Title: New Mexico Centennial Care Section 1115 Demonstration

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

PLEASE NOTE THAT THE FOLLOWING LIST REMAINS SUBJECT TO MATERIAL MODIFICATION AND REVIEW AND APPROVAL FROM THE CENTERS FOR MEDICARE & MEDICAID SERVICES ("CMS").**

WAIVERS OF TITLE XIX REQUIREMENTS FOR
NEW MEXICO CENTENNIAL CARE TITLE XIX STATE PLAN GROUPS

<table>
<tr><td>1.</td><td>Amount, Duration and Scope of Services</td><td>Section 1902(a)(10)(B)
42 CFR 400 Subpart B</td></tr>
<tr><td colspan="3">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 home and community based services ("HCBS") and care coordination services to individuals determined to need such services based on a care assessment evaluation.</td></tr>
<tr><td>2.</td><td>Member Rewards</td><td>Section 1902(a)(10)(C)(i)</td></tr>
<tr><td colspan="3">To the extent necessary to enable the State to exclude funds provided through member reward programs from income and resource tests established under State and Federal law for purposes of establishing Medicaid eligibility.</td></tr>
<tr><td>3.</td><td>Freedom of Choice</td><td>Section 1902(a)(23)
42 CFR 431.51</td></tr>
<tr><td colspan="3">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 included behavioral health, HCBS and institutional services except for services received under the existing Developmental Disabilities 1915(c) waiver and the accompanying Mi Via program for those who meet Institutional Care Facility/Mentally Retarded (ICF/MR) level of care.</td></tr>
<tr><td>4.</td><td>Retroactive Eligibility</td><td>Section 1902(a)(34)
42 CFR 435.914</td></tr>
<tr><td colspan="3">To enable the State not to extend eligibility prior to the date that an application for assistance is made. Notwithstanding the foregoing, the State will comply with maintenance of efforts requirements of the Affordable Care Act. Moreover, this provision (along with the rest of the Centennial Care program) will not be implemented until January 1, 2014.</td></tr>
<tr><td>5.</td><td>Cost Sharing</td><td>Sections 1902(a)(14) and 1916
42 CFR 447.51-447.56</td></tr>
<tr><td colspan="3">To permit the State to impose a copayment for non-emergency use of the emergency room on populations with household incomes above 100% of the federal poverty level that is in excess of the amount permitted pursuant to section 1916A of the Act. Copayments will not be imposed on individuals</td></tr>
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<table>
<tr><td colspan="3">for whom Indian health care providers, as specified in section 1932(h) of the Social Security Act, have a responsibility to treat.</td></tr>
<tr><td>6.</td><td>Self-Direction of Care</td><td>Section 1902(a)(32)</td></tr>
<tr><td colspan="3">To permit persons receiving certain services to self-direct expenditures for such services.</td></tr>
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Under the authority of Social Security Act 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 State Medicaid 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 Act 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)(A)(vi) insofar as it requires compliance with requirements in section 1932(a)(4) and Federal regulations at 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period after enrollment to disenroll without cause that would be longer than 30 days.
    b. 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 member rewards 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 sole community hospitals 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 Social Security Act for covered services furnished to Centennial Care managed care plan enrollees at the Office of Management and Budget rates.
6. Expenditures to provide HCBS and care coordination services not included in the Medicaid State Plan to individuals determined to need such services based on a care assessment evaluation.

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