State of New Mexico
Human Services Department

Centennial Care 2.0 1115 Demonstration
Amendment Request

to

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

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

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

June 12, 2019

TABLE OF CONTENTS

SECTION 1: PURPOSE, GOALS AND OBJECTIVES

A. Statement of Purpose

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

- Remove co-payment requirements for non-emergency use of the hospital emergency department (ED) and non-preferred prescription drugs.
- Remove premium requirements for Centennial Care 2.0 members in the Adult Expansion Group category with household income above 100% of the Federal Poverty Level (FPL), including removal of the grace period and lock-out provisions for non-payment of premiums.
- Remove the requirement to phase-out and eliminate the three-month retroactive coverage period for non-pregnant adults covered under Centennial Care 2.0.
- Increase the number of Community Benefit (CB) allocation slots for members who do not meet standard Medicaid financial eligibility and who have been determined to meet nursing facility level of care (NF LOC). The state proposes an increase of 1,500 slots over the demonstration period from 4,289 to 5,789.
- Expand the number of Centennial Home Visiting (CHV) pilot counties beyond the four counties that are currently approved to allow for future expansion in other parts of the state and to additional Centennial Care 2.0 members.

The requested changes will impact the currently approved waiver authorities, expenditure authorities and Special Terms and Conditions (STCs) for the period between July 1, 2019 and December 31, 2023. Please visit the following link to see the current approved waiver authorities, expenditure authorities and STCs:

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

Please note that the STCs for Centennial Care 2.0 are currently being modified by CMS to make technical corrections identified by both HSD and CMS.

B. Centennial Care 2.0 Goals and Objectives

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

- Assure that Centennial Care 2.0 members receive the right amount of care, delivered at the right time, and in the right setting;
- Ensure that the care and services being provided are measured in terms of their quality and not solely by quantity;
- Slow the growth rate of costs or "bend the cost curve" over time without inappropriate reductions in benefits, eligibility or provider rates; and
- Streamline and modernize the Medicaid program in the state.

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

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

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

As part of the demonstration amendment, the state will continue to expand access to LTSS through the Community Benefit (CB) that includes both the personal care and HCBS benefits, and by allowing eligible members who meet a NF LOC to access the CB without the need for a demonstration slot. Individuals who are not otherwise Medicaid eligible and meet the criteria for the 217-like group will be able to access the CB if a slot is available. As is the case today, managed care enrollment will be required for all members who meet NF level of care or who are dually eligible.

C. Public Process

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

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

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

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

SECTION 2: AMENDMENT PROPOSALS

Amendment Proposal #1: Remove co-payment requirements for non-emergency use of the hospital ED and non-preferred prescription drugs.

The current Centennial Care 2.0 demonstration would allow co-payments of $8 for non-emergency use of the hospital Emergency Department (ED) and $8 for non-preferred prescription drugs for most Centennial Care 2.0 members. HSD does not intend to implement these co-payments, and seeks to move this authority from the demonstration.

HSD sees value in reducing unnecessary use of the health care system but does not believe that co-payments will be an effective strategy in driving changes in provider or member behavior. HSD will work collaboratively with its hospital partners to examine alternative policy options for reducing unnecessary ED use without passing additional costs onto low-income New Mexicans or placing an administrative hardship on the state's provider network through new co-payments.

Amendment Proposal #2: Remove premium requirements for the Adult Expansion Group population with household income above 100% FPL

The current Centennial Care 2.0 demonstration requires HSD to implement monthly premiums of $10 for members of the Adult Expansion Group who have income above 100% FPL. HSD does not intend to implement premiums, and seeks to remove the requirement to implement them from the demonstration. This includes all references in the demonstration to the grace period and lock-out provisions for premium non-payment.

HSD is concerned about the impact that implementing premiums would have on maintaining continuity of coverage for these low-income adults by burdening them with an unnecessary financial hardship. Implementing premiums would also negatively affect New Mexico's already strained provider network by increasing uncompensated care and unpaid medical bills, ultimately resulting in higher costs and greater pent-up demand for services over the long-term.

Amendment Proposal #3: Reinstate Retroactive Eligibility

The current Centennial Care 2.0 demonstration includes a phase-out of the three-month retroactive Medicaid coverage period for non-pregnant adults covered under Centennial Care 2.0. In calendar year 2019, the retroactive period is limited to one month. In calendar year 2020, the demonstration requires the Department to eliminate retroactive coverage for this population completely.

HSD is concerned about the financial strain that removing or limiting retroactive coverage will have on low-income New Mexico residents and on a fragile health care workforce through additional costs, uncompensated care and unmet medical needs. HSD does not intend to proceed with eliminating retroactive coverage in 2020, and seeks federal approval to reinstate the full retroactive coverage period for all affected individuals as quickly as possible. The Department's proposed effective date for reinstating retroactive coverage is July 1, 2019.

Amendment Proposal #4: Increase the number of Community Benefit slots by 1,500 between 2019 and 2023.

Centennial Care 2.0 expanded the availability of Community Benefit (CB) services to individuals who qualify for full Medicaid coverage and meet a Nursing Facility Level of Care (NF LOC) by eliminating the requirement for a demonstration allocation in order to access the full suite of CB services. HSD has continued to provide access to CB for certain members who do not meet standard Medicaid financial eligibility by establishing 4,289 slots in the Centennial Care 2.0 demonstration. Current allocation efforts by HSD are keeping up with attrition; however, HSD anticipates that the need for additional slots will increase. The Department is proposing to increase the number of slots by 1,500 through the demonstration amendment.

The increased slots will permit the state to:

- Continue coverage of the CB for members in the Other Adult Expansion population that lose coverage due to aging out of that category;
- Continue coverage of members that are currently receiving the CB who lose full disability coverage;
- Transition members in nursing facilities to the community through a community reintegration allocation;
- Add new members allocated from the central registry; and
- Provide more individuals access to community services and supports.

Amendment Proposal #5: Expand the number of areas that can be served by the Centennial Home Visiting (CHV) Pilot Program.

The CHV pilot program focuses on prenatal care, post-partum care and early childhood development in up to four state-designated counties. HSD is proposing to remove the restriction on the number of counties in which the home visiting project can be implemented, as well as the number of potential members who can be served by home visiting services. Additional counties providing home visiting services will be designated by the Department throughout the term of the demonstration.

Specifically, HSD's proposed changes to this approved program includes:

- Permitting additional CHV pilot sites beyond the currently approved state-designated four counties;
- Increasing the number of members enrolled in the pilot beyond 300; and
- Allowing the state authority to expand beyond the Nurse Family Partnership (NFP) and Parents as Teachers (PAT) models to include emerging evidence-based models during the duration of the demonstration.

SECTION 3: CURRENT PROGRAM DESIGN

A. Current Populations Covered

Table 1 represents the eligibility groups currently served in Centennial Care 2.0. As of May 2018, New Mexico's Medicaid program covered approximately 828,000 individuals, with more than 660,000 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 – Eligibility Groups Covered in Centennial Care 2.0

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

The following populations are excluded from Centennial Care 2.0:

- Qualified Medicare Beneficiaries;
- Specified Low-Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency medical services;
- Program of All-Inclusive Care for the Elderly;
- Individuals residing in Intermediate Care Facilities for Individuals with an Intellectual Disability;
- Medically Fragile 1915(c) waiver participants for HCBS;
- Developmentally Disabled 1915(c) waiver participants for HCBS;
- Individuals eligible for family planning services only; and
- Mi Via 1915(c) waiver participants for HCBS.

Appendix F provides the complete table of mandatory and optional populations covered in the current demonstration and outlined in the approved STCs.

B. Current Demonstration Benefits

Centennial Care 2.0 provides a comprehensive package of services that include behavioral health, physical health, and long-term care services and supports. Members meeting NF LOC are able to access LTSS through CB services (i.e., home and community-based services) without a demonstration 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 2.0 also includes services only available for individuals enrolled in Centennial Care 2.0, including the Community Interveners for deaf and blind individuals. A Community Intervener is a trained professional who works one-on-one with deaf-blind individuals who are older than four years of age to provide critical connections to other people and the community.

Appendix G provides the comprehensive benefits currently available to Centennial Care 2.0 members and outlined in the approved STCs.

SECTION 4: WAIVER LIST

The following table represents the currently approved waiver authorities that should be eliminated to address the demonstration amendment proposals outlined in Section 3. All other currently approved waiver authorities should remain in force.

A. Title XIX Demonstration Amendment Language Removal/Elimination

2. Reasonable Promptness and Medical Assistance	**Section 1902(a)(8) and (10)**
To the extent necessary to enable the state to begin benefit coverage on the first day of the 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 initial enrollment for individuals who fail to pay required premiums. To the extent necessary to enable the state to suspend coverage for individuals detailed in STC 60(a) who fail to pay required premiums until such time the premiums are paid in full or a hardship waiver, as detailed in STC 60(a)(1), is granted.	
3. Retroactive Eligibility	**Sections 1902(a)(10) and (34) 42 CFR 435.915**
To the extent necessary to enable the state to reduce, and then eliminate in demonstration year 7, coverage for the three-month period prior to the date that an application for medical assistance (and treatment as eligible for medical assistance) is made for specified eligibility groups, as described in STC 23. This waiver does not apply with respect to individuals eligible for Institutional Care (IC) categories of eligibility, pregnant women (including during the 60-day postpartum period beginning on the last day of the pregnancy), infants under age 1, or individuals under age 19.	
4. Premiums	**Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A**
To the extent necessary to enable the state to charge monthly premiums, as described in the STC 60(a).	
5. Comparability	**Sections 1902(a)(17) and 1902(a)(10)(B)**
To the extent necessary to enable the state to charge monthly premiums, as described in the STC 60(a).	

B. Expenditure Authority Requests

No language changes are required as part of the demonstration amendment proposals.

SECTION 5: COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS

The current demonstration including current STCs were approved in December 2018 and are effective for the five-year period between January 1, 2019 to December 31, 2023. As currently approved, New Mexico is compliant with the requirements of the approved Centennial Care 2.0 demonstration.

SECTION 6: APPROACH TO BUDGET NEUTRALITY

A. Budget Neutrality Overview

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

B. CHIP Allotment Neutrality

The amendment proposals will not impact allotment neutrality.

C. Budget Neutrality Summary

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

HSD makes the following assumptions with regard to budget neutrality:

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

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

Demonstration Period Description	Current Approved	Amendment Proposals
Total 5 Year Member Months (Without Waiver)	49,447,203	49,447,203
Total 5 Year Member Months (With Waiver)	49,430,633	49,447,203
Current Waiver Variance (DY1-DY5)	$3,762,696,140	$3,762,696,140
Renewal Demonstration (DY6-DY10)		
Without Waiver	$40,462,231,933	$40,462,231,933
With Waiver	$34,373,294,831	$34,387,745,340
Savings (Without Less With Waiver)	$6,088,937,102	$6,074,486,593
Savings after Phasedown of Savings	$4,166,461,030	$4,157,251,743
Savings with D1-DY5 Carryover and DY6-DY10 Phase-down	**$7,929,157,170**	**$7,919,947,883**

Budget Neutrality Exhibit 1 – Current Period PMPM limits, actual member months and expenditures (Total Computable)

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

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

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

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

Expenditure Variance By Waiver Group						
MEG 1 - TANF and Related	$ 254,057,276	$ 249,690,464	$ 353,245,078	$ 518,572,830	$ 565,333,426	**$ 1,940,899,075**
MEG 2 - SSI Medicaid Only	$ 53,501,511	$ 28,530,550	$ 84,600,468	$ 135,901,312	$ 146,773,240	**$ 449,307,081**
MEG 3 - SSI Dual	$ 191,573,279	$ 223,945,333	$ 261,502,966	$ 334,038,952	$ 361,429,453	**$ 1,372,489,984**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 7,156,360	$ 6,534,268	$ 8,092,509	$ 8,180,502	$ 8,713,377	**$ 38,677,015**

MEG 5 - 217-Like group Dual	$ (38,996,992)	$ (34,921,343)	$ (30,165,308)	$ (31,287,753)	$ (33,911,445)	**$ (169,282,840)**
MEG 6 - VIII Group (Medicaid Expansion)	$ 233,783,564	$ 357,632,233	$ 571,149,167	$ 686,134,812	$ 739,106,162	**$ 2,587,805,937**
Safety Net Care Pool						
Uncompensated Care	$ -	$ 1,594,350	$ -	$ (1)	$ -	**$ 1,594,349**
HQII	$ -	$ 0	$ (1,594,350)	$ 8,825,544	$ -	**$ 7,231,194**
Total Variance	**$ 701,074,997**	**$ 833,005,855**	**$ 1,246,830,531**	**$ 1,660,366,198**	**$ 1,787,444,214**	**$ 6,228,721,795**

Budget Neutrality Exhibit 2 – Amendment PMPM limits, actual member months and expenditures (Total Computable)

Without Waiver	Annualized Trend	New Mexico Budget Neutrality Status By Calendar Year: Adjustments to DY5	DY6 - 2019 Projected	DY7 - 2020 Projected	DY8 - 2021 Projected	DY9 - 2022 Projected	DY10 - 2023 Projected	5-Year Total DY6-DY10
Member Months								
MEG 1 - TANF and Related	3.8%	-	4,974,487	5,161,399	5,355,334	5,556,556	5,765,338	**26,813,113**
MEG 2 - SSI Medicaid Only	1.2%	-	499,659	505,610	511,633	517,727	523,894	**2,558,523**
MEG 3 - SSI Dual	2.9%	-	467,635	481,241	495,244	509,653	524,482	**2,478,255**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.3%	-	4,087	4,222	4,362	4,506	4,655	**21,832**
MEG 5 - 217-Like group Dual	3.9%	-	43,493	45,191	46,954	48,787	50,691	**235,117**
MEG 6 - VIII Group (Medicaid Expansion)	2.5%	-	3,299,404	3,381,662	3,465,970	3,552,381	3,640,945	**17,340,362**
Total Member Months	**3.1%**	-	**9,288,765**	**9,579,325**	**9,879,497**	**10,189,610**	**10,510,006**	**49,447,203**
Without Waiver PMPM								
MEG 1 - TANF and Related	3.8%	$ (6.10)	$ 460.00	$ 477.48	$ 495.62	$ 514.45	$ 534.00	**$ 497.68**
MEG 2 - SSI Medicaid Only	4.1%	$ (20.59)	$ 2,158.77	$ 2,247.28	$ 2,339.42	$ 2,435.34	$ 2,535.19	**$ 2,345.43**
MEG 3 - SSI Dual	4.1%	$ (130.82)	$ 2,057.62	$ 2,141.98	$ 2,229.80	$ 2,321.22	$ 2,416.39	**$ 2,238.54**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.1%	$ (6.38)	$ 5,747.30	$ 5,926.04	$ 6,110.34	$ 6,300.37	$ 6,496.31	**$ 6,128.24**
MEG 5 - 217-Like group Dual	4.1%	$ 1,414.18	$ 3,661.18	$ 3,811.29	$ 3,967.56	$ 4,130.23	$ 4,299.57	**$ 3,986.18**
MEG 6 - VIII Group (Medicaid Expansion)	4.7%	$ -	$ 738.22	$ 772.92	$ 809.24	$ 847.28	$ 887.10	**$ 812.78**
Total PMPM	**3.9%**	**$ (4.40)**	**$ 747.95**	**$ 776.93**	**$ 807.04**	**$ 838.32**	**$ 870.82**	**$ 810.11**
Without Waiver Expenditure								
MEG 1 - TANF and Related		$ (29,231,764)	$ 2,288,249,485	$ 2,464,449,112	$ 2,654,216,451	$ 2,858,596,241	$ 3,078,713,669	**$ 13,344,224,957**
MEG 2 - SSI Medicaid Only		$ (10,166,391)	$ 1,078,650,304	$ 1,136,249,871	$ 1,196,925,236	$ 1,260,840,644	$ 1,328,169,115	**$ 6,000,835,170**
MEG 3 - SSI Dual		$ (59,444,427)	$ 962,212,283	$ 1,030,807,756	$ 1,104,293,355	$ 1,183,017,693	$ 1,267,354,237	**$ 5,547,685,323**
Hypothetical Group								
MEG 4 - 217-Like Medicaid		$ (25,230)	$ 23,490,632	$ 25,021,403	$ 26,651,926	$ 28,388,703	$ 30,238,657	**$ 133,791,320**
MEG 5 - 217-Like group Dual		$ 59,196,558	$ 159,236,444	$ 172,234,893	$ 186,294,405	$ 201,501,592	$ 217,950,139	**$ 937,217,473**
MEG 6 - VIII Group (Medicaid Expansion)		$ -	$ 2,435,685,299	$ 2,613,740,753	$ 2,804,812,563	$ 3,009,852,259	$ 3,229,880,935	**$ 14,093,971,810**
Safety Net Care Pool								
Uncompensated Care Pool		$ -	$ 68,889,323	$ -	$ -	$ -	$ -	**$ 68,889,323**
HQII		$ -	$ 12,000,000	$ 12,000,000	$ 12,000,000	$ -	$ -	**$ 36,000,000**
Total Expenditures		**$ (39,671,254)**	**$ 7,028,413,770**	**$ 7,454,503,788**	**$ 7,985,193,934**	**$ 8,542,197,132**	**$ 9,152,306,752**	**$ 40,162,615,376**

With Waiver	Annualized Trend	New Mexico Budget Neutrality Status By Calendar Year: Adjustments to DY5	DY 06 - 2019 Projected	DY 07 - 2020 Projected	DY 08 - 2021 Projected	DY 09 - 2022 Projected	DY 10 - 2023 Projected	5-Year Total DY 06-DY 10
Member Months								
MEG 1 - TANF and Related	3.8%	-	4,974,487	5,161,399	5,355,334	5,556,556	5,765,338	**26,813,113**
MEG 2 - SSI Medicaid Only	1.2%	-	499,659	505,610	511,633	517,727	523,894	**2,558,523**
MEG 3 - SSI Dual	2.9%	-	467,635	481,241	495,244	509,653	524,482	**2,478,255**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.3%	-	4,087	4,222	4,362	4,506	4,655	**21,832**
MEG 5 - 217-Like group Dual	3.9%	-	43,493	45,191	46,954	48,787	50,691	**235,117**
MEG 6 - VIII Group (Medicaid Expansion)	2.5%	-	3,299,404	3,381,662	3,465,970	3,552,381	3,640,945	**17,340,362**
Total Member Months	**3.1%**	-	**9,288,765**	**9,579,325**	**9,879,497**	**10,189,610**	**10,510,006**	**49,447,203**
With Waiver PMPMs								
MEG 1 - TANF and Related	3.5%	$ -	$ 344.65	$ 356.58	$ 368.93	$ 381.71	$ 394.93	**$ 370.29**
MEG 2 - SSI Medicaid Only	3.9%	$ -	$ 1,880.45	$ 1,953.96	$ 2,030.34	$ 2,109.70	$ 2,192.17	**$ 2,035.17**
MEG 3 - SSI Dual	3.8%	$ -	$ 1,374.41	$ 1,426.59	$ 1,480.76	$ 1,536.98	$ 1,595.34	**$ 1,485.98**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.1%	$ -	$ 5,747.30	$ 5,926.04	$ 6,110.34	$ 6,300.37	$ 6,496.31	**$ 6,128.24**
MEG 5 - 217-Like group Dual	4.1%	$ -	$ 3,661.18	$ 3,811.29	$ 3,967.56	$ 4,130.23	$ 4,299.57	**$ 3,986.18**
MEG 6 - VIII Group (Medicaid Expansion)	4.7%	$ -	$ 738.22	$ 772.92	$ 809.24	$ 847.28	$ 887.10	**$ 812.78**
Total PMPM	**3.7%**	**$ -**	**$ 636.81**	**$ 660.38**	**$ 684.82**	**$ 710.17**	**$ 736.46**	**$ 687.26**
With Waiver Expenditures								
MEG 1 - TANF and Related		$ -	$ 1,714,448,701	$ 1,840,473,788	$ 1,975,762,682	$ 2,120,996,344	$ 2,276,905,791	**$ 9,928,587,306**
MEG 2 - SSI Medicaid Only		$ -	$ 939,585,332	$ 987,942,075	$ 1,038,787,549	$ 1,092,249,839	$ 1,148,463,621	**$ 5,207,028,415**
MEG 3 - SSI Dual		$ -	$ 642,719,561	$ 686,534,045	$ 733,335,383	$ 783,327,189	$ 836,726,959	**$ 3,682,643,136**
Hypothetical Group								
MEG 4 - 217-Like Medicaid		$ -	$ 23,490,632	$ 25,021,403	$ 26,651,926	$ 28,388,703	$ 30,238,657	**$ 133,791,320**
MEG 5 - 217-Like group Dual		$ -	$ 159,236,444	$ 172,234,893	$ 186,294,405	$ 201,501,592	$ 217,950,139	**$ 937,217,473**
MEG 6 - VIII Group (Medicaid Expansion)		$ -	$ 2,435,685,299	$ 2,613,740,753	$ 2,804,812,563	$ 3,009,852,259	$ 3,229,880,935	**$ 14,093,971,810**
Safety Net Care Pool								
Uncompensated Care Pool		$ -	$ 68,889,323	$ -	$ -	$ -	$ -	**$ 68,889,323**
HQII		$ -	$ 12,000,000	$ 12,000,000	$ 12,000,000	$ -	$ -	**$ 36,000,000**
Total Expenditures		**$ -**	**$ 5,996,055,291**	**$ 6,337,946,957**	**$ 6,777,644,507**	**$ 7,236,315,925**	**$ 7,740,166,103**	**$ 34,088,128,783**

Budget Neutrality Variance	DY1 - DY5 Savings	Adjustments to DY5	New Mexico Budget Neutrality Status By Calendar Year					
			DY 06 - 2019 Projected	DY 07 - 2020 Projected	DY 08 - 2021 Projected	DY 09 - 2022 Projected	DY 10 - 2023 Projected	5-Year Total DY 06-DY 10
Expenditure Variance By Waiver Group								
MEG 1 - TANF and Related			$ 573,800,784	$ 623,975,324	$ 678,453,769	$ 737,599,896	$ 801,807,878	**$ 3,415,637,651**
MEG 2 - SSI Medicaid Only			$ 139,064,973	$ 148,307,796	$ 158,137,687	$ 168,590,806	$ 179,705,494	**$ 793,806,755**
MEG 3 - SSI Dual			$ 319,492,722	$ 344,273,711	$ 370,957,972	$ 399,690,504	$ 430,627,278	**$ 1,865,042,187**
Hypothetical Group								
MEG 4 - 217-Like Medicaid			$ -	$ -	$ -	$ -	$ -	$ -
MEG 5 - 217-Like group Dual			$ -	$ -	$ -	$ -	$ -	$ -
MEG 6 - VIII Group (Medicaid Expansion)			$ -	$ -	$ -	$ -	$ -	$ -
Safety Net Care Pool								
Uncompensated Care Pool			$ -	$ -	$ -	$ -	$ -	$ -
HQII			$ -	$ -	$ -	$ -	$ -	$ -
Total Variance			**$ 1,032,358,479**	**$ 1,116,556,831**	**$ 1,207,549,427**	**$ 1,305,881,206**	**$ 1,412,140,650**	**$ 6,074,486,593**
Expenditure Variance, Carry-over and Phase Down								
DY1 - DY5 Variance Carry-over	**$3,762,696,140**							
DY6 - DY10 Variance								
Savings by DY			$ 1,032,358,479	$ 1,116,556,831	$ 1,207,549,427	$ 1,305,881,206	$ 1,412,140,650	
Phase Down %			90.0%	80.0%	70.0%	60.0%	50.0%	
Savings after phase-down			$ 929,122,630.74	$ 893,245,465	$ 845,284,599	$ 783,528,724	$ 706,070,325	**$ 4,157,251,743**
Cumulative Savings			**$ 4,691,818,770**	**$ 5,585,064,235**	**$ 6,430,348,834**	**$ 7,213,877,558**	**$ 7,919,947,883**	**$ 7,919,947,883**

SECTION 7: EVALUATION DESIGN AND QUALITY STRATEGY

The current demonstration includes current STCs that were approved in December 2018 and are effective for the five-year period between January 1, 2019 to December 31, 2023. The current approval provided New Mexico up to 180 days from January 1, 2019 to develop the evaluation design and 90 days from January 1, 2019 to develop the quality strategy. As of the date of this amendment request, the evaluation design and quality strategy is under development and the quality strategy was delivered to CMS on March 14, 2019.

SECTION 8: STATE PUBLIC NOTICE

Draft Demonstration Amendment Application

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

HSD published the draft demonstration amendment application on February 28, 2019. Table 3 outlines the scheduled public hearings scheduled by HSD.

Table 3 – Renewal Timeline

Event	Dates
Notice Period - 60-day advanced notification to Native American/Tribal stakeholders regarding 1115 demonstration renewal application	March 1, 2019
Publish Date – Draft 1115 Demonstration Amendment Application	February 28, 2019
Gather Feedback – Draft Demonstration Amendment Application Public Hearings sites: • Public meeting: Las Cruces • Public meeting: Santa Fe (MAC meeting)	 April 10, 2019 April 15, 2019
Final Demonstration Application Submission to CMS	June 10, 2019

APPENDICES

Appendix A: Glossary

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

Appendix B: Interim Evaluation Report

The interim evaluation report is available on HSD's website at:
http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Final%20Waiver%20Documents/Appendix%20B%20-%20Interim%20Evaluation%20Report.pdf

Appendix C: State Public Notices

Attached are the copies of the following documents demonstrating HSD's adherence to the public notice requirements set forth under 42 CFR Part 431.408.

Public Notice

1. 30-day state public notice and comment period on the Centennial Care 2.0 demonstration amendment providing a comprehensive program description, February 28, 2019
    a. HSD website: https://www.hsd.state.nm.us/centennial-care-2-0.aspx
2. Public notice (abbreviated notice) in the state's newspaper with the widest circulation
    a. Las Cruces Sun-News, March 1, 2019, re: public meetings in Las Cruces and Santa Fe
    b. Albuquerque Journal, March 1, 2019, re: public meetings in Las Cruces and Santa Fe
3. Proposal posting (abbreviated notice) via HSD's electronic mailing lists
    a. Letter and email distribution, March 1, 2019, re: public hearings, website posting and public comment submission

Public Hearings on the 1115 Demonstration Amendment

1. Public meetings in Las Cruces, April 10, 2019
    a. Presentation, Centennial Care 2.0, 1115 Demonstration Amendment – Public Hearing
2. MAC Meeting – Santa Fe, April 15, 2019, Public Hearing
    a. Agenda
    b. Presentation, Centennial Care 2.0, 1115 Demonstration Amendment, Public Hearing

All documents related to the above public notices and input is available on HSD's website at https://www.hsd.state.nm.us/centennial-care-2-0.aspx

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

HSD has tracked comments received since the Draft Centennial Care 2.0 1115 Demonstration Amendment was released on February 28, 2019. Attached are the following documents demonstrating the feedback the feedback received on the draft waiver application.

1. Summary of comments received and HSD's response to the Centennial Care 2.0 1115 Demonstration Amendment Request is available on HSD's website at: https://www.hsd.state.nm.us/centennial-care-2-0.aspx

2. Comprehensive public comments on the Draft 1115 Demonstration Amendment is available on HSD's website at: https://www.hsd.state.nm.us/centennial-care-2-0.aspx

Appendix E: Documents Demonstrating Quality

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

1. Centennial Care 1.0 Quality Strategy is available on HSD's website at: http://www.hsd.state.nm.us/providers/2017-nm-quality-strategy-final.pdf
2. EQRO Summary Reports are available on HSD's website at: http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Final%20Waiver%20Documents/Appendix%20E_2%20-%20EQRO%20Summary%20Report.pdf

Appendix F: Centennial Care 2.0 Eligibility Groups

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

- Table 4 describes the mandatory State Plan populations included in Centennial Care 2.0;
- Table 5 describes the optional State Plan populations included in Centennial Care 2.0; and
- Table 6 below, describes the beneficiary eligibility groups who are made eligible for benefits by virtue of the expenditure authorities expressly granted in this demonstration (i.e. the 217-like group).

Table 4 – Mandatory State Plan Populations

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

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

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

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

Table 5. Optional State Plan Populations

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

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

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

Table 6. Demonstration Expansion Populations

A. Expansion Medicaid Eligibility Group	B. Description Statutory/ Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care 2.0?	E. MEG for Budget Neutrality
Home and Community Based 1915(c) Waivers that were transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who would only be eligible in an institution in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Social Security Act, if the state had not eliminated its 1915(c) AIDS, Colts, and Mi Via-NF waivers	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)
	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.2276 and section 1924 of the Act	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 G: Centennial Care 2.0 Benefits

Table 7 describes the current non-CB services, including services available under the Alternative Benefit Plan (ABP). Table 8 lists the CB services. Table 9 lists the services available only through Centennial Care 2.0 including the three new BH services

Table 7 – Centennial Care 2.0 Non-Community Benefit Services

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

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

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

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

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

Table 8 – Centennial Care 2.0 Current Community Benefit Services

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

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

Table 9 – Services Available to Centennial Care 2.0 Members Only

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

Appendix H: Currently Approved Benefit Definitions and Limits

I. Adult Day Health (ABCB)

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

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

II. Assisted Living (ABCB)

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

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

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

III. Behavior Support Consultation (ABCB and SDCB)

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

Behavior Support Consultation: 1) informs and guides the member's providers with the services and supports as they relate to the member's behavior and his/her medically fragile condition; 2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s); 3) supports effective implementation based on a functional assessment; 4) collaborates with medical and ancillary

therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the member and his/her service and support providers. Based on the member's care plan, services are delivered in an integrated/natural setting or in a clinical setting.

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

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

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

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

VI. Emergency Response (ABCB and SDCB)
Emergency Response services provide an electronic device that enables a member to secure help in an emergency at home and avoid institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when a "help" button is activated. The response center is staffed by trained professionals. Emergency response services include: installing,

testing and maintaining equipment; training members, caregivers and first responders on use of the equipment; twenty-four (24) hour monitoring for alarms; checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.; and reporting member emergencies and changes in the member's condition that may affect service delivery. Emergency categories consist of emergency response and emergency response high need.

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

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

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

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

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

switches, outlets or environmental controls for home devices; and alarm and alert systems and/or signaling devices.

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

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

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

IX. Home Health Aide (ABCB and SDCB)

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

X. Non-Medical Transportation (SDCB)

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

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

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

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

Agency-Based Community Benefit:

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

Self-Directed Community Benefit:

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

XIII. Private Duty Nursing for Adults (ABCB and SDCB)
Private Duty Nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for members who are twenty-one (21) years of age or older with intermittent or extended direct nursing care in the member's home. Services include medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self- care assistance.
Limits or Exclusions: All services provided under Private Duty nursing require the skills of a Licensed Registered Nurse or a Licensed Practical Nurse under written physician's order in accordance with the New Mexico Nurse Practice Act, Code of federal Regulation for Skilled Nursing.

XIV. Related Goods (SDCB)
Related goods are equipment, supplies or fees and memberships, not otherwise provided through under Medicaid. Related goods must address a need identified in the member's care plan (including improving and maintaining the member's opportunities for full membership in the community) and meet the following requirements: be responsive to the member's qualifying

condition or disability; and/or accommodate the member in managing his/her household; and/or facilitate activities of daily living; and/or promote personal safety and health; and afford the member an accommodation for greater independence; and advance the desired outcomes in the member's care plan; and decrease the need for other Medicaid services. Related goods will be carefully monitored by health plans to avoid abuses or inappropriate use of the benefit.

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

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

XV. Respite (ABCB and SDCB)

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

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

XVI. Skilled Maintenance Therapy Services (ABCB and SDCB)

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

> **Physical Therapy**

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

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

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

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

XVII. Specialized Therapies (SDCB)
Specialized Therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A member may include specialized therapies in his/her care plan when the services enhance opportunities to achieve inclusion in community activities and avoid

institutionalization. Services must be related to the member's disability or condition, ensure the member's health and welfare in the community, supplement rather than replace the member's natural supports and other community services for which the member may be eligible, and prevent the member's admission to institutional services. Experimental or investigational procedures, technologies or therapies and those services covered as a Medicaid state plan benefit are excluded. Services in this category include:

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

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

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

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

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

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

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

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

Native American Healers
Native American Healers are a covered benefit under the self-directed community benefit. These services are subject to the $2000 annual specialized therapies limits. These services may also be a value added service provided by the MCO, for which the

MCO does not receive FFP for these services. There are twenty-two sovereign Tribes, Nations and Pueblos in New Mexico, as well as numerous Native American individuals who come from many other tribal backgrounds. Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support members in their communities by addressing their physical and emotional health. Treatments may include dance, song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel. This form of therapy may be provided by community- recognized medicine men and women and others as healers, mentors and advisors to members, and provides opportunities for members to remain connected with their communities. The communal support provided by this type of healing can reduce pain and stress and improve quality of life.

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