) of income during the term of the demonstration. The incremental implementation will allow HSD to evaluate the effectiveness of premiums in demonstrating personal responsibility and member engagement, and to adjust them accordingly as the population becomes more accustomed to making payments. HSD also proposes a household rate for each premium tier at an amount that is double the premium amount for a single-member household. The household rate would cover any household with two or more members subject to premium payments.

Premiums are the norm for private insurance and coverage obtained through the federal Health Insurance Marketplace. The proposed premiums would offset some costs of health care expenditures. The proposed maximum mandatory monthly premiums for individuals with income above 100% FPL are outlined in Table 3.

Table 3 – Proposed Monthly Premiums for Incomes above 100% FPL

FPL Range	Annual Household Income (HH of 1)	Applicable Categories of Eligibility (COE)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
101-150%	$12,060-$18,090	OAG, WDI, TMA	$10	$20	$20	$40
151-200%	$18,091-$24,120	WDI, TMA, CHIP	$15	$30	$30	$60
201-250%	$24,121-$30,150	WDI, TMA, CHIP	$20	$40	$40	$80
251-300%	$30,151-$36,180	TMA, CHIP	$25	$50	$50	$100

Additional Premium Policy Proposals

The state seeks to develop premium enforcement policies based on the state's experience operating a premium-based coverage program known as State Coverage Insurance (SCI). Where applicable, the state also seeks to align Medicaid premium policies with policies for subsidized health insurance coverage through the Federal Marketplace. As such, individuals in a Medicaid category of eligibility that includes premiums must pay the required premium to maintain coverage. The state will develop hardship criteria, such as homelessness, to waive premium payment requirements.

- Native American members will be exempt from premiums;
- Implementation Date of Premium Requirements: HSD proposes to implement the premium payment requirements within six months of the effective date of the Centennial Care 2.0 program;

- Effective Date of Coverage for Individuals with Premium Requirements: Covered benefits will be provided on a prospective basis for individuals who are required to pay premiums. Once determined eligible for Medicaid, individuals in a Medicaid category of eligibility that requires premiums must pay the first month's premium payment before enrollment and services will begin. Benefit coverage begins on the first day of the first month following receipt of the required premium by the premium due date. Coverage will not be retroactive.
- Grace Period for Premium Payment: Failure to pay premiums will result in a loss of benefits. Loss of benefits occurs after a 90-day grace period. At expiration of the grace period, enrollees will be disenrolled from the Medicaid managed care organization for nonpayment of premiums.
- Lock-out Period: Failure to pay required premiums will result in a three month lock out from the program. Medicaid eligibility will be suspended rather than terminated during the three month lock out. Individuals may begin receiving covered benefits after the lockout period upon receipt of required premiums. The individual's benefit coverage will begin per the coverage policy timelines outlined in the Effective Date of Coverage section above.
- Premium Payment Options: HSD proposes to leverage the Member Rewards vendor to assist with premium collection and to administer a program that allows use of earned rewards to offset the premium payment.

Member Engagement and Cost Sharing Proposal #3: Require co-payments for certain populations

To drive more appropriate use of services and promote member responsibility, HSD proposes to implement certain copayments for specific services. HSD currently has copayment requirements for its CHIP and WDI populations and is seeking to streamline the copayments across populations. In Centennial Care 2.0, the adult expansion population with income greater than 100% of the FPL would also be subject to copayments for the same services that require copayments for the CHIP and WDI populations. Additionally, most Centennial Care members will have copayments for non-preferred prescriptions drugs and for non-emergent use of the emergency department. Table 4 below provides a summary of the proposed copayments.

Table 4 – Proposed Co-payments

	Children's Health Insurance Program (CHIP)	Working Disabled Individuals (WDI)	Expansion Adults	All Other Medicaid
Population Characteristics and Service	Age 0-5: 241-300% FPL Age 6-18: 191-240% FPL	Up to 250% FPL	Co-pays for individuals with income greater than 100% FPL.	
Outpatient office visits • Preventive visits exempt • BH outpatient exempt	$5/visit	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	$50/stay	$50/stay	$50/stay	No co-pay
Outpatient surgeries	$50/surgery	$50/surgery	$50/surgery	No co-pay
Prescription drugs, medical equipment and supplies ● Psychotropic drugs and family planning drugs/supplies exempt ● Not charged if non-preferred drug co-pay is applied	$2/prescription	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs ● Psychotropic drugs and family planning drugs/supplies exempt	$8/prescription All FPLs and COEs, certain exemptions will apply			
Non-emergency ER visits	$8/visit All FPLs and COEs, certain exemptions will apply			

The following populations would be exempt from all copayments:

- Native Americans;
- ICF-IID individuals;
- QMB/SLIMB/QI1 individuals;
- Individuals on Family Planning-Only;
- Individuals in the PACE program;
- Individuals on the DD waiver; and
- People receiving hospice care.

Member Engagement and Cost Sharing Proposal #4: Seek authority to modify the tracking requirements for cost sharing

HSD seeks authority to change the frequency of tracking the out-of-pocket maximum cost sharing amounts to align more closely with commercial insurance by tracking the maximum amounts on an annual basis. It also seeks authority to apply the 5% out-of-pocket aggregate maximum for cost-sharing (to include premiums and most co-payments) based on FPL tiers. For example the 5% aggregate maximum would be calculated based on the lowest income in each FPL tier, meaning that the same aggregate maximum will apply for anyone in that FPL tier. This process will make it more administratively feasible to track co-payments, since the 5% aggregate maximum today is based on the income of each individual household. In addition, HSD seeks waiver authority to exclude co-payments for unnecessary use of the hospital Emergency Department and non-preferred prescription drugs from the 5% aggregate maximum. New Mexico believes that the two copayments should always be charged when the individual utilizes these unnecessary services and should not be waived when the out-of-pocket maximum has been met.

Member Engagement and Personal Responsibility Proposal #5: Seek authority for providers to charge nominal fees for three or more missed appointments

With the Adult Expansion of Medicaid, providers have expressed concerns about the rates of missed appointments. Under current rules, Medicaid recipients cannot be required to pay fees or sign financial responsibility forms for missed appointments. HSD will request authority to allow providers to charge a nominal fee of $5.00 after the member misses three scheduled appointments without prior notification by the member to the provider. Medicaid providers will be required to have policies that outline how this change will be implemented for their members. HSD will develop annual provider surveys to understand if the missed appointment fee changes behavior or impacts a reduction in no show appointments.

Member Engagement Proposal #6: Expand opportunities for Native Americans enrolled in Centennial Care

HSD is committed to improving the member experience for Native Americans enrolled in Centennial Care. It will continue to engage the Tribes, Tribal providers and Centennial Care MCOs in efforts to improve the delivery system including resolution of issues that have occurred. As mentioned previously, HSD will maintain all protections and requirements established in the current Centennial Care waiver as well as:

- Continue to require the MCOs to expand contractual or employment arrangements with CHRs throughout the State;
- Work with tribal providers to develop their capacity to enroll as LTSS providers and/or as a Health Home provider; and
- The state seeks authority to collaborate with Indian Managed Care Entities (IMCE) as defined in Section IV of the Federal Indian Health Care Improvement Act and 42 CFR section 438.14, including a pilot project with the Navajo Nation. An IMCE may operate in a defined geographic service area, but would be required to meet all other aspects of federal and state managed care requirements, including but not limited to, financial solvency, licensing, provider network adequacy and access requirements. An IMCE in New Mexico must be able to demonstrate compliance with the requirements in the Centennial Care Managed Care Professional Services Agreement, including delivery of all

Medicaid services as listed. The Department will assess compliance and readiness prior to permitting enrollment of Medicaid members. Implementation may also require several phases during the demonstration waiver.

6. Benefits and Eligibility Administrative Simplification Proposals

One of the core principles of the Centennial Care program is to improve administrative effectiveness and simplicity. In Medicaid, this is a difficult challenge — the program currently subsumes nearly 40 different categories of eligibility, multiple complicated eligibility determination methodologies, and multiple benefit packages for both children and adults. HSD proposes opportunities to streamline some of these administrative complexities and, at the same time, is examining innovations in program design aimed at addressing and resolving issues that will reduce Medicaid administrative costs, reduce health care expenses and help the State maintain a financially viable and sustainable program.

Proposed benefit and administrative refinements include:

- Developing a uniform benefit package for most Medicaid adults;
- Developing a buy-in program (rider) for dental services and vision services for adults, if necessary;
- Incorporating eligibility for Family Planning into the waiver so that it covers men and women through the age 50 who do not have other insurance coverage, with certain exceptions;
- Eliminating the three month retroactive eligibility period for most (non-SSI) Centennial Care members;
- Accelerating the transition off Medicaid for individuals who lose eligibility due to increased earnings by requesting a waiver of the Transitional Medical Assistance program;
- Addressing limitations imposed on the use of Institutions for Mental Disease;
- Covering former foster care individuals up to age 26 who aged out of foster care in another state;
- Securing enhanced administrative funding to maintain an inventory of LARC for certain providers; and
- Continuing to provide access to Community Interveners for deaf and blind individuals.

Benefits and Eligibility Proposal #1: Redesign the Alternative Benefit Plan and provide a uniform benefit package for most Medicaid-covered Adults

Most adults who are enrolled in the Medicaid Expansion Category receive services under the ABP. The ABP is a comprehensive benefit package that covers all services that are defined under the ACA as “essential health benefits” and includes Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for individuals who are age 19 and 20. The ABP is closely aligned with the types of benefit packages that are available on the commercial market, meaning that there are limitations on certain services, such as: physical, occupational and speech therapy and home health services; and that some services are not covered, such as routine vision care and hearing aids. In addition to meeting the Essential Health Benefits standard articulated in the ACA, the New Mexico ABP also includes adult dental services that are aligned with the Medicaid State Plan.

Although most adults in the Medicaid Expansion receive the ABP, individuals who are considered "medically frail" are exempt from the ABP and may receive the standard Medicaid benefit package which includes access to CB services and nursing facility care for individuals who meet the NF LOC criteria.

Non-expansion Medicaid adults (Parent/Caretaker category) receive the standard Medicaid benefit package, which does not have certain coverage limits like the ABP. To ensure the Medicaid program's long-term affordability and sustainability, HSD requests waiver authority to cover adults in the Parent/Caretaker category under the ABP, essentially providing one benefit package to most Medicaid-covered adults. Individuals who are determined "medically frail" will still be able to receive the standard Medicaid benefit package.

In addition, HSD proposes the following modifications for the single, comprehensive adult benefit package.

- Redesign the ABP as "HHS Secretary-approved" coverage, providing HSD with the flexibility to offer a comprehensive benefit package with limitations on certain services, such as physical therapy as exists today, and to eliminate habilitative services. The State also seeks to create options for new service providers and leverage new technologies for the delivery of non-emergency medical transportation by including rideshare services and mobile applications;;
- Include a limited vision benefit as part of the benefit package redesign; and
- Waive the federal EPSDT rule for 19-20 year-olds who are covered under the Expansion Adult and Parent/Caretaker categories in the ABP. Again, any adult who meets the medically-frail criteria is able to receive the standard Medicaid benefit package, which includes long-term services and supports for individuals meeting the NFLOC criteria.

Benefits and Eligibility Proposal #2: Develop buy-in premiums for dental and vision services for adults, if needed
HSD may need to scale back benefit design for adults to ensure the ongoing sustainability of the Medicaid program, contingent upon State budget allocations and potential changes in federal financing. Should HSD need to eliminate or reduce optional dental and vision services for adults, it will develop dental and vision riders that adults could purchase at an affordable premium, similar to those available in the commercial market.

Benefits and Eligibility Proposal #3: Incorporate eligibility requirements of the Family Planning program
Currently, the Family Planning Category, under the state plan, serves as a catchall for individuals who apply for Medicaid, but do not meet the financial eligibility standards to qualify for full coverage. This has resulted in approximately 72,000 individuals enrolled in the program, including many who have other insurance coverage (such as an Exchange plan), or who are outside of the average Family Planning age standards. Based on an analysis of this population, only approximately six (6) percent use Family Planning and related services covered by the program. This is because the benefit package is limited to reproductive health care, contraceptives and related services, and most individuals find that it does not meet their overall health care needs. In addition, the program is administratively burdensome for HSD because all

covered individuals must have their eligibility renewed yearly, at a rate of approximately 6,000 renewals per month.

HSD proposes to better target the program to those individuals who are using it by designing it specifically for men and women through the age of 50 who do not have other health insurance coverage, with certain exceptions. Streamlining the Family Planning program to apply to the appropriate population will preserve the program for those who need it while saving administrative dollars and resources that are being allocated to renewal processes.

Benefits and Eligibility Proposal #4: Eliminate the three month retroactive eligibility period for most Centennial Care members

HSD is moving toward an environment in which Medicaid eligibility, both initial determinations and renewals, is streamlined where possible. Real-Time eligibility is scheduled to roll-out in 2018, meaning that many individuals will receive an eligibility determination at the point of application. Additionally, the ACA and expansion of Medicaid to adults who were previously uninsured have dramatically changed the landscape of coverage options. New Mexico hospitals have substantially reduced their uncompensated care needs and are able to make individuals presumptively eligible for Medicaid at the time of service. In calendar year 2016, only one percent of the Medicaid population requested retroactive coverage (10,000 individuals). Safety Net Clinics are also able to immediately enroll individuals at point of service through the Presumptive Eligibility program and receive payment for services. These changes provide an opportunity to eliminate the administratively complex reconciliation process with the MCOs for retroactive eligibility periods.

- HSD proposes eliminating the three month retroactive eligibility period, which is accompanied by an intensive reconciliation process and substantial administrative burden. As more and more members receive an eligibility determination at the point of application through Real-Time Eligibility capability, the need for retroactive coverage is diminished;
- The retroactive period elimination does not include retroactive status changes processed by the Social Security Administration; and
- Native American recipients and individuals residing in nursing facilities would be exempt from this provision, and will continue to access coverage for a three-month retroactive period, as needed.

Benefits and Eligibility Proposal #5: Accelerate the transition off of Medicaid for individuals who are eligible for the Transitional Medical Assistance (TMA) program due to increased income

HSD is seeking a waiver of TMA for the following reasons:

- TMA is a concept that predates the ACA and was intended to provide coverage to Parent/Caretaker adults whose income increases above the eligibility standard for full coverage and renders them ineligible for Medicaid. The need for this coverage is diminishing as evidenced by declining enrollment; most individuals with increased income move to the adult expansion category;

- In 2013, HSD enrolled 26,000 individuals in this category; today, fewer than 2,000 individuals are enrolled; and
- Individuals with income above the adult expansion category guidelines are eligible to receive subsidies to purchase coverage through the federal Marketplace.

Benefits and Eligibility Proposal #6: Request waiver from limitations imposed on the use of Institutions for Mental Disease

HSD proposes to request expenditure authority for members in managed care and FFS to receive inpatient services in an IMD so long as the cost of care is the same as, or more cost effective, than a setting that is not an IMD. Currently, federal financial participation is limited for when individuals between the ages of 21 and 64 are institutionalized in an IMD. This proposal will improve the availability of residential inpatient treatment services and ensure federal financial participation and simplify the administration of the program for both HSD and the MCOs.

Benefits and Eligibility Proposal #7: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

Under the waiver, HSD proposes to cover former foster care individuals up to age 26 who aged out of foster care in another state. While New Mexico formerly had State Plan authority for this population, CMS recently finalized a regulation retracting states' authority to receive federal Medicaid matching funds to cover this population without a waiver. New Mexico is required to cover this population under state law.

Benefits and Eligibility Proposal #8: Request waiver authority for enhanced administrative funding to expand availability of LARC for certain providers

HSD has made access to LARC a high priority over the past several years, successfully "unbundling" LARC reimbursement from other services in FQHCs, Rural Health Clinics (RHCs), SBHCs and at point of labor/delivery or during postnatal care to safeguard adequate payment and to ensure that providers are not discouraged from informing women about LARC or making it readily and immediately available.

HSD requests authority to receive increased administrative funding (90%, in line with the federal matching rate for Family Planning services and contraceptives) to expand the availability of LARC for certain providers, such as SBHCs. Under this proposal, the State would reimburse the New Mexico Department of Health or other sponsoring agencies for the cost of purchasing and maintaining LARCs to use for Medicaid beneficiaries.

Benefits and Eligibility Proposal #9: Continue to provide access to Community Interveners

The current 1115 Centennial Care Waiver provides for expenditure authority allowing certain individuals enrolled in Centennial Care who are deaf and blind to access the benefit of Community Interveners.

A Community Intervener is a trained professional who meets the criteria as determined by the state. The Intervener works one-on-one with deaf-blind individuals who are five years and older to provide critical connections to other people and the environment. The Intervener opens channels of communication between the individual and others, provides access to information, and facilitates the development and maintenance of self-directed independent living. Services

for Community Interveners are covered and will continue to be covered by Centennial Care MCOs and the costs associated with the Community Interveners may be included in capitation payments from the State to the Centennial Care MCO.

SECTION 3: WAIVER LIST

The following waivers are requested to enable New Mexico to implement the New Mexico Centennial Care 2.0 section 1115 waiver.

A. Title XIX Waiver Requests

1.	Reasonable Promptness	Section 1902(a)(8)
Consistent with existing Home- and Community-Based Services (HCBS) waiver authority (Section 1915(c) of the Social Security Act), to the extent necessary to enable the State to establish enrollment targets for certain HCBS for those who are not otherwise eligible for Medicaid. The State will take into account current demand and utilization rates and will look to increase such enrollment targets in order to appropriately meet the long term care needs of the community. To the extent necessary to enable the State to begin benefit coverage on the first day of the first month following receipt of the required premium by the premium due date for individuals in a Medicaid category of eligibility that requires premiums. To the extent necessary to enable the State to prohibit reenrollment for 3 months for individuals who fail to pay required premiums.		
2.	Amount, Duration and Scope of Services	Section 1902(a)(10)(B)
To the extent necessary to enable the State to permit managed care plans to offer different value added services or cost-effective alternative benefits to enrollees in Centennial Care. To the extent necessary to enable the State to offer certain HCBS and care coordination services to individuals who are Medicaid eligible and who meet nursing facility level of care. To the extent necessary to allow the State to place expenditure boundaries on HCBS and personal care options. To permit the State to serve adults in the Parent/Caretaker category under the same benefit package as Expansion adults using Secretary-approved ABP coverage.		
3.	Recipient Rewards	Section 1902(a)(10)(C)(i)
To the extent necessary to enable the State to exclude funds provided through recipient reward programs from income and resource tests established under State and Federal law for purposes of establishing Medicaid eligibility.		

4.	Freedom of Choice	Section 1902(a)(23)(A) 42 CFR 431.51
To enable the State to require participants to receive benefits through certain providers and to permit the State to require that individuals receive benefits through managed care providers who could not otherwise be required to enroll in managed care. Moreover, all services will be provided through managed care including behavioral health, HCBS and institutional services, except for services received under the existing Developmental Disabilities 1915(c) waiver, Medically Fragile 1915(c) waiver, and the accompanying Mi Via Self-Directed 1915(c) waiver, individuals in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and individuals in the Program of All-Inclusive Care for the Elderly (PACE). Consistent with the current demonstration, mandatory enrollment of American Indians/Alaska Natives is only permitted for receipt of LTSS.		
5.	Cost Sharing	Sections 1902(a)(14), 1916, and 1916A 42 CFR 445.15; 447.51-447.56
To permit the State to impose co-payments for non-emergency use of the emergency room and non-preferred prescription drugs for most categories and income levels; and to impose co-payments on certain populations with household incomes above 100% of the federal poverty level. Co-payments will not be imposed on individuals for whom Indian health care providers, as specified in section 1932(h) of the SSA, have the responsibility to treat. To permit the State to impose an alternative tracking methodology for the aggregate limit on cost-sharing. To permit Centennial Care providers to impose missed appointment fees on members.		
6.	Self-Direction of Care	Section 1902(a)(32)(A)
To permit persons receiving certain services to self-direct their care for such services.		
7.	Retroactive Eligibility	Section 1902(a)(34) 42 CFR 435.915
To enable the State, beginning on January 1, 2019, to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made for Medicaid for some eligibility groups.		
8.	Transitional Medical Assistance (TMA)	Section 1902(e)
To permit the state to waive participation in the TMA program for individuals who lose eligibility due to increased earnings.		

9.	Long-Acting Reversible Contraception (LARC)	
To permit the State to provide enhanced administrative funding for LARC to certain Medicaid providers.		
10.	EPSDT for Adults (19-20 years old)	Section 1902(a)(43)
To permit the State to waive the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements for adults in the Expansion Adult and Parent/Caretaker categories who are 19–20 years-old.		
11.	Premiums	Section 1902(a)(14), 1916, 1916A 42 CFR 447.55, 42 CFR 447.56(f)
To permit the State to impose premiums on certain populations. To permit the State to impose an alternative tracking methodology for the aggregate limit on premiums.		
12.	Alternative Benefit Package	Section 1902(k)(1) and 1937(b), 42 CFR 440.347
To enable the State to not provide coverage for habilitative services to the new adult population.		
13.	Nursing Facility Level of Care Redeterminations	Section 1902(a)(10)(A)(ii)(IV), 42 CFR 441.302(c)(2)
To enable the State to grant Members that meet specified criteria ongoing NF LOC determination.		

B. Expenditure Authority Requests

Under the authority of SSA section 1115(a)(2), expenditures made by the State 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 made under contracts that do not meet the requirements in Section 1903(m) of the SSA specified below. Managed care plans participating in the demonstration will have to meet all the requirements of Section 1903(m), except the following:

    a) Section 1903(m)(2)(H) and Federal regulations at 42 CFR 438.56(g), but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90-days or less in the same managed care plan from which the individual was previously enrolled.

2. Expenditures for recipient reward programs.

3. To the extent necessary, expenditures for valued added services and/or cost-effective alternative services to the extent those services are provided in compliance with federal regulations and the 1115 demonstration.

4. Expenditures for direct payments made by the State to the Safety Net Care Pool (SNCP), where hospitals receive payments out of a pool.

5. Expenditures under contracts with managed care entities where either the State or the managed care entity will provide for payment for Indian health care providers as specified in Section 1932(h) of the SSA for covered services furnished to Centennial Care managed care plan recipients at the Office of Management and Budget (OMB) rates.

6. Expenditures for Centennial Care recipients who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under SSA Section 1902(a)(10)(A)(ii)(VI) and 42 CFR §435.217 in conjunction with SSA section 1902(a)(10)(A)(ii)(V), if the services they receive under Centennial Care were provided under an Home and Community-Based Services (HCBS) waiver granted to the State under SSA Section 1915(c) as of the initial approval date of this demonstration. This includes the application of spousal impoverishment eligibility rules.

7. Expenditures to provide HCBS not included in the Medicaid State Plan to individuals who are eligible for Medicaid.

SECTION 4: APPROACH TO BUDGET NEUTRALITY

This section presents the State's approach for showing budget neutrality including the data and assumptions used in the development of the cost and caseload estimates supporting this 1115 waiver request.

Federal policy requires that section 1115 Demonstration applications be budget neutral to the federal government. This means that an 1115 Demonstration cannot cost the federal government more than what would have otherwise been spent absent the 1115 Demonstration. The particulars of budget neutrality, including methodologies, are subject to negotiation between HSD and CMS.

HSD proposes a per capita budget neutrality model for the populations covered under the Demonstration. HSD proposes an aggregate cap, trended annually for uncompensated care payments and HQII.

The following projections utilize actual Demonstration Year 1-3 expenditures, aggregate per capita cost trend and enrollment trend data for the program, based on the populations expected to be enrolled in the Demonstration.

The financing and budget neutrality forms will be included in the submission to CMS after HSD has received public input on the Waiver Renewal application.

Historical Enrollment and Expenditure Data					
	DY01 (1/1/2014 – 12/31/2014)	DY02 (1/1/2015 – 12/31/2015)	DY03 (1/1/2016 – 12/31/2016)	DY04* (1/1/2017 – 12/31/2017)	DY05* (1/1/2018 – 12/31/2018)
Members	7,360,554	8,162,036	8,660,504	8,946,301	9,241,529
Aggregate Expenditures	$4,007,889,032	$4,657,506,017	$4,571,113,953	$4,816,400,126	$5,074,848,193

**Estimated*

Centennial Care 2.0 - Demonstration Years (DY)					
	DY01 (1/1/2019 – 12/31/2019)	DY02 (1/1/2020 – 12/31/2020)	DY03 (1/1/2021 – 12/31/2021)	DY04 (1/1/2022 – 12/31/2022)	DY05 (1/1/2023 – 12/31/2023)
Members	9,426,360	9,614,887	9,807,185	10,003,329	10,203,396
Aggregate Expenditures	$5,278,7691,600	$5,490,100,477	$5,707,781,670	$5,941,977,426	$6,183,257,976

SECTION 5: EVALUATION DESIGN AND QUALITY STRATEGY

Details regarding evaluation of Centennial Care are found in the Interim Evaluation Report (Appendix B). During Centennial Care 2.0, HSD will maintain the original hypotheses and evaluation design plan but will add new metrics in order to evaluate the impact of proposed policies and programs presented within this waiver renewal application. Table 5 describes these hypotheses and how HSD will evaluate the impact:

Table 5 – Quality Goals and Evaluation

	Hypothesis	Methodology	Data Sources
Goal 1: Improve Member outcomes with refinements to care coordination			
1.1	Enhancements to care coordination will result in decreases for avoidable emergency room visits and hospital readmissions.	Track and trend member utilization of avoidable emergency room visits and hospital readmissions and monitor MCO adherence to common chronic disease management and other social support services requirements for care coordination.	Claims data HEDIS reports MCO reporting
1.2	Birthing outcomes will improve with pregnant women participating in the home visiting pilot.	Track and trend low birthweight, pre-term birth, prenatal/post-partum visits and well child visits for members in pilot.	Claims data HEDIS reports MCO reporting
Goal 2: Increase Behavioral Health Integration			
2.1	Member's utilization of Health Homes will increase.	Track and trend the number of members participating in Health Homes.	Claims data MCO reporting
2.2	Treatment outcomes of members participating in Health Homes will improve.	Track and trend Health Homes' treatment outcomes of common behavioral/physical health conditions and care coordination outcomes such as avoidable emergency	Claims data HEDIS reports MCO reporting

	Hypothesis	Methodology	Data Sources
		room visits, hospital readmissions and follow up after hospitalization for mental illness.	
Goal 3: Expand member access to Long Term Services and Supports			
3.1	Allowing all Medicaid-eligible members who meet a nursing facility level of care to access the Community Benefit will maintain New Mexico's accomplishments in rebalancing efforts.	Track and trend members accessing community benefits.	Claims data
3.2	Increasing caregiver respite hours will improve member outcomes and utilization.	Track and trend member utilization and member outcomes.	Claims data HEDIS reports
3.3	Automatic Nursing Facility Level of Care (NFLOC) approvals will achieve administrative simplification for HSD, the MCOs and members.	Track and trend automatic NFLOC approvals.	MCO reporting
Goal 4: Increase quality of care with Value Based Payment (VBP) arrangements.			
4.1	Healthcare outcomes will improve for members served by providers that have VBP arrangements for the full delegation of care coordination.	Track and trend member utilization and common chronic disease management outcomes of providers with VBP arrangements that include full delegation of care coordination.	Claims data HEDIS reports MCO reporting
4.2	Implementing incremental minimum VBP requirements will support bending the cost curve of Medicaid program costs through	Track and trend program expenditure.	Claims data HEDIS reports MCO reporting

	Hypothesis	Methodology	Data Sources
	alignment with Centennial Care 2.0 program goals of improving care coordination, focus on transitions of care.		
Goal 5: Promoting Member Engagement and Responsibility			
5.1	Members participating in the Centennial Rewards program will continue to have improved healthcare outcomes with decreases in higher-cost services, such as inpatient stays.	Track and trend member utilization of preventive services and rewards credits.	Claims data HEDIS reports MCO/Reward Program Contractor reporting
5.2	Copayments for certain services will drive more appropriate use of services, such as reducing non-emergent use of the emergency department.	Track and trend member utilization of avoidable emergency room visits	Claims data MCO reporting
5.3	Premiums will ensure member engagement and smooth the cost-sharing "cliff" between Medicaid and the commercial market.	Track and trend enrollment rates and rate of churn between Medicaid and commercial/private coverage	Enrollment data Premium collections data
Goal 6: Improve administrative effectiveness and simplicity.			
6.1	Engaging justice-involved members prior to release will improve their health outcomes and begin to reduce recidivism in time.	Track and trend health outcomes and recidivism rates for justice-involved members who are actively participating in the care coordination program.	Claims data MCO reporting HEDIS reports
6.2	Members will have increased access to inpatient services at	Track and trend member utilization of IMDs.	Claims data

	Hypothesis	Methodology	Data Sources
	an Institution for Mental Disease (IMD).		
Goal 7: Improve Delivery System and Access to Services			
7.1	Members will have increased access to CHWs and CHRs.	Track and trend member utilization.	MCO reporting
7.2	Members will have increased access to telehealth.	Track and trend member utilization.	Claims data
7.2	Members will have increased access to Patient Centers Medical Homes.	Track and trend member utilization.	MCO reporting

SECTION 6: STATE PUBLIC NOTICE

The following are highlights of HSD's stakeholder engagement process for renewal of the Centennial Care waiver.

Medicaid Advisory Committee (MAC) Subcommittee for 1115 Waiver Renewal Design
HSD sought stakeholder input and recommendations for Centennial Care 2.0 beginning in October 2016. HSD convened a subcommittee of the MAC between October 2016 and February 2017. The subcommittee of the MAC was comprised of 21 members representing members, advocates, providers, tribal liaisons, other State agencies and was also open to the public. In addition to facilitated discussions during each meeting, individual subcommittee members and the public were asked to submit their recommendations to HSD in writing.

Native American/Tribal Meetings for 1115 Waiver Renewal Design
During the same time HSD was meeting with the subcommittee of the MAC, HSD held monthly NATAC meetings to present the same materials and concepts provided at the MAC subcommittee meetings and to facilitate discussion and obtain feedback about the waiver renewal, specifically related to the needs of the Native American population in Centennial Care. The meetings provided an opportunity for HSD to present concepts and solicit feedback on the key design features for renewal both verbally and in writing from the Tribal and IHS representatives. In addition HSD held a formal Tribal Consultation on June 23, 2017 in Albuquerque.

Additional Public Meetings
HSD's goal is to provide for a transparent Centennial Care waiver renewal process and to clearly convey expectations. Statewide stakeholder meetings about the concept paper occurred throughout the month of June 2017. Additional NATAC and MAC meetings were also held in June to solicit comment and feedback on the concept paper. Comments received from the MAC Subcommittee, NATAC, Tribal consultation and statewide public meetings about the concept paper informed the development of the renewal application.

Waiver Renewal Application
This waiver renewal 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. Public comments related to the waiver renewal continue to be accepted by HSD via the same website.

HSD will publish the draft waiver renewal application by September 1, 2017, and then conduct public hearings and Native American Tribal consultation. HSD intends to submit the final waiver renewal application to CMS November 30, 2017. Table 6 outlines HSD's comprehensive activities and timeline for stakeholder engagement for the waiver renewal.

Table 6 – Renewal Timeline

Event	Dates
Planning and Design Meetings: Subcommittee of the MAC • Santa Fe • Albuquerque • Santa Fe • Albuquerque • Santa Fe	 October 14, 2016 November 18, 2016 December 16, 2016 January 13, 2017 February 10, 2017
NATAC Meetings • Albuquerque • Albuquerque • Santa Fe • Albuquerque	 December 5, 2016 January 20, 2017 February 10, 2017 April 10, 2017
MAC Meetings (All meetings held in Santa Fe)	November 14, 2016 April 3, 2017
Publish Date - Concept Paper	May 19, 2017
Gather Feedback - Concept Paper Statewide Public Input Sessions • Albuquerque • Silver City • Farmington • Roswell	 June 14, 2017 June 19, 2017 June 21, 2017 June 26, 2017
NATAC Meeting (Albuquerque)	July 10, 2017
MAC Meeting (Santa Fe)	July 24, 2017
Formal Tribal Consultation (Albuquerque)	June 23, 2017
Notice Period - 60-day advanced notification to Native American / Tribal stakeholders regarding 1115 waiver renewal application	August 31, 2017
Publish Date - Draft 1115 Waiver Application	September 5, 2017
Gather Feedback - Draft Waiver Application Public Hearings & Tribal Consultation Meeting sites: • Public meeting: Las Cruces • Public meeting: Santa Fe (MAC meeting) • Public meeting: Las Vegas • Tribal consultation (Santa Fe) • Public meeting: Albuquerque	 October 12, 2017 October 16, 2017 October 18, 2017 October 20, 2017 October 30, 2017
Final Waiver Application Submission to CMS	November 30, 2017

SECTION 7: APPENDICES

Appendix A: Glossary

Acronym	Term
ABCB	Agency-Based Community Benefit
ADL	Activities of Daily Living
CB	Community Benefit
CCP	Comprehensive Care Plan
CCSS	Comprehensive Community Support Services
CHIP	Children's Health Insurance Program
CHWs	Community Health Workers
CNA	Comprehensive Needs Assessment
COE	Category of Eligibility
CoLTS	Coordination of Long Term Services
CMS	Centers for Medicare & Medicaid Services
CSA	Core Service Agencies
CY	Calendar Year
CYFD	Children, Youth and Families Department
DOH	Department of Health
DY	Demonstration Year
EDIE	Emergency Department Information Exchange
EPSDT	Early Periodic Screening, Diagnostic and Treatment
FFS	Fee-for-Service
FMAP	Federal Matching Assistance Program
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
HCBS	Home and Community-Based Services
HRA	Health Risk Assessment
HQII	Hospital Quality Improvement Incentive
HSD	New Mexico's Human Services Department
IADL	Instrumental Activities of Daily Living
I/T/U	Indian Health Service, Tribal health provider, and Urban Indian providers
IHS	Indian Health Service
IMD	Institution for Mental Disease
LARC	Long-Acting Reversible Contraception
LOC	Level of Care
LPN	Licensed Practical Nurse
LTSS	Long Term Services and Supports
MAC	Medicaid Advisory Committee
MCO	Managed Care Organization
MEG	Medicaid Eligibility Group
MH/SA	Mental Health / Substance Abuse
MMIS	Medicaid Management Information System
NAAB	Native American Advisory Board
NATAC	Native American Technical Advisory Committee

Acronym	Term
NF	Nursing Facility
NFLOC	Nursing Facility Level of Care
NM	New Mexico
NMICSS	New Mexico Independent Consumer Support System
OMB	Office of Management and Budget
PACE	Program for All-Inclusive Care for the Elderly
PCMH	Patient-Centered Medical Homes
PCS	Personal Care Services
RHC	Rural Health Clinic
RN	Registered Nurse
SBHC	School-Based Health Center
SDCB	Self-Directed Community Benefit
SNCP	Safety Net Care Pool
SMI	Serious Mental Illness
SSA	Social Security Act
SSI	Supplemental Security Income
STC	Standard Terms and Conditions
TANF	Temporary Assistance for Needy Families
TMA	Transitional Medical Assistance program
UC	Uncompensated Care
VBP	Value-Based Purchasing
WDI	Working Disabled Individuals

Appendix B: Interim Evaluation Report

RESERVED – IN PROGRESS

Appendix C: State Public Notices

RESERVED – IN PROGRESS

Appendix D: Summary of Stakeholder Feedback

RESERVED – IN PROGRESS

Appendix E: Feedback from Federally Recognized Tribal Nations

RESERVED – IN PROGRESS

Appendix F: EQRO Reports and Other Demonstration of Quality

RESERVED – IN PROGRESS

Appendix G: Current Centennial Care 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 7 describes the mandatory State Plan populations included in Centennial Care;
- Table 8 describes the optional State Plan populations included in Centennial Care; and
- Table 9 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 Column Descriptions:

- Column A describes the consolidated Medicaid eligibility group for the population in accordance with the Medicaid eligibility regulations that take effect January 1, 2014;
- Column B describes the specific statutory/ regulatory citation of any specific Medicaid eligibility groups that are included in the consolidated group described in column A;
- Column C describes the current income and resource standards and methodologies for each Medicaid eligibility group described in the state plan;
- Column D describes whether there are any limits on inclusion in Centennial Care for each Medicaid eligibility group; and
- Column E describes the budget neutrality Medicaid Eligibility Group (MEG) under which expenditures for the population are reported.

Table 7 – Mandatory State Plan Populations

A. Mandatory Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Parents/ Caretaker Relatives 42 CFR 435.110	Low Income Families (1931) 42 CFR 435.110	Income Test: TANF standards and methods Resource test: No	No	TANF and Related
	Transitional Medical Assistance (12-month extension due to earnings or 4 month extension due to increased child support/ spousal support) • 408(a)(11)(A) and (B) • 1931(c)(1) and (2) • 1925 • 1902(a)(52)	Income test: No Resource test: No	No	TANF and Related
Consolidated group for pregnant women 42 CFR 435.116	Low Income Families (1931) 42 CFR 435.110	Income Test: TANF standards and methods Resource test: No	No	TANF and Related
	Qualified pregnant women • 1902(a)(10)(A)(i)(III) • 1905(n)(1)	Income test: AFDC payment standard Resource test: AFDC	No	TANF and Related
	Mandatory poverty-level related pregnant women section • 1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	Income test: Up to 133% FPL Resource Test: No	No	TANF and Related
	Poverty level pregnant women optional eligible 1902(a)(10)(A)(ii)(IX) 1902(l)(1)(A)	Income test: 133% to 235% FPL Resource Test: No	No	TANF and Related

A. Mandatory Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Consolidated group for children under age 19 435.118	Low Income Families (1931) 42 CFR 435.110	Income Test: TANF standards and methods Resource test: No	No	TANF and Related
	Poverty level related infants • 1902(a)(10)(A)(i)(IV) • 1902(l)(1)(B)	Income Test: Up to 133% FPL Resource Test: No	No	TANF and Related
	Poverty level related children under ages 1-5 • 1902(a)(10)(A)(i)(VI) • 1902(l)(1)(C)	Income Test: Up to 185% FPL Resource Test: No	No	TANF and Related
	Poverty level related children age 6-18 • 1902(a)(10)(A)(i)(VII) • 1902(l)(1)(D)	Income Test: Up to 185% FPL Resource Test: No	No	TANF and Related
	Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay • 1902(e)(7)	Income Test: Up to 185% FPL Resource Test: No	No	TANF and Related
	Newborns deemed eligible for one year 1902(e)(4) 42 CFR 435.117	Income test: No Resource Test: No	No	TANF and Related
Adoption Assistance and foster care children	Children receiving IV-E foster care payments or with IV-E adoption assistance agreements • 1902(a)(10)(i)(I) 473(b)(3) 42 CFR 435.145	Income test: No Resource Test: No	No	TANF and Related
	Former foster care children 1902(a)(10)(A)(i)(IX)	Income test: No Resource Test: No	No	TANF and Related

A. Mandatory Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Individuals Age 19 Through 64	Adult group 1902(a)(10)(A)(i)(VIII) 42 CFR 435.119[1]	Income test: Up to 133% MAGI Resource test: No	No	VIII Group
Refugee Medical Assistance	Refugee Medical Assistance 45 CFR 400.94(d) 45 CFR 400.100-102 45 CFR 400.104	Income test: AFDC income standard Resource test: No	No	TANF and Related
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— §1901(a) (10)(A)(i)(II)(aa)	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals under age 21 eligible for Medicaid in the month they apply for SSI— 1902(a)(10(A)(i)(II)(cc)	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Disabled individual whose earning exceed SSI substantial gainful activity level— 1902(a)(10)(A)(i)(II)§1619(a)	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

[1] Note: Although this group is included in Section 1902(a)(10)(A)(i) of the Social Security Act, the state has the authority to decide whether to include this group.

A. Mandatory Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Aged, Blind, and Disabled (continued)	Individuals receiving mandatory state supplements SSI 42 CFR 435.130	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	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	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals who would be eligible for SSI except for the increase in OASDI benefits under Public Law 92-336 - 42 CFR 435.134	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals ineligible for SSI because of requirements prohibited by Medicaid 42 CFR 435.122	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Aged, Blind, and Disabled (continued)	Disabled widows and widowers 1634(b) Early widows/widowers 1634(b) 42 CFR 435.138	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals who become ineligible for SSI as a result of OASDI cost-of- living increases received after April 1977 42 CFR 435.135	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	1939(a)(5)(E) Disabled adult children 1634(c)	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Disabled individuals whose earnings are too high to receive SSI cash §1619(b)	Earned income is less than the threshold amount as defined by Social Security Unearned income is the SSI amount Resource standard is SSI	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	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) 42 CFR 435.236 1905(a)	Income test: 300% of Federal Benefit Rate with Nursing Facility Level of Care (NF LOC) or PACE / ICFMR eligible Resource test: $2,000	NF LOC: Included PACE: Excluded ICFMR: Excluded	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 8 – Optional State Plan Populations

A. Optional Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Infants and children under age 19	Poverty level infants not mandatorily eligible • 1902(a)(10)(A)(ii)(IX) • 1902(l)(2)	Income test: 133% up to 185% FPL Resource Test: No	No	TANF and Related
	Optional Targeted Low income children under 19 • 1902(a)(10)(a)(ii)(XIV) Note: If sufficient Title XXI allotment is available as described under STC 99, 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 100, then all individuals in this eligibility group are funded through Title XIX.	Income test: 185% up to 235% FPL Resource test: No	No	If Title XIX: TANF and Related If Title XXI: MCHIP Children
Adoption assistance and foster care children	Independent foster care adolescents under age 21 who were in foster care on their 18th birthday • 1902(a)(10)(A)(ii)(XVII)	Income test: No Resource Test: No	No	TANF and Related
Aged, Blind, and Disabled	Working disabled Individuals §1902(A)(10)(A)(ii)(XIII)	Income test: 250% FPL, meet SSI non-income standards Utilize SSI Methodologies Resource test: The state uses 1902(r)(2) disregards in determining eligibility for this group.	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Optional Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Aged, Blind, and Disabled (continued)	Individuals who would be eligible for SSI cash if not in an institution 42 CFR 435.211 1902(a)(10)(A)(ii)(IV) 1905(a)	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Breast and Cervical Cancer Program	Individuals under 65 screened for breast or cervical cancer 1902(a)(10)(A)(ii)(XVIII)	Screened by NM Department Of Health/CDC provider	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	Income test: 300% of Federal Benefit Rate with an ICF/MR Level of Care determination. Resource test: $2,000	Only in Centennial Care for Acute Care	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 435.726 and section 1924 of the Act, through the State's 1915(c) Medically Fragile waiver	Income test: 300% of Federal Benefit Rate with an ICF/MR Level of Care determination. Resource test: $2,000	Only in Centennial Care for Acute Care	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 9 – Demonstration Expansion Populations

A. Expansion Medicaid Eligibility Group	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Home and Community Based 1915(c) Waivers that are being 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	Income test: 300% of Federal Benefit Rate with Nursing Facility Level of Care determination. Resource test: $2000	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Appendix H: Centennial Care Current Benefits

Table 10 describes the non-CB services, including services available under the Alternative Benefit Plan (ABP). Table 11 lists the CB services. Table 12 lists the services available only through Centennial Care including the three new BH services

Table 10 – 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[2]	X	X
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

[2] 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
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	
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

Service	Medicaid State Plan	ABP Services
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 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 11 – 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

Table 12 – Services Available to Centennial Care Members Only

Service Description
Family Support
Behavioral Health Respite
Recovery Services
Community Interveners for the Deaf and Blind

Appendix I: Proposed Community Benefit Definitions and Limits

The following is a list of proposed Community Benefit services for Centennial Care 2.0, including service 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 recipient 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 recipients 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 non-recurring 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 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. Federal financial participation 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 on a more 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.

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.

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 three PCs delivery models.

Under 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.

Under the 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 recipients who are twenty-one (21) years of age or older with intermittent or extended direct nursing care in the recipients 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 recipients 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/MR 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 waiver 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.

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.

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.

Limits or Exclusions: A signed therapy referral for treatment must be obtained from the recipient's primary care physician. The referral will 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.

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.

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.

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.

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.

Native American Healers
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, emotional and spiritual health. Treatments may include prayer, dance, ceremony and song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel and/or other sacred objects. 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 and spiritual support provided by this type of healing can reduce pain and stress and improve quality of life. It is also important to note that some Tribes, Nations and Pueblos prefer to keep these healing therapies and practices safeguarded due to the significance of their religious ties.

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