New Mexico Human Services Department

Susana Martinez, Governor
Sidonie Squier, Secretary

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April 25, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
120F
Washington, D.C. 20201-0004

Dear Secretary Sebelius:

I am pleased to submit the attached Section 1115 Research and Demonstration waiver on behalf of the State of New Mexico. The waiver is the culmination of almost a full year of engaging stakeholders throughout New Mexico in dialogue about how best to modernize our Medicaid program so that it is sustainable now and into the future. In honor of the 100th year anniversary of New Mexico statehood and to reflect our commitment to sustainability for the next 100 years, we have named our program Centennial Care.

We began our journey last year with a series of public meetings held throughout the State during which we asked our stakeholders to engage with us around the four basic principles that we wanted to incorporate into our program. Those principles were and are:

- A single, comprehensive, coordinated system of care that will assure that our recipients get the right care at the right time and in the right settings;
- Providing incentives for individuals to take a great sense of personal responsibility for their own health and for accessing the system more effectively;
- Developing pilot payment reform strategies directed at dealing more effectively with disease state prevalent in New Mexico; and
- Seeking administrative simplicity and increased flexibility in the design and management of our Medicaid program.

Over the fall months, we held a series of workgroup meetings focused on our four principles. We invited participation from providers, advocates, Native Americans and, of course, our own staff. We used these workgroups to solidify

specific approaches to achieving our goals and to "vet" ideas with those who would ultimately have to operationalize the program.

I want to specifically address our extensive outreach to the Native American community. Yesterday, we sent a timeline of all of our formal and informal consultations with the Native American stakeholders in our state; for each event or meeting noted, we also submitted documents that were either presented or discussed at those meetings. We specifically sent a copy of our Concept Paper to every Tribal Governor and to representatives from the Indian Health Service. We believe we have followed not only the letter of the law but have gone beyond to assure that we invited open and honest dialogue with our Native American community. The documentation of our efforts was sent to Ms. Cindy Mann and key members of her staff yesterday.

We do not intend to stop consultation at this point. We have now begun the process of developing a contract document that will provide in even greater detail the specifications of the business arrangement we intend to enter into with managed care plans. We hope to spend the fall in the procurement process. As we develop our procurement documents, we will continue to use the workgroup approach and to invite our stakeholders to participate in these meetings to assure that the program we ultimately implement is the program that best serves New Mexico's unique population.

I had the pleasure of meeting with Ms. Mann in Washington in early March and was able to share with her not only our process but our detailed concept for our Centennial Care program. Ms. Mann was encouraging and graciously agreed to let us "pilot" a new, streamlined waiver format that CMS hopes to use with states seeking to blend their long term care and acute services into a single delivery system. This is the format we have used with the waiver application we submit today.

I mention this specifically because I have high hopes that, using the new format, your staff and mine will quickly reach agreement on Terms and Conditions for our waiver approval. New Mexico is working on a timeframe that assumes we will have our procurement out by this fall and our plans selected and under contract by January 1, 2013. We plan for a program "go-live" on January 1, 2014. We believe that a full year for implementation is critical to assuring that our plans, our providers and, most importantly, our recipients are fully educated and informed and understand exactly how the program will operate on that go-live date.

We can only achieve that goal if your agency works diligently with us for a quick approval of our waiver. We hope not to experience the lengthy and sometimes contentious and prolonged negotiations that can occur with the 1115 waiver process. Towards that end, we pledge that we will respond quickly and thoroughly to questions raised by your staff.

In closing, I want to reiterate that our project is the culmination of almost a year of statewide community input. While not everyone agrees with every aspect of our program, we have had fundamentally positive responses from our stakeholders and all have expressed an eagerness to continue to work with us as we move towards the specifics of a contract document. We hope that you will encourage your staff to work with us in a timely manner to approve our waiver so that we can move on to modernize our program for the benefit of those New Mexicans who rely on our ability to deliver excellent care tailored to the unique needs of our state.

Sincerely,

Sidonie Squier

Sidonie Squier
Secretary
Human Services Department
Santa Fe, New Mexico

Cc: Ms. Cynthia Mann
Mr. Bill Brooks
Ms. Victoria Wachino
Ms. Nicole Kaufman

New Mexico Human Services Department

New Mexico's Centennial Care

A Waiver Request Submitted Under Authority of
Section 1115 of the Social Security Act

to

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

State of New Mexico

Sidonie Squier, Cabinet Secretary
New Mexico Human Services Department

Julie B. Weinberg, Division Director
Medical Assistance Division

April 25, 2012

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SECTION 1: GENERAL DESCRIPTION OF THE NEW PROGRAM

A. Overview

The State of New Mexico (State) is one of the poorest states in the nation and has a faster-than-average growth in its elderly population. These two facts combined place growing demands on its Medicaid program, even before the inclusion of the "newly eligible" population under the Patient Protection and Affordable Care Act (PPACA).

Of the approximately 2 million citizens in the State, more than a quarter (approximately 550,000 people) currently receives their health care through the Medicaid program. This large number of Medicaid recipients presents many challenges for the State including increasing costs, administrative complexities and the difficulty of ensuring quality care for all recipients.

The program is expensive, consuming about 16% of the current State budget – up from 12% last State fiscal year (SFY) and rising to 20% next SFY. Specifically in 2011, New Mexico and the federal government spent approximately $3.8 billion on Medicaid services for New Mexicans. The rate of growth in costs precedes the approximately 175,000 additional people who will be added to the program beginning January 2014 under the PPACA and for whom the State will ultimately bear some costs.

The New Mexico Medicaid program is also administratively complex. Today, the program operates under 12 separate waivers as well as a fee-for-service (FFS) program for those either opting out or exempt from managed care, and seven (7) different health plans execute this complicated delivery system.

Finally, and perhaps most importantly, the State is not necessarily buying quality; rather rates are determined and payments made based on the quantity of services offered. The State pays for services without regard to whether they represent best practices in medicine and without regard to whether those services help make people healthier or help them manage complex medical/behavioral conditions.

For all of these reasons, New Mexico believes that now is the time to modernize Medicaid to assure that the State is buying the most effective, efficient health care possible for our most vulnerable and needy citizens and to create a sustainable program for the future.

New Mexico seeks approval of a section 1115(a) of the Social Security Act (SSA) demonstration authority, with the program going live on January 1, 2014, to attempt an approach to slowing the rate of growth of program costs while avoiding cuts to the Medicaid program. New Mexico's vision is to build a service delivery system that delivers the right amount of care at the right time in the right setting. This vision includes educating our recipients to become more savvy health care consumers, promoting more integrated care, delivering proper case management for the most at-risk recipients, involving recipients in their own wellness and paying providers for outcomes, rather than process.

Managed care has been the primary service delivery system for Medicaid in New Mexico for more than a decade. The State began its Salud! program (Medicaid managed care) in 1997, managed care for behavioral health in 2005 and its Coordination of Long Term

Services (CoLTS) program in 2008. Like managed care companies everywhere, New Mexico's plans have proven that they know how to manage the dollars they receive in capitation and, by and large, how to establish a network and pay claims in a timely and accurate manner. What New Mexico now challenges its plans to do is manage care and deliver outcomes that can be measured in terms of a healthier population. In order to effectively drive the kind of system change New Mexico seeks, plans will have to think and behave differently and support the movement towards care integration and payment reform.

To effectuate this vision, New Mexico seeks to operate a Section 1115(a) waiver that is a single streamlined and efficient program known as Centennial Care.

State Commitment

New Mexico's Human Services Department (HSD), under the leadership of Secretary Sidonie Squier and Medicaid Director Julie B. Weinberg, has been leading the effort for modernizing New Mexico's Medicaid program within the State. HSD has engaged all key State agencies involved in providing services to affected populations in the Centennial Care program design. Such collaboration has helped define Centennial Care. For example, as part of the New Mexico Behavioral Health Purchasing Collaborative (NMBHPC), HSD has partnered with, among other State agencies, the Aging and Long Term Services Department of Aging (ALTSD), Children, Youth and Families Department (CYFD) and the Department of Health (DOH) to ensure a fully integrated physical health and behavioral health program design. The Secretary of the ALTSD sits on the Medicaid Advisory Council and in this capacity has provided guidance in specific policies related to aging issues. Furthermore, early discussions with the DOH resulted in the decision to exclude the Home and Community-Based Services (HCBS) waiver for individuals with developmental disabilities from the program design. Through these formal relationships as well as informal opportunities for collaboration, HSD will continue to actively engage partner agencies in the ongoing design, implementation and monitoring of Centennial Care.

The State remains committed to ensuring all key players, State agencies and populations are involved in the planning and execution of the statewide effort of Medicaid modernization. Centennial Care will set the stage for innovation in New Mexico now and in the years to come.

The Patient Protection and Affordable Care Act Changes

New Mexico is exploring the various provisions and requirements of the PPACA and how it will impact the Centennial Care program. The State anticipates that up to 175,000 individuals will become eligible for the benchmark benefit that will be defined by the State consistent with federal requirements and guidelines and offered through the Medicaid plans. Streamlining the Medicaid system, as proposed under this demonstration, will assist the State and health plans in their ability to more easily absorb this new group of eligibles at the same time provisions take effect in January 2014.

B. Goals of the New Program

In June of 2011, New Mexico embarked on an ambitious plan to modernize its Medicaid program to accomplish the following goals:

- Assuring that Medicaid recipients in the program receive the right amount of care at the right time and in the most cost effective or "right" settings;
- Ensuring that the care being purchased by the program is measured in terms of its quality and not its quantity;
- Slowing the growth rate of costs or "bending the cost curve" over time without cutting services, changing eligibility or reducing provider rates; and
- Streamlining and modernizing the program in preparation for the potential increase of up to 175,000 recipients beginning in January 2014.

As a beginning place for the development of a modernized Medicaid program, the State articulated four (4) guiding principles:

1. Developing a comprehensive service delivery system that provides the full array of benefits and services offered through the State's Medicaid program;
2. Encouraging more personal responsibility so that recipients become more active participants in their own health and more efficient users of the health care system;
3. Increasing the emphasis on payment reforms that pay for performance rather for the quantity of services delivered; and
4. Simplifying administration of the program for the State, for providers and for recipients where possible.

These 4 guiding principles continue to steer New Mexico's Medicaid modernization efforts and serves as the foundation for the Section 1115 waiver proposal. In an effort to consolidate and make the Medicaid program more efficient, New Mexico proposes to consolidate current populations, waivers and services under Centennial Care (see Table 1.1)

Table 1.1
Consolidation of New Mexico's Current Populations and Programs Under Centennial Care

Population/Program	Consolidation in Centennial Care	Mandatory Managed Care	Authority prior to Centennial Care
Children under age 6 and pregnant women with incomes below 133% of Federal Poverty Level (FPL)	Yes	Yes	Salud! 1915(b) Waiver
Children age 6 to 18 below 100% of FPL	Yes	Yes	Salud! 1915(b) Waiver
Temporary Assistance for Needy Families (TANF)	Yes	Yes	Salud! 1915(b) Waiver
Transitional Medicaid	Yes for those below 138% of FPL	Yes	Salud! 1915(b) Waiver
Individuals who receive Supplemental Security Income (SSI)	Yes	Yes	Salud! 1915(b) Waiver
Adults below 200% of (FPL)	Yes for those below 138% of FPL	Yes	Children's Health Insurance Program (CHIP) 1115 Waiver
Individuals living in Medical institutions up to 300% of SSI Income Standard	Yes	Yes	1915(b) Waiver
Low income Medicare recipients	Yes	Yes	State Plan Amendment (SPA)
Relatives or Legal Guardians who are caretakers of children under age 18 (or 19 if still in high school)	Yes	Yes	Salud! 1915(b) Waiver
Children ages 0 to 19 with incomes up to 235% of FPL	Yes	Yes	CHIP 1115 Waiver
Pregnant women up to 185% FPL for pregnancy related services	Yes for those below 138% of FPL	Yes	CHIP 1115 Waiver
Children aging out of foster care up to age 21 years	Yes	Yes	SPA
Women for Breast and Cervical Cancer Treatment	Yes for those below 138% of FPL	Yes	SPA
Working Disabled Individuals	Yes for those below 138% of FPL	Yes	SPA
Medically needy	Yes for those below 138% of FPL	Yes	Salud! 1915(b) Waiver
Medically needy Aged, Blind or Disabled (ABD)	Yes for those below 138% of FPL	Yes	CoLTS 1915(b) Waiver
Children under age 21	Yes	Yes	SPA

who are full-time students			
Low-income parents with incomes above 1996 Aid to Families with Dependent Children (AFDC) level	Yes	Yes	SPA
Program for All-Inclusive Care for the Elderly (PACE)	Yes	Yes	SPA
Salud!	Yes	Yes	1915(b) Waiver
Behavioral Health Services	Yes	Yes	1915(b) Waiver
CoLTS	Yes	Yes	1915(b)/(c) Waiver
Mi Via	Yes	Yes	1915(c) Waiver
Developmental Disabilities (DD)	Acute services only (excluded DD HCBS)	Acute services only (excluded DD HCBS)	1915(c) Waiver
Medically Fragile[1]	Yes	Yes	1915(c) Waiver
AIDS	Yes	Yes	1915(c) Waiver
Traumatic Brain Injury	Yes	Yes	1915(c) Waiver

Source: Medicaid Overview and Operational Structure, HSD. July 2010. http://www.health.state.nm.us/phd/dist3/documents/NMMedicaidStructOpsJul10.pdf.

[1] Medically Fragile HCBS waiver will be phased in effective July 1, 2015 with a 6 month transition period beginning January 2015.

SECTION 2: DEMONSTRATION ELIGIBILITY AND BENEFITS

A. Populations Affected by the Demonstration

The table below delineates the individuals included in a Medicaid eligibility group under the demonstration. These eligibility groups will be subject to all applicable Medicaid laws and regulations, except to the extent such laws and/or regulations are expressively waived in Section 11 of this application.

Table 2.1

New Mexico Centennial Care Waiver Demonstration Groups	Description	Federal Poverty Level (FPL)/Modified Adjusted Gross Income (MAGI)
Childless Adults	Low Income Childless Adults aged 19-65	Below 138% of FPL
Parents	Low income parents	Below 138% of FPL
Pregnant Women	Low income Pregnant Women (includes Presumptive Eligibility)	Below 138% of FPL
Low Income Children	Low income children up to age 19	Below 138% of FPL
Qualified Children	Children over 138% of FPL up to age 19	138-185% FPL
CHIP	Uninsured children above 185% of FPL up to age 19	185-235% FPL
Foster Children	Former foster children up to age 26 who were on Medicaid while in foster care	n/a
ABD SSI Recipients	Individuals receiving SSI	Federal SSI standard
Medically Needy ABD	Individuals who are aged, blind or disabled and 'spend down' to below the SSI standard	Federal SSI standard
Nursing Facility residents	Individuals not otherwise eligible for Medicaid meeting Nursing Facility LOC and residing in Nursing Facilities	300% of SSI standard
Community Long Term Care (LTC)	Individuals not otherwise eligible for Medicaid meeting Nursing Facility LOC and residing in the community (includes those electing self-directed services (Mi Via))	300% of SSI standard

Eligibility Exclusions
The following persons, who are otherwise eligible under the criteria described above, are excluded from the Centennial Care 1115 demonstration waiver:

Table 2.2

Exclusions from Centennial Care	Description	FPL	Resource Standard	Service Delivery	
				Mandatory Managed Care	Fee-for-Service
DD/Intermediate Care Facility/Mental Retardation (ICF/MR)	Developmentally disabled receiving HCBS (all non-HCBS will be handled through Managed Care Organizations (MCOs)) and those in the Mi Via program that meet ICF/MR level of care	Below 300% of SSI	$2,000		X
Qualified Medicare Beneficiaries (QMB)/Specified Low-Income Medicare Beneficiary (SLMB)/Qualified Individuals (QIs)	Low income Medicare recipients cost sharing and premium assistance	100%/120%/ 135% of FPL	$8440		X
Refugees	Aliens granted refugee status by the U.S. Citizenship and Immigration Services (USCIS)	Below TANF standard	n/a		X
Undocumented aliens	Individuals without documentation of citizenship or legal residency	Below TANF standard	n/a		X
Subsidy adoptions with out-of-state placements	Adoption placements by CYFD in other states that are receiving subsidies	n/a	n/a		X

B. Demonstration Benefits

1. Comprehensive Benefit Package
New Mexico proposes to require that all plans deliver the full range of services, including behavioral health services, physical health, and long term care services (both HCBS and institutional services). The following table provides the list of services to be offered under Centennial Care.

Table 2.3

Services Included Under Centennial Care	Physical Health	Behavioral Health	Long Term Care	
				Self-Directed HCBS Services
Accredited Residential Treatment Center Services		X		
Adult Day Health			X	
Ambulatory Surgical Center Services	X			
Anesthesia Services	X			
Assertive Community Treatment Services		X		
Assisted Living			X	
Audiology Services	X			
Behavior Support Consultation			X	X
Behavior Management Skills Development Services		X		
Behavioral Health and Substance Abuse: Outpatient Office Visit and Outpatient Substance Abuse Treatment, Impatient Behavioral Health and Inpatient Detox		X		
Behavioral Health Professional Services		X		
Case Management	X			
Community Transition Services			X	
Comprehensive Community Support Services		X		
Day Treatment Services		X		
Dental Services	X			
Diabetes Treatment	X			
Diagnostic Imaging and Therapeutic Radiology Services	X			
Dialysis Services	X			
Durable Medical Equipment and Supplies	X			
Emergency Response			X	X
Emergency Services (including emergency room visits)	X			
Employment Supports				X
Environmental Modifications			X	X
Experimental or Investigational Procedures, Technology or Non-Drug Therapies	X			
Early Periodic Screening, Diagnostic and Treatment (EPSDT)	X			
EPSDT Rehabilitation Services	X			
EPSDT Personal Care	X			
EPSDT Private Duty Nursing	X			
Family Planning	X			
Family Support		X		
Federally Qualified Health Center Services	X			
Hearing Aids and Related Evaluations	X			
Home Health Aide			X	X
Home Health Services	X			
Hospice Services	X			
Hospital Inpatient	X	X		
Hospital Outpatient	X	X		
Inpatient Hospitalization in Free Standing Psychiatric Hospitals		X		

Services Included Under Centennial Care	Physical Health	Behavioral Health	Long Term Care	
				Self-Directed HCBS Services
Intensive Outpatient Services	X	X		
ICF/MR			X	
Laboratory Services	X			
Licensed Alcohol and Drug Abuse Counselors		X		
Medical Services Providers	X			
Midwife Services	X			
Multi-Systemic Therapy Services		X		
Non-Accredited Residential Treatment Centers and Group Homes		X		
Nursing Facility Services			X	
Nutritional Counseling				X
Nutrition Services	X			
Occupational Therapy	X			
Oral Surgery	X			
Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospital		X		
Outpatient Health Care Professional Services		X		
PACE	X		X	
Personal Care Services (including transportation component)			X	
Pharmacy Services	X	X		
Physical Health Services	X			
Physician Visits	X	X		
Podiatry Services	X			
Pregnancy Termination Procedures	X			
Prescriptions				
Preventive Services	X			
Private Duty Nursing for Adults			X	X
Prosthetics and Orthotics	X			
Psychosocial Rehabilitation Services		X		
Reconstructive Surgery	X			
Recovery Services		X		
Rehabilitation Services	X			
Related Goods				X
Reproductive Health Services	X			
Respite		X	X	X
Rural Health Clinics	X	X		
School-Based Services	X	X		
Skilled Maintenance Therapy Services	X		X	X
Specialized Medical Equipment and Supplies[2]			X	
Special Rehabilitation Services	X			
Specialized Therapies				X
Speech and Language Therapy	X			
Swing Bed Hospital Services	X			
Telehealth Services	X			
Tot-to-Teen Health Checks	X			

[2] Service offered in the Medically Fragile HCBS waiver to be phased in effective July 1, 2015.

Services Included Under Centennial Care	Physical Health	Behavioral Health	Long Term Care	
				Self-Directed HCBS Services
Transplant Services	X			
Transportation (medical)	X			
Treatment Foster Care		X		
Treatment Foster Care II		X		
Vision Services	X			

In addition, as previously explained, New Mexico intends to develop a federally-approved benchmark plan meeting all applicable federal requirements for those in the newly eligible population who are not exempt from benchmark coverage.

2. Making Receipt of Long Term Care Services More Equitable

Today, the LTC service delivery system in New Mexico is complex and inconsistent across populations and income levels. The State is looking for creative ways to equalize the delivery of LTC across all populations in need. However, we understand that given budget constraints, we cannot fully realize our goal at this time. Under Centennial Care, we propose to begin taking steps to provide a less complex and more consistent approach to the delivery of LTC services.

As such, we will move forward in phases. For our first step, we propose to implement a policy that will:

- Simplify the LTC service delivery system;
- Make services more equitable;
- Decrease the number of people waiting for needed HCBS;
- Make sure that limited funds are going to the most needy people; and
- Provide people the right care at the right time.

In the current system, people who are (a) categorically eligible for Medicaid ("otherwise Medicaid eligible") and (b) meet nursing facility level of care (NF LOC) have access to personal care services. If these same people need HCBS, they have to wait for a slot to become available (through the CoLTS 1915(c) waiver program) or go into a nursing home. In addition under the current system, people who are not otherwise Medicaid eligible because of income but (a) meet NF LOC and (b) have income under 300% of SSI can ONLY get Medicaid services (including LTC services) if there is a slot available or by going into a nursing home.

Under Centennial Care, the State will create one comprehensive Community Long Term Care (CLTC) benefit that includes both personal care and the HCBS subsumed under Centennial Care. People who are otherwise Medicaid eligible who meet NF LOC will have access to HCBS and personal care services, without the need for a slot. Those who are not otherwise Medicaid eligible who have incomes below 300% of SSI and meet

NF LOC can gain Medicaid eligibility (including access to CLTC services) if a slot is available.

Health plans will conduct a comprehensive needs assessment for everyone meeting a NF LOC to determine the level of need for CLTC services. The assessment would place people into either the low or high needs group. Boundaries will be imposed on both the low needs level and high needs level and will be applied on an individual basis. This will also apply to slots. As such, slots available for those not otherwise Medicaid eligible will be divided into low needs slots and high needs slots with the respective high and low expenditure limits. Boundaries will be determined based on current utilization data.

New Mexico is confident that this policy will:

- Give more people access to a more extensive array of CLTC services that will help keep people out of higher cost nursing homes;
- Reduce the number of people waiting for HCBS by providing needed services – up to the boundaries – for anyone on Medicaid meeting a NF LOC;
- Move people who are otherwise Medicaid eligible off of HCBS slots, because they will get the same services without using up a slot; and
- Control costs by ensuring that serving someone at a NF LOC in the community is less than caring for that same person in a nursing home.

The objective in establishing the Centennial Care benefit package is to ensure that eligible recipients do not lose access to needed services. HSD will ensure continuity of care regarding HCBS for recipients transitioning from an existing waiver to Centennial Care. Only in the following instances have services been eliminated from the benefit package:

- Where the service was duplicative of other services;
- Where services and/or functions will be assumed by health plans as part of comprehensive care coordination systems; and
- Where the service is offered in both Mi Via waivers but is utilized primarily by the DD population. These services will continue to be available to the DD population outside the Centennial Care program through the Mi Via waiver for persons with DD.

The State is confident that recipients transitioning from HCBS FFS waivers to Centennial Care will not lose any needed services. Additionally, by opening HCBS up to a broader population, more people will have access to a broader package of services that they were not previously eligible to receive.

SECTION 3: SERVICE DELIVERY MODEL

To achieve the vision of Centennial Care, New Mexico is proposing to implement a comprehensive delivery system with the following key features:

- A comprehensive care coordination system will stratify recipients by risk and capitation payment will be adjusted by risk to maximize directing resources to those most in need of health care services;
- Increase the health literacy of its recipients to better understand their health needs and how to access the health care system;
- Increased integration of services through the expansion of patient centered medical homes and health homes with intensive care management provided at the point of service to help recipients manage their health and their use of the health care system;
- Streamlining care for the dually eligible and creating shared savings through participation in the CMS duals demonstration program;
- Increased focus on underserved populations by emphasizing the use of technology to bring health care to underserved populations and maximize the use of alternative care settings over emergency rooms;
- Prepare for the newly eligible population under the PPACA;
- Within the managed care system, a new emphasis on payment reform in selected pilots to reward providers based on patient outcomes, as opposed to the volume of care provided; and
- Fewer plans will deliver the full array of Medicaid services.

A. Current Program Structure

The New Mexico Medicaid program is currently operated under a myriad of federal waivers and a FFS component that combined makes it administratively inefficient and difficult to manage as well as difficult to navigate for the recipients. Currently the State operates:

- A FFS system for certain short-term eligibility groups, including newly eligible enrollees who have not yet been enrolled in Salud! managed care, Native Americans who do not “opt in” to the Salud! managed care program;
- A 1915(b) waiver for its Salud! program;
- A 1915(b) and a 1915(c) for its CoLTS program;
- A 1915(b) waiver for its NMBHPC system;
- Two 1915(c) waivers for its two Mi Via (self directed) programs;

- A 1915(c) waiver for the Medically Fragile;
- A 1915(c) waiver for those with AIDS;
- Two 1115 waivers; one for childless adults and one for the parents of CHIP children (the State Coverage Insurance (SCI) program);
- One 1115 waiver for the CHIP program; and
- A 1915(c) waiver for HCBS services for those with DD.

Under these various waivers, the State contracts with seven (7) managed care organizations: four (4) for Salud!, one (1) for behavioral health, and two (2) for CoLTS. In addition, the State pays its Medicaid Management Information System (MMIS) vendor to process FFS claims, to collect and process encounter data from the managed care organizations (MCOs), and to serve as the Financial Management Agency (FMA) for the Mi Via programs. It also contracts with a plan to act as a Third Party Administrator (TPA) to conduct level of care determinations, determine medical necessity for some services in the FFS program, and to review and approve budgets for the Mi Via programs.

The table below describes the current waivers and populations that will be consolidated under the single 1115 demonstration waiver without reducing the number of people enrolled in the program, shrinking the service package offered, or cutting rates paid to providers.

Table 3.1 – Current Waiver Populations and Programs under Centennial Care

Waiver Name	Waiver Type	Expiration Date	Population Covered	Average SFY 10 Enrollment
Salud!	1915(b)	6/30/2013	Traditional Medicaid	390,571
Behavioral Health Services	1915(b)	6/30/2013	Traditional Medicaid	430,969*
CoLTS	1915(b) 1915(c)	1915(b) - 6/30/2012 1915(c) - 10/31/2011	Medicare & Medicaid Duals and Nursing Facility Level of Care	37,555
MiVia	1915(c)	9/30/2014	ICF Level of Care / Self Directed	215
MiVia	1915(c)	9/30/2014	NF Level of Care / Self Directed	AIDS – 8 Disabled & Elderly – 512 Brain Injury – 358

Waiver Name	Waiver Type	Expiration Date	Population Covered	Average SFY 10 Enrollment
DD	1915(c)	Renewed 7/2011	Developmentally Disabled	3,684
Medically Fragile[3]	1915(c)	6/30/2015	Individuals with both a Medically Fragile Condition and a Developmental Disability	176 Traditional
AIDS	1915(c)	6/30/2015	Disabled Individuals with AIDS	9
CHIP	1115	9/30/2013	185-235% of FPL	9,884
SCI	1115	9/30/2014 Child/Adult 9/30/2012 SCI Parents	Below 133% of FPL	47,818

*Individuals enrolled in CoLTS and Salud! receive their behavioral health services through this program as do individuals receiving services in the fee-for-service system.

B. Key Components of Centennial Care

In order to achieve the comprehensive delivery reform for all New Mexicans, the State intends to implement the following program design elements.

1. Number of Health Plans

It is New Mexico's intention to reduce the number of managed care plans from seven (7) to a smaller, more manageable number. This selection process will be conducted through the State's competitive procurement process taking into account all the necessary 1115 demonstration waiver applicable timelines. The plans ultimately selected to participate in the program will be expected to deliver a full range of services, including physical health, behavioral health and long term care (HCBS and institutional care).

2. Comprehensive Care Coordination System

In order to maximize the integration of health care services, the State will "carve in" all Medicaid behavioral health services and all home- and community-based and institutional services now provided under the non-DD waivers. The capitation for the MCOs participating in the program will be designed to maximize the incentives to support people in their homes and communities and to begin to address those waiting for services for the current CoLTS program. Additional details of the care coordination system New Mexico is proposing can be found in Section 4 – Care Coordination.

3. Health Literacy

New Mexico has had success helping recipients understand their health needs and how to access the health care system. Specifically, the Federally Qualified Health Centers (FQHCs) in New Mexico have relied on community health workers called promotoras to help educate Medicaid recipients. However, the promotoras are not statewide and not all providers are allied with them. Under the Section 1115 demonstration program, New Mexico will require plans to conduct aggressive outreach to their recipients and offer

[3] Medically Fragile HCBS waiver will be phased in effective July 1, 2015 with a 6 month transition period beginning January 2015.

information both about how to navigate and most efficiently use the health care system as well as how to manage their health conditions. Much of this work can be most effectively done through the use of a trained, "lay" workforce to work with recipients to engage in their own health. Whether the plans "make or buy" this service, it will be a contractual requirement that community health workers be available as a resource to both the care coordination staff and to recipients who seek to educate themselves about their health. In addition, plans will be expected to develop culturally sensitive, relevant and accessible materials focused on using the health care system wisely and effectively and addressing chronic health care issues.

4. Health Homes

New Mexico seeks the establishment of health homes as an integral step in the integration of care under the Section 1115 demonstration waiver. New Mexico is currently working with a 2703 planning grant to design its first SPA to establish health homes throughout the State that address recipients with a behavioral health condition. It is the State's intent to develop health homes in Core Service Agencies (CSAs) statewide. This model for behavioral health homes (BHH) is being designed in conjunction with the physical health MCOs under Centennial Care. Over time, the State intends to establish health homes for other chronic conditions through the SPA process. The State will work to closely coordinate the health home model(s) with Centennial Care to ensure the integration of care is achieved at all levels.

The health homes, once established, will assume responsibility for the six services required by federal law:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

Under Centennial Care, the MCO will conduct a telephonic health risk assessment for each new recipient at enrollment to identify whether the recipient would be best served by a behavioral health home.

Care Coordination in a Behavioral Health Home

Once a recipient is enrolled in a BHH, the responsibility for both care management and care coordination is delegated by the MCO to the BHH. Therefore, recipients who are enrolled in the BHH receive "hands-on" care management and care coordination from their BHH with administrative oversight from the MCO. Specifically, the BHH nurse care manager will complete and transmit the comprehensive assessment and care plan to the MCOs care manager who has oversight over the recipient's care plan. Revisions, updates and progress reports would also be communicated to this staff person. For high

risk recipients whose chronic conditions are unstable there will be more frequent communication between the BHH and the MCO (as well as between the BHH and the recipient's Primary Care Practitioner/Patient-Centered Medical Homes (PCP/PCMH)). All personal interaction with the recipient will be conducted by the BHH and the PCP/PCMH.

In the BHH context, comprehensive care management and care coordination have two distinct meanings. Care management focuses on risk assessment, identification of high need recipients, development of a comprehensive care management plan that cuts across behavioral health treatment and medical services, periodic evaluation of the plan as to its effectiveness and modification of the plan as needed, based on that evaluation. Whereas care coordination is the service through which the care management plan is executed by linking recipients to needed services; integrating treatment, services and supports; and by increasing the recipient's motivation to understand and actively manage his or her chronic health conditions. Both services are delivered through strong partnerships with the recipient and his/her family, as appropriate. Current working definitions from the draft Health Home SPA are as follows:

- **Comprehensive Care Management** uses recipient information to determine level of participation in care management services. Risk conditions are assessed and health needs identified in order to develop the comprehensive care management plan which will include recipient goals, preferences and optimal clinical outcomes and identifies specific additional health screenings required based on the recipient's risk assessment. The care management plan is always developed in active partnership with the recipient and the recipient's family, as appropriate. Care management includes the development of treatment guidelines for health teams to follow across risk levels or health conditions and the monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines. Through the care management process health team roles and responsibilities are assigned and the process generates reports that indicate progress toward meeting outcomes for recipient satisfaction, health status, service delivery and costs.

- **Care Coordination** is the implementation of the individualized, culturally appropriate comprehensive care management plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and linkages. Care coordination promotes integration and cooperation among service providers and reinforces treatment strategies that support the recipient's motivation to better understand and actively self-manage his or her chronic health condition. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and recipient/family members.

Relationship Grid

At its simplest, the division of labor across MCOs and BHHs for recipients with and without a BHH would look like this:

	Recipient without a BHH	Recipient with a BHH
Care Management Oversight	MCO	MCO
Care Management	MCO	BHH
Care Coordination	MCO	BHH

The State will work with CMS and its actuaries to assure that services provided by the BHH are not duplicated by the MCOs. The intent is to push comprehensive case management to the point of service with oversight and back-up resources provided by the MCOs' care coordination systems.

5. Self-Direction and Home and Community-Based Services

The State intends to continue the current opportunities for recipients to self-direct their care, with some modifications. As is the case today, recipients choosing to self-direct must take responsibility both for hiring their care providers and developing their own budgets. Under the demonstration waiver, the State proposes to contract with an outside vendor to perform the functions of the FMA. All MCOs will be required to contract with this entity to perform the financial management services of the program.

The State will establish the parameters for the self-assessment instrument. A recipient can voluntarily choose to terminate from participation in self-directed care. The MCO will also be able to submit a request to the State to terminate a recipient from self-direction if there is concern regarding the recipient's health and welfare and interventions, such as designating a representative to assume responsibilities on the recipient's behalf, have not been effective.

Under Centennial Care, the following HCBS services will be available for self-direction:

- Behavior support consultation
- Emergency response
- Employment supports
- Environmental modifications
- Home health aide
- Nutritional counseling
- Private duty nursing for adults
- Related goods
- Respite
- Skilled maintenance therapy services
- Specialized therapies

New Mexico remains committed to the principals of self-direction for its recipients and the important role self-direction plays in maintaining the independence of a recipient receiving services in the community.

6. Behavioral Health Carve-In

New Mexico is proposing under the Section 1115 demonstration waiver proposal to have behavioral health services "carved in" and provided by the contracted MCOs. Behavioral health services have been provided to recipients under a single statewide managed care contract. Under this current model, there is risk for potential care coordination issues because physical health and behavioral health services are provided by different MCOs. It is New Mexico's goal to improve the delivery of these services under the demonstration waiver through integration and transparency.

To that end, consistent with the goals of Centennial Care, the State is committed to ensuring that recipients with behavioral health disorders receive the full array of services to address their needs The integration of behavioral health and physical

health in Centennial Care is an opportunity for New Mexico to achieve better health outcomes as one entity will be responsible for managing care for the whole person.

Facilitating stable and sustained recovery from severe or complex behavioral health disorders such as addiction, serious emotional disturbances in youth or serious mental illness in adults has been demonstrated within the professional literature to typically require a system of care approach. Single services (such as residential treatment or medication) provided in isolation with no linkage to other needed services for severe or complex, chronic behavioral health disorders rarely leads to sustained and stable recovery and wellness. These isolated services can paradoxically exacerbate symptomology and increase risk much as an inadequate dosage of antibiotics can greatly increase the danger from infection.

a) New Behavioral Health Services

With implementation of Centennial Care, New Mexico is moving toward integrating services based on assessed need according to a logical plan within a system of care to more effectively reduce risks associated with addiction, serious emotional disturbances and serious mental illness and to promote recovery and wellness. In order to further promote this policy, the following three services are being recommended for inclusion as benefits under the 1115(a) waiver: Recovery Services, Family Support and Respite for Youth. These services effectively address current service gaps that significantly reduce the efficacy of the service system as a whole. The services provide the following functions:

- ***Recovery Services***: Recovery Services provide a peer to peer instruction within a supportive group setting around developing and enhancing wellness and healthcare practices. The Recovery Service promotes self responsibility through recipients learning new healthcare practices from a peer who has had similar life challenges and who has developed skill efficacy. The service occurs within a supportive group milieu with other recipients who support each other that optimize learning new skills. This skill enhancement then augments the effectiveness of other treatment and recovery support initiatives.

- ***Family Support***: Youth or dependent adults with a complex or severe behavioral health disorder who reside with the family or are closely linked to the family may greatly affect the family dynamics and conversely may be greatly affected by the family dynamics. This interactive effect can promote recovery and wellness or it can inhibit it. The Family Support service allows the service team to focus on the family and the interactive effect through a variety of informational and supportive actions that assist the families and the recipient to develop patterns of interaction that promote wellness and recovery over time. The positive interactive effect between the recipient and family then augments the effectiveness of other treatment and recovery support initiatives.

- ***Respite for Youth***: Youth with serious emotional disturbances disorder who reside with the family and display challenging behaviors may periodically overwhelm the family's ability to provide ongoing supportive care. Respite as part of a comprehensive service system allows the family to strengthen resiliency during the respite while the youth is in a supportive environment.

Recovery Services, Family Support and Respite for Youth occupy critical niches within systems of care for adults and youth who experience serious mental illness, serious emotional disturbance or attraction. They can significantly enhance the ability of the service system to cost effectively facilitate desired outcomes around recovery and wellness.

b) Transparency with Behavioral Health Integration

While physical and behavioral health will be integrated within each MCO, the State will ensure that transparency is maintained in how behavioral health dollars are spent and collect data that will indicate which services and systems are effective. Therefore, the State intends to apply the following standards:

- The MCO will not be permitted to subcontract management of behavioral health to a managed, risk-bearing Behavioral Health Organization (BHO);

- The MCO will be required to employ a licensed, clinical behavioral health psychiatrist as a part of its medical management team to take an active role in clinical and policy decisions; and

- The MCOs will be required to contract with either CSAs and/or qualified core service provider networks to manage much of the delivery of behavioral health services. Some of the service dollars will be spent by the MCO to incentivize maximum integration of physical and behavioral health.

  The State will work with its actuaries to develop an actuarially sound rate to protect the behavioral health dollars.

  Under Centennial Care, the State will also rely on CSAs throughout the State to provide prevention, early intervention, treatment and recovery services related to behavioral health for children and adults throughout the State. These CSAs will be a big part of the delivery system under the Section 1115 demonstration waiver and will specifically:

  - Provide behavioral health services to those recipients who choose the CSA as their provider;

  - Provide regional crisis services;

  - Deliver all out-of-home assessment and service planning; and

  - Provide care coordination to recipients with a primary diagnosis of Severe and Persistent Mental Illness (SPMI) or Serious Emotional Disturbance (SED) as well as being part of an interdisciplinary team of care coordination for recipients with co-morbid diagnoses.

7. Community Reintegration

In Centennial Care, the State will continue its commitment to providing the necessary supports to assist recipients in reintegrating to the community from institutional facilities. The State's activities will include:

- Providing the necessary education and information on the front end for recipients in institutional facilities to understand the available opportunity;
- Identifying eligible recipients;
- Providing the necessary supports to facilitate transition; and
- Monitoring the success of the transition process.

8. The Dually Eligible

New Mexico has a long history of exploring avenues to realize savings for the dual eligible population. New Mexico's first attempt of providing managed care for the dual eligible population was through the State's CoLTS program. While the CoLTS program has had some success, the separate silos of Medicaid and Medicare dollars continue to reduce the economic benefit for the State. As such, in September 2011, New Mexico submitted a Letter of Interest (LOI) to CMS to pursue the capitated integrated care model described in a "Dear State Medicaid Director Letter (SMDL # 11-008)". The letter was issued by the Medicare-Medicaid Coordination Office established under Section 2602 of the PPACA of 2010.

As New Mexico continues its discussions with CMS regarding the development of a capitated integrated care model, the State proposes to include the dual eligible population under the demonstration waiver and align the enrollment dates to match up with Medicare's enrollment dates and choice periods. The State believes this program fits in nicely with the overall goals of the demonstration to provide the right care at the right time, especially for the dual eligible population.

9. Community Long Term Care Capacity

New Mexico will implement Centennial Care with sufficient CLTC capacity (also known as slots) to ensure growth, but at a manageable rate. To accomplish this, the State will implement enrollment targets for each year of the demonstration. The program will go live with a CLTC capacity that will accommodate the following eligible recipients: persons currently enrolled in HCBS waivers with incomes between SSI and 300% of SSI; persons transitioning from nursing facilities to the community; and a pre-determined number of persons waiting for services to community placement. An enrollment target will be established for each demonstration year that reflects growth in available CLTC capacity.

The State will continue to maintain a central registry for persons waiting for CLTC who are not otherwise Medicaid eligible. However, the goal is that the number of people waiting for services will diminish with each year of the program. The central registry will be managed on a statewide basis using a standardized assessment tool and in accordance with criteria to be established by the State. Policies for managing the central registry will be based on objective criteria and applied consistently in all geographic areas served.

HSD will develop new criteria in order to streamline the process for those waiting for services. This new criteria will be objective, be consistently applied and take into consideration a person's functional status as well as their financial eligibility for Medicaid.

10. Native Americans

An integral part of the State's innovation efforts is the inclusion of Native Americans in Centennial Care (see Appendix E for details regarding outreach to Native Americans). New Mexico seeks authority from CMS to mandatorily enroll Native Americans into Medicaid managed care, require plans to contract with onsite care managers and engage a Native American clinical person to assist in developing strategies to reduce health disparities while enhancing cultural appropriateness of care coordination, improving access to services and care delivery. Native Americans will be guaranteed the right to choose an Indian health care provider (as a primary care provider or outside of the managed care network). New Mexico will also ensure there is access to sufficient numbers of Indian health care providers by including specific contract requirements with the MCOs.

New Mexico is unique in that it is home to 22 different tribal nations and pueblos. For over a century, the members of these Tribes have looked to the Indian Health Service (IHS) as the federal obligation to provide their access to health care services under the treaties signed in exchange for their lands. Native Americans are confronted by a fragmented health care delivery system that functions one way when they reside on the reservation and another way when they do not. A potential solution to this fragmented service delivery system is the enrollment of the Medicaid–eligible Native American population in managed care under this demonstration waiver.

New Mexico's experience with serving Native Americans in managed care came with both the Salud! and CoLTS programs. When the Salud! program went live in 1997, Medicaid-eligible Native Americans were enrolled in managed care but had an "opt out" into FFS. Within a year of implementation, the State reversed course and did not enroll Native Americans into managed care but permitted and "opt in" approach. Today, about 20% of the low-income families and children who are Medicaid eligible have chosen to enroll in one of the Salud! plans.

When the CoLTS program went live in 2008, those Native Americans who met both the income and functional criteria for NF LOC were required to enroll in managed care to receive services.

During the initial Centennial Care Tribal Consultation held with the Native American community in August of 2011, many Tribal leaders and attendees at the consultation expressed concern that the State might require mandatory enrollment of the Medicaid eligible Tribal individuals into managed care. The concerns expressed took two directions. The first was that the CoLTS experience for Native Americans has been an unhappy one because allegedly (i) care coordinators failed to show up on the reservations and/or were culturally insensitive and (ii) access to care has not been any better under CoLTS than it was under FFS.

The second concern raised was in regards to the sovereignty of the Native American Tribes and that the State should not dictate where the Native American community

receives its health care. Individuals articulating this theme expressed uniform frustration with the federal government and its broken promises to the Native American community.

To address the wide health disparities in the Native American Community and to bring economic development to the Tribes within the managed care infrastructure, the State convened a small workgroup that included Native American Tribal representatives as well as individuals from the IHS. The workgroup put forward a continuum of ideas that ranged from leaving the Native American community in FFS to providing each Tribe a capitated "per member per year" amount and letting each Tribe buy/manage health services for their Medicaid recipients. In the middle of the continuum was the concept of including the Native Americans in managed care but requiring the managed care plans to contract with the IHS facilities and the Tribal 638 facilities as well as other Tribal providers like transportation vendors or case management entities. When the contract is with an IHS or Tribal 638, the State agreed that the plans would pay the Office of Management and Budget (OMB) rates. The State believes this approach will provide culturally appropriate care that together with the care coordination system will positively impact the alarming health disparities in the Native American Population.

The State will continue to work with the Native American community throughout the development and implementation of Centennial Care. Moreover, to the extent that the Navajo Nation and/or a Tribe or combination of Tribes would like to approach the State and/or federal government with a proposal that permits them to receive some kind of per member per year capitation and/or a block grant to provide either the full Medicaid benefit or some portion thereof, or to participate in a Payment Reform pilot to improve diabetes outcomes, the State is more than willing to encourage and support that approach.

C. Delivery System Innovations

New Mexico also believes that a comprehensive delivery system innovation is an excellent place to make the program less complex to our recipients and reduce the "siloing" of individuals depending upon their eligibility categories. In order to achieve innovation under the Section 1115 demonstration waiver, New Mexico proposes the following innovations in its efforts to improve coordination and quality of care for all Medicaid eligibles. They include:

- Reduced administrative burden in terms of federal reporting and processing of waiver renewals;
- Increased accountability for the more limited number of MCOs that will contract for the entire Medicaid population and their service array;
- Greater ease of provider compliance in dealing with the billing, authorization, formulary, and credentialing requirements of a more limited number of MCOs that will be included as part of the MCO contract;
- More focus from the State on the evolution of a service delivery system that focuses on outcomes and quality; and
- Exploration of ways to make the system less complex and burdensome on both recipients and providers.

New Mexico intends to also procure the services of a single entity to credential and re-credential its providers. The State believes this will reduce administrative efforts for the medical community. The State proposes to procure the services of a National Committee for Quality Assurance (NCQA) accredited agency in order to ensure that no plan would put its NCQA status at risk. A centralized credentialing entity will assist in ensuring that providers' information is accurate and up-to-date to minimize risks that payments will be delayed because a provider is not properly "registered" in the State system.

1. Sole Community Provider Program

New Mexico currently has in place a program through which supplemental payments are made to hospitals that are the sole community providers of inpatient care in their communities. The program provides quarterly supplemental Medicaid payments to qualified and participating hospitals. Today the counties provide the funding. The annual payment of the Sole Community Provider (SCP) Program consists of the base year amount and the upper payment limit (UPL) amount.

The base year amount is established through a request (by hospitals) and approval (by counties) process with the counties paying the State share calculation using the effective federal medical assistance percentage (FMAP) and the base year payment amount. A payment to a hospital has been the lesser of the previous year's payment plus inflation or an amount approved by the county.

In addition to the base year amount, the hospitals, including the teaching hospitals, are eligible for a UPL amount if a UPL pool is available (after the base amount is paid). The UPL pool is based on a year 2000 calculation methodology for three buckets of hospitals: State teaching hospitals; non-State government owned hospitals; and privately owned hospitals. The State's audit agent calculates the UPL pool. The UPL pool is the difference between what Medicare would have paid for Medicaid services. If the payments that Medicaid made have not exceeded the UPL, the State makes an additional supplemental payment to the qualifying hospitals whose counties have agreed to fund the match amount.

The State seeks the authority to maintain the SCP program. The State proposes to divide the pool into two sub-pools; one of which will provide dollars to support the uncompensated care burden borne by the hospitals as New Mexico does not anticipate a 100% "take up" rate among its uninsured population. The second sub-pool would be used to support projects proposed by the hospitals that will support the growth of the health care infrastructure of the State. The State will continue to assure that the unique role and mission of its only state-teaching hospital, the University of New Mexico hospital, will be recognized in the distribution of the pools

New Mexico looks to other states as models, most notably California, Texas, and Florida, which have had such arrangements approved by CMS and seeks to implement a similar approach.

2. Positively Influencing Recipient Behavior

New Mexico also proposes additional innovations under the authority of the demonstration waiver that involve changing recipients' behaviors. These innovative opportunities enhance New Mexico's comprehensive and integrated benefit package design. They include:

a) Incentives

In addition to influencing behavior through personal responsibility of a sliding scale co-payment for non-emergency use of the emergency room (further addressed in Section 5), New Mexico intends to also reward recipients for key preventive activities. Through the 1115 demonstration waiver, the State is considering the following approaches to focus on helping recipients be active participants in their health care:

- Reward of gift cards offered through the MCOs to a "high-risk" recipient who participated in the development of a care plan and complied with that plan for six months a year;
- Reward of gift cards for completing a series of wellness visits and subsequent follow-up visits for children;
- Reward of gift cards tied to quantifiable participation in regular exercise programs for healthy adults; and
- Reward of gift cards tied to children or at-risk adults receiving all appropriate immunizations.

The State would like to implement an Electronic Benefit Transfer (EBT) card with points that a recipient could earn for certain healthy behaviors either in addition to or in lieu of the individual gift card approach. Points could be used to purchase over-the-counter drugs or other items that Medicaid does not pay for.

b) Education

New Mexico is interested in introducing a quarterly Explanation of Benefits (EOB) that would inform recipients who overuse the emergency room or who use 5 or more prescriptions a month. The EOB would inform the recipient of the costs of their care being provided and whether those costs are leading to better outcomes and how, working with a care coordinator, that the recipient might begin to use the system more efficiently. The recipient's MCO would then follow up with focused care management to reduce the unnecessary utilization of the emergency room and evaluate the recipient's prescriptions.

3. Long Term Care Partnership Plan

As a part of New Mexico's efforts to increase the sense of personal responsibility, the State is pursuing a SPA with CMS to become a LTC insurance partnership state. Individuals will be able to purchase private LTC insurance plans at market rates that have the potential to cover much if not all of their eventual LTC needs. This has great potential to assist middle income individuals from having to spend down their savings and assets in order to qualify for Medicaid to gain access to LTC. To the extent that individuals eventually do apply for Medicaid, the program can "count" the full value of the policy as an asset which has the effect of delaying entry into the system until the full value of the policy has been spent on services. Under this scenario, Medicaid agrees not to pursue estate recovery at least to the extent of the value of the policy.

4. Automated System Program and Eligibility Network

New Mexico is in the process of designing, developing, and implementing a replacement eligibility determination system, which will be known as the Automated System Program and Eligibility Network (ASPEN). ASPEN will provide case management, eligibility determination, benefit calculation, and benefit issuance for Medicaid, TANF, Supplemental Nutrition Assistance Program (SNAP), Low-Income Home Energy Assistance Program (LIHEAP), State-funded cash assistance programs, and Refugee Cash Assistance (RCA).

ASPEN will replace the current ISD2 system, which was deployed in New Mexico in 1988 and was based on an even earlier design. The legacy system is fragile, costly to operate and expensive to maintain. The replacement system will be web-based, easily modifiable due to its rules engine, flexible, and scalable. It will contain a public facing web portal, be built within the framework of Service Oriented Architecture, and maintain a multi-tiered security mechanism that utilizes user and role based security and application access. The system meets the seven (7) conditions and standards established by CMS in April 2011 for funding of enhanced eligibility systems.

The State awarded the Design, Development, and Implementation (DDI) services contract to Deloitte Consulting, and the project began September 1, 2011. Pilot county operations are scheduled to start in July 2013 with statewide rollout to be completed by February 2014.

SECTION 4: CARE COORDINATION

Fundamental to the comprehensive system of care that New Mexico seeks to provide under this 1115 demonstration waiver is a robust care coordination system. Managed care organizations that are selected to provide health services will be responsible for providing care coordination at a level appropriate to each recipient's needs and risk stratification.

New Mexico is proposing that its care coordination system be based on creating a patient-centered environment in which recipients are receiving the care they need in the most efficient and appropriate manner. The care coordination approach is continuous and includes:

- Assessing each recipient's physical, behavioral, functional and psychosocial needs;
- Identifying the medical, behavioral and long term care services and other social support services and assistance (e.g., housing, transportation or income assistance) necessary to meet identified needs;
- Ensuring timely access and provision, coordination and monitoring of services needed to help each recipient maintain or improve his or her physical and/or behavioral health status or functional abilities and maximize independence; and
- Facilitating access to other social support services and assistance needed in order to promote each recipient's health, safety and welfare.

The requirements for care coordination New Mexico proposes under the 1115 demonstration waiver are included below.

A. Screening and Initiation of Care Coordination

The initial care coordination contact for each recipient and/or their caregiver will be performed upon entry into an MCO (or within 10 business days of enrollment). The MCO will utilize all available information and initiate a phone call with each new recipient to complete the following:

- Introduce the MCO and provide a brief orientation to benefits and to care coordination;
- Obtain additional information about current care needs that were not indicated in encounter and utilization data;
- Identify any immediate or urgent needs;
- Obtain information about family or other caregivers who may participate in care planning;
- Confirm information about behavioral health or substance abuse care indicated by encounter or utilization data; and
- Make initial risk level assignment.

Based on the recipient outreach call and, in the case of current recipients, utilization and encounter data that the plans will have for their recipients, individuals will be assigned a risk-stratification group. The stratification process will take into consideration many different elements, including but not limited to age, diagnosis, treatment history, and current needs, presence of mental health issues and/or substance abuse and living arrangements.

If the recipient is assigned to a minimum level of need (Level 1 care coordination), it is an indication that they appear to be in stable health and have low needs for support and coordination. These recipients may have the following characteristics:

- No complex or co-morbid health conditions;
- Low emergency room usage;
- Stable housing and social supports; and/or
- No behavioral health or substance abuse treatment needs.

For these low-risk recipients, no further assessment may be needed unless and until claims, encounters or real-time health information data or a trigger event signals a change in status. These recipients will receive an annual health risk assessment (HRA) and have a monthly review of claims, utilization and prior authorizations.

If the recipient is determined to be at a higher level of need (Level 2 care coordination), they may need more intensive care coordination. An example of criteria for a higher level of need might include that the recipient:

- Has co-morbid health conditions;
- Has had frequent emergency room usage in the past 3-month period;
- Has a low-risk mental health or substance use disorder that is stable or presents with minimal functional impairment in home, school/work and community settings; and/or
- Is receiving substance abuse services.

These Level 2 care coordination recipients will receive semi-annual face-to-face visits, an annual comprehensive assessment update and quarterly phone contact by a care coordinator.

Some recipients will require more intensive coordination (Level 3 care coordination), typically those with the most expensive or high-risk service needs. The following is an example of this profile in which the recipient:

- Is medically complex or fragile;
- Has had high emergency room usage in the past 3-month period;
- Has a high-risk mental health diagnosis or is an individual who is seriously and persistently mentally ill;

- Is transient and without a natural support network;
- Has co-occurring mental health and substance abuse diagnosis; and/or
- Requires assistance with two or more activities of daily living (ADLs).

The Level 3 care coordination recipients will receive quarterly face-to-face visits, semi-annual comprehensive assessments and monthly phone contact by a care coordinator.

The initial assignment of a recipient to a risk-stratification group will be based on the entry assessment and will dictate how cases are processed (e.g. time-frames, frequency and type of contact). However, the completion of a comprehensive assessment may be necessary to establish a fully informed risk group assignment. The group assignment may change based on results of the comprehensive assessment that provides more information about the recipient's individualized needs, current risk and future risk-factors.

B. Comprehensive Assessment/Care Planning

Once recipients are assigned an initial risk group an MCO care coordinator will contact recipients who appear to have complex needs and a higher level of risk (Level 2 or 3) to complete a comprehensive assessment. This would confirm that the recipient is in the appropriate risk group and to inform the development of a written care plan. A comprehensive assessment will typically take more time and require that the care coordinator include input from a care planning team as appropriate, including the recipient, family or caregivers (with the recipient's permission), and providers.

Based on the assessment, a care plan will be developed that includes the services and supports that the recipient needs to stabilize or improve the recipient's health, safety and well-being. The care plan document will include all Medicaid and non-Medicaid services identified for the recipient. This will allow the recipient to understand what services are available and create a foundation for discussions about their health between the recipient, the recipient's caregivers, care coordinator and providers.

The MCO may utilize a care coordination team to manage the tasks related to care coordination and assign certain tasks to team members with appropriate education and training. However the process will be designed to require a specific care coordinator to act as the liaison or "face of the program" for the recipient. The design goal is to foster trust and communication, reduce confusion for recipients, their caregivers and families, and providers and ultimately, improve care.

C. Ongoing Care Coordination

Ongoing care coordination conducted by the MCOs will be based on the assigned risk group and will include required elements such as:

- Delivery of initial and on-going comprehensive assessments;
- Required members of the care planning team;
- Frequency and type of contact with recipients;
- Data monitoring requirements; and/or

- Triggers for reassessment and case review.

New Mexico will also rely on certain events and/or data to trigger a review of a recipient's health status and needs. These triggers will include events such as:

- Abuse/neglect reports involving the recipient;
- New diagnosis with significant health or safety impact;
- New diagnosis involving behavioral health or substance abuse;
- Hospitalization;
- Request by provider, caregiver or family recipient; and/or
- Other indications that the recipient may need to move to a new risk group.

In addition, New Mexico will require plans to have software that will enable the care management staff to access patient records in real time and on demand from all network providers in the system. When a trigger event occurs for a recipient, the MCO will assign a care coordinator to complete a comprehensive assessment for low and medium risk recipient or deploy the assigned care coordinator to update the assessment for a recipient who is already receiving complex case management.

Care coordination for recipients who either receive or are in need of behavioral health services and/or substance abuse treatment will include:

- Referrals for service;
- Monitoring of wait times for services; and
- Compliance with recommended treatment including medication.

It is anticipated that these recipients may require more frequent contact by the care manager and more intensive coordination efforts. For those recipients with SPMI, the care manager will focus efforts on reducing emergencies and improving overall stability. For recipients with substance abuse treatment needs, the care manager will focus on prevention of relapse and reduction of physical health issues. In both cases the care manager will develop a care plan that considers and addresses the physical, behavioral and social support needs of these recipients. The care plan team will include any ancillary care providers and/or community services to address the complex nature of these cases.

D. Care Coordination/Patient-Centered Medical Homes and Health Homes

While the basic care coordination model described above will, at least initially, be the responsibility of the MCOs, the State will phase in over the 1115 waiver demonstration period, more intensive care coordination to at the "point of service" by incentivizing the proliferation of patient centered medical homes and health homes. As recipients choose or are enrolled in either the medical home primary care model and/or the health home for the management of chronic conditions or behavioral health issues, those entities will assume responsibility for intensive care coordination. Additional detail on the care

coordination aspect of the behavioral health home model is further discussed in the delivery services section of this application.

The MCOs will be expected to continue to provide overarching care coordination, technical assistance, and to assure the care coordinators in these "point of service" models full access to all of the MCO resources and utilization and encounter data that would be required for a care coordinator to understand the entire spectrum of a recipient's needs.

E. Transition Process under Care Coordination

New Mexico understands the importance of ensuring a seamless transition for each recipient into Centennial Care. While the State is requesting a January 1, 2014 start date, it will work with CMS and the selected health plans to develop a transition plan for new recipients that include a care assessment and coordination of services to best meet their needs. This seamless transition is even more critical for those transitioning from a non-managed care environment into the section 1115 demonstration and into managed care. This includes the transition of the four (4) of the 1915(c) home and community-based waivers currently operating in New Mexico – Mi Via for persons meeting a nursing facility level of care; CoLTS; Medically Fragile; and AIDS waivers. (The Medically Fragile population will be phased in effective July 1, 2015 with a 6 month transition period beginning January 2015.)

Work is currently being done within the State to proactively prepare these at-risk individuals for the transition into managed care with the establishment of a State workgroup focused on this transition process. Additional details will be shared with CMS as they become available.

The State continues to finalize its vision of care coordination and continues to seek further stakeholder input; this is one of many places where the input of the community will lead to a stronger program.

SECTION 5: COST SHARING

The State believes that there is merit in engaging recipients more in the process of staying and/or getting healthy and in using the health care system more efficiently. Towards those ends, the State is seeking authority from CMS to pursue a properly aligned array of incentives with its recipients.

In 2009, the New Mexico legislature enacted statute to impose a sliding scale co-payment on Medicaid recipients with incomes above 100% of the federal poverty level where the individual seeks non-emergency use of the emergency room (ER). The legislation provides that a co-payment may be assessed when the hospital from which the recipient seeks services:

- Conducts an appropriate screening to assure that the recipient does not require emergency services;
- Informs the recipient that he/she does not have a condition requiring emergency services;
- Informs the recipient that if he/she still wants the service, he/she will be subject to a co-pay;
- Provides the recipient with the name and address of a non-emergency Medicaid provider; and
- Offers to provide the referral to the non-emergency provider to facilitate the scheduling of the service.

The amount of the co-pay in State statute is:

- For a child whose household income is 100-150% of the FPL, $6.00;
- For an adult whose household income is 100-150% of the FPL, $25.00;
- For a child whose household income is above 150% of the FPL, $20.00; and
- For an adult whose household income is above 150% of the FPL, $50.00.

The State is requesting waiver authority to implement this existing State law because, as the legislature believed at passage, this approach is one way to incentivize recipients to seek care in more appropriate settings. This is particularly true when coupled, as the State is planning, with incentives to both the hospitals and the MCOs to also participate in a statewide effort to make appropriate care settings available.

The total amount of money assessed to Medicaid recipients calculated in this co-payment would be deducted from the capitation paid to the health plans. The amount of the aggregate deduction would be based on historical data already being analyzed by the State's actuaries. However, the State would preclude the plans from passing the amount of the deduction on to the hospitals (pursuant to statute) and would contractually require the plans to absorb the deduction but seek ways to incentivize their provider

networks to do things to help alleviate the problem such as keeping non-traditional office hours, working more closely their recipients to help educate them on when the ER is appropriate and when care can be provided in a more efficient setting, encouraging recipients to use the nurse advise line, and/or implementing triage lines to help people make better decisions about when to access the ER. Requirements will also be incorporated into MCO contracts to encourage the use of the nurse line to educate recipients on when the ER is the appropriate care setting for described diagnoses and symptoms.

In this way, the system shares in the push to keep people out of the ER for routine and non-emergent care.

In addition to the co-pay for non-emergent use of the ER, the State will seek to implement a modest co-pay of $3.00 for the demand for a legend drug when there is a generic substitute readily available. This co-pay will not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions.

New Mexico will continue to honor the protections of no premiums and cost-sharing for Native Americans who are provided services by Indian Health providers (including Urban Indian organizations) or through referral by contract health services. These protections were established by the American Recovery and Reinvestment Act of 2009 (ARRA).

SECTION 6: QUALITY

Over the course of the five years of initial waiver authority, New Mexico will introduce progressive quality goals focused on health outcomes, employ pilot projects based on both geography and specific populations to develop medical and health homes, and challenge its MCO partners to work cooperatively with the provider community and with the State to achieve a health care delivery system that is efficient and effective, controls costs by improving the health of the people the system serves, and reduces health disparities.

New Mexico has a strong history of quality monitoring to determine the appropriateness of care and the quality of care provided to recipients enrolled in the State's Medicaid managed care delivery system. New Mexico will build on this history with Centennial Care.

The New Mexico quality strategy for the Medicaid managed care service delivery system was established in 2003. The quality strategy is designed to ensure that services provided to enrollees meet or exceed established standards for access to care, clinical quality of care and quality of service.

The strategy is designed to identify and document issues and encourage improvement through specific contract requirements, incentives, or where necessary, through corrective actions. These guiding principals will serve as the building blocks for the quality strategy for Centennial Care.

The State will define clear monitoring and reporting requirements and measures for all MCOs through functions such as:

- Assessing whether State, federal, and contract requirements are met;
- Providing timely feedback to MCOs; and
- Identifying potential best practices and potential concerns.

MCOs will be required to demonstrate compliance with monitoring and reporting requirements through functions such as implementing program modifications and enhancements based upon identified issues.

The Centennial Care quality strategy will be an ongoing, open process. Targeted program goals and benchmarks will be determined through a continuous quality improvement process. Areas for improvement will be constantly evaluated through quality improvement activities that:

- Identify priority areas for improvement;
- Establish outcome-based performance measures and appropriate target goals; and
- Identify, collect, analyze and assess relevant data.

The following are the minimum quality improvement activities that the State, or its designee, will assume to monitor progress towards achieving established targeted program goals and benchmarks:

- Quality assessment and performance improvement requirements in managed care contracts, including performance measures, quality indicators, data collection, evaluation and analysis, corrective action and program improvements;
- Routine monitoring and evaluating of contractor compliance and performance;
- Annual on-site operational review;
- Analysis of periodic reports;
- Review and analysis of program-specific performance measures and performance improvement projects;
- Incentives for health plan and provider compliance and sanctions for poor performance;
- Develop and disseminate clinical standards/guidelines; and
- External quality review organization annual review.

The State will identify for monitoring, as appropriate: 1) measures of process, health outcomes, quality of life, recipient choice, recipient and provider satisfaction and performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

Additional monitoring strategies will be implemented, as appropriate, to assess the following unique Centennial Care program elements:

- Integration of HCBS into the comprehensive State Plan benefit package;
- Increase access to care for Native Americans;
- Identify outcomes associated with integration of care;
- Continuity of care for recipients transitioning to Centennial Care from FFS and between MCOs;
- Continuity of care for recipients transitioning from an institutional setting to community placement, the success of such placement and transition processes;
- Improved quality outcomes; and
- Effectiveness of health homes on health outcomes for eligible recipients with chronic conditions.

The State will continuously review the quality strategy. If a particular activity does not effectively meet targeted program goals or benchmarks or result in program improvement, alterations will be made to the activity or the strategy as a whole.

Additionally, priorities may emerge while analyzing monitored data, through discovery of evidence-based practices, or other research projects, requiring adjustments in strategy elements.

As in the development of Centennial Care, stakeholders will play a key role in program implementation and evaluation. Through informal feedback and formal processes such as grievances and appeals and advisory groups, recipient satisfaction surveys and the Medicaid Advisory Committee (MAC), stakeholders will provide input on a multiplicity of issues including: provider performance, plan performance, access to care, satisfaction with care coordination and quality of care.

New Mexico believes that the modernization of the Medicaid program will result in improved quality of life and satisfaction with services for those who participate and their families. New Mexico will implement a comprehensive quality approach across the entire continuum of services and settings that promotes quality improvement and that focuses on recipient perceptions of quality, with mechanisms to ensure ongoing feedback from persons receiving care and their families in order to immediately identify and resolve issues and to improve the overall quality of services and the system.

SECTION 7: PAYMENT REFORM

New Mexico intends to begin to align incentives and reward providers directly for achieving measurable health outcomes for their recipients under the demonstration. These incentives and rewards include initiatives such as:

- Successful management using evidence-based, best practices for the treatment of conditions prevalent in New Mexico;
- Reduced rates of readmission to the hospital for the same condition; and
- Payment incentives for the health plans and providers.

Payment incentives for health plans and providers can take a variety of forms ranging from non-financial like the reporting of peer-to-peer comparative data on the use of evidence based best practices to financial incentives like the development of bundled rates for hospitals targeted towards reducing the number of readmissions for the same diagnosis within 30 days.

In New Mexico, both asthma and diabetes have potential as targets for payment reform pilots, where providers are not paid simply on the basis of the volume of services delivered but based on some measure of how the care that they provide has actually improved patient outcomes. This approach to payment reform has gained broad acceptance within Medicaid programs across the country. As of July 1, 2006 over half of state Medicaid programs had implemented some form of pay-for-performance and that percentage was expected to rise to over 85% by the end of the decade.[4] With passage of the PPACA, all state Medicaid programs will be required to move even more aggressively to outcomes-based payment, including the adoption of innovations such as Accountable Care Organizations (ACOs) and bundled payments to providers for episodes of care.

New Mexico faces unique challenges in the effort to overcome the disease burden of asthma and other chronic diseases. New Mexico has the 4th highest rate of child poverty in the nation. It is the fifth largest state and has the 4th lowest population density.[5] The presence of 22 Pueblos and Native American Tribes and a large Hispanic population add to the cultural challenges that must be met in improving health status. Further management of chronic diseases outside the hospital is challenging given the large rural and frontier areas in the State where the community hospital may be the only locally available source of health care. While large hospitals with integrated provider networks do exist in the more urban Albuquerque-Santa Fe corridor.

[4] Kuhmerker K, Hartman T, 2007, "Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs", The Commonwealth Fund publication number 1018, http//www.commonwealthfund.org/publications_show.htm?doc_id+472891, Accessed June 4, 2007.

[5] US Census Bureau 2006.

A. Payment Reform Options under Centennial Care

New Mexico believes that an array of payment reform options can work within the capitated payments made to the MCOs. For three diagnostic categories (diabetes, asthma, and pneumonia), New Mexico requests to pilot both of the following approaches under the authority of the Section 1115 demonstration Waiver:

1. Ambulatory Bundled Rates for Adult Diabetes and Pediatric Asthma

The State will work with the physician community to develop metrics that represent best practices for the treatment of children with asthma and adults with diabetes. We will turn these metrics into data points that will be collected via the MCOs and reported within the physician community. We will focus on these two disease states to start and examine whether the reporting on best practices begins to change the practice patterns of the physician community.

New Mexico will develop a bundled ambulatory rate to be paid by the MCOs to the lead practices involved in these pilots. The prospective bundled payment will include all primary care, specialist, and diagnostic and medical social work/case management services as an upfront payment to the practices to incentivize maximum management of pediatric asthma and adult diabetes in the community. MCOs will be allowed to impose withhold a portion of the total ambulatory rate to assess practice performance on specific outcomes including reductions in ER visits and hospital re-admissions.

In addition, for each of the payment reform initiatives described in the waiver document, New Mexico is requesting federal match under the waiver for rewards programs that could include nutrition education for diabetics, smoking cessation programs for adolescents with asthma, or even retail store gift cards to reward recipients for compliance with appointment or drug regimens. As such, all players will be incentivized to promote best practices.

To address the high rate of both adult diabetes and pediatric asthma prevalence in the Native American community, New Mexico will also engage tribal health departments and IHS facilities in one or more sites to model a comprehensive ambulatory bundled rate combined with individual health promotion as separate pilot initiative.

New Mexico anticipates that the shared savings that the practices can expect to participate in as result of a successful pilot will inform the State in future policy decisions regarding physician reimbursement.

2. Bundled Rates for Urban Hospitals

For the two diagnoses that contribute heavily to the rate of hospital re-admissions, (pneumonia and coronary disease), the State proposes to work with its actuaries to develop a bundled rate for an initial hospital stay and the 30-day post-discharge period. The State will use this demonstration to explore whether using a bundled rate will reduce the number of readmissions within 30-days for the same diagnosis and will challenge hospitals, care managers and MCOs to become more vigilant about post-discharge planning and follow-up with recipients. All payments made to the provider would be within the capitation rates paid to the MCOs.

New Mexico presents opportunities as well as challenges in the selection of the hospital or hospitals that will participate in the pilot. The State believes that the best chances of success will be found in working with the integrated hospital/physician networks in the

urban areas. However, in terms of designing a model that can be replicated, full consideration will need to be given to the access and geographic differences between the frontier regions and the urban areas.

As in the case of the ambulatory bundled rates for adult diabetes and pediatric asthma, the State believes that a bundled inpatient rate must include incentives for the hospitals, the physicians, and the recipients in order to be successful. Because of the complexity in designing multiple bundles for inpatient and outpatient services, we will pilot these specific initiatives in urban settings where integrated networks exist. The hospital networks will be challenged by the MCO to create their own measures to share economic incentives between physician practices and the hospitals. Recipients will also be eligible to receive a range of incentives with federal matching funds under the waiver to encourage healthy behaviors.

As this bundled rate initiative gains traction in the State, New Mexico believes that it will set the stage for further developments towards the ACOs contemplated in the PPACA.

SECTION 8: PUBLIC INPUT

New Mexico began its quest for public input with a series of meetings held throughout the State. The meetings were focused and productive. Indeed, for each meeting (except Albuquerque) the Secretary of HSD gave a presentation explaining why the agency was interested in making changes to its Medicaid program and outlining four key principles around which the State wanted to focus discussion. The four principles were:

1. Create a comprehensive and coordinated service delivery system that would focus on outcomes and assuring that recipients got the services they need to be as healthy as possible;

2. Introduce concepts of personal responsibility that might include both incentives to recipients for engaging in healthy behaviors as well as potential co-payments to attempt to influence the settings in which people sought care;

3. Look at payment reforms that would support the concept of buying quality rather than quantity of service; and

4. Introduce more administrative simplicity for the State, providers and recipients.

After the Secretary's briefing, the attendees were divided into groups of 12 to 14 and each group was given two questions relating to the principles and asked to spend an hour in debate and discussion and report the group's recommendations at the end of the hour. This process, while cumbersome in the larger forums, proved to be an excellent way to have the public actually wrestle with the difficult questions around reform as opposed to a question and answer town hall format. The only two forums in which this process was not followed were Albuquerque which had 227 attendees and Santa Fe which had 132 attendees. These two meetings followed the more traditional question and answer town hall format and were arguably less productive in terms of getting real and helpful feedback.

The State held meetings in Clovis (41 attendees); Farmington (140 attendees); Roswell (42 attendees); Las Cruces (145 attendees); and had a special briefing for members of the State Legislature. The State also engaged in a formal Tribal Consultation on August 8th which was not well attended by elected Tribal officials, but for which 132 tribal members came to voice their opinions on the four principles of reform.

In total, the two months of public meetings in July and August of 2011 were attended by 1046 individuals throughout New Mexico.

After the public meetings, the State compiled the feedback and used it to organize a series of workgroups in which a smaller number of people provided advice and ideas, again organized around the four principles of reform. Each workgroup met for 4 hours a day over two days for a total of 8 hours of work on their subject area.

The following is a description of each workgroup:

- The Comprehensive, Coordinated Service Delivery System workgroup was attended by 14 people: 4 health plan representatives, 3 providers, 3 advocates and 4 State employees representing both Medicaid and Behavioral Health.

- The Payment Reform workgroup was attended by 19 people: 6 health plans representatives, 1 representative from the New Mexico Hospital Association, 2 hospitals Chief Executive Officers (CEO), 1 representative from the Primary Care Association, 1 physician from the IHS, 3 advocates, and 5 State employees from Medicaid and Behavioral Health.

- The Personal Responsibility workgroup was attended by 14 people: 5 representatives from health plans, 1 representative from the New Mexico Hospital Association, 1 hospital CEO, 1 representative from the New Mexico Pharmacy Association, 2 advocates and 4 State employees from Medicaid and Behavioral Health.

The State did not hold a workgroup on Administrative Simplicity but is committed to working on developing concepts to implement under Centennial Care. It did, however, convene a small working group to further discuss concerns relative to the Native American community (see Appendix E for details regarding outreach to Native Americans). There were 19 attendees at the Native American workgroup: 5 from the IHS, 10 from different Tribes, 1 from the University of New Mexico and 3 State employees, including the Native American liaison from the Medicaid program.

The State also created a website and widely circulated the information to encourage individuals around the State to submit comments, concerns and ideas for the reform effort. That website continues to be used to post documents, including the Concept Paper on February 22nd as well as the List of Specific Waivers that the State intends to seek from CMS which was posted on March 21, 2012.

The State also sought the advice and council of its MAC who was briefed on the four principles in early September and, once the concept paper was released, held a full day's hearing on the paper and "next steps."

As a result of this widespread consultation and stakeholder outreach, the State's vision of a movement towards integration and payment reform began to emerge with the support of the stakeholders. Their input was ultimately woven into the Centennial Care concept paper.

The State intends to continue working with its stakeholders throughout the process of waiver negotiation, contract and request for proposal (RFP) development and, ultimately, readiness. The State has organized on-going workgroups to continue fleshing out the ideas in the concept paper and to assure that the final contract will accurately describe the business arrangement the State seeks to have with its plans as well as providing for adequate and frequent communication with recipients.

As these workgroups begin to produce contract language, individuals in the community have been, and will continue to be, invited to review, revise, advise and participate in the process. In addition, the State is developing a series of podcasts around the reform effort to provide information to the public at large. It also continues to use the website to post critical information and to seek input from the public.

There is much work still to be done to finalize the details of the State's approach to modernizing its Medicaid program. But the State is acutely aware that the continued involvement and active participation of providers, advocates, recipients, the Native American community, and the public at large is vital to ensuring that, when completed, Centennial Care is uniquely New Mexican and provides the best possible care for its citizens.

SECTION 9: 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. The ability to show budget neutrality is a significant concern to the State. In today's economic climate, the State realizes that programs must be evaluated carefully to ensure that they are sustainable long term. The State is proposing a demonstration that encompasses most services and eligible populations under a single authority to provide broad flexibility to more effectively manage its programs while pursuing innovations to enhance access to quality care in Medicaid and CHIP.

Overview

The proposed waiver program would begin on January 1, 2014, subject to CMS approval, with the five-year demonstration going through December 31, 2018. The five-year term of the demonstration project, thus, covers Calendar Year (CY) 2014 through 2018 (Federal Fiscal Year 14 (FFY14) through FFY19). The time periods for the five-year demonstration period are detailed in the table below:

Table 9.1 – Demonstration Year (DY) Time Periods

Demonstration Year	DY1	DY2	DY3	DY4	DY5
Time period	1/1/2014 – 12/31/2014	1/1/2015 – 12/31/2015	1/1/2016 – 12/31/2016	1/1/2017 – 12/31/2017	1/1/2018 – 12/31/2018

Data was available from SFY2007 through SFY2011 to support the development of cost and caseload projections. The most recent SFY2011 data was incomplete and was used for trending purposes only. SFY2010 was chosen as the base year throughout the cost and caseload projections. The following tables (9.2a and 9.2b) present historical program funding and caseload for SFY 2007 to 2011.

Table 9.2a Historical Data
Total Computable

	SFY07 (7/1/06 - 6/30/07)	SFY08 (7/1/07 - 6/30/08)	SFY09 (7/1/08 - 6/30/09)	SFY10 (7/1/09 - 6/30/10)	SFY11 (7/1/10 - 6/30/11)	5-YEARS
TANF & Related						
TOTAL EXPENDITURES						
Eligible Member Months	3,222,890	3,345,269	3,650,469	3,974,052	4,172,356	
Total Cost per Eligible	$ 307.80	$ 325.50	$ 318.57	$ 307.94	$ 287.24	
Total Expenditure	$ 991,993,925	$ 1,088,890,637	$ 1,162,938,641	$ 1,223,786,435	$ 1,198,461,186	$ 5,666,070,824
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		3.8%	9.1%	8.9%	5.0%	5.9%
Total Cost per Eligible		5.8%	-2.1%	-3.3%	-6.7%	-1.5%
Total Expenditure		9.8%	6.8%	5.2%	-2.1%	4.3%
SSI & Related						
TOTAL EXPENDITURES						
Eligible Member Months	402,027	402,561	412,018	430,982	423,827	
Total Cost per Eligible	$ 1,000.24	$ 1,159.95	$ 1,070.80	$ 962.88	$ 891.91	
Total Expenditure	$ 402,121,878	$ 466,952,008	$ 441,189,869	$ 414,982,990	$ 378,015,652	$ 2,103,262,398
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.1%	2.3%	4.6%	-1.7%	1.2%
Total Cost per Eligible		16.0%	-7.7%	-10.1%	-7.4%	-2.5%
Total Expenditure		16.1%	-5.5%	-5.9%	-8.9%	-1.4%
NF LOC - Dual						
TOTAL EXPENDITURES						
Eligible Member Months	171,654	181,257	177,244	181,300	188,179	
Total Cost per Eligible	$ 2,310.04	$ 2,436.33	$ 2,645.65	$ 2,825.40	$ 2,845.49	
Total Expenditure	$ 396,526,760	$ 441,602,101	$ 468,926,248	$ 512,245,920	$ 535,461,624	$ 2,354,762,653
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		5.6%	-2.2%	2.3%	3.8%	2.1%
Total Cost per Eligible		5.5%	8.6%	6.8%	0.7%	4.7%
Total Expenditure		11.4%	6.2%	9.2%	4.5%	6.9%
NF LOC - Medicaid Only						
TOTAL EXPENDITURES						
Eligible Member Months	50,504	59,305	63,722	66,073	74,528	
Total Cost per Eligible	$ 3,022.39	$ 3,211.10	$ 3,609.85	$ 4,159.19	$ 4,186.70	
Total Expenditure	$ 152,643,034	$ 190,434,170	$ 230,027,087	$ 274,810,073	$ 312,026,746	$ 1,159,941,111
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		17.4%	7.4%	3.7%	12.8%	9.0%
Total Cost per Eligible		6.2%	12.4%	15.2%	0.7%	7.5%
Total Expenditure		24.8%	20.8%	19.5%	13.5%	17.2%
Healthy Dual						
TOTAL EXPENDITURES						
Eligible Member Months	219,137	217,174	209,794	200,159	197,003	
Total Cost per Eligible	$ 125.93	$ 127.10	$ 214.97	$ 203.12	$ 180.82	
Total Expenditure	$ 27,596,538	$ 27,602,922	$ 45,100,358	$ 40,657,024	$ 35,621,687	$ 176,578,530
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		-0.9%	-3.4%	-4.6%	-1.6%	-2.3%
Total Cost per Eligible		0.9%	69.1%	-5.5%	-11.0%	8.4%
Total Expenditure		0.0%	63.4%	-9.9%	-12.4%	5.8%

Table 9.2a Historical Data
Total Computable – Continued

	SFY07 (7/1/06 - 6/30/07)	SFY08 (7/1/07 - 6/30/08)	SFY09 (7/1/08 - 6/30/09)	SFY10 (7/1/09 - 6/30/10)	SFY11 (7/1/10 - 6/30/11)	5-YEARS
Mi Via - Dual						
TOTAL EXPENDITURES						
Eligible Member Months	0	0	5,661	6,756	6,927	
Total Cost per Eligible	$ -	$ -	$ 2,643.36	$ 2,799.62	$ 3,145.27	
Total Expenditure	$ -	$ -	$ 14,964,080	$ 18,914,221	$ 21,787,312	$ 55,665,613
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.0%	0.0%	19.3%	2.5%	0.0%
Total Cost per Eligible		0.0%	0.0%	5.9%	12.3%	0.0%
Total Expenditure		0.0%	0.0%	26.4%	15.2%	0.0%
Mi Via - Medicaid Only						
TOTAL EXPENDITURES						
Eligible Member Months	0	0	2,432	2,521	2,353	
Total Cost per Eligible	$ -	$ -	$ 3,851.56	$ 4,048.61	$ 4,363.71	
Total Expenditure	$ -	$ -	$ 9,366,988	$ 10,206,551	$ 10,267,810	$ 29,841,349
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.0%	0.0%	3.7%	-6.7%	0.0%
Total Cost per Eligible		0.0%	0.0%	5.1%	7.8%	0.0%
Total Expenditure		0.0%	0.0%	9.0%	0.6%	0.0%
Family Planning						
TOTAL EXPENDITURES						
Eligible Member Months	289,758	310,193	299,416	293,738	353,776	
Total Cost per Eligible	$ 17.68	$ 18.37	$ 19.00	$ 17.91	$ 15.02	
Total Expenditure	$ 5,122,599	$ 5,699,647	$ 5,688,223	$ 5,261,916	$ 5,313,881	$ 27,086,267
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		7.1%	-3.5%	-1.9%	20.4%	4.5%
Total Cost per Eligible		3.9%	3.4%	-5.7%	-16.2%	-3.6%
Total Expenditure		11.3%	-0.2%	-7.5%	1.0%	0.8%

Table 9.2b Historical Data
Federal Share

	SFY07 (7/1/06 - 6/30/07)	SFY08 (7/1/07 - 6/30/08)	SFY09 (7/1/08 - 6/30/09)	SFY10 (7/1/09 - 6/30/10)	SFY11 (7/1/10 - 6/30/11)	5-YEARS
TANF & Related						
TOTAL EXPENDITURES						
Eligible Member Months	3,222,890	3,345,269	3,650,469	3,974,052	4,172,356	
Total Cost per Eligible	$ 221.40	$ 231.24	$ 225.80	$ 219.72	$ 200.44	
Total Expenditure	$ 713,541,230	$ 773,547,909	$ 824,290,908	$ 873,171,622	$ 836,286,215	$ 4,020,837,884
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		3.8%	9.1%	8.9%	5.0%	5.9%
Total Cost per Eligible		4.4%	-2.3%	-2.7%	-8.8%	-2.2%
Total Expenditure		8.4%	6.6%	5.9%	-4.2%	3.6%
SSI & Related						
TOTAL EXPENDITURES						
Eligible Member Months	402,027	402,561	412,018	430,982	423,827	
Total Cost per Eligible	$ 719.47	$ 824.03	$ 758.98	$ 687.01	$ 622.37	
Total Expenditure	$ 289,246,267	$ 331,722,707	$ 312,715,379	$ 296,090,363	$ 263,779,322	$ 1,493,554,038
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.1%	2.3%	4.6%	-1.7%	1.2%
Total Cost per Eligible		14.5%	-7.9%	-9.5%	-9.4%	-3.2%
Total Expenditure		14.7%	-5.7%	-5.3%	-10.9%	-2.0%
NF LOC - Dual						
TOTAL EXPENDITURES						
Eligible Member Months	171,654	181,257	177,244	181,300	188,179	
Total Cost per Eligible	$ 1,661.61	$ 1,730.77	$ 1,875.24	$ 2,015.93	$ 1,985.58	
Total Expenditure	$ 285,221,699	$ 313,714,133	$ 332,374,925	$ 365,487,464	$ 373,645,121	$ 1,670,443,341
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		5.6%	-2.2%	2.3%	3.8%	2.1%
Total Cost per Eligible		4.2%	8.3%	7.5%	-1.5%	4.0%
Total Expenditure		10.0%	5.9%	10.0%	2.2%	6.2%
NF LOC - Medicaid Only						
TOTAL EXPENDITURES						
Eligible Member Months	50,504	59,305	63,722	66,073	74,528	
Total Cost per Eligible	$ 2,174.01	$ 2,281.16	$ 2,558.66	$ 2,967.58	$ 2,921.48	
Total Expenditure	$ 109,796,134	$ 135,284,435	$ 163,043,200	$ 196,076,987	$ 217,732,264	$ 821,933,019
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		17.4%	7.4%	3.7%	12.8%	9.0%
Total Cost per Eligible		4.9%	12.2%	16.0%	-1.6%	6.8%
Total Expenditure		23.2%	20.5%	20.3%	11.0%	16.4%
Healthy Dual						
TOTAL EXPENDITURES						
Eligible Member Months	219,137	217,174	209,794	200,159	197,003	
Total Cost per Eligible	$ 90.58	$ 90.29	$ 152.37	$ 144.93	$ 126.17	
Total Expenditure	$ 19,850,190	$ 19,609,116	$ 31,967,133	$ 29,008,787	$ 24,856,813	$ 125,292,040
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		-0.9%	-3.4%	-4.6%	-1.6%	-2.3%
Total Cost per Eligible		-0.3%	68.8%	-4.9%	-12.9%	7.6%
Total Expenditure		-1.2%	63.0%	-9.3%	-14.3%	5.1%

Table 9.2b Historical Data
Federal Share -– Continued

	SFY07 (7/1/06 - 6/30/07)	SFY08 (7/1/07 - 6/30/08)	SFY09 (7/1/08 - 6/30/09)	SFY10 (7/1/09 - 6/30/10)	SFY11 (7/1/10 - 6/30/11)	5-YEARS
Mi Via - Dual						
TOTAL EXPENDITURES						
Eligible Member Months	0	0	5,661	6,756	6,927	
Total Cost per Eligible	$ -	$ -	$ 1,873.62	$ 1,997.53	$ 2,194.77	
Total Expenditure	$ -	$ -	$ 10,606,540	$ 13,495,297	$ 15,203,187	$ 39,305,023
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.0%	0.0%	19.3%	2.5%	0.0%
Total Cost per Eligible		0.0%	0.0%	6.6%	9.9%	0.0%
Total Expenditure		0.0%	0.0%	27.2%	12.7%	0.0%
Mi Via - Medicaid Only						
TOTAL EXPENDITURES						
Eligible Member Months	0	0	2,432	2,521	2,353	
Total Cost per Eligible	$ -	$ -	$ 2,729.98	$ 2,888.68	$ 3,045.00	
Total Expenditure	$ -	$ -	$ 6,639,321	$ 7,282,374	$ 7,164,878	$ 21,086,573
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.0%	0.0%	3.7%	-6.7%	0.0%
Total Cost per Eligible		0.0%	0.0%	5.8%	5.4%	0.0%
Total Expenditure		0.0%	0.0%	9.7%	-1.6%	0.0%
Family Planning						
TOTAL EXPENDITURES						
Eligible Member Months	289,758	310,193	299,416	293,738	353,776	
Total Cost per Eligible	$ 12.72	$ 13.05	$ 13.47	$ 12.78	$ 10.48	
Total Expenditure	$ 3,684,686	$ 4,049,029	$ 4,031,812	$ 3,754,377	$ 3,708,026	$ 19,227,931
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		7.1%	-3.5%	-1.9%	20.4%	4.5%
Total Cost per Eligible		2.6%	3.2%	-5.1%	-18.0%	-4.2%
Total Expenditure		9.9%	-0.4%	-6.9%	-1.2%	0.1%

All Title XIX and Title XXI medical expenditures (unless specifically identified within this waiver application as being excluded), disproportionate share hospital (DSH) allotment and Sole Community Provider Hospital (SCPH) payments, are proposed to be included under the demonstration. The following populations are excluded from the waiver application:

- All 1915(c) waiver service costs for the DD population are excluded from the Budget Neutrality (all time periods); and

- 1915(c) costs for the Medically Fragile population are excluded for 1/1/2014 through 6/30/2015 and then included for 7/1/2015 forward.

Additionally, Centennial Care Without and With Waiver projections beginning in January 1, 2014 exclude any population in excess of 138% of FPL (133% + 5% Income Disallow), with the exception of children, currently covered under the existing Medicaid program: Specifically these populations include:

- Limited benefit pregnant women above 138%;

- Breast and Cervical Cancer Prevention and Treatment (BCCPT) above 138%; and

- Family planning program participants above 138%.

The State will continue to pay DSH and SCPH under its State Plan-approved methodology.

Budget Neutrality Approach
This section provides background information about the methods and data sources used to develop the proposed 1115 waiver budget.

The State proposes that the budget neutrality limit for Federal Title XIX funding be determined using a combined per capita cost method, aggregate DSH and aggregate SCPH method with annual budget targets. The risk for the per capita cost would be applicable to the Medicaid eligibles in Medicaid eligibility groups (MEGs) described below, but the State would not be at risk for conditions (economic or other) that may impact caseload levels in each of the groups for the demonstration years. For the per member per month (PMPM) portion of the budget neutrality, the State is not liable for any caseload growth within a MEG but is liable for excess costs over the PMPM limits. Budget neutrality would not be limited to each individual MEG PMPM, but rather across all MEG PMPMs for the entire five-year demonstration (i.e., PMPM savings in one MEG for the five years may offset PMPM costs in another MEG for the five years).

Sole Community Provider Hospital
New Mexico currently has in place a program through which supplemental payments are made to hospitals that are the sole community providers of inpatient care in their communities. The program provides quarterly supplemental Medicaid payments to qualified and participating hospitals. The non-federal share of the payments to the hospitals are funded by New Mexico counties. The annual payment of the Sole Community Provider program consists of the base year amount and the UPL amount. The budget neutrality includes the SCP hospital expenditures.

The base year expenditures for SCPH is SFY2011 not SFY2010. The calculation of sole community provider payments to private hospitals in SFY2011 includes an adjustment that reduces the payment amount for those facilities that had made donations to the counties that transferred funds to the State that were used to fund the SCP payments. The adjustment methodology was the same as was used in determining the amount to be returned to CMS in response to the draft audit for federal fiscal year 2009. This adjustment is not intended to reflect a position one way or the other on the validity of the donations in question (which are the subject of current litigation), but rather to eliminate any issues as to the level of SCP payments in SFY2011 to be used in establishing the amount of the safety net care pool under the requested demonstration project.

The annual budget neutrality expenditure limit for the demonstration as a whole would be the sum of the DSH allotment plus the SCPH expenditures plus the annual expenditure caps for each eligibility group. The overall budget neutrality expenditure cap for the five-year demonstration period would be the sum of the annual budget neutrality expenditure caps for each of the 5 years.

The State expects this demonstration to be budget neutral on a total funds basis based on various initiatives to be applied to the managed care and FFS Medicaid populations. The State is not penalized for any modifications in the FMAP. Several groups of recipient's behavior are expected to be modified through this Medicaid waiver. In the

Without Waiver population, the State has placed at risk total funds of Medicaid expenditures for the FFS and managed care Medicaid populations. In the With Waiver population, the savings earned from the initiatives will compensate for the costs of the population

CHIP Allotment Neutrality

This section presents the State's approach for showing CHIP allotment neutrality as well as the data and assumptions used in the development of the cost and caseload estimates supporting this 1115 waiver request. The State has projected that the CHIP allotment will be neutral using the CMS allotment neutrality spreadsheet. See Table 9.3 below for details.

Base Year

In FFY2010, which is the base year for the allotment neutrality, New Mexico received $345,313,250 million in CHIP allotment. Included in the expenditures $24,839,080 million was spent on its Medicaid Expansion CHIP for recipients between 185% and 235% of the FPL, $71,358,965 million was spent on Qualified Children between 133% and 185% of the FPL. An additional $190,251,461 million was spent on the SCI population. New Mexico experienced an $114,687,115 million allotment carryover to FFY2011.

Note that the CHIP allotment funded the adult parents and childless adults covered under SCI through December 31, 2009. Beginning in January 1, 2010 only adult parents were funded with CHIP allotment and the childless adults were covered under a separate 1115 waiver.

CHIP Administration

The Allotment Neutrality administrative component was a total of $2,013,452 for FFY2010. It is broken into two pieces:

- Administration allocated to Medicaid expansion CHIP Children $741,798; and
- Administration allocated to the SCI Program $1,271,654.

Waiver Timeframe and Trend Rates

The historical data illustrates decreases to enrollment for Qualified Children (133%-185%) and CHIP (186%-235%). Through re-certification, many Qualified Children and CHIP clients were reclassified as TANF children. This explains why there is a negative trend for these recipients. It can be expected that as the economy recovers, these recipients will re-certify as Qualified Children and CHIP. For FFY2012 to FFY2019 the State held the enrollment flat. Projections do not include the impact of the implementation of the ACA in January 1, 2014.

The five-year historical period for the SCI Parents includes data from the beginning of the program where enrollment was small. Over time enrollment increased through a series of outreach activities until SFY2010 when enrollment peaked. In SFY2010 enrollment into the program was capped and as illustrated in SFY2011 as recipients recertify some have lost eligibility resulting in a reduction in enrollment over time. For SCI Parents, the CHIPRA waiver expires in September 30, 2013. At this time these

recipients will be transitioned out of CHIP allotment to be covered using Title XIX FMAP rather than the Title XXI FMAP.

Summary of Budget Neutrality
For this demonstration project, the federal share of combined CHIP expenditures for all population groups covered under the CHIP portion of the demonstration project will not exceed the federal CHIP allotment. Table 9.3 summarizes the allotment neutrality estimates for the base year and over the five-year period.

Notes for Table 9.3
The information in table 9.3 includes the following footnotes:

- The CHIP (Line 13) and Qualified Children (Line 40) cost PMPM represents a blend of managed care and FFS costs. The majority of the underlying expenditures for CHIP and Qualified Children are managed care expenditures. Non-Native American recipients are mandated to enroll in Medicaid managed care while Native Americans can opt-out of managed care.

- The FFS expenditures represent Native American Opt-Outs and prior period or retroactive eligibility coverage before enrollment into a Medicaid managed care organization.

- Pursuant to CHIPRA, title XXI funds will not be available after September 30, 2013. It is assumed that that CMS will work with the State to evaluate coverage options under title XIX for the parents currently covered with title XXI funds for the period of October 1, 2013 to December 31, 2013.

- The table is split into two components, FFY2010 to FFY2013 and FFY2014 to FFY2019.

Table 9.3 – Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations FFY2010 – FFY2014

1	**Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations - FFY2010 through FFY2014**					
2		**Previous Federal Fiscal Year 2010**	**Previous Federal Fiscal Year 2011**	**Federal Fiscal Year 2012**	**Federal Fiscal Year 2013**	**Federal Fiscal Year 2014**
3	State's Allotment	**$ 345,313,250**	**$ 245,491,788**	**$ 258,650,148**	**$ 258,650,148**	**$ 258,650,148**
4	Funds Carried Over From Prior Year(s)	**$ -**	**$ 114,687,115**	**$ 212,496,336**	**$ 273,518,922**	**$ 320,858,148**
5	SUBTOTAL (Allotment + Funds Carried Over)	**$ 345,313,250**	**$ 360,178,903**	**$ 471,146,484**	**$ 532,169,070**	**$ 579,508,296**
6	Reallocated Funds (Redistributed or Retained that are Currently Available	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
7	TOTAL (Subtotal + Reallocated funds)	**$ 345,313,250**	**$ 360,178,903**	**$ 471,146,484**	**$ 532,169,070**	**$ 579,508,296**
8	State's Enhanced FMAP Rate	**79.95%**	**78.85%**	**78.55%**	**78.55%**	**78.55%**
9	**COST PROJECTIONS OF APPROVED SCHIP PLAN**					
10	**Benefit Costs**					
11	Insurance payments					
12	Total Managed Care			$ 31,276,694	$ 33,431,658	$ 35,567,941
13	per member/per month rate			$277	$296	$315
14	# of eligibles (MM)			112,973	112,973	112,973
15	Total Fee for Service			$ -	$ -	$ -
16	per member/per month rate			$0	$0	$0
17	# of eligibles (MM)			-	-	-
18	Total Benefit Costs (Managed Care + Fee for Service)	$ 24,839,080	$ 18,662,476	$ 31,276,694	$ 33,431,658	$ 35,567,941
19	(Offsetting beneficiary cost sharing payments) (negative number)					
20	**Net Benefit Costs**	**$ 24,839,080**	**$ 18,662,476**	**$ 31,276,694**	**$ 33,431,658**	**$ 35,567,941**
21						
22	**Administration Costs**					
23	Personnel	$ 741,798	$ 160,394	$ 700,000	$ 700,000	$ 700,000
24	General administration					
25	Contractors/Brokers					
26	Claims Processing					
27	Outreach/marketing costs					
28	Other (specify)					
29	**Total Administration Costs**	**$ 741,798**	**$ 160,394**	**$ 700,000**	**$ 700,000**	**$ 700,000**
30	10% Administrative Cap	$ 2,759,898	$ 2,073,608	$ 3,475,188	$ 3,714,629	$ 3,951,993
31						
32	Federal Title XXI Share	$ 20,451,912	$ 14,841,833	$ 25,117,693	$ 26,810,417	$ 28,488,467
33	State Share	$ 5,128,966	$ 3,981,037	$ 6,859,001	$ 7,321,241	$ 7,779,474
34	**TOTAL COSTS OF APPROVED SCHIP PLAN**	**$ 25,580,878**	**$ 18,822,870**	**$ 31,976,694**	**$ 34,131,658**	**$ 36,267,941**
35						
36	**COST PROJECTIONS OF ALLOWANCE FOR QUALIFYING STATES**					
37	**Benefit Costs**					
38	Insurance payments					
39	Total Managed Care			$ 64,147,344	$ 68,567,096	$ 72,948,533
40	per member/per month rate			$241	$257	$274
41	# of eligibles (MM)			266,456	266,456	266,456
42	Total Fee for Service			$ -	$ -	$ -
43	per member/per month rate			$0	$0	$0
44	# of eligibles (MM)			-	-	-
45	Total Benefit Costs (Managed Care + Fee for Service)	$ 71,358,965	$ 54,206,754	$ 64,147,344	$ 68,567,096	$ 72,948,533
46	**Net Benefit Costs**	**$ 71,358,965**	**$ 54,206,754**	**$ 64,147,344**	**$ 68,567,096**	**$ 72,948,533**
47						
48	Federal Title XXI Share	**$ 57,051,493**	**$ 42,742,026**	**$ 50,387,739**	**$ 53,859,454**	**$ 57,301,073**
49	State Share	**$ 14,307,472**	**$ 11,464,728**	**$ 13,759,605**	**$ 14,707,642**	**$ 15,647,460**
50	**TOTAL COSTS OF ALLOWANCE FOR QUALIFYING STATES**	**$ 71,358,965**	**$ 54,206,754**	**$ 64,147,344**	**$ 68,567,096**	**$ 72,948,533**
51						
52	**COST PROJECTIONS FOR DEMONSTRATION PROPOSAL**					
53	**Benefit Costs for Demonstration Population #1: Parent/Guardian Adults**					
54	Insurance payments					
55	Total Managed Care			$ 154,270,566	$ 165,115,787	$ -
56	per member/per month rate			$770	$825	$0
57	# of eligibles (MM)			200,237	200,237	-
58	Total Fee for Service			$ -	$ -	$ -
59	per member/per month rate			$0	$0	$0
60	# of eligibles (MM)			-	-	-
61	Total Benefit Costs (Managed Care + Fee for Service)	$ 124,235,135	$ 113,990,997	$ 154,270,566	$ 165,115,787	$ -
62	**Benefit Costs for Demonstration Population #2: Childless Adults**					
63	Insurance payments					
64	Total Managed Care			$ -	$ -	$ -
65	per member/per month rate			$0	$0	$0
66	# of eligibles (MM)			-	-	-
67	Total Fee for Service			$ -	$ -	$ -
68	per member/per month rate			$0	$0	$0
69	# of eligibles (MM)			-	-	-
70	Total Benefit Costs (Managed Care + Fee for Service)	$ 66,016,326	$ -	$ -	$ -	$ -
71						
72	**Total Benefit Costs (For All Demonstration Populations)**	**$ 190,251,461**	**$ 113,990,997**	**$ 154,270,566**	**$ 165,115,787**	**$ -**
73	(Offsetting beneficiary cost sharing payments) (negative number)					
74	**Net Benefit Costs**	**$ 190,251,461**	**$ 113,990,997**	**$ 154,270,566**	**$ 165,115,787**	**$ -**
75						
76	**Administration Costs**					
77	Personnel	$ 1,271,654	$ 274,962	$ 1,200,000	$ 1,200,000	$ -
78	General administration					
79	Contractors/Brokers					
80	Claims Processing					
81	Outreach/marketing costs					
82	Other (specify)					
83	**Total Administration Costs**	**$ 1,271,654**	**$ 274,962**	**$ 1,200,000**	**$ 1,200,000**	**$ -**
84	10% Administrative Cap	$ 21,139,051	$ 12,665,666	$ 17,141,174	$ 18,346,199	$ -
85						
86	Federal Title XXI Share	$ 153,122,730	$ 90,098,708	$ 122,122,130	$ 130,641,051	$ -
87	State Title XXI Share	$ 38,400,385	$ 24,167,251	$ 33,348,436	$ 35,674,736	$ -
88	**TOTAL COSTS FOR DEMONSTRATION**	**$ 191,523,115**	**$ 114,265,959**	**$ 155,470,566**	**$ 166,315,787**	**$ -**
89						
90	**TOTAL TITLE XXI PROGRAM COSTS (State Plan + Demonstration)**	**$ 288,462,958**	**$ 187,295,583**	**$ 251,594,603**	**$ 269,014,540**	**$ 109,216,474**
91	Federal Title XXI Share	$ 230,626,135	$ 147,682,567	$ 197,627,562	$ 211,310,922	$ 85,789,540
92	State Title XXI Share	$ 57,836,823	$ 39,613,016	$ 53,967,041	$ 57,703,618	$ 23,426,934
93						
94	**Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)**	**$ 345,313,250**	**$ 360,178,903**	**$ 471,146,484**	**$ 532,169,070**	**$ 579,508,296**
95	**Total Federal Title XXI Program Costs (State Plan + Demonstration)**	**$ 230,626,135**	**$ 147,682,567**	**$ 197,627,562**	**$ 211,310,922**	**$ 85,789,540**
96	**Unused Title XXI Funds Expiring (Allotment or Reallocated)**					
97	**Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)**	**$ 114,687,115**	**$ 212,496,336**	**$ 273,518,922**	**$ 320,858,148**	**493,718,756**

Table 9.3 – Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations – Continued – FFY2015 – FFY2019

1	**Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations - FFY2015 through FFY2019**					
2		**Federal Fiscal Year 2015**	**Federal Fiscal Year 2016**	**Federal Fiscal Year 2017**	**Federal Fiscal Year 2018**	**Federal Fiscal Year 2019**
3	State's Allotment	**$ 258,650,148**	**$ 258,650,148**	**$ 258,650,148**	**$ 258,650,148**	**$ 258,650,148**
4	Funds Carried Over From Prior Year(s)	**$ 493,718,756**	**$ 661,558,745**	**$ 824,542,730**	**$ 981,268,062**	**$ 1,130,947,834**
5	SUBTOTAL (Allotment + Funds Carried Over)	**$ 752,368,903**	**$ 920,208,893**	**$ 1,083,192,878**	**$ 1,239,918,210**	**$ 1,389,597,982**
6	Reallocated Funds (Redistributed or Retained that are Currently Available	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
7	TOTAL (Subtotal + Reallocated funds)	**$ 752,368,903**	**$ 920,208,893**	**$ 1,083,192,878**	**$ 1,239,918,210**	**$ 1,389,597,982**
8	State's Enhanced FMAP Rate	**78.55%**	**78.55%**	**78.55%**	**78.55%**	**78.55%**
9	**COST PROJECTIONS OF APPROVED SCHIP PLAN**					
10	**Benefit Costs**					
11	Insurance payments					
12	Total Managed Care	$ 37,662,892	$ 39,689,156	$ 42,300,702	$ 45,240,601	$ 48,375,775
13	per member/per month rate	$333	$351	$374	$400	$428
14	# of eligibles (MM)	112,973	112,973	112,973	112,973	112,973
15	Total Fee for Service	$ -	$ -	$ -	$ -	$ -
16	per member/per month rate	$0	$0	$0	$0	$0
17	# of eligibles (MM)	-	-	-	-	-
18	Total Benefit Costs (Managed Care + Fee for Service)	$ 37,662,892	$ 39,689,156	$ 42,300,702	$ 45,240,601	$ 48,375,775
19	(Offsetting beneficiary cost sharing payments) (negative number)					
20	**Net Benefit Costs**	**$ 37,662,892**	**$ 39,689,156**	**$ 42,300,702**	**$ 45,240,601**	**$ 48,375,775**
21						
22	**Administration Costs**					
23	Personnel	$ 700,000	$ 700,000	$ 700,000	$ 700,000	$ 700,000
24	General administration					
25	Contractors/Brokers					
26	Claims Processing					
27	Outreach/marketing costs					
28	Other (specify)					
29	**Total Administration Costs**	**$ 700,000**	**$ 700,000**	**$ 700,000**	**$ 700,000**	**$ 700,000**
30	10% Administrative Cap	$ 4,184,766	$ 4,409,906	$ 4,700,078	$ 5,026,733	$ 5,375,086
31						
32	Federal Title XXI Share	$ 30,134,052	$ 31,725,682	$ 33,777,052	$ 36,086,342	$ 38,549,021
33	State Share	$ 8,228,840	$ 8,663,474	$ 9,223,650	$ 9,854,259	$ 10,526,754
34	**TOTAL COSTS OF APPROVED SCHIP PLAN**	**$ 38,362,892**	**$ 40,389,156**	**$ 43,000,702**	**$ 45,940,601**	**$ 49,075,775**
35						
36	**COST PROJECTIONS OF ALLOWANCE FOR QUALIFYING STATES**					
37	**Benefit Costs**					
38	Insurance payments					
39	Total Managed Care	$ 77,245,202	$ 81,400,994	$ 86,757,179	$ 92,786,803	$ 99,216,928
40	per member/per month rate	$290	$305	$326	$348	$372
41	# of eligibles (MM)	266,456	266,456	266,456	266,456	266,456
42	Total Fee for Service	$ -	$ -	$ -	$ -	$ -
43	per member/per month rate	$0	$0	$0	$0	$0
44	# of eligibles (MM)	-	-	-	-	-
45	Total Benefit Costs (Managed Care + Fee for Service)	$ 77,245,202	$ 81,400,994	$ 86,757,179	$ 92,786,803	$ 99,216,928
46	**Net Benefit Costs**	**$ 77,245,202**	**$ 81,400,994**	**$ 86,757,179**	**$ 92,786,803**	**$ 99,216,928**
47						
48	Federal Title XXI Share	**$ 60,676,106**	**$ 63,940,481**	**$ 68,147,764**	**$ 72,884,034**	**$ 77,934,897**
49	State Share	**$ 16,569,096**	**$ 17,460,513**	**$ 18,609,415**	**$ 19,902,769**	**$ 21,282,031**
50	**TOTAL COSTS OF ALLOWANCE FOR QUALIFYING STATES**	**$ 77,245,202**	**$ 81,400,994**	**$ 86,757,179**	**$ 92,786,803**	**$ 99,216,928**
51						
52	**COST PROJECTIONS FOR DEMONSTRATION PROPOSAL**					
53	**Benefit Costs for Demonstration Population #1: Parent/Guardian Adults**					
54	Insurance payments					
55	Total Managed Care	$ -	$ -	$ -	$ -	$ -
56	per member/per month rate	$0	$0	$0	$0	$0
57	# of eligibles (MM)	-	-	-	-	-
58	Total Fee for Service	$ -	$ -	$ -	$ -	$ -
59	per member/per month rate	$0	$0	$0	$0	$0
60	# of eligibles (MM)	-	-	-	-	-
61	Total Benefit Costs (Managed Care + Fee for Service)	$ -	$ -	$ -	$ -	$ -
62	**Benefit Costs for Demonstration Population #2: Childless Adults**					
63	Insurance payments					
64	Total Managed Care	$ -	$ -	$ -	$ -	$ -
65	per member/per month rate	$0	$0	$0	$0	$0
66	# of eligibles (MM)	-	-	-	-	-
67	Total Fee for Service	$ -	$ -	$ -	$ -	$ -
68	per member/per month rate	$0	$0	$0	$0	$0
69	# of eligibles (MM)	-	-	-	-	-
70	Total Benefit Costs (Managed Care + Fee for Service)	$ -	$ -	$ -	$ -	$ -
71						
72	**Total Benefit Costs (For All Demonstration Populations)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
73	(Offsetting beneficiary cost sharing payments) (negative number)					
74	**Net Benefit Costs**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
75						
76	**Administration Costs**					
77	Personnel	$ -	$ -	$ -	$ -	$ -
78	General administration					
79	Contractors/Brokers					
80	Claims Processing					
81	Outreach/marketing costs					
82	Other (specify)					
83	**Total Administration Costs**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
84	10% Administrative Cap	$ -	$ -	$ -	$ -	$ -
85						
86	Federal Title XXI Share	$ -	$ -	$ -	$ -	$ -
87	State Title XXI Share	$ -	$ -	$ -	$ -	$ -
88	**TOTAL COSTS FOR DEMONSTRATION**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
89						
90	**TOTAL TITLE XXI PROGRAM COSTS (State Plan + Demonstration)**	**$ 115,608,094**	**$ 121,790,150**	**$ 129,757,882**	**$ 138,727,404**	**$ 148,292,703**
91	Federal Title XXI Share	$ 90,810,158	$ 95,666,163	$ 101,924,816	$ 108,970,376	$ 116,483,918
92	State Title XXI Share	$ 24,797,936	$ 26,123,987	$ 27,833,066	$ 29,757,028	$ 31,808,785
93						
94	**Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)**	**$ 752,368,903**	**$ 920,208,893**	**$ 1,083,192,878**	**$ 1,239,918,210**	**$ 1,389,597,982**
95	**Total Federal Title XXI Program Costs (State Plan + Demonstration)**	**$ 90,810,158**	**$ 95,666,163**	**$ 101,924,816**	**$ 108,970,376**	**$ 116,483,918**
96	**Unused Title XXI Funds Expiring (Allotment or Reallocated)**					
97	**Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)**	**$ 661,558,745**	**$ 824,542,730**	**$ 981,268,062**	**$ 1,130,947,834**	**$ 1,273,114,064**

Medicaid Eligibility Groups/Program Groups

The proposed MEGs that would be subject to per capita cost budget neutrality are identified in table 9.4 below. The annual budget neutrality expenditure cap for the demonstration as a whole is proposed to be the sum of DSH allotment, SCPH expenditures plus the five-year sum of annual expenditure caps for each Medicaid eligibility group.

Table 9.4 – Eligibility Groups/Program Groups

Medicaid Eligibility Group/Program Group	Description	Wavier Population Type
TANF & Related	Populations include: - TANF children and adults - Pregnant Women - Foster Care Children - Transitional Medicaid	Medicaid State Plan
SSI & Related	Populations include: - Aged, blind, disabled children and adults - Working disabled - Acute care services (physical health and behavioral health) for clients enrolled in 1915(c) waivers	Medicaid State Plan
NF LOC Dual Eligible	Recipients that meet nursing facility level of care who are receiving long term care, physical health and behavioral health services. Recipients represented including those residing in nursing homes, disabled and elderly HCBS, and personal care option services. These clients are dually eligible for Medicare and Medicaid	Medicaid State Plan
NF LOC Medicaid Only	Recipients that meet nursing facility level of care who are receiving long term care, physical health and behavioral health services. Recipients represented including those residing in nursing homes, disabled and elderly HCBS, and personal care option services. These clients are not eligible for Medicare	Medicaid State Plan
Healthy Dual	Recipients who are dually eligible for Medicare and Medicaid and do not meet the nursing facility level of care criteria	Medicaid State Plan
Mi Via Dual Eligible	Recipients who would be classified in the NF LOC Dual Eligible group but have elected to receive services under the Mi Via – Self Directed program	Medicaid State Plan
Mi Via Medicaid Only	Recipients who would be classified in the NF LOC Medicaid Only group but have elected to receive services under the Mi Via – Self Directed program	Medicaid State Plan
Family Planning	Recipients that are receiving family planning services, a limited Medicaid benefit	Medicaid State Plan
DSH	DSH Allotment	Medicaid State Plan
SCPH	Sole Community Provider Hospital	Medicaid State Plan

Cost and Caseload

Cost and caseload data was available for the five-year historical period from SFY2007 through SFY2011 for the Medicaid/SCI eligible populations. SFY2010, the most recent complete historical period, was chosen as the base year throughout the cost and

caseload estimates. More recent data from SFY2011 was incomplete and was used for limited trending purposes only.

During the course of the five-year historical period the State implemented a variety of initiatives to address the cost of their Medicaid program which impacted the observed historical per capita cost growth. These initiatives reflect various one-time adjustments to the program that will not reoccur in future periods. These initiatives all contribute to the observed decreases in the historical per capita expenditures and include impacts related to cost containment measures such as one-time reductions to Medicaid fees and transitioning a previously unmanaged population into managed care. The following outlines items that most significantly impacted the historical period:

- Implementation of numerous cost containment efforts as permissible under the American Reinvestment and Recovery Act (ARRA) that impacted the per capita spending for both managed care programs and FFS since July 2009. This includes one-time, non-recurring reductions to Medicaid fees implemented as cost-containment measures for the Medicaid program.

- Implementation of a statewide managed LTC program. The LTC program is mandatory and was phased-in beginning in August 2008 and throughout SFY2009. This program had the effect of slowing and reducing per capita costs for LTC-eligible recipients.

- The economic downturn also impacted enrollment and per capita costs. During periods of downturns increased enrollment in Medicaid programs occurs. The health status of the newly eligible recipients also can impact the per capita costs since these newly eligible recipients generally have lower health acuity because they may have previously had health coverage through an employer and are therefore less costly. Conversely, as economic conditions improve the result will be an increase to the per capita cost because less acute or healthier recipients lose eligibility and leave the program.

Each of these actions influenced both the enrollment growth and per capita costs growth observed from SFY2007 to SFY2011. Although negative trends are observed for many of the MEGs in the five-year historical period it is not appropriate to conclude that these trends will continue. For the first time in many periods the per capita cost is expected to increase and not decrease in the upcoming SFY2013 period.

For FFY2011 to FFY2018, the State utilized the President's budget trend rates to trend PMPM expenditures and the State's caseload estimates for the State budget to project recipient month growth. Table 9.5a summarizes the trend rate and overall cost and caseload for the populations for the five-year demonstration period. This includes the trend applied to SCPH.

Table 9.5a – Without and With Waiver annual Medical Cost Trends

Demonstration Year	Base - DY1	DY1 - DY2	DY2 - DY3	DY3 - DY4	DY4 - DY5
Blind/Disabled	4.51%	5.68%	6.23%	6.25%	6.35%
Children	5.64%	5.76%	5.68%	6.67%	6.95%
Adults	6.24%	6.76%	6.85%	7.38%	7.19%

PPACA Program Transition to Medicaid in 2014

The impact of the PPACA for newly eligibles is not included in the With or Without Waiver projections. Additionally, the estimated impact of increased reimbursement for primary care physicians (PCPs) at 100% of Medicare for CY2013 and CY2014 are also not included. The State will update the budget neutrality to reflect the impact of the newly eligible populations and impact of the PCP reimbursement increase to 100% of Medicare during the waiver evaluation period.

The Without and With Wavier include adjustments to remove recipients that in 2014 will no longer be eligible for Medicaid. The State has not included a projection of recipients and expenditures for the newly eligibles effective in January 1, 2014 nor has the State reflected the costs of implementing the benchmark benefit for SCI recipients in the Without or With Waiver calculations. The State will update the budget neutrality when the State determines the benchmark benefit package. Additional adjustments applied to the Without and With Waiver are summarized in table 9.5b.

Table 9.5b – Eligibility Groups / Program Group Adjustments

Medicaid Eligibility Group/Program Group	Without Waiver	With Waiver
TANF & Related	- Methadone Coverage	- Methadone Coverage - Managed care efficiencies - Non-emergent ER copayment - Care and service coordination - Implementation of health homes
SSI & Related	- Methadone Coverage	- Methadone Coverage - Managed care efficiencies - Non-emergent ER copayment - Care and service coordination - Implementation of health homes
NF LOC Dual Eligible	- Nursing facility per diem fee increase	- Nursing facility per diem fee increase - Managed care efficiencies - Care and service coordination - Implementation of health homes
NF LOC Medicaid Only	- Nursing facility per diem fee increase	- Nursing facility per diem fee increase - Managed care efficiencies - Non-emergent ER copayment - Care and service coordination - Implementation of health homes

Medicaid Eligibility Group/Program Group	Without Waiver	With Waiver
Healthy Dual		- Methadone Coverage - Managed care efficiencies - Care and service coordination - Implementation of health homes
Mi Via Dual Eligible		- Methadone Coverage - Managed care efficiencies - Care and service coordination - Implementation of health homes
Mi Via Medicaid Only		- Managed care efficiencies - Non-emergent ER copayment - Care and service coordination - Implementation of health homes
Family Planning		- None

The following tables (9.6a through 9.6d) summarize the trend rate and overall cost and caseload for the populations for the five-year Demonstration period

Table 9.6a Without Waiver
Total Computable

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WOW
			DY 01 (1/1/14 - 12/31/14)	DY 02 (1/1/15 - 12/31/15)	DY 03 (1/1/16 - 12/31/16)	DY 04 (1/1/17 - 12/31/17)	DY 05 (1/1/18 - 12/31/18)	
TANF & Related								
Eligible Member Months	2.08%	54	4,738,676	4,873,255	5,032,123	5,104,585	5,144,401	
Total Cost Per Eligible	7.00%	54	$ 398.78	$ 425.71	$ 454.66	$ 487.71	$ 522.62	
Total Expenditure			$ 1,889,678,042	$ 2,074,589,756	$ 2,287,916,335	$ 2,489,574,407	$ 2,688,582,187	$ 11,430,340,727
SSI & Related								
Eligible Member Months	1.07%	54	437,615	441,948	446,456	451,411	456,648	
Total Cost Per Eligible	6.44%	54	$ 1,176.15	$ 1,248.49	$ 1,331.98	$ 1,417.28	$ 1,509.40	
Total Expenditure			$ 514,703,101	$ 551,766,805	$ 594,669,232	$ 639,774,643	$ 689,262,569	$ 2,990,176,350
NF LOC - Dual								
Eligible Member Months	1.78%	54	214,337	218,002	221,796	225,810	230,033	
Total Cost Per Eligible	5.68%	54	$ 3,514.73	$ 3,696.44	$ 3,907.51	$ 4,135.32	$ 4,383.85	
Total Expenditure			$ 753,337,572	$ 805,833,200	$ 866,668,401	$ 933,796,402	$ 1,008,429,024	$ 4,368,064,600
NF LOC - Medicaid Only								
Eligible Member Months	1.07%	54	76,467	77,224	78,012	78,878	79,793	
Total Cost Per Eligible	6.13%	54	$ 5,125.82	$ 5,416.96	$ 5,754.44	$ 6,114.09	$ 6,502.34	
Total Expenditure			$ 391,957,019	$ 418,320,957	$ 448,915,053	$ 482,266,636	$ 518,840,097	$ 2,260,299,762
Healthy Dual								
Eligible Member Months	1.78%	54	203,970	207,458	211,068	214,888	218,906	
Total Cost Per Eligible	5.68%	54	$ 241.39	$ 253.87	$ 268.37	$ 284.01	$ 301.08	
Total Expenditure			$ 49,236,210	$ 52,667,190	$ 56,643,222	$ 61,030,536	$ 65,908,333	$ 285,485,491
Mi Via - Dual								
Eligible Member Months	1.78%	54	7,560	7,689	7,823	7,965	8,114	
Total Cost Per Eligible	5.68%	54	$ 3,327.03	$ 3,499.04	$ 3,698.83	$ 3,914.48	$ 4,149.74	
Total Expenditure			$ 25,152,191	$ 26,904,898	$ 28,936,044	$ 31,177,292	$ 33,669,102	$ 145,839,527
Mi Via - Medicaid Only								
Eligible Member Months	1.07%	54	2,531	2,556	2,582	2,611	2,641	
Total Cost Per Eligible	6.13%	54	$ 4,937.61	$ 5,218.06	$ 5,543.15	$ 5,889.59	$ 6,263.58	
Total Expenditure			$ 12,498,198	$ 13,338,856	$ 14,314,399	$ 15,377,870	$ 16,544,075	$ 72,073,398
Family Planning								
Eligible Member Months	2.08%	54	316,318	325,302	335,907	340,744	343,401	
Total Cost Per Eligible	6.94%	54	$ 23.19	$ 24.74	$ 26.41	$ 28.32	$ 30.33	
Total Expenditure			$ 7,333,984	$ 8,047,601	$ 8,870,875	$ 9,648,316	$ 10,414,919	$ 44,315,695
DSH								
Total Allotment			$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 144,938,276
SCPH								
Total Allotment	8.40%	42	$ 369,591,008	$ 400,787,339	$ 436,841,166	$ 472,920,172	$ 510,347,317	$ 2,190,487,002
Total Expenditure			$ 4,042,474,980	$ 4,381,244,259	$ 4,772,762,383	$ 5,164,553,929	$ 5,570,985,277	$ 23,932,020,828

Note:

1. Sole Community Provider Hospital (SCPH) base year is SFY11.

Table 9.6b Without Waiver
Federal Share

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WOW
			DY 01 (1/1/14 - 12/31/14)	DY 02 (1/1/15 - 12/31/15)	DY 03 (1/1/16 - 12/31/16)	DY 04 (1/1/17 - 12/31/17)	DY 05 (1/1/18 - 12/31/18)	
TANF & Related								
Eligible Member Months	2.08%	54	4,738,676	4,873,255	5,032,123	5,104,585	5,144,401	
Total Cost Per Eligible	7.00%	54	$ 276.59	$ 295.27	$ 315.35	$ 338.28	$ 362.49	
Total Expenditure			$ 1,310,680,690	$ 1,438,935,455	$ 1,586,898,770	$ 1,726,768,809	$ 1,864,800,605	$ 7,928,084,328
SSI & Related								
Eligible Member Months	1.07%	54	437,615	441,948	446,456	451,411	456,648	
Total Cost Per Eligible	6.44%	54	$ 815.78	$ 865.95	$ 923.86	$ 983.02	$ 1,046.92	
Total Expenditure			$ 356,998,071	$ 382,705,456	$ 412,462,579	$ 443,747,693	$ 478,072,518	$ 2,073,986,316
NF LOC - Dual								
Eligible Member Months	1.78%	54	214,337	218,002	221,796	225,810	230,033	
Total Cost Per Eligible	5.68%	54	$ 2,437.82	$ 2,563.85	$ 2,710.25	$ 2,868.26	$ 3,040.64	
Total Expenditure			$ 522,514,940	$ 558,925,908	$ 601,121,203	$ 647,681,184	$ 699,446,371	$ 3,029,689,607
NF LOC - Medicaid Only								
Eligible Member Months	1.07%	54	76,467	77,224	78,012	78,878	79,793	
Total Cost Per Eligible	6.13%	54	$ 3,555.27	$ 3,757.20	$ 3,991.28	$ 4,240.73	$ 4,510.02	
Total Expenditure			$ 271,861,388	$ 290,147,416	$ 311,367,481	$ 334,500,138	$ 359,867,492	$ 1,567,743,915
Healthy Dual								
Eligible Member Months	1.78%	54	203,970	207,458	211,068	214,888	218,906	
Total Cost Per Eligible	5.68%	54	$ 167.43	$ 176.08	$ 186.14	$ 196.99	$ 208.83	
Total Expenditure			$ 34,150,235	$ 36,529,963	$ 39,287,739	$ 42,330,780	$ 45,714,020	$ 198,012,736
Mi Via - Dual								
Eligible Member Months	1.78%	54	7,560	7,689	7,823	7,965	8,114	
Total Cost Per Eligible	5.68%	54	$ 2,307.63	$ 2,426.93	$ 2,565.51	$ 2,715.08	$ 2,878.26	
Total Expenditure			$ 17,445,560	$ 18,661,237	$ 20,070,040	$ 21,624,570	$ 23,352,889	$ 101,154,296
Mi Via - Medicaid Only								
Eligible Member Months	1.07%	54	2,531	2,556	2,582	2,611	2,641	
Total Cost Per Eligible	6.13%	54	$ 3,424.72	$ 3,619.25	$ 3,844.73	$ 4,085.02	$ 4,344.42	
Total Expenditure			$ 8,668,750	$ 9,251,830	$ 9,928,467	$ 10,666,090	$ 11,474,970	$ 49,990,109
Family Planning								
Eligible Member Months	2.08%	54	316,318	325,302	335,907	340,744	343,401	
Total Cost Per Eligible	6.94%	54	$ 16.08	$ 17.16	$ 18.32	$ 19.64	$ 21.04	
Total Expenditure			$ 5,086,851	$ 5,581,816	$ 6,152,839	$ 6,692,072	$ 7,223,788	$ 30,737,366
DSH								
Total Allotment			$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 100,529,188
SCPH								
Total Allotment	8.40%	42	$ 256,348,323	$ 277,986,098	$ 302,993,033	$ 328,017,431	$ 353,976,899	$ 1,519,321,785
Total Expenditure			$ 2,803,860,646	$ 3,038,831,018	$ 3,310,387,989	$ 3,582,134,605	$ 3,864,035,388	$ 16,599,249,646

Note:

1. Assumes FMAP of 69.36% for Title XIX for each demonstration year.
2. Sole Community Provider Hospital (SCPH) base year is SFY11.

Table 9.6c With Waiver
Total Computable

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01 (1/1/14 - 12/31/14)	DY 02 (1/1/15 - 12/31/15)	DY 03 (1/1/16 - 12/31/16)	DY 04 (1/1/17 - 12/31/17)	DY 05 (1/1/18 - 12/31/18)	
TANF & Related								
Eligible Member Months	2.08%	54	4,738,676	4,873,255	5,032,123	5,104,585	5,144,401	
Total Cost Per Eligible	6.49%	54	$ 396.10	$ 414.01	$ 445.43	$ 476.59	$ 509.40	
Total Expenditure			$ 1,876,988,004	$ 2,017,559,475	$ 2,241,475,867	$ 2,432,796,708	$ 2,620,579,064	$ 11,189,399,118
SSI & Related								
Eligible Member Months	1.07%	54	437,615	441,948	446,456	451,411	456,648	
Total Cost Per Eligible	5.83%	54	$ 1,168.59	$ 1,213.16	$ 1,302.64	$ 1,381.12	$ 1,465.72	
Total Expenditure			$ 511,394,652	$ 536,155,376	$ 581,569,262	$ 623,454,329	$ 669,316,398	$ 2,921,890,016
NF LOC - Dual								
Eligible Member Months	1.78%	54	214,337	218,002	221,796	225,810	230,033	
Total Cost Per Eligible	5.15%	54	$ 3,497.96	$ 3,596.62	$ 3,830.44	$ 4,043.64	$ 4,275.98	
Total Expenditure			$ 749,744,087	$ 784,072,211	$ 849,573,957	$ 913,095,876	$ 983,615,777	$ 4,280,101,908
NF LOC - Medicaid Only								
Eligible Member Months	1.07%	54	76,467	77,224	78,012	78,878	79,793	
Total Cost Per Eligible	5.59%	54	$ 5,101.42	$ 5,270.79	$ 5,641.06	$ 5,978.70	$ 6,342.50	
Total Expenditure			$ 390,091,696	$ 407,032,735	$ 440,070,243	$ 471,586,981	$ 506,086,656	$ 2,214,868,312
Healthy Dual								
Eligible Member Months	1.78%	54	203,970	207,458	211,068	214,888	218,906	
Total Cost Per Eligible	5.15%	54	$ 240.24	$ 247.03	$ 263.09	$ 277.74	$ 293.70	
Total Expenditure			$ 49,001,782	$ 51,247,815	$ 55,529,605	$ 59,682,072	$ 64,292,027	$ 279,753,302
Mi Via - Dual								
Eligible Member Months	1.78%	54	7,560	7,689	7,823	7,965	8,114	
Total Cost Per Eligible	5.61%	54	$ 3,295.86	$ 3,426.41	$ 3,657.18	$ 3,869.24	$ 4,100.56	
Total Expenditure			$ 24,916,540	$ 26,346,425	$ 28,610,210	$ 30,817,027	$ 33,270,140	$ 143,960,343
Mi Via - Medicaid Only								
Eligible Member Months	1.07%	54	2,531	2,556	2,582	2,611	2,641	
Total Cost Per Eligible	5.88%	54	$ 4,900.13	$ 5,097.14	$ 5,462.58	$ 5,797.36	$ 6,158.46	
Total Expenditure			$ 12,403,331	$ 13,029,747	$ 14,106,352	$ 15,137,051	$ 16,266,411	$ 70,942,892
Family Planning								
Eligible Member Months	2.08%	54	316,318	325,302	335,907	340,744	343,401	
Total Cost Per Eligible	6.94%	54	$ 23.19	$ 24.74	$ 26.41	$ 28.32	$ 30.33	
Total Expenditure			$ 7,333,984	$ 8,047,601	$ 8,870,875	$ 9,648,316	$ 10,414,919	$ 44,315,695
DSH								
Total Allotment			$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 144,938,276
SCPH								
Total Allotment	8.38%	42	$ 369,549,795	$ 400,575,408	$ 436,438,777	$ 472,484,540	$ 509,877,200	$ 2,188,925,721
Total Expenditure			$ 4,020,411,527	$ 4,273,054,450	$ 4,685,232,805	$ 5,057,690,554	$ 5,442,706,247	$ 23,479,095,584

Note:

1. Sole Community Provider Hospital (SCPH) base year is SFY11.

Table 9.6d With Waiver
Federal Share

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01 (1/1/14 - 12/31/14)	DY 02 (1/1/15 - 12/31/15)	DY 03 (1/1/16 - 12/31/16)	DY 04 (1/1/17 - 12/31/17)	DY 05 (1/1/18 - 12/31/18)	
TANF & Related								
Eligible Member Months	2.08%	54	4,738,676	4,873,255	5,032,123	5,104,585	5,144,401	
Total Cost Per Eligible	6.49%	54	$ 274.73	$ 287.15	$ 308.95	$ 330.56	$ 353.32	
Total Expenditure			$ 1,301,878,880	$ 1,399,379,252	$ 1,554,687,662	$ 1,687,387,796	$ 1,817,633,639	$ 7,760,967,228
SSI & Related								
Eligible Member Months	1.07%	54	437,615	441,948	446,456	451,411	456,648	
Total Cost Per Eligible	5.83%	54	$ 810.54	$ 841.45	$ 903.51	$ 957.95	$ 1,016.62	
Total Expenditure			$ 354,703,330	$ 371,877,369	$ 403,376,440	$ 432,427,922	$ 464,237,853	$ 2,026,622,915
NF LOC - Dual								
Eligible Member Months	1.78%	54	214,337	218,002	221,796	225,810	230,033	
Total Cost Per Eligible	5.15%	54	$ 2,426.19	$ 2,494.62	$ 2,656.79	$ 2,804.67	$ 2,965.82	
Total Expenditure			$ 520,022,499	$ 543,832,486	$ 589,264,497	$ 633,323,299	$ 682,235,903	$ 2,968,678,683
NF LOC - Medicaid Only								
Eligible Member Months	1.07%	54	76,467	77,224	78,012	78,878	79,793	
Total Cost Per Eligible	5.59%	54	$ 3,538.35	$ 3,655.82	$ 3,912.64	$ 4,146.82	$ 4,399.16	
Total Expenditure			$ 270,567,601	$ 282,317,905	$ 305,232,721	$ 327,092,730	$ 351,021,705	$ 1,536,232,661
Healthy Dual								
Eligible Member Months	1.78%	54	203,970	207,458	211,068	214,888	218,906	
Total Cost Per Eligible	5.15%	54	$ 166.63	$ 171.34	$ 182.48	$ 192.64	$ 203.71	
Total Expenditure			$ 33,987,636	$ 35,545,485	$ 38,515,334	$ 41,395,485	$ 44,592,950	$ 194,036,890
Mi Via - Dual								
Eligible Member Months	1.78%	54	7,560	7,689	7,823	7,965	8,114	
Total Cost Per Eligible	5.61%	54	$ 2,286.01	$ 2,376.56	$ 2,536.62	$ 2,683.71	$ 2,844.15	
Total Expenditure			$ 17,282,112	$ 18,273,881	$ 19,844,042	$ 21,374,690	$ 23,076,169	$ 99,850,894
Mi Via - Medicaid Only								
Eligible Member Months	1.07%	54	2,531	2,556	2,582	2,611	2,641	
Total Cost Per Eligible	5.88%	54	$ 3,398.73	$ 3,535.38	$ 3,788.85	$ 4,021.05	$ 4,271.51	
Total Expenditure			$ 8,602,950	$ 9,037,433	$ 9,784,166	$ 10,499,058	$ 11,282,383	$ 49,205,990
Family Planning								
Eligible Member Months	2.08%	54	316,318	325,302	335,907	340,744	343,401	
Total Cost Per Eligible	6.94%	54	$ 16.08	$ 17.16	$ 18.32	$ 19.64	$ 21.04	
Total Expenditure			$ 5,086,851	$ 5,581,816	$ 6,152,839	$ 6,692,072	$ 7,223,788	$ 30,737,366
DSH								
Total Allotment			$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 100,529,188
SCPH								
Total Allotment	8.38%	42	$ 256,208,873	$ 277,718,930	$ 302,583,004	$ 327,573,531	$ 353,497,863	$ 1,517,582,202
Total Expenditure			$ 2,788,446,570	$ 2,963,670,394	$ 3,249,546,542	$ 3,507,872,423	$ 3,774,908,090	$ 16,284,444,019

Summary of Budget Neutrality

The federal share of combined Medicaid expenditures for all population groups covered under this demonstration project will not exceed what the federal share of Medicaid expenditures would be without the waiver. The savings attributable to this waiver would be realized by improving the quality of care and controlling the costs for the Medicaid/SCI populations. The multiple savings initiatives demonstrated under With Waiver are based on a foundation of a comprehensive delivery system intended to provide recipients with the right services in the right setting. This is accomplished by implementing the following framework:

- Consolidating and better integrating the delivery of services such as physical health, behavioral health and long term services through fewer managed care organizations which removes fragmented delivery of services.
- Improve health literacy outreach.
- Comprehensive care management and coordination to identify and direct appropriate resources to those in the most need of services.
- Implementing and integrating patient centered medical homes and health homes to help recipients manage their health care.
- Utilize technology to bring health care to underserved populations and areas.
- Implementing expenditure limits for each year of the demonstration for home- and community-based eligible recipients. The effect will be the avoidance and/or delay of these eligible recipients from entering nursing homes which are more costly than HCBS in concert with the goals and objectives of Centennial Care.

Table 9.7a Summary of Without Waiver and With Waiver Projected Medicaid Expenditures – Total Computable*

Without Waiver	With Waiver	Savings
$23,932,020,828	$23,479,095,584	$452,925,244

** See disclaimer*

Table 9.7b Summary of Without Waiver and With Waiver Projected Medicaid Expenditures – Federal Share*

Without Waiver	With Waiver	Savings
$16,599,249,646	$16,284,444,019	$314,805,627

** See disclaimer*

Other Budget Neutrality Positions and Assumptions

The State makes the following assumptions with regard to budget neutrality:

- The State understands that it is CMS policy that administrative costs to the State for administration of this waiver both incurred by the State are not subject to budget neutrality. Administrative expenditures are not included in the historical expenditures and budget neutrality Without or With Waiver projections.

- The State is assuming the implementation of Section 2703 Health Home option within this demonstration proposal. The State Plan amendment for recipients designated as SMI/SED and having a chronic physical ailment is estimated to be submitted during CY2012.

- Nothing in this demonstration application precludes the State from applying for enhanced Medicaid funding, such as the 90% Federal match for improving Medicaid eligibility and 90% Federal match for health information technology through Medicaid.

- Nothing in this demonstration application precludes the State from pursuit of integrated care model promoted by CMS for the dual eligible population.

- The State is assuming the budget neutrality agreement is in terms of total computable so that the State is adversely affected by future changes to FMAP rate on services.

PPACA Considerations

Most initial Section 1115 demonstration waivers are requested for a five-year period, which for the purposes of this demonstration would begin at the same time the Medicaid expansion under PPACA and other PPACA-related provisions are scheduled to be implemented under current law. The State has not modeled the impact of certain components of PPACA implementation in the budget neutrality estimates. These components include:

- Impact of “newly eligible” populations up to 138% (133% + 5% income disallow); and

- Impact of the Medicaid benchmark benefit packages consistent with the guidance from the HHS Secretary.

As necessary, the State expects to amend or otherwise revise the demonstration, including the budget neutrality agreement, to reflect new federal requirements during the evaluation and negotiation of the waiver as additional federal guidance is released and New Mexico makes its own decisions about the Medicaid expansion. To that end, the budget neutrality calculations presented in the tables at the end of this section include adjustments to remove populations currently covered above 138% that will not be covered under Medicaid beginning in January 1, 2014, but do not include explicit adjustments for PPACA or any other initiatives beyond that date. Only the application of trend has been made to cost and caseload estimates beyond December 31, 2013.

Disclaimer

Mercer has prepared these projections exclusively for the State of New Mexico, to estimate the future cost of the Medicaid populations covered under this 1115 Waiver. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available at a point in time and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability from the estimates.

Further, the estimates set forth in this document have been prepared before all regulations needed to implement the Patient Protection and Affordable Care Act (PPACA) and Health Care Education and Reconciliation Act (HCERA), together referred to as the ACA, have been issued, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required.

For our analysis, we relied on data and information and other sources of data as described in this report. We have relied on these data without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data, and it should also be noted that our review of data may not always reveal imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

In addition, the projections we show in this document are dependent upon a number of assumptions regarding the future economic environment, medical trend rates, carrier behavior, the behavior of individuals and employers in light of incentives and penalties, and a number of other factors. These assumptions are disclosed and have been discussed with the State. Users of this analysis should recognize that our projections involve estimates of future events, and are subject to economic, statistical and other unforeseen variations from projected values. To the extent that future conditions are at variance with the assumptions we have made in developing these projections, actual results will vary from our projections, and the variance may be substantial.

Lastly the State understands that Mercer is not engaged in the practice of law. While this report may include commenting on legal issues or regulations it does not constitute and is not a substitute for legal advice. Mercer recommends that the State secure advice from its legal counsel with respect to any legal matters related to this report or otherwise.

SECTION 10: APPROACH TO EVALUATION

New Mexico will develop a comprehensive evaluation design to measure the impact and success of Centennial Care. At a minimum, the scope of the evaluation will include measuring program objectives, lessons learned, cost savings, quality improvements, and clinical outcomes.

A major focus of the evaluation design will be to measure the impact of developing a comprehensive CLTC benefit package. The key will be to determine the extent to which recipients will receive increased access to HCBS and associated health outcomes over a 2-3 year evaluation period.

The State's evaluation design will also assess key program objectives such as:

- The role of comprehensive care coordination in increasing access to needed services, ensuring that services are provided in a timely manner and improving health outcomes;
- The effect of incentives in improving the quality of care provided to recipients; and
- The impact of health homes on integration of care and access to care for recipients with chronic conditions.

Evaluation activities of performance will include the monitoring and evaluation of:

- Hospital admissions and inappropriate use of ER;
- Health disparities;
- Utilization of HCBS;
- Utilization of health home services; and
- Number of recipients enrolled in health homes.

As in the program design phase, stakeholder engagement in the program evaluation design will be critical. Through informal feedback and formal processes such advisory groups, recipient satisfaction surveys and the MAC, stakeholders will provide input on evaluation design elements including program evaluation questions, data sources and program impact.

The State will submit to CMS a specific design plan that includes the outcome measures, data sources and sampling methodology. New Mexico is also agreeable to other approaches to the evaluation of Centennial Care through discussions with CMS.

SECTION 11: Waiver List

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

A. Title XIX Waiver Requests

1.	**Reasonable Promptness**	**Section 1902(a)(8)**
Consistent with existing 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.		
2.	**Amount, Duration and Scope of Services**	**Section 1902(a)(10)(B)** **42 CFR 400 Subpart 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.		
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)** **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 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 ICF/MR level of care.		
5.	**Retroactive Eligibility**	**Section 1902(a)(34)** **42 CFR 435.914**
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 PPACA. Moreover, this provision (along with the rest of the Centennial Care program) will not be implemented until January 1, 2014.		
6.	**Cost Sharing**	**Sections 1902(a)(14) and 1916** **42 CFR 447.51-447.56**
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 for whom Indian health care providers, as specified in section 1932(h) of the SSA, have the responsibility to treat.		
7.	**Self-Direction of Care**	**Section 1902(a)(32)**
To permit persons receiving certain services to self-direct their care for such services.		

B. Expenditure Authority Waiver 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:

    - 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's 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 SCPH 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 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 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 12: APPENDICES

Appendix A: Glossary

Acronym	Term
ABD	Aged, Blind and Disabled
ACO	Accountable Care Organization
ADL	Activities of Daily Living
AFDC	Aid for Families with Dependent Children
ALTSD	Aging and Long Term Services Department
ARRA	American Recovery and Reinvestment Act of 2009
ASPEN	Automated System Program and Eligibility Network
BCCPT	Breast and Cervical Cancer Prevention and Treatment
BHH	Behavioral Health Home
BHO	Behavioral Health Organization
BRFSS	Behavioral Risk Factor Surveillance System
CEO	Chief Executive Officer
CHIP	Children's Health Insurance Program
CLTC	Community Long Term Care
CoLTS	Coordination of Long Term Services
COPD	Chronic Obstructive Pulmonary Disease
CMS	Centers for Medicare & Medicaid Services
CSA	Core Service Agencies
CY	Calendar Year
CYFD	Children, Youth and Families Department
DD	Developmentally Disabled
DDI	Design, Development and Implementation
DOH	Department of Health
DRG	Diagnostic Related Groups
DSH	Disproportionate Share Hospital
DY	Demonstration Year
EBT	Electronic Benefit Transfer
EOB	Explanation of Benefits
EPSDT	Early Periodic Screening, Diagnostic and Treatment
ER	Emergency Room
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FMA	Fiscal Management Agency
FMAP	Federal Matching Assistance Program
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
HCBS	Home and Community-Based Services
HCERA	Health Care Education and Reconciliation Act
HID	Hospital Inpatient dataset
HRA	Health Risk Assessment
HSD	New Mexico's Human Services Department
ICF/MR	Intermediate Care Facility/Mentally Retarded
IHS	Indian Health Service
LIHEAP	Low-Income Home Energy Assistance Program
LOC	Level of Care
LOI	Letter of Interest
LTC	Long Term Care
LTSS	Long Term Services and Support
MAC	Medicaid Advisory Committee
MCFAAB	Managed Care; Financial Accounting and Analysis Bureau
MCO	Managed Care Organization

Acronym	Term
MEG	Medicaid Eligibility Group
MF	Medically Fragile
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NFLOC	Nursing Facility Level of Care
NM	New Mexico
NMBHPC	New Mexico Behavioral Health Purchasing Collaborative
OMB	Office of Management and Budget
OT	Occupational Therapy
PACE	Program for All-Inclusive Care for the Elderly
PCMH	Patient-Centered Medical Homes
PCO	Personal Care Option
PCP	Primary Care Physician
PMPM	Per Member Per Month
PPACA	Patient Protection and Affordable Care Act of 2010
PT	Physical Therapy
QI	Qualified Individual
QMB	Qualified Medicare Beneficiary
RCA	Refugee Cash Assistance
RFP	Request for Proposal
SCI	State Coverage Insurance
SCP	Sole Community Provider
SCPH	Sole Community Provider Hospital
SED	Severe Emotional Disturbance
SFY	State Fiscal Year
SLMB	Specified Low-Income Medicare Beneficiary
SLT	Speech and Language Therapy
SMDL	State Medicaid Director's Letter
SNAP	Supplemental Nutrition Assistance Program
SPA	State Plan Amendment
SPMI	Severe and Persistent Mental Illness
SSA	Social Security Act
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TPA	Third Party Administrator
UPL	Upper Payment Limit
USCIS	U.S. Citizenship and Immigration Services

Appendix B: Summary of Stakeholder Input

During the months of July & August 2011, the State conducted a series of public stakeholder meetings to collect the concerns, opinions and advice of recipients, advocates, providers and citizens of all regions of New Mexico. Public meetings were heavily publicized and well-attended in the following locations:

Clovis, Civic Center – Wednesday, July 6, 2011
Farmington, San Juan College – Tuesday, July 12, 2011
Roswell, Public Library – Tuesday, July 26, 2011
Las Cruces, New Mexico Farm & Ranch Museum – Wednesday, July 27, 2011
Albuquerque, University of New Mexico – Thursday, July 28, 2011
Santa Fe, Willie Ortiz Building – Tuesday, August 2, 2011
Tribal Consultation, Indian Pueblo Cultural Center – Wednesday August 3, 2011

The following tables represent individual public comments made by attendees. The comments are categorized according to the four principles of the Medicaid Modernization project.

Principle 1: Comprehensive Coordinated Delivery System

Comment/Consideration	Program Area
Single provider coordinating care for cancer patients.	Care Coordination
Outcome Measures focused on screening, care coordination, quality of life.	Quality
PACE model of care is best for Pueblo communities to deliver long term care.	LTC
Include State Supplemental Payment services to the deaf/blind community as a Medicaid covered service.	Benefits
Need to increase the ability for small businesses and individuals to provide in small areas.	Providers
Support for community health workers. Have preventive care at home or community-based or school based health centers	Access
More support for care givers. Programs like Mi Via people can hire their own support.	Benefits
Make it easier for people to keep working and get services at home.	Access
Respite for care givers. People who provide long term services develop their own problems.	Benefits
Not penalizing docs for conditions they can't control. Can't monitor when people eat or going to gym.	Benefits
Ending gross receipts tax for doctors.	Providers
Co-pays hurt patients and providers. Docs see fewer patients and patients seek fewer care.	Benefits
Improve access to services and resources to rural areas and create a competition; Transportation in rural areas.	Access
Comprehensive directory of providers would be helpful to patients; Even just a once a month clinic that came in to release pressure could relieve costs.	Access
Better verification of eligibility.	Quality
Early intervention and preventative care make a big difference and are working. Would like to see more of that.	Benefits
Integrate physical and behavioral health.	Model
Individualize teaching and training for a specific client or caregiver or family to take better care at home.	LTC
Consumer wants to have more input into their care plan.	Care Coordination
Respite hours based on acute level.	Model

Comment/Consideration	Program Area
Ability to bank that respite if not used one year. Roll over to the next year or get credit back at least.	
Supply coordination. Continuing to get supplies that they don't need. Huge waste. Local recycle deposit for the supplies	Model
More vouchers for assisting people with rent.	Benefits
Services coordinators for MCOs have too large caseloads.	Care Coordination
Better management of Fraud and abuse.	Quality
Don't cut attendant care hours. This leads to other things that cost more – example: hours cut and suffered injury while attendant wasn't there.	Benefits
Reward patient and providers for getting and giving preventative care, rather than charging co-payments for services. Would be a true partnership between patient and provider.	Model
Long term care – 30-day requirement to get the waiver from a LTC facility to home. Instead waive these requirements so people can get out when they want to get out. Cost savings will justify.	LTC
Adult Daycare may help people stay in home; Occupational Therapy, Physical Therapy and Speech Therapy Home-based services.	Benefits
Criteria of services need to be addressed.	Benefits
Quicker assessments; Base assessments on what the client is telling them instead of prompting them on what they may need.	Care Coordination
Define the diagnosis of developmental disability.	Benefits
Incentives. Giving people an incentive to go to work to get programs. Example: SSI or Social Security Disability Insurance Ticket to Work program.	Model
More education to people about resources, i.e. behavioral health.	Model
Increase income limits, the guideline to obtaining waiver services.	Model
More Preventive services.	Benefits
Expand Tele-health.	Model
Cover vision services.	Benefits
Extend reenrollment; Express eligibility, if a child qualifies for free food, auto-enroll in New MexiKids.	Model
Healthcare for undocumented.	Model
Reduce prior authorizations required by MCO.	Model
Increase hours for Traumatic Brain Injuries.	Benefits
Keep PCO.	Benefits

Principle 2: Personal Responsibility

Comment/Consideration	Program Area
Include health education; More education on taking medications. Keep them out of hospital; Quality of care givers under PCO. There needs to be better quality care givers. More than 40 hours of training and training should be specialized, especially with those people with Developmental Disabilities. Caregivers may not have the experience or training to support needs; Need outreach workers that go to communities.	Model
Include assistance scheduling preventive care.	Benefits
Offer nutrition classes.	Benefits
Offer access to exercise facilities.	Benefits
Study Native American populations separately when designing programs for health promotion and disease prevention; Reward and incentives need to be client specific.	Model
Internet access is not reliable in rural areas; Phone-based for those without internet	Access
Stop smoking aids	Benefits
Access to healthy foods in rural areas	Access
Don't make documentation by providers too labor intensive	Providers
Support service providers are working well	Benefits
Comprehensive Health Plan where everybody played a part – providers and patients Skill building activities Utilizing PCP to set goals Preventative services as a mandatory benefits for participant of Medicaid Mandatory training Education Economics All in conjunction with Behavioral Health, agree with parity.	Model
Providers responsibility Rewarding patient by acknowledgement Nurses are big on preventative care and can be an example Provider incentives when patient gets healthier and stays healthier Patient should see a benefit too by decreased co-pays. Universal electronic medical records will help with keeping track of medications	Model
Cut off payment after 2nd baby – pay for 2 babies only; Time limit to program…moves to stair-step program to get them off.	Benefits
In ER, to prevent a violation the client has to be seen by a medical providers…could that be a nurse practitioner or MD who says this is not an emergency situation go to walk-in clinic.	ER
Need more dental health willing to take Medicaid	Benefits
If you don't have an area where a medical professional is available, do a triage and have a medical hotline that has the professional education to ask the right questions about an ER situation – make mandatory.	ER
Keep Medicaid in schools and funding for school based health centers.	Access
Better transportation and access.	Access
Nurse and medical hotline.	Access
Extended hours for urgent care centers.	Access
Child care assistance.	Benefits
Co-payment for non-emergency ER if urgent care is open.	ER
Ensure more behavioral health and substance abuse providers.	Access
Financial incentives – gas cards and school supplies.	Model
State needs to be better, effective outreach programs.	Model
Develop a stair-step program to get people off Medicaid.	Model

Comment/Consideration	Program Area
Better regulation on TANF and Food Stamps (can't buy candy or pop or cigarettes).	Model
Could be a sliding scale to co-pays; No co-pays for non-generic drugs. Generic medications react different with some people.	Benefits
Volunteer to help pay for the premiums.	Model
Often times people go to ER because they run out of medications. – need a better way to get them their medications.	Access
Health home for physical care – what about a pharmacy home? Coordination between pharmacies to help manage the medications.	Model
Funding mobile crisis response in rural areas.	Access
No shows, cost money. Needs to be some kind of consequence that is very sensitive and tailor made.	Model

Principle 3: Pay for Performance

Comment/Consideration	Program Area
IHS should be a performance based pay provider using bench marks and quality control measures.	Quality
IHS needs to develop secondary services based on epidemiology data, chronic disease patterns.	Access
Reward PCPs who achieve healthy behaviors of their patient panels.	Model
Limited access to PCP in rural areas Access to specialists Follow up services Preventative services Telemedicine Crisis units in rural areas	Access
Cost to copy records.	Technology
Access between physicians. Physicians not talking to each other.	Providers
Electronic Medical Systems not universal.	Technology
Service duplication due to records.	Technology
Information not being shared between doctors and hospitals.	Technology
Helping providers hold people accountable – need more doctors that can spend a longer period of time with patients to get to know them and develop a relationship to encourage them to take more responsibility for their own care.	Providers
Relates to recruitment and retention of doctors in rural and frontier areas.	Access
Should be rewards built in for preventative health care, particularly there seems to be a lack of services for adults on the Medicaid side.	Model
Coordination of care activities for both physical health and behavioral health need to have parity with face to face contact or treatment activities to coordinate care.	Care Coordination
ECHO program – telemedicine/teleheatlh program that is involved with educating providers as well as volunteers, aimed at chronic disease. Now been informed that Molina is paying providers to present cases. In a larger area not a big deal, but in rural area it is. Can it be incorporated at some level in Medicaid Modernization.	Benefits
Expansion of promotoras throughout the State.	Model
Doctors not getting adequate reimbursement.	Providers
Lose middle management.	Model
Have all service fees the same across the board for all providers.	Providers
State needs to focus on the top five arenas of physical and mental health.	Model
Operational definitions need to be identified.	Model
Look at high users and provide incentive goals to lower use.	Model
Let providers develop and incentivize.	Model
On recipient end – have levels of co pays. People who do not take doctor's advice to improve their health will be charged higher co pays after the first year on the	Model

Comment/Consideration	Program Area
program.	
Part of Medicaid eligibility requirement is to make a mandatory one year screening package. Saves catastrophic down the road.	Model
Incentives – like car insurance if you don't have accidents you get money back. Under Health Care Reform would be good to have incentives for not over-utilizing care.	Model
Keep all 12 waivers as we have them. Global gives opportunity below 1902 baseline. Very risky to manage ourselves.	Model
Home visits generated by providers. If providers generate it will help keep people healthy. Check-ups would reduce visits to hospital.	Benefits
Money incentives to stay healthy.	Model
Make recipients aware of the costs. Send out information on how much their visits cost.	Model
System change, such as student loan forgiveness program for Medicaid providers. Look at percentage of Medicaid clients they take throughout their career.	Model
Needs to be an easier process for prescribing doctors to be able to order medication. MCOs need to be better at helping people get the right medications.	Access
Need to see people more quickly before an ER visit.	ER
Rural areas, such as Hatch and Anthony don't have urgent care and their only option is ER; Urgent care is not available or closes early.	ER
Need to use a hot/warm line staffed by nurses to determine if an ER visit is necessary.	ER
How come Medicaid only covers certain transportation companies and not a wider variety.	Access
Community-based health at the schools.	Access
Alternative hours/extended hour.	Access
Penalty fee for no shows and cancellations.	Model
Incentivize clinics for holding patients accountable.	Model

Principle 4: Administrative Simplicity

Comment/Consideration	Program Area
Native Americans should be allowed to opt-out for CoLTS and Salud!.	Model
Consider a waiver specifically for Native American "carve-out" and make them totally dependent on federal funding thus relieving the State of FMAP.	Model
Understanding eligibility is problematic in reservation communities.	Model
Design and implement a centralized Managed care; Financial Accounting and Analysis Bureau (MCFAAB) Meet all financial reporting requirements Complete capitation reconciliation Managed care enrollment Desktop Recoupments MCO/State expenditure analysis Related performance measure computations Provide data to actuaries, Legislative committee, etc	Model
Hospitals would like to see a reduction in the number of MCOs to negotiate with.	Providers
Include behavioral health to coordinate physical and behavioral through a single MCO.	Model
Streamline physical and administrative access of Native Americans to the healthcare system.	Model
Slowly decrease non-mandatory services by reducing services to the healthy first and chronically ill last.	Model
Do not introduce additional premiums or co-payments.	Model

Comment/Consideration	Program Area
Review Scopes of Practice and allow providers to work at the "top of their scope" and to the fullest extent of their education and NM law.	Providers
Consider competitive bidding.	Model
Simplify re-enrollment process, especially with chronic conditions.	Model
Simplify the credentialing process for providers.	Model
Increase provider incentives to work in rural areas.	
Tort reform brought up to increase doctors who want to practice in NM and reduce overutilization of services.	Model
Have to have a one-stop shop for eligibility.	Model

Appendix C: Budget Neutrality Tables

The following tables summarize the trend rate and overall cost and caseload for the populations for the five-year demonstration period:

Table 9.2a Historical Data
Total Computable

	SFY07 (7/1/06 - 6/30/07)	SFY08 (7/1/07 - 6/30/08)	SFY09 (7/1/08 - 6/30/09)	SFY10 (7/1/09 - 6/30/10)	SFY11 (7/1/10 - 6/30/11)	5-YEARS
TANF & Related						
TOTAL EXPENDITURES						
Eligible Member Months	3,222,890	3,345,269	3,650,469	3,974,052	4,172,356	
Total Cost per Eligible	$ 307.80	$ 325.50	$ 318.57	$ 307.94	$ 287.24	
Total Expenditure	$ 991,993,925	$ 1,088,890,637	$ 1,162,938,641	$ 1,223,786,435	$ 1,198,461,186	$ 5,666,070,824
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		3.8%	9.1%	8.9%	5.0%	5.9%
Total Cost per Eligible		5.8%	-2.1%	-3.3%	-6.7%	-1.5%
Total Expenditure		9.8%	6.8%	5.2%	-2.1%	4.3%
SSI & Related						
TOTAL EXPENDITURES						
Eligible Member Months	402,027	402,561	412,018	430,982	423,827	
Total Cost per Eligible	$ 1,000.24	$ 1,159.95	$ 1,070.80	$ 962.88	$ 891.91	
Total Expenditure	$ 402,121,878	$ 466,952,008	$ 441,189,869	$ 414,982,990	$ 378,015,652	$ 2,103,262,398
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.1%	2.3%	4.6%	-1.7%	1.2%
Total Cost per Eligible		16.0%	-7.7%	-10.1%	-7.4%	-2.5%
Total Expenditure		16.1%	-5.5%	-5.9%	-8.9%	-1.4%
NF LOC - Dual						
TOTAL EXPENDITURES						
Eligible Member Months	171,654	181,257	177,244	181,300	188,179	
Total Cost per Eligible	$ 2,310.04	$ 2,436.33	$ 2,645.65	$ 2,825.40	$ 2,845.49	
Total Expenditure	$ 396,526,760	$ 441,602,101	$ 468,926,248	$ 512,245,920	$ 535,461,624	$ 2,354,762,653
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		5.6%	-2.2%	2.3%	3.8%	2.1%
Total Cost per Eligible		5.5%	8.6%	6.8%	0.7%	4.7%
Total Expenditure		11.4%	6.2%	9.2%	4.5%	6.9%
NF LOC - Medicaid Only						
TOTAL EXPENDITURES						
Eligible Member Months	50,504	59,305	63,722	66,073	74,528	
Total Cost per Eligible	$ 3,022.39	$ 3,211.10	$ 3,609.85	$ 4,159.19	$ 4,186.70	
Total Expenditure	$ 152,643,034	$ 190,434,170	$ 230,027,087	$ 274,810,073	$ 312,026,746	$ 1,159,941,111
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		17.4%	7.4%	3.7%	12.8%	9.0%
Total Cost per Eligible		6.2%	12.4%	15.2%	0.7%	7.5%
Total Expenditure		24.8%	20.8%	19.5%	13.5%	17.2%
Healthy Dual						
TOTAL EXPENDITURES						
Eligible Member Months	219,137	217,174	209,794	200,159	197,003	
Total Cost per Eligible	$ 125.93	$ 127.10	$ 214.97	$ 203.12	$ 180.82	
Total Expenditure	$ 27,596,538	$ 27,602,922	$ 45,100,358	$ 40,657,024	$ 35,621,687	$ 176,578,530
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		-0.9%	-3.4%	-4.6%	-1.6%	-2.3%
Total Cost per Eligible		0.9%	69.1%	-5.5%	-11.0%	8.4%
Total Expenditure		0.0%	63.4%	-9.9%	-12.4%	5.8%

Table 9.2a Historical Data
Total Computable – Continued

	SFY07 (7/1/06 - 6/30/07)	SFY08 (7/1/07 - 6/30/08)	SFY09 (7/1/08 - 6/30/09)	SFY10 (7/1/09 - 6/30/10)	SFY11 (7/1/10 - 6/30/11)	5-YEARS
Mi Via - Dual						
TOTAL EXPENDITURES						
Eligible Member Months	0	0	5,661	6,756	6,927	
Total Cost per Eligible	$ -	$ -	$ 2,643.36	$ 2,799.62	$ 3,145.27	
Total Expenditure	$ -	$ -	$ 14,964,080	$ 18,914,221	$ 21,787,312	$ 55,665,613
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.0%	0.0%	19.3%	2.5%	0.0%
Total Cost per Eligible		0.0%	0.0%	5.9%	12.3%	0.0%
Total Expenditure		0.0%	0.0%	26.4%	15.2%	0.0%
Mi Via - Medicaid Only						
TOTAL EXPENDITURES						
Eligible Member Months	0	0	2,432	2,521	2,353	
Total Cost per Eligible	$ -	$ -	$ 3,851.56	$ 4,048.61	$ 4,363.71	
Total Expenditure	$ -	$ -	$ 9,366,988	$ 10,206,551	$ 10,267,810	$ 29,841,349
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.0%	0.0%	3.7%	-6.7%	0.0%
Total Cost per Eligible		0.0%	0.0%	5.1%	7.8%	0.0%
Total Expenditure		0.0%	0.0%	9.0%	0.6%	0.0%
Family Planning						
TOTAL EXPENDITURES						
Eligible Member Months	289,758	310,193	299,416	293,738	353,776	
Total Cost per Eligible	$ 17.68	$ 18.37	$ 19.00	$ 17.91	$ 15.02	
Total Expenditure	$ 5,122,599	$ 5,699,647	$ 5,688,223	$ 5,261,916	$ 5,313,881	$ 27,086,267
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		7.1%	-3.5%	-1.9%	20.4%	4.5%
Total Cost per Eligible		3.9%	3.4%	-5.7%	-16.2%	-3.6%
Total Expenditure		11.3%	-0.2%	-7.5%	1.0%	0.8%

Table 9.2b Historical Data
Federal Share

	SFY07 (7/1/06 - 6/30/07)	SFY08 (7/1/07 - 6/30/08)	SFY09 (7/1/08 - 6/30/09)	SFY10 (7/1/09 - 6/30/10)	SFY11 (7/1/10 - 6/30/11)	5-YEARS
TANF & Related						
TOTAL EXPENDITURES						
Eligible Member Months	3,222,890	3,345,269	3,650,469	3,974,052	4,172,356	
Total Cost per Eligible	$ 221.40	$ 231.24	$ 225.80	$ 219.72	$ 200.44	
Total Expenditure	$ 713,541,230	$ 773,547,909	$ 824,290,908	$ 873,171,622	$ 836,286,215	$ 4,020,837,884
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		3.8%	9.1%	8.9%	5.0%	5.9%
Total Cost per Eligible		4.4%	-2.3%	-2.7%	-8.8%	-2.2%
Total Expenditure		8.4%	6.6%	5.9%	-4.2%	3.6%
SSI & Related						
TOTAL EXPENDITURES						
Eligible Member Months	402,027	402,561	412,018	430,982	423,827	
Total Cost per Eligible	$ 719.47	$ 824.03	$ 758.98	$ 687.01	$ 622.37	
Total Expenditure	$ 289,246,267	$ 331,722,707	$ 312,715,379	$ 296,090,363	$ 263,779,322	$ 1,493,554,038
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.1%	2.3%	4.6%	-1.7%	1.2%
Total Cost per Eligible		14.5%	-7.9%	-9.5%	-9.4%	-3.2%
Total Expenditure		14.7%	-5.7%	-5.3%	-10.9%	-2.0%
NF LOC - Dual						
TOTAL EXPENDITURES						
Eligible Member Months	171,654	181,257	177,244	181,300	188,179	
Total Cost per Eligible	$ 1,661.61	$ 1,730.77	$ 1,875.24	$ 2,015.93	$ 1,985.58	
Total Expenditure	$ 285,221,699	$ 313,714,133	$ 332,374,925	$ 365,487,464	$ 373,645,121	$ 1,670,443,341
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		5.6%	-2.2%	2.3%	3.8%	2.1%
Total Cost per Eligible		4.2%	8.3%	7.5%	-1.5%	4.0%
Total Expenditure		10.0%	5.9%	10.0%	2.2%	6.2%
NF LOC - Medicaid Only						
TOTAL EXPENDITURES						
Eligible Member Months	50,504	59,305	63,722	66,073	74,528	
Total Cost per Eligible	$ 2,174.01	$ 2,281.16	$ 2,558.66	$ 2,967.58	$ 2,921.48	
Total Expenditure	$ 109,796,134	$ 135,284,435	$ 163,043,200	$ 196,076,987	$ 217,732,264	$ 821,933,019
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		17.4%	7.4%	3.7%	12.8%	9.0%
Total Cost per Eligible		4.9%	12.2%	16.0%	-1.6%	6.8%
Total Expenditure		23.2%	20.5%	20.3%	11.0%	16.4%
Healthy Dual						
TOTAL EXPENDITURES						
Eligible Member Months	219,137	217,174	209,794	200,159	197,003	
Total Cost per Eligible	$ 90.58	$ 90.29	$ 152.37	$ 144.93	$ 126.17	
Total Expenditure	$ 19,850,190	$ 19,609,116	$ 31,967,133	$ 29,008,787	$ 24,856,813	$ 125,292,040
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		-0.9%	-3.4%	-4.6%	-1.6%	-2.3%
Total Cost per Eligible		-0.3%	68.8%	-4.9%	-12.9%	7.6%
Total Expenditure		-1.2%	63.0%	-9.3%	-14.3%	5.1%

Table 9.2b Historical Data
Federal Share – Continued

	SFY07 (7/1/06 - 6/30/07)	SFY08 (7/1/07 - 6/30/08)	SFY09 (7/1/08 - 6/30/09)	SFY10 (7/1/09 - 6/30/10)	SFY11 (7/1/10 - 6/30/11)	5-YEARS
Mi Via - Dual						
TOTAL EXPENDITURES						
Eligible Member Months	0	0	5,661	6,756	6,927	
Total Cost per Eligible	$ -	$ -	$ 1,873.62	$ 1,997.53	$ 2,194.77	
Total Expenditure	$ -	$ -	$ 10,606,540	$ 13,495,297	$ 15,203,187	$ 39,305,023
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.0%	0.0%	19.3%	2.5%	0.0%
Total Cost per Eligible		0.0%	0.0%	6.6%	9.9%	0.0%
Total Expenditure		0.0%	0.0%	27.2%	12.7%	0.0%
Mi Via - Medicaid Only						
TOTAL EXPENDITURES						
Eligible Member Months	0	0	2,432	2,521	2,353	
Total Cost per Eligible	$ -	$ -	$ 2,729.98	$ 2,888.68	$ 3,045.00	
Total Expenditure	$ -	$ -	$ 6,639,321	$ 7,282,374	$ 7,164,878	$ 21,086,573
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		0.0%	0.0%	3.7%	-6.7%	0.0%
Total Cost per Eligible		0.0%	0.0%	5.8%	5.4%	0.0%
Total Expenditure		0.0%	0.0%	9.7%	-1.6%	0.0%
Family Planning						
TOTAL EXPENDITURES						
Eligible Member Months	289,758	310,193	299,416	293,738	353,776	
Total Cost per Eligible	$ 12.72	$ 13.05	$ 13.47	$ 12.78	$ 10.48	
Total Expenditure	$ 3,684,686	$ 4,049,029	$ 4,031,812	$ 3,754,377	$ 3,708,026	$ 19,227,931
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
Eligible Member Months		7.1%	-3.5%	-1.9%	20.4%	4.5%
Total Cost per Eligible		2.6%	3.2%	-5.1%	-18.0%	-4.2%
Total Expenditure		9.9%	-0.4%	-6.9%	-1.2%	0.1%

Table 9.3 – Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations FFY2010 – FFY2014

1	**Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations - FFY2010 through FFY2014**					
2		**Previous Federal Fiscal Year 2010**	**Previous Federal Fiscal Year 2011**	**Federal Fiscal Year 2012**	**Federal Fiscal Year 2013**	**Federal Fiscal Year 2014**
3	State's Allotment	**$ 345,313,250**	**$ 245,491,788**	**$ 258,650,148**	**$ 258,650,148**	**$ 258,650,148**
4	Funds Carried Over From Prior Year(s)	**$ -**	**$ 114,687,115**	**$ 212,496,336**	**$ 273,518,922**	**$ 320,858,148**
5	SUBTOTAL (Allotment + Funds Carried Over)	**$ 345,313,250**	**$ 360,178,903**	**$ 471,146,484**	**$ 532,169,070**	**$ 579,508,296**
6	Reallocated Funds (Redistributed or Retained that are Currently Available	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
7	TOTAL (Subtotal + Reallocated funds)	**$ 345,313,250**	**$ 360,178,903**	**$ 471,146,484**	**$ 532,169,070**	**$ 579,508,296**
8	State's Enhanced FMAP Rate	**79.95%**	**78.85%**	**78.55%**	**78.55%**	**78.55%**
9	**COST PROJECTIONS OF APPROVED SCHIP PLAN**					
10	**Benefit Costs**					
11	Insurance payments					
12	Total Managed Care			$ 31,276,694	$ 33,431,658	$ 35,567,941
13	per member/per month rate			$277	$296	$315
14	# of eligibles (MM)			112,973	112,973	112,973
15	Total Fee for Service			$ -	$ -	$ -
16	per member/per month rate			$0	$0	$0
17	# of eligibles (MM)			-	-	-
18	Total Benefit Costs (Managed Care + Fee for Service)	$ 24,839,080	$ 18,662,476	$ 31,276,694	$ 33,431,658	$ 35,567,941
19	(Offsetting beneficiary cost sharing payments) (negative number)					
20	**Net Benefit Costs**	**$ 24,839,080**	**$ 18,662,476**	**$ 31,276,694**	**$ 33,431,658**	**$ 35,567,941**
21						
22	**Administration Costs**					
23	Personnel	$ 741,798	$ 160,394	$ 700,000	$ 700,000	$ 700,000
24	General administration					
25	Contractors/Brokers					
26	Claims Processing					
27	Outreach/marketing costs					
28	Other (specify)					
29	**Total Administration Costs**	**$ 741,798**	**$ 160,394**	**$ 700,000**	**$ 700,000**	**$ 700,000**
30	10% Administrative Cap	$ 2,759,898	$ 2,073,608	$ 3,475,188	$ 3,714,629	$ 3,951,993
31						
32	Federal Title XXI Share	$ 20,451,912	$ 14,841,833	$ 25,117,693	$ 26,810,417	$ 28,488,467
33	State Share	$ 5,128,966	$ 3,981,037	$ 6,859,001	$ 7,321,241	$ 7,779,474
34	**TOTAL COSTS OF APPROVED SCHIP PLAN**	**$ 25,580,878**	**$ 18,822,870**	**$ 31,976,694**	**$ 34,131,658**	**$ 36,267,941**
35						
36	**COST PROJECTIONS OF ALLOWANCE FOR QUALIFYING STATES**					
37	**Benefit Costs**					
38	Insurance payments					
39	Total Managed Care			$ 64,147,344	$ 68,567,096	$ 72,948,533
40	per member/per month rate			$241	$257	$274
41	# of eligibles (MM)			266,456	266,456	266,456
42	Total Fee for Service			$ -	$ -	$ -
43	per member/per month rate			$0	$0	$0
44	# of eligibles (MM)			-	-	-
45	Total Benefit Costs (Managed Care + Fee for Service)	$ 71,358,965	$ 54,206,754	$ 64,147,344	$ 68,567,096	$ 72,948,533
46	**Net Benefit Costs**	**$ 71,358,965**	**$ 54,206,754**	**$ 64,147,344**	**$ 68,567,096**	**$ 72,948,533**
47						
48	Federal Title XXI Share	**$ 57,051,493**	**$ 42,742,026**	**$ 50,387,739**	**$ 53,859,454**	**$ 57,301,073**
49	State Share	**$ 14,307,472**	**$ 11,464,728**	**$ 13,759,605**	**$ 14,707,642**	**$ 15,647,460**
50	**TOTAL COSTS OF ALLOWANCE FOR QUALIFYING STATES**	**$ 71,358,965**	**$ 54,206,754**	**$ 64,147,344**	**$ 68,567,096**	**$ 72,948,533**
51						
52	**COST PROJECTIONS FOR DEMONSTRATION PROPOSAL**					
53	**Benefit Costs for Demonstration Population #1: Parent/Guardian Adults**					
54	Insurance payments					
55	Total Managed Care			$ 154,270,566	$ 165,115,787	$ -
56	per member/per month rate			$770	$825	$0
57	# of eligibles (MM)			200,237	200,237	-
58	Total Fee for Service			$ -	$ -	$ -
59	per member/per month rate			$0	$0	$0
60	# of eligibles (MM)			-	-	-
61	Total Benefit Costs (Managed Care + Fee for Service)	$ 124,235,135	$ 113,990,997	$ 154,270,566	$ 165,115,787	$ -
62	**Benefit Costs for Demonstration Population #2: Childless Adults**					
63	Insurance payments					
64	Total Managed Care			$ -	$ -	$ -
65	per member/per month rate			$0	$0	$0
66	# of eligibles (MM)			-	-	-
67	Total Fee for Service			$ -	$ -	$ -
68	per member/per month rate			$0	$0	$0
69	# of eligibles (MM)			-	-	-
70	Total Benefit Costs (Managed Care + Fee for Service)	$ 66,016,326	$ -	$ -	$ -	$ -
71						
72	**Total Benefit Costs (For All Demonstration Populations)**	**$ 190,251,461**	**$ 113,990,997**	**$ 154,270,566**	**$ 165,115,787**	**$ -**
73	(Offsetting beneficiary cost sharing payments) (negative number)					
74	**Net Benefit Costs**	**$ 190,251,461**	**$ 113,990,997**	**$ 154,270,566**	**$ 165,115,787**	**$ -**
75						
76	**Administration Costs**					
77	Personnel	$ 1,271,654	$ 274,962	$ 1,200,000	$ 1,200,000	$ -
78	General administration					
79	Contractors/Brokers					
80	Claims Processing					
81	Outreach/marketing costs					
82	Other (specify)					
83	**Total Administration Costs**	**$ 1,271,654**	**$ 274,962**	**$ 1,200,000**	**$ 1,200,000**	**$ -**
84	10% Administrative Cap	$ 21,139,051	$ 12,665,666	$ 17,141,174	$ 18,346,199	$ -
85						
86	Federal Title XXI Share	$ 153,122,730	$ 90,098,708	$ 122,122,130	$ 130,641,051	$ -
87	State Title XXI Share	$ 38,400,385	$ 24,167,251	$ 33,348,436	$ 35,674,736	$ -
88	**TOTAL COSTS FOR DEMONSTRATION**	**$ 191,523,115**	**$ 114,265,959**	**$ 155,470,566**	**$ 166,315,787**	**$ -**
89						
90	**TOTAL TITLE XXI PROGRAM COSTS (State Plan + Demonstration)**	**$ 288,462,958**	**$ 187,295,583**	**$ 251,594,603**	**$ 269,014,540**	**$ 109,216,474**
91	Federal Title XXI Share	$ 230,626,135	$ 147,682,567	$ 197,627,562	$ 211,310,922	$ 85,789,540
92	State Title XXI Share	$ 57,836,823	$ 39,613,016	$ 53,967,041	$ 57,703,618	$ 23,426,934
93						
94	**Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)**	**$ 345,313,250**	**$ 360,178,903**	**$ 471,146,484**	**$ 532,169,070**	**$ 579,508,296**
95	**Total Federal Title XXI Program Costs (State Plan + Demonstration)**	**$ 230,626,135**	**$ 147,682,567**	**$ 197,627,562**	**$ 211,310,922**	**$ 85,789,540**
96	**Unused Title XXI Funds Expiring (Allotment or Reallocated)**					
97	**Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)**	**$ 114,687,115**	**$ 212,496,336**	**$ 273,518,922**	**$ 320,858,148**	**493,718,756**

Table 9.3 – Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations – Continued – FFY2015 – FFY2019

1	**Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations - FFY2015 through FFY2019**					
2		**Federal Fiscal Year 2015**	**Federal Fiscal Year 2016**	**Federal Fiscal Year 2017**	**Federal Fiscal Year 2018**	**Federal Fiscal Year 2019**
3	State's Allotment	**$ 258,650,148**	**$ 258,650,148**	**$ 258,650,148**	**$ 258,650,148**	**$ 258,650,148**
4	Funds Carried Over From Prior Year(s)	**$ 493,718,756**	**$ 661,558,745**	**$ 824,542,730**	**$ 981,268,062**	**$ 1,130,947,834**
5	SUBTOTAL (Allotment + Funds Carried Over)	**$ 752,368,903**	**$ 920,208,893**	**$ 1,083,192,878**	**$ 1,239,918,210**	**$ 1,389,597,982**
6	Reallocated Funds (Redistributed or Retained that are Currently Available	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
7	TOTAL (Subtotal + Reallocated funds)	**$ 752,368,903**	**$ 920,208,893**	**$ 1,083,192,878**	**$ 1,239,918,210**	**$ 1,389,597,982**
8	State's Enhanced FMAP Rate	**78.55%**	**78.55%**	**78.55%**	**78.55%**	**78.55%**
9	**COST PROJECTIONS OF APPROVED SCHIP PLAN**					
10	**Benefit Costs**					
11	Insurance payments					
12	Total Managed Care	$ 37,662,892	$ 39,689,156	$ 42,300,702	$ 45,240,601	$ 48,375,775
13	per member/per month rate	$333	$351	$374	$400	$428
14	# of eligibles (MM)	112,973	112,973	112,973	112,973	112,973
15	Total Fee for Service	$ -	$ -	$ -	$ -	$ -
16	per member/per month rate	$0	$0	$0	$0	$0
17	# of eligibles (MM)	-	-	-	-	-
18	Total Benefit Costs (Managed Care + Fee for Service)	$ 37,662,892	$ 39,689,156	$ 42,300,702	$ 45,240,601	$ 48,375,775
19	(Offsetting beneficiary cost sharing payments) (negative number)					
20	**Net Benefit Costs**	**$ 37,662,892**	**$ 39,689,156**	**$ 42,300,702**	**$ 45,240,601**	**$ 48,375,775**
21						
22	**Administration Costs**					
23	Personnel	$ 700,000	$ 700,000	$ 700,000	$ 700,000	$ 700,000
24	General administration					
25	Contractors/Brokers					
26	Claims Processing					
27	Outreach/marketing costs					
28	Other (specify)					
29	**Total Administration Costs**	**$ 700,000**	**$ 700,000**	**$ 700,000**	**$ 700,000**	**$ 700,000**
30	10% Administrative Cap	$ 4,184,766	$ 4,409,906	$ 4,700,078	$ 5,026,733	$ 5,375,086
31						
32	Federal Title XXI Share	$ 30,134,052	$ 31,725,682	$ 33,777,052	$ 36,086,342	$ 38,549,021
33	State Share	$ 8,228,840	$ 8,663,474	$ 9,223,650	$ 9,854,259	$ 10,526,754
34	**TOTAL COSTS OF APPROVED SCHIP PLAN**	**$ 38,362,892**	**$ 40,389,156**	**$ 43,000,702**	**$ 45,940,601**	**$ 49,075,775**
35						
36	**COST PROJECTIONS OF ALLOWANCE FOR QUALIFYING STATES**					
37	**Benefit Costs**					
38	Insurance payments					
39	Total Managed Care	$ 77,245,202	$ 81,400,994	$ 86,757,179	$ 92,786,803	$ 99,216,928
40	per member/per month rate	$290	$305	$326	$348	$372
41	# of eligibles (MM)	266,456	266,456	266,456	266,456	266,456
42	Total Fee for Service	$ -	$ -	$ -	$ -	$ -
43	per member/per month rate	$0	$0	$0	$0	$0
44	# of eligibles (MM)	-	-	-	-	-
45	Total Benefit Costs (Managed Care + Fee for Service)	$ 77,245,202	$ 81,400,994	$ 86,757,179	$ 92,786,803	$ 99,216,928
46	**Net Benefit Costs**	**$ 77,245,202**	**$ 81,400,994**	**$ 86,757,179**	**$ 92,786,803**	**$ 99,216,928**
47						
48	Federal Title XXI Share	**$ 60,676,106**	**$ 63,940,481**	**$ 68,147,764**	**$ 72,884,034**	**$ 77,934,897**
49	State Share	**$ 16,569,096**	**$ 17,460,513**	**$ 18,609,415**	**$ 19,902,769**	**$ 21,282,031**
50	**TOTAL COSTS OF ALLOWANCE FOR QUALIFYING STATES**	**$ 77,245,202**	**$ 81,400,994**	**$ 86,757,179**	**$ 92,786,803**	**$ 99,216,928**
51						
52	**COST PROJECTIONS FOR DEMONSTRATION PROPOSAL**					
53	**Benefit Costs for Demonstration Population #1: Parent/Guardian Adults**					
54	Insurance payments					
55	Total Managed Care	$ -	$ -	$ -	$ -	$ -
56	per member/per month rate	$0	$0	$0	$0	$0
57	# of eligibles (MM)	-	-	-	-	-
58	Total Fee for Service	$ -	$ -	$ -	$ -	$ -
59	per member/per month rate	$0	$0	$0	$0	$0
60	# of eligibles (MM)	-	-	-	-	-
61	Total Benefit Costs (Managed Care + Fee for Service)	$ -	$ -	$ -	$ -	$ -
62	**Benefit Costs for Demonstration Population #2: Childless Adults**					
63	Insurance payments					
64	Total Managed Care	$ -	$ -	$ -	$ -	$ -
65	per member/per month rate	$0	$0	$0	$0	$0
66	# of eligibles (MM)	-	-	-	-	-
67	Total Fee for Service	$ -	$ -	$ -	$ -	$ -
68	per member/per month rate	$0	$0	$0	$0	$0
69	# of eligibles (MM)	-	-	-	-	-
70	Total Benefit Costs (Managed Care + Fee for Service)	$ -	$ -	$ -	$ -	$ -
71						
72	**Total Benefit Costs (For All Demonstration Populations)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
73	(Offsetting beneficiary cost sharing payments) (negative number)					
74	**Net Benefit Costs**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
75						
76	**Administration Costs**					
77	Personnel	$ -	$ -	$ -	$ -	$ -
78	General administration					
79	Contractors/Brokers					
80	Claims Processing					
81	Outreach/marketing costs					
82	Other (specify)					
83	**Total Administration Costs**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
84	10% Administrative Cap	$ -	$ -	$ -	$ -	$ -
85						
86	Federal Title XXI Share	$ -	$ -	$ -	$ -	$ -
87	State Title XXI Share	$ -	$ -	$ -	$ -	$ -
88	**TOTAL COSTS FOR DEMONSTRATION**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
89						
90	**TOTAL TITLE XXI PROGRAM COSTS (State Plan + Demonstration)**	**$ 115,608,094**	**$ 121,790,150**	**$ 129,757,882**	**$ 138,727,404**	**$ 148,292,703**
91	Federal Title XXI Share	$ 90,810,158	$ 95,666,163	$ 101,924,816	$ 108,970,376	$ 116,483,918
92	State Title XXI Share	$ 24,797,936	$ 26,123,987	$ 27,833,066	$ 29,757,028	$ 31,808,785
93						
94	**Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)**	**$ 752,368,903**	**$ 920,208,893**	**$ 1,083,192,878**	**$ 1,239,918,210**	**$ 1,389,597,982**
95	**Total Federal Title XXI Program Costs (State Plan + Demonstration)**	**$ 90,810,158**	**$ 95,666,163**	**$ 101,924,816**	**$ 108,970,376**	**$ 116,483,918**
96	**Unused Title XXI Funds Expiring (Allotment or Reallocated)**					
97	**Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)**	**$ 661,558,745**	**$ 824,542,730**	**$ 981,268,062**	**$ 1,130,947,834**	**$ 1,273,114,064**

Table 9.4 – Eligibility Groups/Program Groups

Medicaid Eligibility Group/Program Group	Description	Wavier Population Type
TANF & Related	Populations include: - TANF children and adults - Pregnant Women - Foster Care Children - Transitional Medicaid	Medicaid State Plan
SSI & Related	Populations include: - Aged, blind, disabled children and adults - Working disabled - Acute care services (physical health and behavioral health) for clients enrolled in 1915(c) waivers	Medicaid State Plan
NF LOC Dual Eligible	Recipients that meet nursing facility level of care who are receiving long term care, physical health and behavioral health services. Recipients represented including those residing in nursing homes, disabled and elderly HCBS, and personal care option services. These clients are dually eligible for Medicare and Medicaid	Medicaid State Plan
NF LOC Medicaid Only	Recipients that meet nursing facility level of care who are receiving long term care, physical health and behavioral health services. Recipients represented including those residing in nursing homes, disabled and elderly HCBS, and personal care option services. These clients are not eligible for Medicare	Medicaid State Plan
Healthy Dual	Recipients who are dually eligible for Medicare and Medicaid and do not meet the nursing facility level of care criteria	Medicaid State Plan
Mi Via Dual Eligible	Recipients who would be classified in the NF LOC Dual Eligible group but have elected to receive services under the Mi Via – Self Directed program	Medicaid State Plan
Mi Via Medicaid Only	Recipients who would be classified in the NF LOC Medicaid Only group but have elected to receive services under the Mi Via – Self Directed program	Medicaid State Plan
Family Planning	Recipients that are receiving family planning services, a limited Medicaid benefit	Medicaid State Plan
DSH	DSH Allotment	Medicaid State Plan
SCPH	Sole Community Provider Hospital	Medicaid State Plan

Table 9.5a – Without and With Waiver annual Medical Cost Trends

Demonstration Year	Base - DY1	DY1 - DY2	DY2 - DY3	DY3 - DY4	DY4 - DY5
Blind/Disabled	4.51%	5.68%	6.23%	6.25%	6.35%
Children	5.64%	5.76%	5.68%	6.67%	6.95%
Adults	6.24%	6.76%	6.85%	7.38%	7.19%

Table 9.5b – Eligibility Groups / Program Group Adjustments

Medicaid Eligibility Group/Program Group	Without Waiver	With Waiver
TANF & Related	- Methadone Coverage	- Methadone Coverage - Managed care efficiencies - Non-emergent ER copayment - Care and service coordination - Implementation of health homes
SSI & Related	- Methadone Coverage	- Methadone Coverage - Managed care efficiencies - Non-emergent ER copayment - Care and service coordination - Implementation of health homes
NF LOC Dual Eligible	- Nursing facility per diem fee increase	- Nursing facility per diem fee increase - Managed care efficiencies - Care and service coordination - Implementation of health homes
NF LOC Medicaid Only	- Nursing facility per diem fee increase	- Nursing facility per diem fee increase - Managed care efficiencies - Non-emergent ER copayment - Care and service coordination - Implementation of health homes

Medicaid Eligibility Group/Program Group	Without Waiver	With Waiver
Healthy Dual		- Methadone Coverage - Managed care efficiencies - Care and service coordination - Implementation of health homes
Mi Via Dual Eligible		- Methadone Coverage - Managed care efficiencies - Care and service coordination - Implementation of health homes
Mi Via Medicaid Only		- Managed care efficiencies - Non-emergent ER copayment - Care and service coordination - Implementation of health homes
Family Planning		- None

Table 9.6a Without Waiver
Total Computable

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WOW
			DY 01 (1/1/14 - 12/31/14)	DY 02 (1/1/15 - 12/31/15)	DY 03 (1/1/16 - 12/31/16)	DY 04 (1/1/17 - 12/31/17)	DY 05 (1/1/18 - 12/31/18)	
TANF & Related								
Eligible Member Months	2.08%	54	4,738,676	4,873,255	5,032,123	5,104,585	5,144,401	
Total Cost Per Eligible	7.00%	54	$ 398.78	$ 425.71	$ 454.66	$ 487.71	$ 522.62	
Total Expenditure			$ 1,889,678,042	$ 2,074,589,756	$ 2,287,916,335	$ 2,489,574,407	$ 2,688,582,187	$ 11,430,340,727
SSI & Related								
Eligible Member Months	1.07%	54	437,615	441,948	446,456	451,411	456,648	
Total Cost Per Eligible	6.44%	54	$ 1,176.15	$ 1,248.49	$ 1,331.98	$ 1,417.28	$ 1,509.40	
Total Expenditure			$ 514,703,101	$ 551,766,805	$ 594,669,232	$ 639,774,643	$ 689,262,569	$ 2,990,176,350
NF LOC - Dual								
Eligible Member Months	1.78%	54	214,337	218,002	221,796	225,810	230,033	
Total Cost Per Eligible	5.68%	54	$ 3,514.73	$ 3,696.44	$ 3,907.51	$ 4,135.32	$ 4,383.85	
Total Expenditure			$ 753,337,572	$ 805,833,200	$ 866,668,401	$ 933,796,402	$ 1,008,429,024	$ 4,368,064,600
NF LOC - Medicaid Only								
Eligible Member Months	1.07%	54	76,467	77,224	78,012	78,878	79,793	
Total Cost Per Eligible	6.13%	54	$ 5,125.82	$ 5,416.96	$ 5,754.44	$ 6,114.09	$ 6,502.34	
Total Expenditure			$ 391,957,019	$ 418,320,957	$ 448,915,053	$ 482,266,636	$ 518,840,097	$ 2,260,299,762
Healthy Dual								
Eligible Member Months	1.78%	54	203,970	207,458	211,068	214,888	218,906	
Total Cost Per Eligible	5.68%	54	$ 241.39	$ 253.87	$ 268.37	$ 284.01	$ 301.08	
Total Expenditure			$ 49,236,210	$ 52,667,190	$ 56,643,222	$ 61,030,536	$ 65,908,333	$ 285,485,491
Mi Via - Dual								
Eligible Member Months	1.78%	54	7,560	7,689	7,823	7,965	8,114	
Total Cost Per Eligible	5.68%	54	$ 3,327.03	$ 3,499.04	$ 3,698.83	$ 3,914.48	$ 4,149.74	
Total Expenditure			$ 25,152,191	$ 26,904,898	$ 28,936,044	$ 31,177,292	$ 33,669,102	$ 145,839,527
Mi Via - Medicaid Only								
Eligible Member Months	1.07%	54	2,531	2,556	2,582	2,611	2,641	
Total Cost Per Eligible	6.13%	54	$ 4,937.61	$ 5,218.06	$ 5,543.15	$ 5,889.59	$ 6,263.58	
Total Expenditure			$ 12,498,198	$ 13,338,856	$ 14,314,399	$ 15,377,870	$ 16,544,075	$ 72,073,398
Family Planning								
Eligible Member Months	2.08%	54	316,318	325,302	335,907	340,744	343,401	
Total Cost Per Eligible	6.94%	54	$ 23.19	$ 24.74	$ 26.41	$ 28.32	$ 30.33	
Total Expenditure			$ 7,333,984	$ 8,047,601	$ 8,870,875	$ 9,648,316	$ 10,414,919	$ 44,315,695
DSH								
Total Allotment			$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 144,938,276
SCPH								
Total Allotment	8.40%	42	$ 369,591,008	$ 400,787,339	$ 436,841,166	$ 472,920,172	$ 510,347,317	$ 2,190,487,002
Total Expenditure			$ 4,042,474,980	$ 4,381,244,259	$ 4,772,762,383	$ 5,164,553,929	$ 5,570,985,277	$ 23,932,020,828

Note:

1. Sole Community Provider Hospital (SCPH) base year is SFY11.

Table 9.6b Without Waiver
Federal Share

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WOW
			DY 01 (1/1/14 - 12/31/14)	DY 02 (1/1/15 - 12/31/15)	DY 03 (1/1/16 - 12/31/16)	DY 04 (1/1/17 - 12/31/17)	DY 05 (1/1/18 - 12/31/18)	
TANF & Related								
Eligible Member Months	2.08%	54	4,738,676	4,873,255	5,032,123	5,104,585	5,144,401	
Total Cost Per Eligible	7.00%	54	$ 276.59	$ 295.27	$ 315.35	$ 338.28	$ 362.49	
Total Expenditure			$ 1,310,680,690	$ 1,438,935,455	$ 1,586,898,770	$ 1,726,768,809	$ 1,864,800,605	$ 7,928,084,328
SSI & Related								
Eligible Member Months	1.07%	54	437,615	441,948	446,456	451,411	456,648	
Total Cost Per Eligible	6.44%	54	$ 815.78	$ 865.95	$ 923.86	$ 983.02	$ 1,046.92	
Total Expenditure			$ 356,998,071	$ 382,705,456	$ 412,462,579	$ 443,747,693	$ 478,072,518	$ 2,073,986,316
NF LOC - Dual								
Eligible Member Months	1.78%	54	214,337	218,002	221,796	225,810	230,033	
Total Cost Per Eligible	5.68%	54	$ 2,437.82	$ 2,563.85	$ 2,710.25	$ 2,868.26	$ 3,040.64	
Total Expenditure			$ 522,514,940	$ 558,925,908	$ 601,121,203	$ 647,681,184	$ 699,446,371	$ 3,029,689,607
NF LOC - Medicaid Only								
Eligible Member Months	1.07%	54	76,467	77,224	78,012	78,878	79,793	
Total Cost Per Eligible	6.13%	54	$ 3,555.27	$ 3,757.20	$ 3,991.28	$ 4,240.73	$ 4,510.02	
Total Expenditure			$ 271,861,388	$ 290,147,416	$ 311,367,481	$ 334,500,138	$ 359,867,492	$ 1,567,743,915
Healthy Dual								
Eligible Member Months	1.78%	54	203,970	207,458	211,068	214,888	218,906	
Total Cost Per Eligible	5.68%	54	$ 167.43	$ 176.08	$ 186.14	$ 196.99	$ 208.83	
Total Expenditure			$ 34,150,235	$ 36,529,963	$ 39,287,739	$ 42,330,780	$ 45,714,020	$ 198,012,736
Mi Via - Dual								
Eligible Member Months	1.78%	54	7,560	7,689	7,823	7,965	8,114	
Total Cost Per Eligible	5.68%	54	$ 2,307.63	$ 2,426.93	$ 2,565.51	$ 2,715.08	$ 2,878.26	
Total Expenditure			$ 17,445,560	$ 18,661,237	$ 20,070,040	$ 21,624,570	$ 23,352,889	$ 101,154,296
Mi Via - Medicaid Only								
Eligible Member Months	1.07%	54	2,531	2,556	2,582	2,611	2,641	
Total Cost Per Eligible	6.13%	54	$ 3,424.72	$ 3,619.25	$ 3,844.73	$ 4,085.02	$ 4,344.42	
Total Expenditure			$ 8,668,750	$ 9,251,830	$ 9,928,467	$ 10,666,090	$ 11,474,970	$ 49,990,109
Family Planning								
Eligible Member Months	2.08%	54	316,318	325,302	335,907	340,744	343,401	
Total Cost Per Eligible	6.94%	54	$ 16.08	$ 17.16	$ 18.32	$ 19.64	$ 21.04	
Total Expenditure			$ 5,086,851	$ 5,581,816	$ 6,152,839	$ 6,692,072	$ 7,223,788	$ 30,737,366
DSH								
Total Allotment			$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 100,529,188
SCPH								
Total Allotment	8.40%	42	$ 256,348,323	$ 277,986,098	$ 302,993,033	$ 328,017,431	$ 353,976,899	$ 1,519,321,785
Total Expenditure			$ 2,803,860,646	$ 3,038,831,018	$ 3,310,387,989	$ 3,582,134,605	$ 3,864,035,388	$ 16,599,249,646

Note:

1. Assumes FMAP of 69.36% for Title XIX for each demonstration year.
2. Sole Community Provider Hospital (SCPH) base year is SFY11.

Table 9.6c With Waiver
Total Computable

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01 (1/1/14 - 12/31/14)	DY 02 (1/1/15 - 12/31/15)	DY 03 (1/1/16 - 12/31/16)	DY 04 (1/1/17 - 12/31/17)	DY 05 (1/1/18 - 12/31/18)	
TANF & Related								
Eligible Member Months	2.08%	54	4,738,676	4,873,255	5,032,123	5,104,585	5,144,401	
Total Cost Per Eligible	6.49%	54	$ 396.10	$ 414.01	$ 445.43	$ 476.59	$ 509.40	
Total Expenditure			$ 1,876,988,004	$ 2,017,559,475	$ 2,241,475,867	$ 2,432,796,708	$ 2,620,579,064	$ 11,189,399,118
SSI & Related								
Eligible Member Months	1.07%	54	437,615	441,948	446,456	451,411	456,648	
Total Cost Per Eligible	5.83%	54	$ 1,168.59	$ 1,213.16	$ 1,302.64	$ 1,381.12	$ 1,465.72	
Total Expenditure			$ 511,394,652	$ 536,155,376	$ 581,569,262	$ 623,454,329	$ 669,316,398	$ 2,921,890,016
NF LOC - Dual								
Eligible Member Months	1.78%	54	214,337	218,002	221,796	225,810	230,033	
Total Cost Per Eligible	5.15%	54	$ 3,497.96	$ 3,596.62	$ 3,830.44	$ 4,043.64	$ 4,275.98	
Total Expenditure			$ 749,744,087	$ 784,072,211	$ 849,573,957	$ 913,095,876	$ 983,615,777	$ 4,280,101,908
NF LOC - Medicaid Only								
Eligible Member Months	1.07%	54	76,467	77,224	78,012	78,878	79,793	
Total Cost Per Eligible	5.59%	54	$ 5,101.42	$ 5,270.79	$ 5,641.06	$ 5,978.70	$ 6,342.50	
Total Expenditure			$ 390,091,696	$ 407,032,735	$ 440,070,243	$ 471,586,981	$ 506,086,656	$ 2,214,868,312
Healthy Dual								
Eligible Member Months	1.78%	54	203,970	207,458	211,068	214,888	218,906	
Total Cost Per Eligible	5.15%	54	$ 240.24	$ 247.03	$ 263.09	$ 277.74	$ 293.70	
Total Expenditure			$ 49,001,782	$ 51,247,815	$ 55,529,605	$ 59,682,072	$ 64,292,027	$ 279,753,302
Mi Via - Dual								
Eligible Member Months	1.78%	54	7,560	7,689	7,823	7,965	8,114	
Total Cost Per Eligible	5.61%	54	$ 3,295.86	$ 3,426.41	$ 3,657.18	$ 3,869.24	$ 4,100.56	
Total Expenditure			$ 24,916,540	$ 26,346,425	$ 28,610,210	$ 30,817,027	$ 33,270,140	$ 143,960,343
Mi Via - Medicaid Only								
Eligible Member Months	1.07%	54	2,531	2,556	2,582	2,611	2,641	
Total Cost Per Eligible	5.88%	54	$ 4,900.13	$ 5,097.14	$ 5,462.58	$ 5,797.36	$ 6,158.46	
Total Expenditure			$ 12,403,331	$ 13,029,747	$ 14,106,352	$ 15,137,051	$ 16,266,411	$ 70,942,892
Family Planning								
Eligible Member Months	2.08%	54	316,318	325,302	335,907	340,744	343,401	
Total Cost Per Eligible	6.94%	54	$ 23.19	$ 24.74	$ 26.41	$ 28.32	$ 30.33	
Total Expenditure			$ 7,333,984	$ 8,047,601	$ 8,870,875	$ 9,648,316	$ 10,414,919	$ 44,315,695
DSH								
Total Allotment			$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 28,987,655	$ 144,938,276
SCPH								
Total Allotment	8.38%	42	$ 369,549,795	$ 400,575,408	$ 436,438,777	$ 472,484,540	$ 509,877,200	$ 2,188,925,721
Total Expenditure			$ 4,020,411,527	$ 4,273,054,450	$ 4,685,232,805	$ 5,057,690,554	$ 5,442,706,247	$ 23,479,095,584

Note:

1. Sole Community Provider Hospital (SCPH) base year is SFY11.

Table 9.6d With Waiver
Federal Share

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY) DY 01 (1/1/14 - 12/31/14)	DY 02 (1/1/15 - 12/31/15)	DY 03 (1/1/16 - 12/31/16)	DY 04 (1/1/17 - 12/31/17)	DY 05 (1/1/18 - 12/31/18)	TOTAL WW
TANF & Related								
Eligible Member Months	2.08%	54	4,738,676	4,873,255	5,032,123	5,104,585	5,144,401	
Total Cost Per Eligible	6.49%	54	$ 274.73	$ 287.15	$ 308.95	$ 330.56	$ 353.32	
Total Expenditure			$ 1,301,878,880	$ 1,399,379,252	$ 1,554,687,662	$ 1,687,387,796	$ 1,817,633,639	$ 7,760,967,228
SSI & Related								
Eligible Member Months	1.07%	54	437,615	441,948	446,456	451,411	456,648	
Total Cost Per Eligible	5.83%	54	$ 810.54	$ 841.45	$ 903.51	$ 957.95	$ 1,016.62	
Total Expenditure			$ 354,703,330	$ 371,877,369	$ 403,376,440	$ 432,427,922	$ 464,237,853	$ 2,026,622,915
NF LOC - Dual								
Eligible Member Months	1.78%	54	214,337	218,002	221,796	225,810	230,033	
Total Cost Per Eligible	5.15%	54	$ 2,426.19	$ 2,494.62	$ 2,656.79	$ 2,804.67	$ 2,965.82	
Total Expenditure			$ 520,022,499	$ 543,832,486	$ 589,264,497	$ 633,323,299	$ 682,235,903	$ 2,968,678,683
NF LOC - Medicaid Only								
Eligible Member Months	1.07%	54	76,467	77,224	78,012	78,878	79,793	
Total Cost Per Eligible	5.59%	54	$ 3,538.35	$ 3,655.82	$ 3,912.64	$ 4,146.82	$ 4,399.16	
Total Expenditure			$ 270,567,601	$ 282,317,905	$ 305,232,721	$ 327,092,730	$ 351,021,705	$ 1,536,232,661
Healthy Dual								
Eligible Member Months	1.78%	54	203,970	207,458	211,068	214,888	218,906	
Total Cost Per Eligible	5.15%	54	$ 166.63	$ 171.34	$ 182.48	$ 192.64	$ 203.71	
Total Expenditure			$ 33,987,636	$ 35,545,485	$ 38,515,334	$ 41,395,485	$ 44,592,950	$ 194,036,890
Mi Via - Dual								
Eligible Member Months	1.78%	54	7,560	7,689	7,823	7,965	8,114	
Total Cost Per Eligible	5.61%	54	$ 2,286.01	$ 2,376.56	$ 2,536.62	$ 2,683.71	$ 2,844.15	
Total Expenditure			$ 17,282,112	$ 18,273,881	$ 19,844,042	$ 21,374,690	$ 23,076,169	$ 99,850,894
Mi Via - Medicaid Only								
Eligible Member Months	1.07%	54	2,531	2,556	2,582	2,611	2,641	
Total Cost Per Eligible	5.88%	54	$ 3,398.73	$ 3,535.38	$ 3,788.85	$ 4,021.05	$ 4,271.51	
Total Expenditure			$ 8,602,950	$ 9,037,433	$ 9,784,166	$ 10,499,058	$ 11,282,383	$ 49,205,990
Family Planning								
Eligible Member Months	2.08%	54	316,318	325,302	335,907	340,744	343,401	
Total Cost Per Eligible	6.94%	54	$ 16.08	$ 17.16	$ 18.32	$ 19.64	$ 21.04	
Total Expenditure			$ 5,086,851	$ 5,581,816	$ 6,152,839	$ 6,692,072	$ 7,223,788	$ 30,737,366
DSH								
Total Allotment			$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 20,105,838	$ 100,529,188
SCPH								
Total Allotment	8.38%	42	$ 256,208,873	$ 277,718,930	$ 302,583,004	$ 327,573,531	$ 353,497,863	$ 1,517,582,202
Total Expenditure			$ 2,788,446,570	$ 2,963,670,394	$ 3,249,546,542	$ 3,507,872,423	$ 3,774,908,090	$ 16,284,444,019

Table 9.7a Summary of Without Waiver and With Waiver Projected Medicaid Expenditures – Total Computable*

Without Waiver	With Waiver	Savings
$23,932,020,828	$23,479,095,584	$452,925,244

** See disclaimer*

Table 9.7b Summary of Without Waiver and With Waiver Projected Medicaid Expenditures – Federal Share*

Without Waiver	With Waiver	Savings
$16,599,249,646	$16,284,444,019	$314,805,627

** See disclaimer*

Appendix D: HCBS and New Medicaid Behavioral Health Service Definitions

Adult Day Health
Adult Day Health services provide structured therapeutic, social and rehabilitative services designed to meet the specific needs and interests of eligible recipients 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 eligible recipients 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.

Limits or Exclusions: Minimum of two hours per day for one or more days per week.

Assisted Living
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 eligible recipient 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.

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

Behavior Support Consultation: 1) informs and guides the eligible recipient's providers with the services and supports as they relate to the eligible recipient'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 eligible recipient and his/her service and support providers. Based on the eligible recipient's care plan, services are delivered in an integrated/natural setting or in a clinical setting.

Community Transition Services
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. 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.

Emergency Response
Emergency Response services provide an electronic device that enables an eligible recipient to secure help in an emergency at home and avoid institutionalization.
The eligible recipient may also wear a portable "help" button to allow for mobility. The system is connected to the eligible recipient'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 eligible recipients, 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 eligible recipient emergencies and changes in the eligible recipient's condition that may affect service delivery. Emergency categories consist of emergency response, emergency response high need, and emergency response.

Limits or Exclusions: Eligible recipient must have a landline phone.

Employment Supports
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 an individual 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 eligible recipient and co-workers on rights and responsibilities; and benefits counseling. The service must be tied to a specific goal specified in the individual's care plan.

Job development is a service provided to eligible recipients 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 eligible recipients 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.

Environmental Modifications
Environmental Modification services include the purchase and/or installation of equipment and/or making physical adaptations to an eligible recipient's residence that are necessary to ensure the health, welfare, and safety of the eligible recipient or enhance the eligible recipient's 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 eligible recipient.

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 eligible recipient'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 an eligible recipient's health and safety needs exceed the specified limit.

Family Support Services

Family Support Services involve community-based, face-to-face interaction with the eligible recipients and family members/significant others that identify the recovery and resiliency service needs and within a recovery plan to enhance the eligible recipient's and families' strengths, capacities, and resources so as to promote their ability to reach the recovery and resiliency behavioral health goals they consider most important. Key service components include:

- Services are provided in family homes, schools and school-based health centers, work places, local community centers and other places most suited to youth or adult eligible recipients and their families.

- Services are designed to be available when needed with support availability including evening and weekend hours, if indicated.

- Services are directed toward recovery, restoration, enhancement, and maintenance of the eligible recipient's functioning and to increase the family's ability to effectively interact with the eligible recipient, the behavioral health system, and general community supports in the context of care for the eligible recipient in his or her home and community.

- Services focus on the support needed to prevent youth or adult eligible recipients from being placed in out of home mental health settings such as hospitals, residential treatment centers, therapeutic foster care, or detention settings; or to quickly return them to their local communities from out of home placements.

Services occur within the environment of the family's culture and uses strengths based approach to focus on what the eligible recipient/family wants; and supports the transition from formal mental health services to natural and community supports.

Home Health Aide
Home Health Aide services provide total care or assist an eligible recipient 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 eligible recipient in a manner that promotes an improved quality of life and a safe environment for the eligible recipient. Home Health Aide services can be provided outside the eligible recipient'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 eligible recipients 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 recipient's residence at least every two weeks to observe and determine whether goals are being met.

Nutritional Counseling
Nutritional Counseling services include assessment of the eligible recipient's nutritional needs, development and/or revision of the eligible recipient's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan.

Private Duty Nursing for Adults
Private Duty Nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for recipients who are twenty-one 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.

Recovery Service
Recovery Service is a group service that is offered within a CSA constellation of integrated services. Recovery Services are provided after a care plan is completed, and the service is specified in the eligible recipient's (individual's) self directed Recovery Plan. Recovery Services provide the platform for eligible recipient developed service activities that incorporate the eligible recipient's social support.

Recovery Services promote recovery and resiliency through enhancing the individuals' strengths and building on their capabilities to address challenges and life barriers to life goals precipitated by mental illness, substance abuse and/or co-occurring (mental illness *and* substance use) disorders. Services are provided in a manner that embraces diversity and that is culturally sensitive. This service is embedded within an integrated multi-disciplinary approach, through the CSA provider agency. Eligible recipients receiving this service shall be able to identify additional needs and be able to link themselves to additional support as a result of this service.

Related Goods
Related goods are equipment, supplies or fees and memberships, not otherwise provided through under Medicaid. Related goods must address a need identified in the eligible recipient's care plan (including improving and maintaining the eligible recipient's opportunities for full membership in the community) and meet the following requirements: be responsive to the eligible recipient's qualifying condition or disability; and/or accommodate the eligible recipient in managing his/her household; and/or facilitate activities of daily living; and/or promote personal safety and health; and afford the eligible recipient an accommodation for greater independence; and advance the desired outcomes in the eligible recipient'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 eligible recipient 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 eligible recipient's individual budget.

Limits or Exclusions: Experimental or prohibited treatments and goods are excluded. Related goods are limited to $500 per person per care plan year.

Respite
Respite is provided to eligible recipients unable to care for themselves and furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite services may be provided in an eligible recipient's home or in the community.

Services include assistance with routine ADLs (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play, and other recreational activities and to allow community integration opportunities.

Respite is also available to children and youth up to 21 years of age diagnosed with a serious emotional or behavioral health disorder as defined by the DSM IV whose primary caregivers typically are the same people day after day. The service involves the supervision and/or care of children and youth residing at home in order to provide an interval of rest and/or relief to the person and/or their primary care givers and may include a range of activities to meet the social, emotional and physical needs of the person 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. Respite may be provided on either a planned or an unplanned basis and may be provided in a variety of settings. If unplanned respite is needed, the appropriate agency personnel will assess the situation and, with the caregiver, recommend the appropriate

setting for respite. Services must only be provided on an intermittent or short-term basis because of the absence or need for relief of those persons normally providing care. Parents receiving behavioral health services may receive necessary respite services for their non-enrolled children as indicated in their service plan.

Limits or Exclusions: Respite services are limited to a maximum of 100 hours annually per care plan year provided there is a primary caretaker. Additional hours may be requested if an eligible recipient's health and safety needs exceed the specified limit.

For children and youth up to 21 years of age diagnosed with a serious emotional or behavioral health disorder, respite services are limited to 720 hours a year or 30 days.

Skilled Maintenance Therapy Services
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.

Skilled Maintenance Therapy services specifically 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 eligible recipient.

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 eligible recipient.

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 eligible recipient'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 eligible recipient.

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.

Specialized Medical Equipment and Supplies
Specialized Medical Equipment and Supplies include: (a) devices, controls or appliances specified in the care plan that enable eligible recipients to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the eligible recipient to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State Plan that is necessary to address eligible recipient functional limitations; and (e) necessary medical supplies not available under the Medicaid State Plan. Items reimbursed are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the eligible recipient. The costs of maintenance and upkeep of equipment are included in the cost of equipment and supplies. All items shall meet applicable standards of manufacture, design, and installation.

Limits or Exclusions: Medical equipment and supplies that are furnished by the Medicaid State Plan are not covered in the Specialized Medical Equipment and Supplies. This service does not include nutritional or dietary supplements, disposable diapers or bed pads, or disposable wipes. The service is limited to $1,000 per care plan year.

Specialized Therapies
Specialized Therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. An eligible recipient 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 eligible recipient's disability or condition, ensure the eligible recipient's health and welfare in the community, supplement rather than replace the eligible recipient's natural supports and other community services for which the eligible recipient may be eligible, and prevent the eligible recipient'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 eligible recipients' physiological information of which they are normally unaware. This technique enables an eligible recipient 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 eligible recipients with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the eligible recipient use cognitive functioning, especially for sequencing and memory. Eligible recipients 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, an eligible recipient'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 eligible recipients 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 eligible recipients, and provides opportunities for eligible recipients 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.

Play Therapy
Play therapy is a variety of play and creative arts techniques (the 'Play Therapy Tool-Kit') utilized to alleviate chronic, mild and moderate psychological and emotional conditions in children that are causing behavioral problems and/or are preventing children from realizing their potential. The Play Therapist works integratively using a wide range of play and creative arts techniques, mostly responding to the child's wishes.

Appendix E: Outreach to Native Americans

Meeting and Attendees	Date
Tribal Consultation, Pueblo Cultural Center, Albuquerque. 79 individuals attended. Secretary Squier outlined the 4 principles of the Modernization effort and the State's desire to create a comprehensive, integrated system of care for New Mexico. There was mixed feedback from the attendees ranging from an emphasis on the state and the federal governments honoring the treaty obligations to provide health care to Native Americans to concerns about managed care to advocating of managed care as a way of decreasing health disparities.	August 3, 2011
As part of the outreach effort, the Department of Human Services and Alicia Smith & Associates scheduled a 2-day workgroup with invited staff from the Indian Health Service and the tribes. The meetings were held at the HSD offices in Santa Fe, New Mexico. The attendees included: Brent Earnest – Deputy Secretary HSD Theresa Belanger – Native American Liaison HSD Betina McCracken – Secretary's Office HSD Kim Horan – HSD David Antle – Pueblo of Isleta Roxanne Spruce Bly – Bernalillo County off-Reservation Native American Health Commission Robin Clemmons – Pueblo of Acoma Richie Grinnell – IHS Earlene Groseclose – IHS Lisa Maves – Pueblo of Jemez April Wilkinson – Pueblo of Acoma Jennifer Nanez – Pueblo of Acoma Sandra Winfrey – IHS Comments included: • Concerns with the managed care experience with the CoLTS program. Some stated that it their recipient had never seen a care coordinator from the CoLTS plans; • Both the tribal and HIS participants expressed their opposition to the elimination of the "opt/out" option from managed care enrollment for Native Americans on Medicaid; • Recent experiences with Salud plans have been better; • A full-blown Native American MCO is probably not an option at this point, although there was interest in managing discrete portions of the Medicaid benefit; • Discussion of the role that IHS and tribal 638 facilities could play in managed care as Patient Centered Medical Homes and/or Health Homes as both a means of economic opportunity and a way to let Native American's play a more active role in providing care; and • Care coordination and case management must be done locally if it is to be meaningful and successful for tribal members.	September 28 to 29, 2011
As a follow-up to the workgroup meetings, Alicia Smith and David Parrella from Alicia Smith & Associates met with Governor Luarkie at the Laguna pueblo to discuss economic opportunities that could be available to the tribes under a managed care model.	October 4, 2011
Alicia Smith met with Dr. Ron Lujan and his son, Eric as well as with Robin Clemmons from Acoma to discuss their concerns and desire for a more	Week of October 10th, 2011

Meeting and Attendees	Date
active role in providing care to their own Tribes. They also shared their concerns that the current plans in New Mexico do not contract with and/or reimburse Tribes for care management and transportation services they provide. They would like to see a replication of a PACE-like model.	
David Parrella travelled to Window Rock to meet with Roselyn Begay, the Director of the Navajo Nation Department of Health, and the members of her staff. Also in attendance was Floyd Thompson from the Window Rock Area Office of the Indian Health Service. Comments included: • Interest in contracting with the State to manage some portion of the Medicaid budget, but frustration that they could not contract directly with CMS; • One stated goal was that ultimately the Navajo Nation would like to be able to manage its own Medicaid program as a carve out from the Four Corners states (New Mexico, Arizona, Utah, Colorado); • Any contract with the State to manage Medicaid benefits would need to include risk corridors to protect the tribe from catastrophic costs; and • Eligibility intake at the IHS facilities is an issue since many tribal members lack transportation and have to hitch-hike to the hospital for services. When they are referred to out-stationed eligibility workers for Medicaid intake, they often do not have the necessary documentation with them and are required to make another trip to apply.	November 4, 2011
David Parrella met with Dr. Ron Lujan and his son, Eric, from the Taos Pueblo in Albuquerque. Comments included: • Dr. Lujan was opposed to any attempt to force the enrollment of Native Americans in private for-profit managed care companies. He was very clear about his desire for the State to maintain the “opt out” option from managed care for Native Americans; and • Dr. Lujan is interested in a model where the State would contract to a consortium of Native American service providers for the elderly along the lines of the PACE program.	November 4, 2011
Presentation to the Native American Stakeholder Group on Medicaid Update and Health Care Reform (60 to 75 people in attendance).	November 10, 2011
David Parrella met with members of the Albuquerque Area Indian Health Board.	December 8, 2011
“Save the Date” Notice sent to all Tribal Leaders via email and regular mail alerting them to the date for the State-Tribal Consultation on Medicaid Modernization.	February 17, 2012
Copy of Centennial Care Concept Paper mailed to all Tribal Leaders.	February 22, 2012
Presentation to representatives from the Navajo Nation Division of Health and Navajo Area HIS in Window Rock, Arizona.	March 13, 2012
State-Tribal Consultation – 8:30 a.m. to 3:30 p.m., updated concept paper printed for all attendees along with draft list of waivers and Power point presentation. Concept paper and Power point presentation also posted on Centennial Care webpage on HSD website.	March 20, 2012
Revised concept paper and list of waivers sent to Tribal leaders by regular mail and email.	March 21, 2012
Follow-up email from Theresa Belanger to schedule meetings.	March 22, 2012
State-Tribal Consultation Meeting notes posted on Centennial Care page of HSD website.	March 23, 2012
Face to face meeting in Albuquerque with the Bernalillo County	March 26, 2012

Meeting and Attendees	Date
Off-Reservation Native American Health Commission.	
Presentation at the Managed Care Organization (MCO) Annual Meeting with Tribal Representation (250 in attendance).	March 29, 2012
Face to face meeting in Santa Fe with representatives from the Albuquerque Area IHS – representatives from Navajo Area IHS joined the meeting via conference call.	March 30, 2012
State-Tribal Consultation Follow-up letter – letter sent to all Tribal members summarizing the consultation and clarifying issues brought up during the consultation.	April 20, 2012