DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

October 16, 2024

Dana Flannery
Medicaid Director, Medical Assistance Division
New Mexico Human Services Department
State Capitol
Room 400
Sante Fe, NM 87501

Dear Director Flannery:

In accordance with section 1115(a) of the Social Security Act (the Act), the Centers for Medicare & Medicaid Services (CMS) is approving New Mexico's request to amend the demonstration titled "New Mexico Turquoise Care" (Project Number 11-W-00285/6) (the "demonstration"), to provide expenditure authority for coverage of traditional health care practices. This approval is effective from October 16, 2024, through December 31, 2029, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

With this amendment, New Mexico will have expenditure authority to provide coverage for traditional health care practices received through Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA) (here called Tribal facilities), or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act (IHCIA) (here called urban Indian organization facilities). Coverage of these traditional health care practices will be available to Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

We are pleased to approve this amendment, which is part of a groundbreaking demonstration initiative that is expected to promote the objectives of Medicaid by broadening the health coverage that can be furnished by states to Medicaid beneficiaries who are able to receive services delivered by or through IHS, Tribal, and urban Indian organization facilities. This demonstration coverage is expected to be particularly impactful for American Indian and Alaska Native populations and individuals with physical or behavioral health needs because it is expected to improve their access to coverage of culturally appropriate health care. American Indian and Alaska Native traditional health care practices have historically been paid for and delivered by or through IHS, Tribal, or urban Indian organization facilities, but have not until now been covered or paid for by Medicaid. Medicaid payment for these services will promote access to care for American Indian and Alaska Native Medicaid beneficiaries and improve access to services at IHS, Tribal, and urban Indian organization facilities.

CMS's approval is subject to the limitations specified in the attached expenditure authorities, special terms and conditions (STC), and any supplemental attachment defining the nature, character, and extent of federal involvement in this project. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been identified in the attached expenditure authorities list as not applicable to expenditures under the amendment.

Section 1115(a) of the Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. This approval will permit CMS to evaluate the effects of providing Medicaid coverage for these traditional health care practices, which cannot currently be covered under the Medicaid state plan.

Extent and Scope of Demonstration Amendment

Background

Traditional health care practices are described by the World Health Organization as the "sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness."[1] American Indian and Alaska Natives have long recognized the contribution of traditional healers and practitioners who are valued for their role in aiding the healing process. There are 574 federally recognized Tribes in the United States,[2] each with its own traditional health care practices. Some Tribes, bands, groups, pueblos, rancherias, nations, colonies, or communities, including Native villages or Native groups, see traditional health care practices as a fundamental element of health care that can help patients with specific physical and mental ailments.

American Indians and Alaska Natives experience significantly worse health disparities as compared to the general population, including higher incidence and prevalence of obesity, diabetes, tobacco addiction, and cancer. In addition to significant physical health issues, American Indians and Alaska Natives face mental health illnesses, substance use disorders, and suicide rates that impact Tribal communities at rates significantly higher than the general population.[3] A number of factors contribute to these persistent disparities, including barriers to quality and timely medical care; geographic isolation; contemporary threats to culture, language,

[1] https://www.who.int/health-topics/traditional-complementary-and-integrative-medicine#tab=tab_1. NOTE: This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

[2] https://www.usa.gov/tribes#:~:text=The%20federal%20government%20recognizes%20574,and%20learn%20how%20to%20enroll

[3] https://www.cms.gov/files/document/ttag-strategic-plan-2020-2025.pdf

and lifeways; and lack of access to traditional foods.[4,5] However, several studies have demonstrated that traditional health care practices might help to improve mental health symptoms and outcomes and quality of life, including with respect to individuals with substance use disorder.[6,7,8] Section 1115 demonstrations can therefore further test the effects of providing coverage for traditional health care practices in Medicaid.

The Indian Health Care Improvement Act (IHCIA) (25 U.S.C. 1601 *et seq*.) serves as one of the federal government's statutory authorities for IHS's provision of health care to American Indians and Alaska Natives and is based on the unique government-to-government relationship between the federal government and Indian Tribes. The United States Department of Health and Human Services promotion of traditional health care practices is authorized in the IHCIA at 25 U.S.C. 1680u.[9] Over the years, the provision of traditional health care practices has been supported primarily through IHS appropriations, Tribal resources, various pilot programs, and grant funding. Additionally, Medicaid is the largest source of third-party payment for services billed by IHS and Tribal facilities, accounting for nearly two-thirds of health coverage payments to these facilities.[10] Fifty-five percent of patients served by urban Indian organization facilities in 2021 had Medicaid or CHIP coverage.[11] Given the significant role of Medicaid as a payer for IHS, Tribal, and urban Indian organization facility services, authorizing Medicaid payment to these facilities for traditional health care practices may potentially improve patient access to culturally appropriate practices to maintain and sustain health and otherwise support these facilities' ability to serve their patients.

As noted above, with this amendment, New Mexico will have expenditure authority to provide coverage for traditional health care practices received through IHS, Tribal, or urban Indian organization facilities by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.[12] CMS expects that this amendment will broaden the health coverage

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[4] https://www.cms.gov/files/document/ttag-strategic-plan-2020-2025.pdf
[5] https://minorityhealth.hhs.gov/american-indianalaska-native-health
[6] https://ncuih.org/research/third-party-billing/
[7] https://pubmed.ncbi.nlm.nih.gov/26851329/
[8] https://pubmed.ncbi.nlm.nih.gov/24842541/
[9] 25 U.S.C. 1680u specifically provides that "the Secretary may promote traditional health care practices, consistent with the [IHS] standards for the provision of health care, health promotion, and disease prevention under [title 25, chapter 18 of the U.S. Code]."
https://uscode.house.gov/view.xhtml?req=(title:25%20section:1680u%20edition:prelim)%20OR%20(granuleid:USC-prelim-title25-section1680u)&f=treesort&edition=prelim&num=0&jumpTo=true.
[10] Assistant Secretary of Planning and Evaluation (ASPE),
How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives, Report No. HP-2022-21, (Washington, DC, 2022),
https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf
[11] https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2021_UIO_UDS_Summary_Report_Final.pdf
[12] Whether a beneficiary is able to receive services from a qualifying facility will be determined by the applicable facility. Under IHS authorities, IHS and Tribal facilities serve Medicaid and CHIP beneficiaries who are able (authorized) to receive services from the facility under IHS regulations at 42 CFR part 136, and also may serve other Medicaid and CHIP beneficiaries under 25 U.S.C. 1680c. Under IHS authorities, urban Indian organization facilities that receive funding from IHS are authorized to use the IHS funding to serve urban Indians (as defined in 25 U.S.C.

that can be furnished by states to these Medicaid beneficiaries. The amendment is also expected to expand utilization of these traditional health care practices and improve access to culturally appropriate care; support these facilities' ability to serve their patients; maintain and sustain health; improve health outcomes and the quality and experience of care; and reduce existing disparities in access to and quality of care and health outcomes. This amendment also aligns with this Administration's policy priorities articulated in the 2022 guidance and implementation memorandum for Federal Agencies on recognizing and including Indigenous Knowledge in Federal research, policy, and decision making.[13] Furthermore, this approval supports the CMS Tribal Technical Advisory Group (TTAG) Strategic Plan 2020-2025 Objective 1C, Task 4, which states that CMS will support work to evaluate, use, and inform states on how the use of state plan amendments, section 1115 demonstrations, or other demonstrations can improve access for Tribal citizens and other IHS-eligible individuals to timely health care services.[14] Lastly, Medicaid and CHIP provide health coverage for approximately 35 percent of all American Indian and Alaska Native nonelderly adults and more than 60 percent of American Indian and Alaska Native children.[15] Given the scope of the American Indian and Alaska Native population covered by Medicaid, this demonstration approval can play a key role in enhancing health equity for these populations.

Scope of Approval

Traditional health care practices vary widely by Tribe, facility, and geographic area. Under this amendment, traditional health care practices received through IHS, Tribal, or urban Indian organization facilities will be covered when provided to a Medicaid beneficiary who is able to receive services delivered by or through these qualifying providers. Whether a beneficiary is able to receive services from a qualifying provider will be determined by the applicable provider. Purchased/referred care under 25 U.S.C. 1603(5) and 42 CFR 136.21(e) is included in this coverage. To be covered, the traditional health care practices must be provided by practitioners or providers who are employed by or contracted with one of these facilities (which could include an urban Indian organization contracted with an IHS or Tribal facility), in order to ensure that the practices are provided by culturally appropriate and qualified practitioners at facilities that are enrolled in Medicaid. The qualifying facility is expected to make the following determinations and to provide documentation of these determinations to the state, upon request. Each qualifying facility is responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices 1) is qualified to provide traditional health care practices to the qualifying facility's patients; and 2) has the necessary experience and appropriate training. The qualifying facility also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to

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1603(28)), residing in the urban centers (as defined in 25 U.S.C. 1603(27)) in which such organizations are situated, including Medicaid and CHIP beneficiaries who also meet those definitions. Urban Indian organization facilities may also serve other Medicaid and CHIP beneficiaries with non-IHS funds, such as those that are dual-funded by IHS and the Health Resources & Services Administration's Health Center Program. https://www.hrsa.gov/about/organization/offices/hrsa-iea/tribal-affairs/tribal-urban-indian-health-centers (including, for example, the urban Indian organization Native American Rehabilitation Association).

[13] https://www.whitehouse.gov/ceq/news-updates/2022/12/01/white-house-releases-first-of-a-kind-indigenous-knowledge-guidance-for-federal-agencies/

[14] https://www.cms.gov/files/document/ttag-strategic-plan-2020-2025.pdf

[15] https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/

provide traditional health care practices, 2) bill Medicaid or CHIP for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request.

CMS is also approving expenditure authority for administrative implementation expenditures to support provider development and implementation of this amendment, such as for accounting and billing systems; electronic health records and modifications to internal systems to accept referrals from other providers for these services; workforce development; and outreach, education, and community engagement.

Because some of the traditional health care practices covered under this demonstration may be considered religious or may contain elements of religious or spiritual practices, the state must attest, as a condition of receiving federal matching funds for its expenditures under this approval, to: 1) providing adequate access to secular alternatives, including but not limited to preventive services, primary care, pharmacy services, mental health and substance use disorder services, as approved in its state plan, 1115 demonstration(s), or 1915 waiver(s), and in compliance with federal laws and regulations; 2) for any condition(s) addressed by and through covered traditional health care practices, ensuring beneficiaries have a genuine, independent choice to use other Medicaid- and CHIP-covered services; and 3) assuring that traditional health care practices may not be used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered under the state plan, 1115 demonstration(s), or 1915 waiver(s) and that the state will not deny access to services or settings on the basis that the beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. Provided that all other applicable requirements for claiming FFP have been met, the state may begin claiming FFP for its expenditures on traditional health care practices only after submitting this attestation to CMS. The state must notify beneficiaries of their rights to file grievances, complaints, and appeals related to this attestation and take any needed actions or monitoring, consistent with federal laws and regulations regarding grievances, complaints, and appeals. As per the STCs, the state must report any such grievances, complaints, and appeals to CMS in Monitoring Reports. CMS will review all reports and will follow up on credible concerns in those reports, as well as any credible concerns raised by members of the public. If the state is found to be out of compliance with the attestation and related STCs, CMS may: 1) require the state to submit a corrective action plan, 2) issue a deferral, or 3) withdraw authority for traditional health care practices.

Consistent with CMS's longstanding interpretation of section 1905(b) of the Act, the state will receive a 100 percent federal medical assistance percentage (FMAP) for its expenditures on the services for which coverage is authorized under this approval when those services are received through IHS or Tribal facilities by Medicaid beneficiaries who are American Indians or Alaska Natives.[16] State expenditures for these services when delivered to Medicaid beneficiaries by urban Indian organization facilities and state expenditures for these services when delivered by or through qualifying facilities to Medicaid beneficiaries who are not American Indians or

[16] Section 1905(b) of the Social Security Act (third sentence). Under CMS's longstanding interpretation of this statutory language, the 100 percent FMAP applies only when services are received through IHS and Tribal facilities by American Indian or Alaska Native Medicaid beneficiaries.

Alaska Natives will be federally matched at the otherwise applicable state service match. CMS will federally match state expenditures to support development and implementation of this amendment at the regularly applicable federal matching percentage for administrative expenditures. New Mexico is approved to cover traditional health care practices for any Medicaid beneficiary who is able to receive services delivered by or through IHS, Tribal facilities, or urban Indian organization facilities. Implementation of the amendment will be subject to the approval of the state legislature if the state is required to secure non-federal share for the expenditures authorized by this amendment.

As discussed in State Health Official letter #16-002, IHS facilities and facilities operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act "may enter into care coordination agreements with [non-IHS or Tribal] providers to furnish certain services for their patients who are [American Indian and Alaska Native] Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching…of 100 percent."[17]

Budget Neutrality

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstration is likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 demonstration approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration, the "without waiver" (WOW) costs.

As discussed earlier, the expenditure authority provided for the coverage of traditional health care practices is limited to practices that are delivered by or through certain facility types that are defined by the IHCIA and ISDEAA (laws that stem from the unique government-to-government relationship between the federal government and Indian Tribes). This expenditure authority is also limited to coverage for Medicaid beneficiaries who are able to receive services from those facilities. Further, traditional health care practices are being covered as a complement to services covered by Medicaid under existing authority. This expenditure authority is not likely to increase overall expenditures beyond what those expenditures could have been without the demonstration. This expenditure authority will not expand the Medicaid-eligible populations, and CMS anticipates that the Medicaid payment rate for most

[17] https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf.

of these services will be the IHS All-Inclusive Rate that is published annually in the Federal Register.[18] CMS has therefore determined that this coverage of traditional health care practices is expected to be budget neutral and will not require a specific budget neutrality expenditure sub-limit. The state will be held to the general monitoring and reporting requirements, as per the STCs, and will continue to be held accountable to the overall budget neutrality expenditure limit of the demonstration (for more information on CMS's current approach to budget neutrality, see State Medicaid Director letter #24-003). Failure to meet the monitoring and reporting requirements might result in CMS requiring the state to include these expenditures in the budget neutrality agreement for this demonstration, to ensure that CMS has sufficient information to support its initial determination that the approval of these expenditures is expected to be budget neutral. CMS reserves the right to request budget neutrality expenditures and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 7. This amendment includes the addition of a "with waiver" only expenditure authority for implementation expenditures, which will be paid for with demonstration savings.

Monitoring and Evaluation

The state is required to conduct systematic monitoring and robust evaluation of the demonstration amendment in accordance with the STCs. In collaboration with CMS, the state must update its demonstration Monitoring Protocol to incorporate how it will monitor the amendment components, including relevant metrics data as well as narrative details describing progress with implementing the amendment.

The state is required to incorporate the amendment into its evaluation to support a comprehensive assessment of whether the initiatives are effective in producing the desired outcomes for beneficiaries and the state's overall Medicaid program. Evaluation of the amendment is expected to assess beneficiary awareness and understanding of traditional health care practices; access to, utilization and cost of traditional health care practices; quality and experience of care; and physical and behavioral health outcomes. Additionally, the state's monitoring and evaluation efforts must facilitate understanding the extent to which the amendment might support reducing existing disparities in access to and quality of care and health outcomes.

Consideration of Public Comments

New Mexico met the requirements for public notice for the demonstration application and CMS deemed the application complete. The state's public comment period for the New Mexico Turquoise Care traditional health care practices request was held from September 6, 2022, through October 31, 2022. The federal comment period for this request was open from December 29, 2022, through January 28, 2023. A total of three comments were received through the federal comment period related to the traditional health care practices request. These comments were submitted by advocacy and medical organizations. All three comments were supportive of the proposal to cover traditional health care practices because of the commitment to culturally appropriate services. One of the organizations expressed the need to ensure that American

[18] See https://www.ihs.gov/businessoffice/reimbursement-rates/.

Indians and Alaska Natives are obtaining safe and evidence-informed services through the demonstration. Section 1115 demonstrations can further test the effects of providing coverage for traditional health care practices in Medicaid and CHIP.

CMS also consulted with Tribal governments consistent with Executive Order 13175 and the CMS Tribal Consultation Policy by seeking advice and input from Tribal leaders on CMS policies that have Tribal implications. CMS obtained advice and input from the CMS Tribal Technical Advisory Group on July 26, 2023, and March 6, 2024. In addition, CMS held an All Tribes Consultation Webinar on April 3, 2024, and presented on this request during the Department of Health and Human Services Annual Budget Tribal Consultation Session on April 10, 2024. CMS requested Tribal comments from March 6, 2024, through May 3, 2024. A total of 26 comments were received through these consultation efforts that related to the traditional health care practices request.

Comments received through these consultations with Tribes were supportive of Medicaid coverage of traditional health care practices. However, some commenters advised CMS to be flexible in developing its approach to reviewing these demonstration proposals. The most prevalent themes in the comments supporting the demonstration amendments were that CMS needs to be flexible to honor Tribal sovereignty and that urban Indian organization facilities need to be included as they are a vital piece of the Indian health system and are sometimes the only facility accessible to American Indians or Alaska Natives. CMS has made efforts to be inclusive and flexible in its approach to approving traditional health care practices demonstrations and states may choose to include urban Indian organizations in these demonstrations.

During Tribal consultation, most commenters urged CMS to continue consulting with Tribes and conferring with urban Indian organizations on the design and implementation of demonstrations that would provide coverage of traditional health care practices. Commenters expressed concerns about CMS limiting coverage to only those services delivered by or through IHS or Tribal facilities because it would exclude services provided by urban Indian organization facilities. Commenters relayed during Tribal consultation that Tribal sovereignty requires CMS to let Tribal Nations decide what should be considered an appropriate traditional health care practice provided to their Tribal community. Commenters also wanted to clarify that traditional health care practices should include services provided outside of the four walls of a clinic. After receiving this feedback during the consultation process, CMS decided that urban Indian organizations could be a qualifying provider type option for states. Medicaid coverage and payment for clinic services furnished outside the four walls of a clinic is the topic of a separate CMS rulemaking and we will address comments on that topic as part of that rulemaking.[19] The services that can be covered under this approval are not "clinic services" within the meaning of section 1905(a)(9) of the Act, 42 CFR 440.90, or the pending separate CMS rulemaking; there is no requirement under this demonstration approval that, to be covered, traditional health care practices must be provided in the four walls of a qualifying facility. CMS will also permit IHS, Tribal, and urban Indian organization facilities to determine the scope of services that they provide under this amendment, based on facilities' knowledge of these services and their patient populations.

[19] https://www.federalregister.gov/documents/2024/07/22/2024-15087/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical

During Tribal consultation, commenters agreed that using general standards to determine who is a qualified practitioner, including using a high-level position description, is important so that each facility can tailor provider qualifications for their traditional health care practitioners. Commenters expressed interest in how the traditional health care practices approved in demonstrations would align or deviate from the IHCIA and what is currently delivered by or through IHS, Tribal, or urban Indian organization facilities. CMS has developed an approach to approving traditional health care practices demonstration proposals that is intended to be as flexible as possible to allow qualifying facilities to determine practitioner qualifications and scope of practices. Consistent with the IHCIA, IHS, Tribal, and urban Indian organization facilities currently furnish traditional health care practices consistent with the IHS "standards for the provision of health care, health promotion, and disease prevention."[20]

Commenters were highly supportive of providing implementation funding for evaluation activities. However, commenters recommend having Tribes and their practitioners direct demonstration evaluation activities so that they align with the cultural protocols for sharing information for each Tribe, in addition to providing flexibility to design the performance evaluations and customer service satisfaction surveys that are culturally appropriate. With this approval, states are encouraged to consult with Tribes and qualifying facilities on the development of evaluation activities.

Consistent with the government-to-government relationship, CMS is available to continue its dialogue with Tribal governments, urban Indian organizations, and the CMS Tribal Technical Advisory Group and to provide technical assistance, as needed.

Other Information

CMS's approval of this amendment is conditioned upon compliance with the enclosed amended set of expenditure authorities and STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Sandra Phelps. She is available to answer any questions concerning this amendment. Ms. Phelps's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Sandra.Phelps@cms.hhs.gov

[20] 25 U.S.C. 1680u, at https://uscode.house.gov/view.xhtml?req=(title:25%20section:1680u%20edition:prelim)%20OR%20(granuleid:USC-prelim-title25-section1680u)&f=treesort&edition=prelim&num=0&jumpTo=true.

We appreciate your state's commitment to improving the health of people in New Mexico, and we look forward to partnering with you on the New Mexico Turquoise Care section 1115(a) demonstration. If you have questions regarding this approval, please contact Ms. Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,



Daniel Tsai
Deputy Administrator and Director

Enclosures

cc: Dana Brown, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITIES

NUMBER: **11W 00285/6**

TITLE: **Turquoise Care Medicaid 1115 Demonstration**

AWARDEE: **New Mexico Health Care Authority**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or specified as not applicable in the following list, shall apply to the Turquoise Care Medicaid section 1115 demonstration beginning July 25, 2024, unless otherwise stated. The waiver authorities will continue through December 31, 2029, unless otherwise stated.

The following waivers shall enable New Mexico to implement the Turquoise Care Medicaid section 1115 demonstration.

A. Title XIX

1. **Amount, Duration and Scope of Services** **Section 1902(a)(10)(B)**

To the extent necessary to enable the state to vary the amount, duration, and scope of services offered to individuals regardless of eligibility category, by permitting managed care plans to offer varied medically appropriate value-added services to beneficiaries who are enrolled in Turquoise Care.

To the extent necessary to enable the state to offer certain long-term services and supports and care coordination services to individuals who are Medicaid eligible and who meet nursing facility level of care, as described in paragraph 37 of the Special Terms and Conditions (STCs).

To the extent necessary to enable the state place expenditure boundaries on Home and Community Based Services (HCBS) and personal care options.

To the extent necessary to enable the state to offer Pre-Tenancy and Tenancy Services to a limited number of Turquoise Care recipients with Serious Mental Illness (SMI), and in limited geographical areas of the state as described in the STCs.

2. **Freedom of Choice** **Section 1902(a)(23)(A)**
42 CFR 431.51

To the extent necessary to enable the state to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. Mandatory enrollment of American Indians/Alaskan Natives (AI/ANs) is only permitted as specified in STC 5.4. No waiver of freedom of choice is authorized for family planning providers.

3. **Self-Direction of Care** **Section 1902(a)(32)**

To the extent necessary to enable the state to permit persons receiving certain services to self-direct their care for such services.

4. **Nursing Facility Level of Care Redeterminations** **Section 1902(a)(10)(A)(ii)(IV)**
42 CFR 441.302(c)(2)

To the extent necessary to enable the state to implement a streamlined nursing facility level of care approval with specific criteria for individuals whose condition is not expected to change.

5. **Provision of Medical Assistance** **Section 1902(a)(8) and (10)**

To the extent necessary to enable the state to limit the provision of Medical Assistance (and treatment as eligible for Medical Assistance) for individuals described in the eligibility group under section 1902(a)(10)(A)(ii)(XX) of the Social Security Act (the Act) and the state plan to only former foster care youth who are under 26 years of age, were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as such former state has elected), and who were enrolled in Medicaid on that date, and are now residents in New Mexico applying for Medicaid.

To the extent necessary to enable the state to limit the provision of Medical Assistance (and treatment as eligible for Medical Assistance) for individuals described in the eligibility group under section 1902(a)(10)(A)(ii)(XXI) of the Act and the state plan to only family planning services as described in section 1905(a)(4)(C) and only to individuals age 50 or under who do not have other health insurance coverage, or under age 65 who have only Medicare coverage that does not include family planning. This waiver authority will expire on December 31, 2025.

6. **Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release**

Section 1902(a)(84)(D)

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11W 00285/6**

TITLE: **Turquoise Care Medicaid 1115 Demonstration**

AWARDEE: **New Mexico Health Care Authority**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by New Mexico for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities must only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable New Mexico to implement the Turquoise Care Medicaid section 1115 demonstration. All other requirements of the Medicaid program expressed in law, regulation, and policy statements must apply to these expenditures, unless identified as not applicable below.

1. Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m), except the following:

    a. Section 1903(m)(2)(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 eligibility or whose eligibility is suspended for a period of three months or less in the same managed care plan in which the individual was previously enrolled.

    b. Expenditures made under contracts that do not meet the requirements of 1903(m)(2)(A)(iii) and implementing regulations at 42 CFR 438.5(b)(4) but only insofar as to allow the state to include in calculating Managed Care Organization (MCO) capitation rates the provision of beneficiary rewards program incentives for health-related items or services in accordance with Section 7 of the STCs.

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

3. Expenditures for community intervener services furnished to deaf and blind Turquoise Care beneficiaries, as defined in STC 6.20.

4. Expenditures for home visiting services to eligible pregnant individuals, postpartum individuals, infants, and children up to age five residing in the state-designated counties, as defined in STC 6.21.

5. Expenditures to pilot pre-tenancy and tenancy services furnished to seriously mental ill Turquoise Care beneficiaries, as defined in STC 6.22.

6. Expenditures for continued benefits for children who have been determined eligible as specified in STC 4.8 for the continuous eligibility period who would otherwise lose coverage during an eligibility determination.

7. Use of Legally Responsible Individuals to Render Personal Care Services (PCS). Expenditures for the state to provide payment for personal care services rendered by legally responsible individuals (which could be inclusive of legally responsible family caregivers) for members receiving Community Benefit services under the Home and Community Based Services benefit and members receiving 1905(a) services under the Early and Periodic Screening, Diagnostic, and Testing (EPSDT) benefit providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements.

8. **Health-Related Social Needs (HRSN) Services**. Expenditures for health-related social needs services not otherwise eligible for Medicaid payment that are furnished to individuals who meet the qualifying criteria as described in Section 10. This expenditure authority is contingent on compliance with Section 11, as well as all other applicable STCs.

9. **Expenditures for HRSN Services Infrastructure.** Expenditures for payments for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized in Section 10 of the STCs. This expenditure authority is contingent on compliance with Section 11 of the STCs, as well as all other applicable STCs.

10. **Expenditures for Pre-Release Services**. Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative under this demonstration.

11. **Expenditures for Pre-Release Administrative Costs**. Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 9.13, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.

12. **Traditional Health Care Practices.** Expenditures for traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement

Act, by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

13. **Traditional Health Care Practices Implementation Expenditures.** Expenditures for allowable administrative and implementation costs not otherwise determined eligible for Medicaid payment, to the extent such activities are authorized as described in STC 11.7. This expenditure authority is contingent on compliance with STC 11, as well as all other applicable STCs.

14. Expenditures to provide HCBS not included in the Medicaid State Plan to individuals who are eligible for Medicaid as described in the STCs.

Substance Use Disorder

15. Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder who are short-term residents in facilities that meet the definition of an Institution for Mental Diseases (IMD).

Serious Mental Illness/ Serious Emotional Disturbance

16. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for an SMI or SED who are short-term residents in facilities that meet the definition of an IMD.[1]

High Fidelity Wrap Around Intensive Care Coordination

Expenditures for high fidelity wrap around intensive care coordination for beneficiaries who meet the eligibility requirements in STC 6.36.

TITLE XIX REQUIREMENTS NOT APPLICABLE TO ALL EXPENDITURE AUTHORITIES

All requirements of the Medicaid program explicitly waived under the Waiver List herein shall not apply to expenditures made by the state pursuant to the Expenditure Authorities described above.

REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITY 4

Statewide Operation — Section 1902(a)(1)

To the extent necessary to enable the state to operate on less than a statewide basis for Pre-Tenancy and Tenancy services for up to 450 beneficiaries in the Turquoise Care program with SMI/SED in geographically limited areas of the state.

[1] New Mexico uses the term severe emotional disturbance, in accordance with 8>321 of New Mexico Administrative Code (NMAC).

REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITIES 4 AND 5

The following Medicaid requirements are not applicable to the Turquoise Care Pre-Tenancy and Tenancy Services and Home Visiting Services:

Reasonable Promptness Section 1902(a)(8)

To enable New Mexico to establish numeric enrollment limitations for the populations receiving services under expenditure authorities 4 and 5, and to place applicants on a waiting list for enrollment to the extent the enrollment limitation has been reached.

REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITIES 8 AND 9

The following Medicaid requirements are not applicable to the HRSN Expenditure Authorities:

Statewide Operation **Section 1902(a)(1)**

To the extent necessary to enable the state to provide HRSN services on a less than a statewide basis.

Comparability; Amount, Duration, and Scope **Section 1902(a)(10)(B); Section 1902(a)(17)**

To the extent necessary to enable the state to provide a varying amount, duration, and scope of HRSN services to a subset of beneficiaries, depending on beneficiary needs.

Comparability; Provision of Medical Assistance and Reasonable Promptness **Section 1902(a)(10)(B), Section 1902(a)(17), Section 1902(a)(8)**

To the extent necessary to allow the state to offer HRSN services to an individual who meets the qualifying criteria for HRSN services, including delivery system enrollment, as described in Section 10 of the STCs.

To the extent necessary to allow the state to delay the application review process for HRSN services in the event the state does not have sufficient funding to support providing these services to eligible beneficiaries.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services:

Statewideness **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B)

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

Freedom of Choice Section 1902(a)(23)(A)

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITY 12

Comparability; Freedom of Choice Section 1902(a)(23)
Section 1902(a)(10)(B)

To the extent necessary to allow the state to offer the coverage described in Expenditure Authority 12 only if the covered traditional health care practices are received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11W 00285/6

TITLE: Turquoise Care Medicaid 1115 Demonstration

AWARDEE: New Mexico Health Care Authority

1. PREFACE

The following are the Special Terms and Conditions (STCs) for Turquoise Care Medicaid 1115 Demonstration (hereinafter "demonstration") to enable the New Mexico Health Care Authority (hereinafter "the state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (the Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated.

These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter, and the waiver and expenditure authorities for this demonstration extension will begin July 25, 2024 and expire December 31, 2029, unless otherwise specified. This demonstration is approved through December 31, 2029.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Eligibility and Enrollment
5. Native American Participation and Protection
6. Programs and Benefits
7. Member Engagement
8. Delivery System
9. Reentry Demonstration Initiative
10. Health Related Social Needs Services
11. Traditional Health Care Practices
12. Provider Rate Increase Requirements
13. General Financial Requirements
14. Monitoring Budget Neutrality for the Demonstration
15. Monitoring and Reporting Requirements
16. Evaluation of the Demonstration
17. Schedule of State Deliverables for the Demonstration Extension Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A.	Turquoise Care Community Benefit Definitions and Limits
Attachment B.	Medicaid Home Visiting Services
Attachment C.	SUD Continuum of Care
Attachment D.	Developing the Evaluation Design
Attachment E.	Evaluation Design [Reserved]
Attachment F.	Preparing the Interim and Summative Evaluation Reports
Attachment G.	Monitoring Protocol [Reserved]
Attachment H.	SUD Implementation Plan Protocol
Attachment I.	Pre-Tenancy/Tenancy Services
Attachment J.	SMI/SED Implementation Plan [Reserved]
Attachment K.	Reentry Demonstration Initiative Implementation Plan [Reserved]
Attachment L.	Reentry Demonstration Initiative Reinvestment Plan [Reserved]
Attachment M.	HRSN Implementation Plan [Reserved]
Attachment N.	Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services Protocol [Reserved]
Attachment O.	Provider Rate Increase Attestation Table [Reserved]

2. PROGRAM DESCRIPTION AND OBJECTIVES

In the extension of this demonstration for New Mexico's Medicaid managed care program, known as Centennial Care, the state must continue to provide the most effective, efficient health care possible for its most vulnerable and needy citizens and continue the healthcare delivery reforms that were initiated during the previous demonstration period. Specifically, the state is required to continue to further the following goals:

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

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

This extension represents the evolution of Centennial Care and its next iteration-Centennial Care 2.0. The state will continue to advance successful initiatives begun under the previous demonstration while implementing new, targeted initiatives to address specific gaps in care and improve healthcare outcomes for its most vulnerable members. Key initiatives include:

- Improving continuity of coverage, encouraging individuals to obtain health coverage as soon as possible after becoming eligible, and increasing utilization of preventive services;
- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;

- Continue to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Continue the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative;
- Build upon policies that seek to enhance members' ability to become more active and involved participants in their own health care; and
- Further simplify administrative complexities and implement refinements in program and benefit design.

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

The state must also continue its expanded care coordination program for members who require additional support and coordination of services, and its member reward program, known as Centennial Rewards, which provides incentives for members to pursue healthy behaviors.

In addition, the state must implement initiatives to improve existing substance use disorder (SUD) services. Initiatives to improve SUD services will ensure the appropriate level of treatment is provided, increase the availability of medication assisted treatment (MAT), and enhance coordination between levels of care. The state must continue offering a full range of SUD treatment options using American Society for Addiction Medicine (ASAM) criteria for assessment and treatment decision making.

Lastly, the state launched several new services and program requirements during the demonstration extension, including but not limited to: home visiting services focusing on prenatal care, post-partum care and early childhood development; supportive housing services for individuals with serious mental illness; and SUD services.

On February 7, 2020, the demonstration was amended to incorporate the following five changes into the demonstration: 1) removal of co-payments for Centennial Care members, 2) removal of premiums requirements for beneficiaries in the Adult Expansion Group, 3) removal of the waiver of retroactive eligibility, 4) increase the number of Community Benefit slots by 1,500 throughout the remainder of the current demonstration approval period, and 5) expansion of the Centennial Home Visiting Pilot Program by removing restrictions on the number of counties and number of individuals that may participate in the pilot program.

On March 28, 2023, the demonstration was amended to incorporate the serious mental illness (SMI) and serious emotional disturbance (SED) demonstration authority and make improvements to HCBS such as increasing the number of enrollment slots for the Community Benefit Program by 200, bringing the total number of slots to 5,989. In addition, the demonstration amendment increases the service limits for Community Transition and Environmental Modification Services described in Attachment A. Finally, this amendment provides New Mexico with expenditure authority to implement a High Fidelity Wraparound Intensive Care Coordination program.

In the SMI/SED amendment, the state will aim to maintain and enhance access to mental health services and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment of Medicaid beneficiaries with SMI and SED. The SMI/SED demonstration component will provide the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SMI and SED while they are short-term residents in residential and inpatient treatment settings that qualify as an Institutions for Mental Diseases (IMD). It will also support state efforts to enhance provider capacity and improve access to a continuum of SMI/SED evidence-based services at varied levels of intensity.

During the demonstration period, the state seeks to achieve the following goals which align with the SMI SMDL #18-011:

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

On December 15, 2023, the demonstration was amended to incorporate the following five changes into the demonstration: 1) incorporate the COVID authorities to provide payment for legally responsible individuals to provide personal care services in to the demonstration on a long-term basis for Community Benefit and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit; 2) increase enrollment slots by 1,000 for Community benefit members; 3) provide continuous enrollment for children up to age six; 4) expand home visiting models to incorporate four additional evidence-based models; and 5) increase supportive housing enrollment from 180 to 450 members annually.

On July 25, 2024, the Centennial Care 2.0 demonstration was extended to December 31, 2029 and with the extension, New Mexico requested to change the demonstration name was changed to Turquoise Care at the state's and CMS approved this request with the extension approval. With

this extension, the state received approval for the continuation of the demonstration program with the exception of the Uncompensated Care program which expired with the previous demonstration period. The state requested and received approval for two new programs in the demonstration extension 1) provide reentry services for eligible individuals for up to 90-days pre-release from a carceral facility, and 2) provided health related social need services for individuals meeting eligibility criteria for short-term post hospitalization housing and home delivered meals for pregnant individuals. In addition to the new programs for the demonstration extension, the state expanded its providers for the pre-tenancy/tenancy support program, and the expanded Community Benefit services to provide individuals meeting eligibility criteria up to two meals per day.

On October 16, 2024, CMS approved an amendment to provide expenditure authority for coverage of traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

3. GENERAL PROGRAM REQUIREMENTS

3.1. Compliance with Federal Non-Discrimination Statutes. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Patient Protection and Affordable Care Act (Section 1577).

3.2. Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy. All requirements of the Medicaid program and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph Further, the state may seek an amendment to the demonstration (as per STC 3.7 of the section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. State Plan Amendments. The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12, which must include a summary of any public feedback

received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS at least 12 months in advance from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). State that do not intend to request an extension of the demonstration beyond the period authorized in the STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP

eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior

to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

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

3.13. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration, including administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or later, as expressly stated within these STCs.

3.14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. Common Rule Exemption. The state must ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and which are designed to study, evaluate, or otherwise examine the or CHIP program – including public benefit or service programs; procedures for obtaining Medicaid or CHIP benefits or services; possible changes in or alternatives to Medicaid or CHIP programs or procedures; or possible changes in methods or level of payment for benefits or services under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. Eligibility Groups Affected By the Demonstration. Mandatory and optional state plan groups described below derive their eligibility through the Medicaid State Plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and as described in these

STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration. These state plan eligible members are included in the demonstration for use of the managed care network and access to additional benefits not described in the state plan.

Table 1, below, describes the mandatory state plan populations included in Turquoise Care. Table 2 describes the optional state plan populations included in Turquoise Care. Table 3, below, describes the member eligibility groups who are made eligible for benefits by virtue of the expenditure authorities expressly granted in this demonstration (i.e., the 217-like group).

In tables 1 and 2, Column A describes the current consolidated Medicaid eligibility group for the population in accordance with the Medicaid eligibility regulations, and Column B describes the specific statutory/regulatory citation of any specific Medicaid eligibility groups that are included in the consolidated group described in column A. Column C describes whether there are any limits on inclusion in Turquoise Care for each Medicaid eligibility group. Column D describes the budget neutrality Medicaid Eligibility Group (MEG) under which expenditures for the population will be reported (as described further in STC 13.10).

4.2. The populations described in Table 1 and 2 below derive their eligibility from the Medicaid state plan and will be updated as needed to conform with any amendments to the state plan. Should the state amend the state plan to make any changes to eligibility for populations listed below in Table 1 or Table 2, the state must notify CMS demonstration staff in writing upon submission of the state plan amendment and request corresponding updates to the tables below. The effective date of any corresponding updates to the table below will align with the approved state plan.

Those member eligibility groups described below in Table 3 who are made eligible for benefits by virtue of the expenditure authorities expressly granted in this demonstration (i.e., the 217-like group) are subject to Medicaid laws or regulations unless otherwise specified in the expenditure authorities for this demonstration. In Table 3, Column A describes the eligibility group, Column B describes the specific statutory/regulatory citation of any specific Medicaid eligibility groups that are included, Column C describes the income and resource standards and methodologies the group, Column D describes whether there are any limits on inclusion in Turquoise Care, and Column E describes the budget neutrality MEG under which expenditures for the population will be reported (as described further in STC 13.10).

Table 1: Mandatory State Plan Populations

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Turquoise Care?	D. MEG for Budget Neutrality
Parents/Caretaker Relatives	Low Income Families (1931) 42 CFR 435.110	No	TANF and Related
Transitional Medical Assistance	Families with 12-month extension due to earnings • §408(a)(11)(A) • §1931(c)(2) • §1925 • §1902(a)(52) and 1902(e)(1)	No	TANF and Related
Extension due to Spousal Support	Families with 4-month extension due to increased collection of spousal support • §408(a)(11)(B) • §1931(c)(1) 42 CFR 435.115	No	TANF and Related
Pregnant Individuals	Consolidated group for pregnant individuals • §§1902(a)(10)(A)(i)(III) and (IV) • §§1902(a)(10)(A)(ii)(I), (IV) and (IX) • §1931(b) and (d) 42 CFR 435.116	No	TANF and Related
Children under Age 19	Consolidated group for children under age 19 • §§1902(a)(10)(A)(i)(III), (IV), (VI) and (VII) • §§1902(a)(10)(A)(ii)(IV) and (IX) • §1931(b) and (d) 42 CFR 435.118	No	TANF and Related

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Turquoise Care?	D. MEG for Budget Neutrality
Continuous Eligibility for Hospitalized Children	Children eligible under 42 CFR 435.118 receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay §1902(e)(7) 42 CFR 435.172	No	TANF and Related
Deemed Newborns	Newborns deemed eligible for one year §1902(e)(4) 42 CFR 435.117	No	TANF and Related
Adoption Assistance and Foster Care Children	Children receiving IV-E foster care or guardianship maintenance payments or with IV-E adoption assistance agreements • §1902(a)(10)(A)(i)(I) • §473(b)(3) 42 CFR 435.145	No	TANF and Related
Former Foster Care Children	Former foster care children under age 26 not eligible for another mandatory group 1902(a)(10)(A)(i)(IX) 42 CFR 435.150	No	TANF and Related
Adult group	Non-pregnant individuals age 19 through 64 with income at or below 133% FPL 1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	No	VIII Group

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Turquoise Care?	D. MEG for Budget Neutrality
Aged, Blind, and Disabled	Individuals receiving SSI cash benefits 1902(a)(10)(A)(i)(II) Disabled children no longer eligible for SSI benefits because of a change in the definition of disability	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals under age 21 eligible for Medicaid in the month they apply for SSI 1902(a)(10)(A)(i)(II)(cc)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Disabled individual whose earning exceed SSI substantial gainful activity level 1902(a)(10)(A)(i)(II) 1619(a)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals receiving mandatory state supplements 42 CFR 435.130	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Institutionalized individuals continuously eligible for SSI in December 1973 42 CFR 435.132 Blind and disabled individuals eligible for SSI in December 1973 42 CFR 435.133	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Turquoise Care?	D. MEG for Budget Neutrality
	Individuals who would be eligible for SSI except for the increase in OASDI benefits under Public Law 92-336 42 CFR 435.134	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals ineligible for SSI because of requirements inapplicable in Medicaid 42 CFR 435.122	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Disabled widows and widowers Early widows/widowers 1634(b) 42 CFR 435.138	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals who become ineligible for SSI as a result of OASDI cost-of- living increases received after April 1977 42 CFR 435.135	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	1939(a)(5)(E) Disabled adult children 1634(c)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Disabled individuals whose earnings are too high to receive SSI cash 1902(a)(10)(A)(i)(II)(bb); 1905(q) 1619(b)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 2. Optional State Plan Populations

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/Regulatory Citations	C. Limitations on Turquoise Care?	D. MEG for Budget Neutrality
Optional Targeted Low-Income Children	Optional group for uninsured children under age 6 1902(a)(10)(A)(ii)(XIV) 42 CFR 435.229	No	If Title XIX: TANF and Related If Title XXI: MCHIP Children
Optional Reasonable Classification of Children	Optional group for children under age 19 not eligible for a mandatory group §§1902(a)(10)(A)(ii)(I) and (IV) 42 CFR 435.222	No	TANF and Related
Independent Foster Care Adolescents	Individuals under age 21 who were in foster care on their 18th birthday 1902(a)(10)(A)(ii)(XVII) 42 CFR 435.226	No	TANF and Related
Out-of-State Former Foster Care Children under the Individuals above 133% FPL under Age 65 group	Individuals under age 26 who were in foster care in a state other than New Mexico (or tribe in such other state) when they aged out of foster care, not otherwise eligible for Medicaid 1902(a)(10)(A)(ii)(XX) 42 CFR 435.218	No	TANF and Related
Aged, Blind, and Disabled	Working disabled Individuals 1902(A)(10)(A)(ii)(XIII)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard.	NF LOC: Included PACE: Excluded	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

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

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

Table 3: Demonstration Expansion Populations

A. Expansion Medicaid Eligibility Group	B. Description Statutory/Regulatory Citations	C. Financial Eligibility Standards	D. Limitations on inclusion in Turquoise Care?	E. MEG for Budget Neutrality
Home and Community Based 1915(c) Waivers that were transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility rules for individuals who would only be eligible in an institution in the same manner as specified under 42 CFR 435.217 and 435.236 and section 1924 of the Act, if the state had not eliminated its 1915(c) AIDS, Colts, and Mi Via-NF waivers	Income test: 300% of Federal Benefit Rate with Nursing Facility Level of Care determination. Resource test: $2,000	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals whose eligibility is determined using institutional eligibility rules for individuals who are eligible as specified under 42 CFR 435.217 and 435.236 and section 1924 of the Act	Income test: 300% of Federal Benefit Rate with Nursing Facility Level of Care determination. Resource test: $2,000	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

4.3. Populations Excluded from Turquoise Care. The following populations, who are otherwise eligible under the criteria described above, are excluded from the demonstration:

a. Qualified Medicare Beneficiaries (QMBs) – 1902(a)(10)(E)(i); 1905(p)
b. Specified Low-Income Medicare Beneficiaries (SLMBs) – 1902(a)(10)(E)(iii)
c. Qualifying Individuals (QIs) – 1902(a)(10)(E)(iv)
d. Qualified Disabled Working Individuals (QDWIs) – 1902(a)(10)(E)(ii); 1905(s)

e. Non-citizens only eligible for emergency medical services – 1903(v)
f. Program for All-Inclusive Care for the Elderly (PACE) Participants – 1934
g. Individuals residing in ICFs/IID – 1905(a)(15)
h. Developmental Disabilities Waiver, Mi Via Waiver, and Supports Waiver participants for HCBS services only
i. Medically Fragile Waiver participants for HCBS services only
j. Except as provided in STC 4.9, individuals receiving family planning-only benefits through the Family Planning category of eligibility.

4.4. Eligibility and Post Eligibility Treatment of Income for Turquoise Care Members who are Institutionalized. Except as specified in STC 4.2 above, in determining eligibility for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. All members receiving institutional services must be subject to post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 CFR 435.725 of the federal regulations.

4.5. Regular and Post-Eligibility Treatment of Income for Turquoise Care Individuals Receiving HCBS (Specified at 42 CFR 435.726 of the Federal Regulations and 1924 of the Social Security Act). For individuals receiving 1915(c)-like services, the state must use institutional eligibility and post-eligibility rules for individuals who would be eligible in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 of the federal regulations and section 1924 of the Act, if the home and community-based services were provided under a section 1915(c) waiver.

4.6. For individuals receiving 1915(c) services, the state must use institutional eligibility and post-eligibility rules as specified under 42 CFR 435.217, 435.236 and 435.726 of the federal regulations and section 1924 of the Act, as specified the under the state approved HCBS 1915(c) waivers.

4.7. Eligibility for Out of State Former Foster Care Youth. Individuals eligible as "out-of-state former foster care youth" are defined as individuals under age 26, who turned 18 on or before December 31, 2022, who were in foster care in another state or tribe in such other state when they turned 18 (or such higher age as such other state has elected for termination of foster care assistance under title IV-E of the Act), were enrolled in Medicaid at that time, are now residents in the state applying for Medicaid, and are not otherwise eligible for any other Medicaid category.

4.8. Continuous Eligibility for Children up to Age 6.

a. Eligible members. Members ages zero through five, who enroll in Medicaid shall qualify for continuous eligibility until the end of the month in which their sixth birthday falls.

b. Continuous Eligibility Period. The state is authorized to provide continuous eligibility for children ages zero through the end of the month of their sixth birthday regardless of the delivery system through which these populations receive Medicaid benefits. Coverage shall be continuous for children ages 0 through 5 who qualify for

continuous eligibility until the end of the month in which their 6th birthday falls. The child's continuous eligibility period begins on the effective date of the child's eligibility under 42 CFR 435.915. The state will redetermine eligibility consistent with 42 CFR 435.916 when the child turns age 6. The state will continue to redetermine eligibility during a period of continuous enrollment in limited circumstances, if appropriate.

c. Exceptions. If any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be redetermined or terminated:

   i. The individual is no longer a New Mexico resident;
   ii. The individual requests termination of eligibility;
   iii. The individual dies; or
   iv. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

d. Beneficiary-Reported Information and Periodic Data Checks. Consistent with 42 CFR 435.919, the state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in this demonstration, such as a change in state residency, and are able to report other information relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

   For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. The state should follow its typical processes that it would otherwise use to verify continued residency at renewal if continuous eligibility was not available for these individuals. Additionally, at least once every 12 months, the state must follow its typical processes to attempt to confirm the individual is not deceased, consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d). The state must redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.916(d) and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j).

   The state is required to provide CMS a narrative update annually on the processes it conducted and a summary of its findings regarding the successes and challenges in conducting such verifications. This information shall be provided in the demonstration's Annual Monitoring Reports (see STC 15.6).

e. Annual Updates to Beneficiary Information. For all continuous eligibility periods longer than 12 months, the state must have procedures and processes in place to

accept and update beneficiary contact information and must attempt to update beneficiary contact information on an annual basis, which may include annually checking data sources and partnering with managed care organizations to encourage beneficiaries to update their contact information. The state is reminded that updated contact information obtained from third-party sources with an in-state address is not an indication of a change affecting eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but without additional follow up by the state per 42 CFR 435.952(d), the receipt of this third-party data is not sufficient to make a definitive determination that beneficiaries no longer meet state residency requirements.

Each demonstration year (DY), through the Annual Monitoring Reports (see STC 15.5), the state must submit to CMS a summary of activities and outcomes from these efforts to update beneficiary contact information on an annual basis.

4.9. Family Planning Services. The state will phase out the limitations on Family Planning eligibility by December 31, 2025 to otherwise eligible individuals age 50 and under who do not have other health insurance coverage and individuals who are under age 65 who have only Medicare coverage that does not include family planning benefits.

4.10. Mandatory Enrollment. With the exception of American Indian/Alaska Native (AI/AN) individuals described in STC 5.4, the state may mandatorily enroll members served through this demonstration in MCOs to receive benefits pursuant to Section 5 of the STCs. The mandatory enrollment will apply and may occur only when the MCOs have been determined by the state to meet readiness and network requirements established by the state to ensure sufficient access, quality of care, and care coordination for members, as required by 42 CFR 438.66(d); these requirements must be approved by CMS before the state begins mandatorily enrolling recipients with MCOs.

4.11. Choice of MCO. The state must ensure that at the time of initial enrollment and on an ongoing basis, individuals have a choice between a minimum of two (2) MCOs that meet all federal regulatory requirements.

4.12. MCO Selection/Enrollment Process. Individuals new to Medicaid are required to enroll in an MCO at the time of applying for Medicaid eligibility.

a. Individuals currently eligible for Medicaid. Individuals who are currently enrolled in an MCO under Centennial Care 2.0 and who must select a new MCO under Turquoise Care because their prior MCO is not providing coverage under Turquoise Care, as well any individuals receiving benefits under fee for service (FFS), must have 60 days to enroll in a Turquoise Care MCO.

b. AI/AN individuals. Consistent with STC 5.4, the state must not require AI/AN individuals to enroll with a Turquoise Care MCO, unless they are dually eligible and/or meet a NF LOC. AI/AN individuals who the state may not require to enroll may elect to enroll at their option.

c. Any member who does not make an active selection will be assigned, by default, to a participating Turquoise Care MCO. The state must develop an auto-assignment process that is compliant with 42 CFR 438.54(d)(5).

d. Transition Activities for current MCO enrollees. If current enrollees need to select a new MCO due to the state's procurement of Turquoise Care MCOs, and have an existing care plan, the state must require each outgoing MCO (the sending plan) to share transition materials as required by the Transition Management Agreements (TMAs) and the Turquoise Care Transition Systems Manual to allow sufficient time for transition planning with the new Turquoise Care MCOs (the receiving plan).

4.13. Notice Requirement for a Change in Plan Choice or Plan Network. The state must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior if possible) a potential change in the number of plans available for choice within an area, or any changes impacting proposed network adequacy. The state must not mandatorily enroll individuals into any plan that does not meet network adequacy requirements as defined in 42 CFR 438.206.

4.14. MCO Disenrollment. Members must be informed of opportunities no less than annually for disenrollment and ongoing MCO choice opportunities regularly in a manner consistent with 42 CFR part 438.

4.15. For Cause Disenrollment. Enrollees must have the right to disenroll from an MCO for cause at any time for any of the reasons specified in 42 CFR 438.56(d)(2).

5. NATIVE AMERICAN PARTICIPATION AND PROTECTION

5.1. General. Recognizing the federal government's historic and unique relationship with Indian tribes as well as the state's tribal consultation obligation, this section describes additional protections for AI/AN enrolled in Turquoise Care.

5.2. Native American Advisory Bodies. The state must solicit advice and guidance from two Native American advisory bodies to seek input on the quality of care and access to services provided to AI/ANs through the demonstration. These bodies were formed in 2014 as part of the original Turquoise Care program: the Native American Advisory Board (NAAB) and the Native American Technical Advisory Committee (NATAC). The state must invite the New Mexico Tribes to appoint representatives to serve as members on these advisory bodies.

a. NAAB. The NAAB is a board of tribal membership that meets quarterly with and provides feedback to all Turquoise Care MCOs on issues related to program service delivery and operations. The state must require MCOs to solicit advice and guidance from the NAAB regarding Turquoise Care implementation and ongoing programmatic issues. The state must monitor the MCOs' work with NAAB and report on NAAB's and MCOs' activities in its quarterly reports, as further specified in STC 15.6.

b. NATAC. The state must continue to work directly with the NATAC, which advises the state on issues pertaining to AI/ANs, including but not limited to notices, payment, and quality issues. The NATAC will meet at least quarterly and the state must report on the NATAC activities in its quarterly reports, as further specified in STC 15.6.

5.3. Maintenance of opt-in for AI/AN individuals**.** AI/AN individuals will maintain a choice to opt-in to managed care or to access care through an FFS delivery system. AI/AN individuals who are dually eligible or who have a NF LOC, however, will continue to be required to enroll in managed care.

5.4. Minimum Managed Care Guarantees. The state must require each MCO, at a minimum, provide the following contractual delivery service protections for AI/ANs:

a. The state must require MCOs offer contracts to all IHS, tribes and tribal organizations operating health programs under the Indian Self-Determination and Education Assistance Act; and urban Indian organizations operating health programs under title V of the Indian Health Care Improvement Act; hereinafter referred to as Indian Healthcare Providers (IHPs). IHPs will not be required to contract with the plans, and all of the IHPs, whether or not they are contracted with an MCO, will be reimbursed consistent with the requirements in 42 CFR 438.14;

b. The state must require MCOs provide education and training to IHPs on steps needed to ensure appropriate referrals to non-IHS providers in and outside of the MCO network;

c. The state must require MCOs to offer contracts to other Tribal health care delivery enterprises which are properly licensed and/or credentialed, like care coordinators, transportation vendors, behavioral health providers and long-term care (LTC) providers;

d. Native Americans must be permitted to select a provider who is practicing in an IHP as their primary care physician or other primary care provider (PCP) and/or to access care at an IHP whether or not that facility is contracted with the member's MCO;

e. The state must require MCOs to offer technical assistance to Tribes and any other entities that seek to become certified and accredited Patient-Centered Medical Homes and/or Health Home providers; and

f. The state must require MCOs to work directly with IHPs on billing and provider issues.

5.5. Expand Opportunities. The state must continue to engage the Tribes, Tribal providers, and Turquoise Care MCOs in efforts to improve the service delivery experience of Native Americans, including by continuing to work with Tribal providers to develop their capacity to enroll as LTSS providers and/or as Health Home providers.

5.6. Ongoing evaluation and continuous improvement. The state must closely monitor and evaluate the experience of AI/AN who are enrolled in Turquoise Care as part of the demonstration evaluation and demonstration annual reports, described in STC 15.6.

6. DEMONSTRATION PROGRAMS AND BENEFITS

6.1. Turquoise Care Benefits. Members subject to the demonstration must receive comprehensive benefits that are at least equal in amount, duration and scope to those described in the state plan, with the exception of the Adult Group, who will receive the benefits in their approved Alternative Benefit Plan (ABP). Those in the Adult Group who are medically frail will have a choice of the approved ABP with the ten essential health benefits, or the ABP with the approved state plan benefit package.

6.2. Home and Community-Based Services. Under Turquoise Care, enrollees who meet the NF LOC criteria will be eligible for the CB in Turquoise Care. Enrollees who are eligible for Medicaid under the state plan (i.e., described as a mandatory or optional state plan population in STC 4.1) will be able to access the CB without the need for an available enrollment slot, to the extent the state is maintaining a waiting list. Enrollees who are made eligible for the demonstration as a result of their NF LOC (the 217-like group) will be subject to the enrollment limits described in STC 4.1.

6.3. The CB service categories (and applicable limits) are listed below and further defined in Attachment A. Table 4 also indicates which services are available through either the agency-based benefit community (ABCB) or the self-directed community benefit (SDCB) and which services are available in both.

Table 4. Community Benefit Services Included Under Turquoise Care

Community Benefit Services Included Under Turquoise Care			
	Agency-Based Benefit	**Self-Direction Benefit**	**Service Limits**
Adult Day Health	X		
Assisted Living	X		
Behavior Support Consultation	X	X	
Community Transition Services	X		a
Customized Community Supports		X	
Emergency Response	X	X	
Employment Supports	X	X	
Environmental Modifications	X	X	a
Home Delivered Meals	X	X	
Home Health Aide	X	X	
Nutrition Counseling	X	X	
Personal Care Services*	X	X	
Private Duty Nursing for Adults	X	X	
Related Goods		X	b
Respite	X	X	a

Community Benefit Services Included Under Turquoise Care			
	Agency-Based Benefit	**Self-Direction Benefit**	**Service Limits**
Skilled Maintenance Therapy	X	X	
Specialized Therapies		X	b
Transportation (non-medical)		X	b

* Note: Personal care services may be self-directed.
a: Service limits apply to all ABCB or SDCB members regardless of their date of enrollment.
b: Service limits apply to members electing SDCB.

6.4. Community Benefit Cost of Care. The state must require each MCO to conduct a comprehensive needs assessment (CNA) that will be used to determine an eligible participant's Comprehensive Care Plan (CCP) for the CB (see STC 6.6). The maximum allowable cost of care for the CB will continue to be tied to the state's annual cost of care for persons served in a private NF. However, the maximum allowable cost of care is not an entitlement. A participant's actual cost of care for the CB will be determined by the CNA.

6.5. Community Benefit Service Planning Transition. The state must require the MCOs, through contract requirements, to prioritize the care planning process for those individuals whose care plans expire in the first 90 days of Turquoise Care or whose needs change and necessitate a new service plan. For individuals who have a care plan expiring without a new care plan implemented, the state must require the MCOs extend their existing care plan (including with respect to scope of services and providers) until such time that the new care plan is implemented.

6.6. Nursing Facility Level of Care (NF LOC) Assessment for LTC Members. The following procedures and policies must continue to apply to enrollees receiving the LTC benefit:

a. A NF LOC assessment must be conducted either by the state, or as a contractual requirement, by the MCO for all applicants for whom there is a reasonable indication that NF services may be needed in the future. If an individual contacts the MCO directly before filing an application for Medicaid eligibility, the state must require the MCO to direct the individual to the appropriate state office to first complete a Medicaid application and to select a health plan for enrollment prior to the MCO conducting the NF LOC assessment.

b. The NF LOC assessment process and instruments will be implemented as specified by the state, either the state's own process, or the MCO's process as defined through contractual requirements. When MCOs are conducting the NF LOC assessment process, the state must require MCOs use common elements within their tools that are based on the Minimum Data Set (MDS). The state must approve the evaluation tool used by each MCO for this LOC determination, and the MCO must be contractually required to inform the state of the member's NF LOC eligibility and enrollment status.

c. All Turquoise Care enrollees must be reevaluated at least annually or as otherwise specified by the state. Where MCOs are conducting the NF LOC assessment, the state must require reevaluation at least annually through contractual requirements with the MCO. The state is not required to conduct an annual reevaluation, nor to contractually require MCOs to conduct an annual reevaluation, for members meeting state-defined criteria (e.g., members who are unlikely to have a change in status as a result of their condition and therefore are expected to continuously meet NF LOC). Defined criteria is included in the Managed Care Policy Manual and the NF LOC Criteria and instructions on the state's website. The state must continue to redetermine members' eligibility, including financial eligibility, on an annual basis. Additionally, the state must require the MCOs to complete an annual CNA and annually update the CCP.

d. The state must require the MCOs that are conducting NF LOC assessments to provide objective LOC determinations based on criteria developed by the state. The state must require such MCOs to report to the state quarterly, a monthly breakdown on the NF LOC determinations/redeterminations they conduct, with the reports capturing information including, but not limited to, the number of NF LOC determinations completed, number completed within required timeframes, and the number of assessments where the member did not meet the state-specified NF LOC criteria. Members must have the opportunity to appeal determinations through the MCO appeals process and the state's fair hearing process, and must have the right to file grievances regarding determinations and the determination process. The MCO's NF LOC assessment function will be performed by an MCO Care Coordinator that is administratively separate from the MCO's Utilization Management team that performs care plan provision and monitoring functions, unless an exception is specifically approved by the state.

6.7. Freedom of Choice. The state must ensure that MCO care coordinators are required to inform each participant or member of any alternatives available, including the choice of IC versus HCBS during the assessment process. Documentation of choice must be incorporated into the service plan.

6.8. Enrollment Limit. Over the life of the demonstration, the state will work to expand access to the CB; however, the state will impose enrollment limits for persons who are not otherwise eligible for Medicaid under the state plan and who have been determined to meet NF LOC, in order to manage the growth of the program. The maximum number of slots will be 6,989. The state may expand the number of slots by an additional 800 slots, bringing the total number of slots to 7,789, if the state finds it has sufficient funding. The state must update CMS on the total number of expanded slots in the applicable quarterly monitoring report.

6.9. Quality Strategy for 1915(c)-like HCBS Service. For services that could have been authorized to individuals under a 1915(c) HCBS waiver, the state must have an approved Quality Improvement Strategy (QIS) that encompass LTSS specific measures set forth in the federal managed care rule at 42 CFR 438.330 and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver

assurances set forth in 42 CFR 441.301 and 441.302. and is required to develop performance measures to address the following assurances.

6.10. Integration of Section 1915(c) Waiver Assurances and Program Requirements into Turquoise Care. The state must implement Turquoise Care to comply with federal 1915(c) waiver assurances and other program requirements for all HCBS services, including 1915(c)-like services provided under the demonstration, including:

a. Administrative Authority. Performance measures must be developed to demonstrate that the State Medicaid Agency (SMA) retains ultimate administrative authority and responsibility for the operation of the HCBS program by exercising oversight of any functions delegated to other state and local/regional non-state agencies (if appropriate) and contracted entities, unless already captured in another performance measure.

b. LOC. The state must have performance measures to demonstrate each of the following:

i. That an evaluation for level of care is provided to all applicants for whom there is reasonable indication that 1915(c)-like HCBS services may be needed in the future, and

ii. That the process and instruments described in the approved demonstration are applied appropriately and according to the approved description to determine initial participant level of care. While a performance measure for annual levels of care is not required to be reported, the state is expected to ensure that initial levels of care are determined.

c. Qualified Providers.

i. The MCO provider credentialing requirement in 42 CFR 438.214 must apply to all CB providers.

ii. To the extent that the MCO's credentialing policies and procedures do not address non-licensed non-certified providers, the state must require the MCO to create alternative mechanisms applicable to such providers to ensure the health and safety of enrollees. The state must have performance measures to demonstrate each of the following:

1. That the state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing 1915(c)-like HCBS services;

2. That the state monitors that non-certified/non-licensed providers assure adherence to demonstration requirements; and

3. That the state verifies that provider training is conducted in accordance with state requirements and the approved demonstration.

d. Service Plan. The state must have performance measures to demonstrate each of the following:

i. Participants are afforded choice between/among 1915(c)-like HCBS services and providers;

ii. Service plans address all assessed needs (including health and safety risk factors) and personal goals either by the provision of 1915(c)-like HCBS services or through other means;

iii. Services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan; and

iv. Service plans are updated/revised at least annually or when warranted by changes in participant's needs.

6.11. Health and Welfare of Enrollees. The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants' health and welfare. The state, or the MCO for CB enrolled individuals, through an MCO contract, must be required on a continuous basis to identify, address, and seek to prevent instances of abuse, neglect and exploitation through the Critical Incident Management System. The state must have performance measures to demonstrate each of the following: a) that, on an ongoing basis, seeks to prevent, identify, track, and address instances of abuse, neglect, exploitation and unexplained death; b) that an incident management system is in place that effectively resolves incidents and prevents further incidents to the extent possible; c) that state policies and procedures for the use or prohibition of restrictive interventions are followed; and d) that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

6.12. Financial Accountability. The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the HCBS program. For CB, this requires the state to demonstrate actuarial soundness on an annual basis pursuant to 42 CFR Part 438.

6.13. The state must submit the QIS and performance measures to CMS for review and approval within 90 days following approval of the demonstration.

6.14. 1915(c)-like HCBS Reporting Requirements.

a. The state will submit a report to CMS following receipt of an Evidence Request letter and report template from the Division of HCBS Operations and Oversight (DHCBSO), no later than 21 months prior to the end of the approved demonstration period, which includes evidence on the status of the approved HCBS quality performance measures and assurances that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in § 1915(c) Home and Community-Based Waivers. Following receipt of the state's evidence report, the DHCBSO will issue a draft report to the state and the state will have 90 days to respond. The DHCBSO will review and assess the

evidentiary report to determine whether the performance measures and requirements have been met and will issue a final report to the state 60 days following receipt of the state's response to the draft report.

b. The state must also report annually the deficiencies found during the monitoring and evaluation of the 1915(c)-like HCBS performance measures and assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or unexplained death, the actions taken regarding the incidents and how they were resolved. Submission is due no later than 6 months following the end of the demonstration year).

6.15. Electronic Visit Verification System (EVV). The state will demonstrate compliance with the EVV requirements for personal care services (PCS) and home health services in accordance with section 1903(l) of the Act, as added by section 12006 of the 21st Century Cures Act.

a. 1915(c)-like and 1915(i)-like HCBS Beneficiary Protections.

i. Critical Incident Management System. The SMA must operate a critical incident management system according to the SMA's established policies, procedures and regulations. On an ongoing basis, the SMA must ensure that all entities, including the MCOs, have an effective system in place to prevent, detect, report, investigate, and remediate instances of abuse, neglect and exploitation, and ensures participant rights are maintained through policies concerning seclusion, restraint, and medication management.

ii. The state must ensure that MCOs, providers and participants are educated about this system initially at the start or at hire, and at least annually thereafter. If the SMA delegates the responsibility for the critical incident management systems to the participating MCOs, the SMA must collect and analyze the data collected by the MCOs on a regular, periodic basis, and ensure that individual situations are remediated in a timely manner and that system-wide issues are identified and addressed.

iii. Person-Centered Planning and Individual Service Plans.

1. The state must require the use of a person-centered and directed planning process, consistent with federal requirements at 42 CFR 441.301(c)(1) – (2) to identify the strengths, capacities, and preferences of the enrollee as well as to identify an enrollee's LTC needs and the resources available to meet these needs, and to provide access to additional care options as specified by the contract.

2. The state must require that a process is in place that permits participants to request a change to the person-centered plan if the participant's circumstances necessitate a change. The state, through the MCO contract, must require all HCBS service plans to be updated and/or

revised annually or when warranted by changes in the enrollee's needs as required by 42 CFR 441.365(e).

3. The state must require the development of a back-up plan to ensure that needed assistance will be provided in the event that the regular services and supports identified in the individual service plan are temporarily unavailable. The back-up plan may include other individual assistants or services.

iv. Demonstration Participant Protections.

1. The state must ensure that children, youth, and adults in CB programs are afforded linkages to protective services (e.g., Ombudsman services, Protection and Advocacy, Division of Child Protection and Permanency) through all service entities, including the MCOs. The state will ensure that these linkages are in place before, during, and after the transition to the CB as applicable.

2. The state/MCOs must develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.

b. Conflict of Interest. The state assures compliance with the HCBS conflict of interest protections at 42 CFR 441.301(c)(1)(vi) and 441.730(b). The state assures that the entity that authorizes the services is external to the agency or agencies that provide the HCBS services. The state also assures that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

c. HCBS Settings Requirements. The state must assure compliance with the characteristics of HCBS settings as described in 42 CFR 441.301(c)(4) and 42 CFR 710(a)(1) and (2) in accordance with implementation/effective dates as published in the Federal Register.

d. The state, either directly or through its MCO contracts, must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant within the scope of the programs (Community Benefit Rule – NMAC 8.308.12).

e. Members may change managed care plans at any time if their residential or employment support provider is no longer available through their current plan.

f. Each beneficiary eligible for LTSS will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person-centered service planning personnel will receive training on these options.

6.16. Option for Participant Direction. Turquoise Care participants who elect to direct their care must have the option to participate in SDCB. SDCB must afford demonstration participants the opportunity to have choice and control over how services are provided and who provides the services. Member participation in SDCB is voluntary, and members may participate in or withdraw from SDCB at any time. The services, goods, and supports that a participant self-directs must be included in the calculations of the participant's budget. The state must ensure the following supports and protections are made available to facilitate SDCB:

a. Information and Assistance in Support of Participant Direction. The state or MCO must have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets. Participants must be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants must also have access to the support system throughout the time that they are self-directing their care. Support activities must include, but are not limited to Financial Management Services and Support Brokerage assistance.

b. Participant Direction by Representative. Participants who self-direct personal care services may appoint a volunteer (unpaid) designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Services must be directed by a legal representative of the participant or by a non-legal representative freely chosen by an adult participant. A person who serves as a designated representative of a participant for the purpose of directing personal care services cannot serve as a provider of personal care services for that participant.

c. Independent Advocacy. Each enrollee must have access to an independent advocate or advocacy system in the state. This function is performed by individuals or entities that do not provide direct services, perform assessments, or have monitoring, oversight or fiscal responsibilities for the demonstration or services provided under the demonstration. The state must require the MCO to provide participants with information regarding independent advocacy supports.

d. Participant Employer Authority. The state must ensure that the participant (or the participant's designated representative) has the following decision-making authority over workers who provide services to the participant.

6.17. Participant/Common Law Employer. The participant (or the participant's designated representative) is the common law employer of workers who provide services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.

6.18. Decision Making Authority. The participant (or the participant's designated representative) exercises the following decision making activities: recruit staff, select staff from worker registry (if available), hire staff as common law employer, verify staff qualifications, obtain criminal history and/or background investigation of staff, specify additional staff

qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

a. Members transitioning from ABCB to SDCB may receive one-time funding of up to $2,000.00 to be used for items that are identified in the CCP as essential for successful management of self-directed services, as outlined in Attachment A.

b. Existing SDCB members who, at implementation of Turquoise Care, have budgets that exceed the service limits applicable under Turquoise Care for related goods and services, specialized therapies or non-medical transportation, will have their current budgets carried over until 2023. After 2023, the budgets for these members must be based upon the approved amounts consistent with the then-applicable Turquoise Care service limits. Members newly receiving SDCB will be subject to the Turquoise Care service limitations beginning on January 1, 2019. See Attachment A for details regarding service limits.

c. Disenrollment from Participant-Direction. A participant may voluntarily disenroll from SDCB at any time and return to a traditional service delivery system. To the extent possible, the member shall provide his/her provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. A participant may be involuntarily disenrolled by the state from SDCB: 1) for cause, if continued participation would not permit the participant's health, safety, or welfare needs to be met, or 2) the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct personal care services, including repeated premature depletions of his/her budget, or 3) if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant directed services. If a participant is terminated voluntarily or involuntarily from SDCB, the state must require the MCO to transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.

d. Appeals and State Fair Hearings. The state must ensure that members are permitted to file an appeal with their MCO of any adverse benefit determination, as defined in 42 CFR 438.400(b). Pursuant to 42 CFR 438.402(c), 42 CFR 431.200(b), and 42 CFR 431.220(a)(4), participants may use the state fair hearing process after they have exhausted the MCO appeal process to request reconsideration of an adverse benefit determination that is upheld by the MCO.

6.19. Home and Community-Based Provider Settings. All HCBS provider settings must be assessed by the MCOs, prior to providing the CB and as part of ongoing monitoring, to ensure that they meet all applicable federal requirements for appropriate settings (42 CFR 441.301(c)(4)-(5)). Ongoing monitoring activities must be multi-faceted and include: 1) care coordinators verifying whether members are receiving services in compliant settings as part of care coordination touch point meetings as required in the MCO contract, 2) MCOs verifying that all requirements are met and continue to be met as part of credentialing and re-credentialing activities, for credentialed providers, and 3) state and MCOs responding to complaints and allegations of noncompliance. The state must ensure

that services are not furnished in provider settings that are not compliant with applicable requirements until identified issues are successfully remediated. The state must hold MCOs accountable, through contractual requirements, for monitoring ongoing provider compliance and must require MCOs to regularly report to the state on provider status and monitoring activities. This STC does not include the SMI/SED pre-tenancy and tenancy referred to in STC 6.22 or short-term post hospitalization housing for members experiencing homelessness.

6.20. Community Interveners. Deaf and blind individuals enrolled in Turquoise Care may access the benefit of Community Interveners. A Community Intervener is a trained professional who meets the criteria as determined by the state. The Intervener works one-on-one with deaf-blind individuals who are five years and older to provide critical connections to other people and the environment. The Intervener opens channels of communication between the individual and others, provides access to information, and facilitates the development and maintenance of self-directed independent living. Community Intervener services may be covered by Turquoise Care MCOs and the costs associated with the Community Interveners may be included in capitation payments from the state to the Turquoise Care MCO. The state will continue supporting and encouraging the use of Community Interveners.

6.21. Medicaid Home Visiting Pilot Program: Evidenced-based Home Visiting Services Pilot Program. In collaboration with New Mexico Children, Youth and Families Department (CYFD), New Mexico Department of Health (DOH) and Early Childhood Education and Care Department (ECECD), the state must require the Turquoise Care MCOs to provide an evidence-based, early childhood home visiting pilot project that focuses on pre-natal care, post-partum care and early childhood development. The services will be delivered to eligible pregnant individuals residing in any county by agencies providing the evidence-based early childhood home visiting delivery model as defined by the US Department of Health and Human Services (DHHS) and as contracted with the Turquoise Care MCOs. Additional program details, including services, approved evidence-based models, and provider qualifications, are in Attachment B. The Medicaid Home Visiting (MHV) pilot program will align with HHS approved evidence-based early childhood home visiting delivery models focused on the health of pregnant individuals and their infants and promote parenting skills and child development. The state may incorporate new HHS approved evidence-based early childhood home visiting delivery models into the demonstration following approval from CMS. The state must provide CMS a written request with the proposed model it is requesting, an overview of the model including the populations and estimated members that will benefit from implementing the program criteria for screening of potential individuals, and the estimated implementation date for the model at least 90 days prior to the model implementation date.

6.22. Peer Delivered Pre-Tenancy and Tenancy Services. The aim of 1915(i)-like pre-tenancy and tenancy services is to assist members in acquiring, retaining and maintaining stable housing, making it more conducive for members to participate in ongoing treatment of their illness and improve the management of their mental and physical health issues. Pre-tenancy and tenancy services do not include tenancy assistance in the form of rent or subsidized housing; instead they expand the availability of basic housing supports provided today

through comprehensive community support services (CCSS), currently authorized under the state plan as case management, habilitation, and other similar services. The pre-tenancy and tenancy services authorized under this demonstration are specified in Attachment I. The state will use its existing program infrastructure and network of provider agencies associated with the Linkages Supportive Housing Program and/or Local Lead Agency providers associated with the Set Aside Housing Program to deliver pre-tenancy and tenancy services. Linkages providers will be expected to utilize community support workers, case managers, supportive housing coordinators, or certified peer support workers (CPSWs) who have similar lived experience, are on a solid footing in their recovery, and are employed by Linkages providers or Local Lead Agency provider for service delivery. This approach builds upon a successful statewide supportive housing model; expands the peer workforce; and improves the engagement, service delivery and outcomes for individuals with SMI/SED.

a. Pre-Tenancy and Tenancy Services will be made available to a range of 180 to 450 of demonstration members annually.

b. Participants eligible for pre-tenancy and tenancy services are:

    i. Members with a Serious Mental Illness (SMI) who are part of the Linkages Supportive Housing Program; and

    ii. Members associated with the Special Needs/Set Aside Housing Program (SAHP)/Local Lead Agencies who are homeless or at risk of homelessness and are:

        1. Individuals with SMIs;
        2. Individuals with SUDs;
        3. Individuals with intellectual/developmental disabilities;
        4. Individuals with physical, sensory, or cognitive disability occurring after the age of 22;
        5. Individuals with a disability caused by chronic illness (i.e., people with HIV/AIDS, diabetes, etc. or other incapacitating illness); or
        6. Individuals with an age-related disability (i.e., frail elderly, or young adults with other special needs who have been in the foster care of juvenile services system).

c. The state must submit an updated Attachment I "Pre-Tenancy and Tenancy Supports" which includes the state's proposed needs-based criteria for the 1915(i)-like population within 90 days of demonstration approval.

d. Pre-Tenancy and Tenancy Services will be limited to areas where the Linkages Supportive Housing Program or the SAHP/Local Lead Agencies operate.

6.23. Quality Strategy for 1915(i)-like HCBS Services. For services that could have been authorized to individuals under a 1915(i) HCBS state plan amendment, the state must have

an approved QIS that encompass LTSS specific measures set forth in the federal managed care rule at 42 CFR 438.330 and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal requirements at 42 CFR 441.745(b) and is required to develop performance measures to address the following requirements:

a. The state must have performance measures to demonstrate that the service plans:

    i. Address assessed needs of the 1915(i)-like participants;

    ii. Are updated annually; and

    iii. Document choice of services and providers.

b. Eligibility requirements. The state must have performance measures to demonstrate each of the following:

    i. That an evaluation for pre-tenancy and tenancy services eligibility is provided to all applicants for whom there is reasonable indication that pre-tenancy and tenancy services may be needed in the future;

    ii. That the processes and instruments described in the approved program for determining pre-tenancy and tenancy services eligibility are applied appropriately; and

    iii. Eligibility of enrolled individuals is reevaluated at least annually (end of DY) or if more frequent, as specified in the approved program.

    iv. The state must have performance measures to demonstrate that providers meet required qualifications.

    v. The state must have performance measures to demonstrate the SMA retains authority and responsibility for program operations and oversight by MCOs as required in the MCO contract.

    vi. The state must have performance measures to demonstrate the SMA maintains financial accountability through payment of claims by MCOs for services that are authorized and furnished to participants by qualified providers.

    vii. The state must have performance measures to demonstrate that the state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death, including the use of restraints.

    viii. The state must have performance measures to demonstrate that settings meet the home and community-based settings requirements in accordance with 42 CFR 441.710(a)(1) and (2).

    ix. The state must submit the QIS and performance measures to CMS for review and approval within 90 days following approval of the demonstration.

c. 1915(i)-like HCBS Reporting Requirements.

i. The state must report annually the actual number of unduplicated individuals enrolled in the 1915(i)-like demonstration in the previous year and the estimated number of individuals to be enrolled in the 1915(i)-like demonstration for the following year. This report is due 90 days post the end of each DY.

ii. The state will submit a report to CMS, following receipt of an Evidence Request letter and report template from the Division of HCBS Operations and Oversight (DHCBSO), no later than 21 months prior to the end of the approved demonstration period, which includes evidence on the status of the approved HCBS quality performance measures and requirements that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community–Based Waivers. Following receipt of the state's evidence report, the DHCBSO will issue a draft report to the state and the state will have 90 days to respond. The DHCBSO will review and assess the evidentiary report to determine whether the performance measures and requirements have been met and will issue a final report to the state 60 days following receipt of the state's response to the draft report.

6.24. Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program. Effective upon CMS' approval of the OUD/SUD Implementation Plan Protocol, the demonstration benefit package for the state's Medicaid members will include OUD/SUD treatment services, including short term residential services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for services provided to members who are short-term residents in IMDs under the terms of this demonstration, including for OUD/SUD benefits that would otherwise be matchable if the member were not residing in an IMD. The state must aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 15.5, to ensure short-term residential treatment stays. Under this demonstration, members will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings.

6.25. With approval of the state's OUD/SUD Implementation Plan on May 21, 2019, the coverage of OUD/SUD treatment services and withdrawal management during short-term residential and inpatient stays in IMDs expanded the state's SUD benefit package available to all of the state's Medicaid members as outlined in Table 5 below. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 5: New Mexico OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Expenditure Authority
Outpatient Services	*State plan (Individual services covered)*	
Intensive Outpatient Services	*State plan (Individual services covered)*	
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	*State Plan*	
Youth Residential Treatment (Age 18-21)	*State plan (Individual services covered)*	Services provided to individuals in IMDs
Adult Residential Treatment	*State plan (Individual services covered)*	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	*State plan*	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	*State plan*	Services provided to individuals in IMDs

6.26. SUD Implementation Plan Protocol. The state's OUD/SUD Implementation Plan, initially approved for the period of May 21, 2019 through December 31, 2023, and during the temporary extension, remains in effect for the approval period from July 25, 2024 through December 31, 2029, and is affixed to the STCs, as Attachment H. Any future modifications to the approved Implementation Plan will require CMS approval Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral. The approved SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration program:

a. Access to Critical Levels of Care for OUD and other SUDs. Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;

b. Use of Evidence-based SUD-specific Patient Placement Criteria. Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

c. Patient Placement. Establishment of a utilization management approach such that members have access to SUD services at the appropriate LOC and that the interventions are appropriate for the diagnosis and LOC, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

d. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Accredited Residential Treatment Facilities. Currently, residential treatment service providers must be accredited by either Joint Commission, Council on Accreditation or the Commission on Accreditation of Rehabilitation Facilities depending on the accrediting body for the Accredited Residential Treatment Facility the provider is employed by. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized SUD specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12 – 24 months of demonstration approval.

e. Standards of Care. Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

f. Standards of Care. Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;

g. Sufficient Provider Capacity at each LOC including MAT for SUD/OUD. An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of demonstration approval;

h. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs (PDMPs);

i. Improved Care Coordination and Transitions between levels of care. Establishment and implementation of policies to ensure residential and inpatient facilities link members with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

j. SUD Health IT Plan. Implementation of the Substance Use Disorder Health Information Technology Plan which describes technology that will support the airs of the demonstration. Further information which describes milestones and metrics as detailed in STC 6.28 or Attachment H.

6.27. SUD Health Information Technology Plan ("Health IT Plan"). The SUD Health IT plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan(s) (see STC 6.26(a) and 6.26(c), to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

The Health IT Plan should describe how technology can support outcomes through care coordination; linkages to public health and PDMPs; establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR 433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 42 CFR part 170, subpart B.

The state must include in its Monitoring Protocol (see STC 15.5) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Report (see STC 14.5).

As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable state procurements (e.g., including managed care contracts) that are associated with this demonstration.

Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally recognized standards.

Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally recognized ISA standards.

Components of the Health IT Plan include:

1. The Health IT Plan must describe the state's alignment with section 1944 of the Act as added by section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified PDMP[2].

2. The Health IT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders. States should favor procurement strategies that incorporate qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in RX Check for Interstate data sharing.

3. The Health IT Plan will describe how technology will support SUD prevention and treatment outcomes described by the demonstration.

4. In developing the Health IT Plan, states should use the following resources:

    a. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).
    b. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.
    c. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.
    d. States should review the Office of the National Coordinator's Interoperability Standards Advisory (https://www.healthit.giv/isa/) for information on appropriate standards which may not be required per 45 CFR part 170, subpart B for enhanced funding, but still should be considered industry standards per 42 CFR 433.112(b)(12).

6.28. Unallowable Expenditures Under the SUD Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for the following: Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

[2] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

6.29. SMI/SED Program Benefits. Under this demonstration, beneficiaries will have access to the full range of otherwise covered Medicaid services, including SMI/SED treatment services. These SMI/SED services will range in intensity from short-term acute care in inpatient settings for SMI/SED, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve an average length of stay of no more than 30 days for beneficiaries receiving treatment in an IMD treatment setting through this demonstration's SMI/SED program, to be monitored pursuant to the SMI/SED Monitoring Plan as outlined in STC 15.5.

6.30. SMI/SED Implementation Plan. The state must submit the SMI/SED Implementation Plan within ninety (90) calendar days after approval of the SMI/SED demonstration amendment for CMS review and comment. If applicable, the state must submit a revised SMI/SED Implementation Plan within sixty (60) calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI/SED under the expenditure authority until CMS has approved the SMI/SED Implementation Plan and the SMI/SED financing plan described in STC 6.30. After approval of the required Implementation Plan and Financing Plan, FFP will be available prospectively, but not retrospectively. FFP will only be available for services provided pursuant to the demonstration to beneficiaries who are short-term residents in IMDs that meet the criteria specified in STC 6.34, as applicable, as further detailed in the approved SMI/SED Implementation Plan; these providers are referred to as participating hospitals or participating residential treatment providers.

a. Once approved, the SMI/SED Implementation Plan will be incorporated into the STCs as Attachment J and once incorporated, may be altered only with CMS approval. Failure to submit an SMI/SED Implementation Plan, within 90 calendar days after approval of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 15.1.

   At a minimum, the SMI/SED Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

   i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.

      A. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be

in compliance with the conditions of participation set forth in 42 CFR Part 482 and be either: a) certified by the state agency as being in compliance with those conditions through a state agency survey, or b) deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.

Establishment of an oversight and auditing process that includes unannounced visits for ensuring psychiatric hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;

Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;

Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues); and

Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitions to Community-Based Care.

Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);

Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where available;

Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider the beneficiary was referred to;

Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);

Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability (the state must provide updates on how it has increased the availability of mental health services in every Annual Monitoring Report);

Commitment to implement the SMI/SED Financing Plan described in STC 6.32. The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 15.5;

Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible; and

Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., Level of Care Utilization System (LOCUS) or, The Child and Adolescent Service Intensity Instrument (CASII)) to determine appropriate level of care and length of stay.

Earlier Identification and Engagement in Treatment and Increased Integration

Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;

Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers; and

Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

6.31. SMI/SED Health Information Technology (Health IT) Plan. The Health IT Plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it has a sufficient health IT infrastructure "ecosystem" at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the applicable Implementation Plan (see STC 6.30), to develop the infrastructure/capabilities of the state's health IT infrastructure.

a. The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them

(see Attachment J) and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

b. The state will include in its Monitoring Protocol (see STC 15.5) an approach to monitoring its SMI/SED Health IT Plan which will include performance metrics to be approved in advance by CMS.

c. The state will monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Monitoring Report (see STC 15.5).

d. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications (ISA) in developing and implementing the state's SMI/SED Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

e. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or Accountable Care Organization (ACO) participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B "Standards and Implementation Specifications for HIT.' If there is no relevant standard in 45 CFR 170 Subpart B, the state should review the Office of the National Coordinator for Health Information Technology's Interoperability Standards Advisory (https://www.healthit.gov/isa/) to locate other industry standards in the interest of efficient implementation of the state plan.

f. Components of the Health IT Plan include:

    i. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SMI/SED care delivery. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

    ii. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

    iii. In developing the Health IT Plan, states should use the following resources:

        1. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).

2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.
3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

6.32. SMI/SED Financing Plan. As part of the SMI/SED Implementation Plan referred to in STC 6.30, the state must submit, within 90 calendar days after approval of the demonstration, a Financing Plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the Implementation Plan in Attachment J and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI/SED Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Components of the financing plan must include:

A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings.

6.33. Maintenance of Effort (MOE). The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration. The annual MOE will be reported and monitored as part of the annual monitoring report described in STC 15.5.

6.34. Availability of FFP for the SMI/SED Services Under Expenditure Authority #10. FFP is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD to receive acute care for a primary diagnosis of SMI/SED. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for

FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for stays up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days, as relevant.

6.35. Unallowable Expenditures Under the SMI/SED Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

6.36. High Fidelity Wraparound Intensive Care Coordination. A beneficiary is eligible to receive high fidelity wraparound (HFW) intensive care coordination services, if they meet the following criteria:

a. Children or youth with an SED diagnosis;

b. Current or historical involved in two or more systems such as special education, behavioral health, protective services or juvenile justice; or at risk for such involvement in the case of children aged 0 to 5;

c. At risk or in an out of home placement; and

d. Services are recommended by a physician or other licensed practitioner.

6.37. Within 30 days of enrollment in the HFW intensive care coordination services, a, functional impairment test in which two or more domains identified by the Child and Adolescent Needs and Strength (CANS) tool is completed.

6.38. New Mexico will implement the HFW intensive care coordination in a phased-approach. Phase One will be children in protective services custody who are most at risk and Phase Two will include all children who meet high fidelity wraparound intensive care coordination.

6.39. HFW beneficiaries receive the following benefits:

a. Intensive Care Coordination through dedicated full-time care coordinators working with small numbers of children and families. The care coordinator will be required to follow state guidelines for care of children with SED who are eligible for HFW. Care coordinators work in partnership with representatives of key stakeholder groups, including families, agencies, providers, and community representatives to plan, implement, and oversee HFW coordination plans.

b. Treatment Planning: The individualized care coordination plans are developed by engaging with the beneficiary's family or caretakers and other members of the beneficiary's community. Such plans must be: family and youth-driven, team-based, collaborative, individualized, and outcomes-based. The plan of care must address youth and family needs across domains of physical and behavioral health and social services.

6.40. Program Requirements for High Fidelity Wraparound Intensive Care Coordination.

a. Wraparound Facilitator

i. Complete the requirements of the Facilitator in Training (FIT) track as described in the New Mexico Wraparound Program Manual and Provider Implementation Guide;

ii. Obtain Wraparound certification from the New Mexico Credentialing Board for Behavioral Health Professionals (NMCBBHP) within 6 to 12 months of hire and maintain certification thereafter;

iii. Wraparound Facilitators must be certified or be actively enrolled as a FIT to begin serving families. Wraparound facilitators must also be certified in Wraparound by the NMCBBHP between 6 to 12 months from completing the "Foundations of Wraparound Practice" training; and

A Bachelor's degree in an equivalent field with a minimum of two (2) years lived and/or paid experience working with the target population. Or may have a high school diploma or General Educational Development (GED) with a minimum of six (6) years lived and/or paid experience working with the target population. Or may have an Associate's Degree in social services, human services, or an equivalent field with a minimum of four (4) years lived and/or paid experience working with the target population.

b. Wraparound Supervisor-Coach. A Wraparound Supervisor-Coach will provide coaching/technical assistance to Wraparound Facilitators in their implementation of the New Mexico Wraparound model. The Wraparound Supervisor-Coach must be required to:

i. Complete the requirements of the FIT track as described in New Mexico Wraparound Program Manual and Provider Implementation Guide;

ii. Obtain Wraparound certification from the NMCBBHP within 6 to 12 months of hire and maintain certification thereafter;

iii. Complete the requirements of the Coach in Training (CIT) track as described in New Mexico Wraparound Program Manual and Provider Implementation Guide; and

iv. Obtain Coaching Endorsement from CYFD-BHS within 6 months of being accepted in the CIT track.

v. Obtain a Bachelor's Degree in social services, human services, or an equivalent field with a minimum of two (2) years of paid experience working with the target population and/or High Fidelity Wraparound program and supervision. Lived experience can count for one (1) of the two (2) years required experience; or may have a high school diploma or General Educational Development (GED) with a minimum of two (2) years of paid experience working with the target population and four (4) years lived and/or paid experience working with the target population and have a NM HFW Coach Endorsement or currently enrolled in the NM HFW Coach Endorsement Track; or

vi. A Master's Degree in social services, human services, or an equivalent field with a minimum of two (2) years experience working with the target population and/or High Fidelity Wraparound program and supervision. Lived experience can count for one (1) of the two (2) years experience.

c. Family Peer Support Worker. The Family Peer Support Worker (FPSW) must be supervised by a qualified professional and must be required to:

i. Complete Parent Peer Support Provider Module Trainings;

ii. Take and pass the Certified Family Peer Support Worker (CFPSW) certification exam through the NMCBBHP;

iii. Complete the 40-hour required work/volunteer experience within 90-days of passing the CFPSW certification exam;

iv. Maintain CFPSW certification, including continuing education requirements;

v. Be at least 18 years of age or older;

vi. Have a valid Driver's License;

vii. Have a high school diploma or GED; and

viii. Must have been or are a parent or primary caregiver of a child or youth who: 1) Received a mental health diagnosis or developmental disability diagnosis with a co-occurring mental health diagnosis before the age of 18; and 2) Navigated child serving systems on behalf of the child.

d. Program Director or Administrator. The Program Director or Administrator must:

i. Have demonstrated working knowledge of clinical assessments, determination of admission criteria, clinical oversight for all rounds, and crisis safety planning;

ii. Have Prior work experience in various community settings dealing with SED identified youth; and

iii. Must meet agency's requirements for Program Director or equivalent.

e. Clinical Director. The Clinical Director must:

i. Link Wraparound to agencies internal and external processes for referral and coordination;

ii. Clinically oversee patient care;

iii. Be an Independently Licensed Clinician pursuant to NM Regulations/Boards (Licensed Clinical Social Worker (LCSW) or Licensed Professional Clinical Counselor (LPCC));

iv. Meet all experience, training, and other requirements as defined by the provider agency; and

v. Complete Foundational Wraparound Training for administrators within 3-months of hire.

6.41. Beneficiary-Reported Information and Periodic Data Checks. The state must have procedures designed to ensure that members can make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in this demonstration, such as a change in state residency, and are able to report other information relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The member must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

a. For members who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. The state should follow its typical processes that it would otherwise use to verify continued residency at renewal if continuous eligibility was not available for these individuals. Additionally, at least once every 12 months, the state must follow its typical processes to attempt to confirm the individual is not deceased, consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d). The state must redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.916(d) and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j).

b. The state is required to provide CMS a narrative update annually on the processes it conducted and a summary of its findings regarding the successes and challenges in

conducting such verifications. This information shall be provided in the demonstration's Annual Monitoring Reports (see STC 15.5).

6.42. Annual Updates to Beneficiary Information. For all continuous eligibility periods longer than 12 months, the state must have procedures and processes in place to accept and update beneficiary contact information and must attempt to update beneficiary contact information on an annual basis, which may include annually checking data sources and partnering with coordinated care organizations to encourage beneficiaries to update their contact information. The state is reminded that updated contact information obtained from third-party sources with an in-state address is not an indication of a change affecting eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but without additional follow up by the state per 42 CFR 435.952(d), the receipt of this third-party data is not sufficient to make a definitive determination that beneficiaries no longer meet state residency requirements.

a. Each demonstration year, through the Annual Monitoring Reports (see STC 15.5), the state must submit to CMS a summary of activities and outcomes from these efforts to update beneficiary contact information on an annual basis.

7. MEMBER ENGAGEMENT

7.1. Member Rewards Program Defined. The Member Rewards Program is a voluntary program and not a condition of eligibility or enrollment, which provides incentives through the MCO to demonstration enrollees for participating in state defined activities that promote healthy behaviors. A member who participates in a state defined activity that promotes healthy behaviors earns credits that are applied to an individual's Member Rewards account, which is managed by the MCO. Earned credits may be used for health-related expenditures as approved under the Member Rewards Program. Additional details regarding the rewards program not found in these STCs may be found the Member Rewards Guide.

7.2. Administration Overview. The state must maintain a list of healthy behavior activities that generate contributions to the account. The state must provide the list of healthy behaviors to CMS, and update CMS whenever any changes are made. The state must ensure that the MCO provides members with this list, as well as a list of the health-related items and services (Member Rewards catalog) on which participating members may spend their credits earned under the program. The list of healthy behavior activities must specify how many credits a participant would earn for completing the activity, and the Member Rewards catalog must specify the cost (in credits) of each item. The credit amount available to participating members in their Member Rewards account will depend on the activities in which they participate and complete. Once a member completes an approved activity, he/she is an active participant in the Member Rewards program and will receive applicable credits in his or her Member Rewards account. The state must require the MCO to timely post earned credits into the Member Rewards account for use by the member. Additional credits may be earned as the member participates in additional activities. In no instance will the individual receive cash.

a. Members can use the reward credits earned through the Member Rewards Program to pay for health-related items and services from the Member Rewards catalog.

7.3. Rewards programs administered by MCOs must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States Department of Health and Human Services, Office of Inspector General (OIG). MCOs are encouraged to seek an advisory opinion from OIG once the specifics of their healthy behavior rewards programs are determined.

7.4. Participants Earning Member Rewards. The state must ensure that all enrollees in a Turquoise Care plan must be eligible to voluntarily participate in activities to earn Member Rewards points, and to redeem such points for qualifying health-related items, for the duration of their enrollment.

7.5. Member Access to Credits. The state must require the MCO provide access to an individual's earned credits in his or her Member Rewards account for one year from the date of last enrollment, for an individual who is no longer enrolled in Turquoise Care (either due to loss of eligibility or change of eligibility to an eligibility group not authorized to participate in Turquoise Care) but who had a positive balance in his or her account when most recently enrolled, unless the demonstration and/or the Member Rewards program is sooner terminated. If an individual regains eligibility to participate in Turquoise Care within one year of his or her last enrollment under the program, the member may resume earning additional credits, which will be added to his or her prior accrued balance.

8. DELIVERY SYSTEM

Turquoise Care must provide a comprehensive service delivery system that provides the full array of benefits and services offered under the program. This includes the integration of a participant's physical health, behavioral health, home and community based and long-term care needs as further articulated by the delivery system requirements set forth below.

8.1. Managed Care Requirements. The state must ensure that it, its MCOs, and any subcontractors performing activities under the managed care contract must comply with the managed care regulations published at 42 CFR 438, except as expressly waived or specified as not applicable to an expenditure authority. Capitation rates must be developed and certified as actuarially sound, in accordance with 42 CFR 438.4. The certification must identify historical utilization of state plan and HCBS services used in the rate development process.

8.2. Managed Care Benefit Package. Individuals enrolled in Turquoise Care MCOs must receive the benefits as identified in Section 6 of the STCs.

8.3. Managed Care Contracts. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of the demonstration, such contracts and/or contract amendments. The state must submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 90 days to review and approve changes. CMS reserves

the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

8.4. Public Contracts. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, must not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the Consumer Price Index (CPI-U) for Medical Care).

8.5. Care Coordination in Turquoise Care. The state must require MCO contracts provide comprehensive care coordination to members in accordance with 42 CFR 438.208.

8.6. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT-eligible members ages birth to twenty-one, in accordance with 1905(r) of the Act.

8.7. Requirements for Quality Measurement and Performance Improvement. The state must meet all the requirements of 42 CFR 438 Subpart E, including but not limited to quality assessment and performance improvement programs (42 CFR 438.330), quality strategy (42 CFR 438.340) and external quality review (42 CFR 438.350-370). Pursuant to STC 15.5, the state must also provide CMS with annual reports on the implementation and effectiveness of their Quality Strategy impacting the demonstration.

8.8. State Advisory Committee. The state must maintain for the duration of the demonstration a public managed care advisory group comprised of stakeholders impacted by the demonstration's use of managed care, regarding the impact and effective implementation of these changes. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving CB services, as well as other members subject to the demonstration. The state's Medicaid advisory committee, or a subcommittee thereof, may perform this function in lieu of a newly created advisory group. The state must maintain minutes from these meetings and use them in evaluating program operations and identifying necessary program changes. Copies of committee meeting minutes must be made available to CMS upon request and the outcomes of the meetings may be discussed on the demonstration monitoring calls described in STC 15.10.

8.9. MCO Participant Advisory Committees. The state must require each MCO, through its contracts, to create and maintain participant advisory committees through which the MCO can share information and capture enrollee feedback. The MCOs will be required to support and facilitate participant involvement and submit meeting minutes to the state. Copies of meeting minutes must be made available to CMS upon request.

8.10. Indian Managed Care Capitated Entity (IMCE) Readiness operational of IMCEs pursuant to 438.66(d). Assignment into an IMCE will only begin when the IMCE has been determined by the state and CMS to meet certain readiness processes and procedures and provider network requirements.

8.11 State Oversight of Medical Loss Ratio (MLR).

a. For risk-based plans, the state must submit the plan-generated reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR 438.8(k) to CMS at DMCPMLR@cms.hhs.gov.
    i. For managed care plans that delegate risk to subcontractors, the state's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to such subcontractors; see https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf .https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf. The state must submit its plan to operationalize STC 8.11.b. through e. no later than six months after the demonstration approval. This plan must outline key deliverables and timelines to meet the requirements of STC 8.11.b. through e.

b. Effective July 1, 2025, the state must require risk-based plans contracted with the state to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.
c. No later than July 1, 2026, the state must require risk-based plans contracted with the state to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities.
d. STC 8.11.a, 8.11.b, and 8.11.c must apply for all of the following entities:
    i. Risk-based plans for which the state receives FFP for associated expenditures;
    ii. Full and partially delegated plans;
    iii. Other subcontractors, as applicable, that assume delegated risk from either the primary managed care plan contracted with the state, or plans referenced in STC 8.11.e.ii; and
    iv. Other subcontractors, as applicable, that assume delegated risk from entities referenced in STC 8.11.e.iii.
e. The state must work with CMS to effectuate an audit of the MLR data for all complete rating periods (i.e., MLR reporting periods) in this 1115 demonstration package. Final audit results and reporting must be provided to CMS no later than two years after the expiration of the current demonstration period.

9. REENTRY DEMONSTRATION INITIATIVE

9.1. Overview of Pre-Release Services and Program Objectives. This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to qualifying Medicaid individuals who are residing in a tribal, state or local jail; tribal or, state prisons; jail or youth correctional facility (hereinafter "correctional facility") as specified in STC 9.5, the implementation timeline in STC 9.8, and the implementation plan in STC 9.10.

9.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with

community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The Reentry Demonstration Initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of MAT and other SUD and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs, and health-related social needs;

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care;

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release;

i. Improve the physical and behavioral health of individuals upon community reentry;

j. Reduce recidivism;

k. Decrease the number of formerly incarcerated individuals struggling with homelessness or housing insecurity;

l. Ensure medication and medical resource continuity upon community reentry; and

m. Strengthen community-based supports to prevent costly and avoidable emergency department visits or inpatient hospitalizations.

9.3. Qualifying Criteria for Pre-Release Services. To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 9.1; and

b. Be enrolled in Medicaid.

9.4. Scope of Pre-Release Services. The pre-release services authorized under the Reentry Demonstration Initiative include the following services.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs, and health-related social needs;

ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;

iii. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy;

iv. Diagnostic services, including laboratory and radiology services, and treatment services in addition to those identified in 9.4(a)(ii);;

v. Prescribed drugs, in additional to those identified in STCs 9.4(a)(ii) and 9.4(a)(iii), and medication administration;

vi. Medical equipment and supplies and/or medical equipment provided upon release;

vii. Family planning services and supplies;

viii. Services provided by community health workers;

ix. Peer support services;

x. Treatment for Hepatitis C; and

xi. Physical and behavioral health clinical consultation services, as clinically appropriate, to diagnose health conditions, provide treatment, and support pre-release case managers' development of a post-release treatment plan and discharge planning.

b. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the Reentry Demonstration Initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule, effective January 1, 2025, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the New Mexico Medicaid State Plan, as relevant, that are not included in the above-described pre-release services benefit for qualifying Medicaid individuals are not available to qualifying individuals through the Reentry Demonstration Initiative.

9.5. Participating Correctional Facilities. The pre-release services will be provided at correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to New Mexico Health Care Authority approval of a facility's readiness, according to the implementation timeline described in STC 9.9. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the Reentry Demonstration Initiative.

9.6. Participating Providers.

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under New Mexico scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as a Medicaid provider.

b. Participating providers eligible to deliver services under the Reentry Demonstration Initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the Reentry Demonstration Initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

9.7. Suspension of Coverage. Upon entry of a Medicaid individual into a correctional facility, New Mexico's Health Care Authority must not terminate and generally shall suspend their Medicaid coverage.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an

application for Medicaid and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

9.8. Interaction with Mandatory State Plan Benefits for Eligible Juveniles. To the extent New Mexico's reentry demonstration includes coverage otherwise required to be provided under section 1902(a)(84)(D) of the Act, and because this coverage is included in the base expenditures used to determine the budget neutrality expenditure limit, the state will claim for these expenditures and related transitional non-service expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

9.9. Reentry Demonstration Initiative Implementation Timeline. Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). The Health Care Authority will determine that each applicable facility is ready to participate in the Reentry Demonstration Initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid application and enrollment processes for individuals who are not enrolled in Medicaid prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 9.3;

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable;

d. New Mexico will require participating facilities to select a Service Level for implementation. Service Level One consists of the required pre-release services as indicated in the SMDL and identified in STC 9.4 a and b, and must be the first Service Level category that is implemented. The state may define additional Service Level categories in its Implementation Plan. As applicable, additional service levels may be phased-in by facilities in any order, e.g., Service Level Two would not be a prerequisite for phasing-in Service Level Three, except that no facility may be a participating correctional facility that does not at least achieve and maintain provision of Service Level One. A facility must demonstrate to the state that it is prepared to implement all the services in Service Level One and within any chosen Service Level, if applicable;

e. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to,

physical and behavioral health community-based providers, social service departments, and managed care plans;

f. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the 90-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;

g. Operational approaches related to implementing certain Medicaid requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the Reentry Demonstration Initiative;

h. A data exchange process to support the care coordination and transition activities described in (d), (e), and (f) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

i. Reporting of data requested by the Health Care Authority to support program monitoring, evaluation, and oversight; and

j. A staffing and project management approach for supporting all aspects of the facility's participation in the Reentry Demonstration Initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

9.10. Reentry Demonstration Initiative Implementation Plan. The state is required to submit a Reentry Demonstration Initiative Implementation Plan in alignment with the expectations outlined in the State Medicaid Director Letter (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated). As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the Reentry Demonstration Initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment K titled "Reentry Demonstration Initiative Implementation Plan," and may be revised only with CMS approval.

CMS will provide the state with a template to support developing and obtaining approval of the Implementation Plan. Contingent upon CMS's approval of the state's Implementation Plan, the state may begin claiming FFP for services provided through the Reentry Demonstration Initiative starting from the date of inclusion of the Implementation Plan as an attachment to these STCs.

9.11. Reentry Demonstration Initiative Reinvestment Plan. To the extent that the Reentry Demonstration Initiative covers services that are the responsibility of and were previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment L). The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the Reentry Demonstration Initiative, defined as services not previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals prior to the facility's implementation of the Reentry Demonstration Initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the Reentry Demonstration Initiative, with respect to the relevant increase in expenditures, as described in Attachment L the Reentry Demonstration Initiative Reinvestment Plan) is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

    i. The state share of funding associated with new services covered under the Reentry Demonstration Initiative, as specified in this STC;

    ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

    iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the Reentry Demonstration Initiative opportunity;

    iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment L) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment L titled "Reentry Demonstration Initiative Reinvestment Plan."

9.12. Reentry Demonstration Initiative Planning and Implementation.

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid pre-release applications. In addition, Reentry Demonstration Initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the Reentry Demonstration Initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among the Health Care Authority and Qualified Applicants listed in STC 9.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid. These allowable expenditures may include the following:

i. Technology and IT Services. Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the Reentry

Demonstration Initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic interfaces for Qualified Applicants listed in STC 9.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 9.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

ii. Hiring of Staff and Training. Expenditures for Qualified Applicants listed in STC 9.12(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

iii. Adoption of Certified Electronic Health Record Technology. Expenditures for providers' purchase or necessary upgrades of certified EHR technology and training for the staff that will use the EHR.

iv. Purchase of Billing Systems. Expenditures for the purchase of billing systems for Qualified Applicants.

v. Development of Protocols and Procedures. Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid enrollment process, suspension/unsuspension process for eligible individuals, and provision of care coordination and reentry planning for a period for up to 90 days immediately prior to the expected date of release for individuals qualifying for Reentry Demonstration Initiative services.

vi. Additional Activities to Promote Collaboration. Expenditures for additional activities that will advance collaboration among New Mexico's Qualified Applicants in STC 9.12(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vii. Planning. Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid; (2) assisting with the completion of a Medicaid application; (3) submitting the Medicaid application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

viii. Other activities to support a milieu appropriate for provision of pre-release services. Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 6. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 6. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
Total Computable Expenditures	$20,007,032	$60,021,097	$60,021,097	$60,021,097	$0	$0

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

d. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include the SMA, correctional facilities, other state agencies supporting carceral health, probation offices, and other entities as relevant to the needs of justice-involved individuals, including health care providers, as approved by the SMA.

10. HEALTH RELATED SOCIAL NEEDS SERVICES

This section of the STCs establishes a framework for health-related social needs (HRSN) services authorized through expenditure authority in order for the state and CMS to better evaluate the effects of HRSN on the Medicaid population.

10.1. Health-Related Social Needs (HRSN) Services. The state may claim FFP for expenditures for certain qualifying HRSN services identified in Attachment N and this STC, subject to the restrictions described below, including Section 11 of these STCs, and outlined in any

related CMS published guidance on HRSN services[3,4]. Expenditures are limited to expenditures for items and services not otherwise covered under title XIX but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. All HRSN interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and HRSN criteria across services and with other non-Medicaid social support agencies, to the extent possible. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 10.7 (Service Delivery) and Attachment N.

10.2. Allowable HRSN services. The state may cover the following HRSN services:

i. Housing interventions, including:

i. Short-term post-hospitalization housing with room and board for up to 6 months per year, only where integrated, clinically oriented recuperative or rehabilitative services and supports are provided. Post-hospitalization housing are limited to a clinically appropriate amount of time.

ii. Nutrition Interventions, considered standalone outside of joint room and board interventions:

i. Home delivered meals, tailored to health risk or pantry stocking for pregnant individuals who meet the risk and needs-based criteria in Attachment P. Additional meal support is permitted when provided to the household of a pregnant individual, as defined in the risk and needs-based criteria in Attachment P.

ii. Nutrition prescriptions, tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example, fruit and vegetable prescriptions, protein box prescriptions, food pharmacies, and/or healthy food vouchers. Individuals who receive nutrition prescriptions cannot concurrently receive other nutritional HRSN interventions for pregnant individuals who meet the risk and needs-based criteria in Attachment N. Additional support is permitted when provided to the household of a pregnant individual, as defined in the risk and needs-based criteria in Attachment N. Individuals who

[3] "Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program," *CMCS Informational Bulletin*, published on November 16, 2023.
[4] "Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)," published on November 16, 2023.

receive nutrition prescriptions cannot concurrently receive other nutritional HRSN interventions.

10.3. HRSN Infrastructure.

a. The state may claim FFP in infrastructure investments in order to support the development and implementation of HRSN services, subject to Section 10. This FFP will be available for the following activities:

i. Technology – e.g., electronic referral systems, shared data platforms, EHR modifications or integrations, screening tool and/or case management systems, databases/data warehouses, interoperability with the State Health Information Network for New Mexico, information security, data analytics and reporting, data protection and privacy, accounting and billing systems.

ii. Development of business or operational practices – e.g., procurement and planning, screening and referral processes, capacity building for social service providers and network development, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation.

iii. Workforce development – e.g., cultural competency training, trauma informed training, traditional health worker certification, training staff on new policies and procedures.

iv. Outreach, educations, and stakeholder convening – e.g., design and production of outreach and education materials, translation, obtaining community input, investments in stakeholder convening.

b. The state may claim FFP in HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 7. In the event that the state does not claim the full amount of FFP for given a demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 7. Annual Limits of Total Computable Expenditures for HRSN Infrastructure

	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17	Total
Total Computable Expenditures	$6,693,195	$49,737,110	$39,789,688	$2,984,227	$0	$0	$99,474,220

c. Infrastructure investments will receive the applicable administrative match for the expenditure.

d. This infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The state must ensure that HRSN

infrastructure expenditures described in STC 10.3.a. are not factored into managed care capitation payments, and that there is no duplication of funds.

e. The state may not claim any FFP in HRSN infrastructure expenditures until the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualification is approved, as described in STC 10.6. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date.

f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

10.4. Excluded HRSN Services and Infrastructure. Excluded items, services, and activities that are not covered as HRSN services or infrastructure include, but are not limited to:

iii. Construction costs (bricks and mortar).

iv. Capital investments.

v. Room and board outside of specifically enumerated care or housing transitions beyond 6 months, expect as specified in STC 10.2.

vi. Research grants and expenditures not related to monitoring and evaluation.

vii. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting, except those HRSN-related case management services provided as part of an approved reentry demonstration initiative.

viii. Services provided to individuals who are not lawfully present in the United States or are undocumented.

ix. Expenditures that supplant services and activities funded by other state and federal governmental entities.

x. School-based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education and/or state or the local education agency.

xi. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

xii. Any other projects or activities not specifically approved by CMS as qualifying for coverage as a HRSN item or service under this demonstration.

10.5. Covered Populations. Expenditures for HRSN services may be made for the specified populations listed below. To receive HRSN services, individuals in the specified

populations must have a documented medical need for the services and the services must be determined medically appropriate, as described in the HRSN Services STC 10.2, for the documented need. Medical appropriateness must be based on clinical and health-related social risk factors, including whether the service would have a reasonable expectation of improving maintaining the health or overall function of the beneficiary. This determination must be documented in the beneficiary's HRSN service plan or medical record. Additional detail on specified populations, including the clinical and other health-related social needs criteria, is outlined in Attachment N. The allowable covered populations are individuals meeting the following criteria:

a. Nutrition Supports: Pregnant and postpartum individuals with qualifying nutrition-sensitive conditions identified in the protocol.

b. Post-Hospitalization Stays: Individuals experiencing homelessness or at risk of homelessness recovering from a hospitalization who have qualifying clinical conditions identified in the protocol.

10.6. Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications. The state must complete and submit to CMS for approval a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 days after approval of these authorities. The protocol(s) must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for defining a medically appropriate population for each service, the process by which that criteria will be applied including care plan requirements or other documented processes, proposed uses of HRSN infrastructure funds, and provider qualification criteria for each service. Each protocol may be submitted and approved separately. The state must resubmit an updated protocol, as required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP for HRSN services or HRSN infrastructure expenditures until CMS approves the associated protocol, except as otherwise provided herein. Once the associated protocol is approved, the state can claim FFP for HRSN services and HRSN infrastructure retrospectively to the beginning of the extension approval date as the approved protocol(s) will be appended to the STCs as Attachment N.

Specifically, the protocol must include the following information:

i. Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

ii. A list of the covered HRSN services (not to exceed those allowed under STC 10.1) with associated service descriptions and service-specific provider qualification requirements.

iii. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

iv. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may deem the service to be medically appropriate.

v. Plan to identify medical appropriateness based on clinical and social risk factors.

vi. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries and stakeholders.

vii. A description of the process for developing care plans based on assessment of need.

i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.

ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma-informed.

viii. Plan to avoid duplication/displacement of existing food assistance/nutrition services including how the state will prioritize and wrap around SNAP and/or WIC enrollment, appropriately adjust Medicaid benefits for individuals also receiving SNAP and/or WIC services, and ensure eligible beneficiaries are enrolled to receive SNAP and/or WIC services.

ix. An affirmation that the state agrees to meet the enhanced monitoring and evaluation requirements stipulated in STC 15.5 and STC 16.4 which require the state to monitor and evaluate how the renewals of recurring nutrition services in STC 10.2 affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services. As required in STC 15.5 and STC 16.4, the monitoring protocol and evaluation design are subject to CMS approval.

10.7. Service Delivery. HRSN services will be provided in the managed care and fee-for-service delivery system. Nutrition services will expand to fee-for-service over the course of the demonstration. As outlined in STC 10.2, HRSN services will be delivered by HRSN service providers. Terms applicable to all HRSN Services:

i. HRSN services will be paid on a FFS basis when those HRSN services are provided to beneficiaries enrolled in Medicaid FFS.

ii. When HRSN services are provided to beneficiaries enrolled in Medicaid managed care, the following terms will also apply:

i. For a non-risk payment, the MCO is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362 and may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, fee-for-service as defined in 42 CFR 447.362 is the fee-for-service authorized in this

demonstration for HRSN Services paid on a fee-for-service basis by the state. The managed care plan contracts must clearly document the process and methodology for non-risk payments.

ii. When the state incorporates the HRSN Services into the risk-based capitation rates in Medicaid managed care, it must comply with all applicable federal requirements, including but not limited to 42 CFR 438.4, 438.5, 438.6, and 438.7, and the state may no longer utilize non-risk payments.

iii. Any applicable HRSN 1115 services that are delivered by managed care plans in a risk arrangement, must be included in the managed care contracts and rate certifications submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) and 438.7(a). The state must monitor and provide narrative updating through its Monitoring Reports on the inclusion of HRSN services in managed care programs.

iv. When HRSN (i.e., HRSN services defined in STC 10.2 for the covered populations outlined in STC 10.5) is included in capitation rates to managed care plans under risk-based contracts, and only then, HRSN services should be reported in the medical loss ratio (MLR) reporting as incurred claims. The state must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HRSN services in risk-based managed care contracts and capitation rates. The state should submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs. In accordance with STC 10.13, CMS expects the state to have appropriate encounter data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care development purposes as well as appropriate documentation for claims payment in both managed care and FFS. Therefore, CMS requires that for HRSN services provided in a managed care delivery system, the state must include the name and definition of each HRSN service as well as the coding to be used on claims and encounter data in the managed care plan contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology costs that identify each HRSN service. Additionally, for HRSN services provided in an FFS delivery system, this information must be clearly documented for contracted providers. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 10.14.

v. The state must monitor and provide narrative updates through its Monitoring Reports on the inclusion of HRSN services in managed care programs and in FFS.

10.8. Contracted Providers. Consistent with managed care contract and applicable to all HRSN services:

i. Managed care plans will contract with providers to deliver the elected HRSN services authorized under the demonstration.

ii. Managed care plans must establish a network of provider and ensure the Social Service Providers have sufficient experience and training in the provision of the HRSN services being offered. Social Service Providers do not need to be licensed, however, staff offering services through Social Service Providers must be licensed when appropriate and applicable.

iii. The managed care plan and contracted providers will use rates set by the state for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements.

iv. Any state direction of managed care plan expenditures under risk-based contract(s) and risk-based payments would only be considered a state directed payment subject to the requirements in 42 CFR 438.6(c).

10.9. Provider Network Capacity. Managed care plans must ensure the HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid/operating agency guidance.

10.10. Compliance with Federal Requirements. The state shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.

10.11. Person Centered Plan. The state shall ensure there is a service plan for each individual receiving HRSN services that is person-centered, identifies the member's needs and individualized strategies and interventions for meeting those needs, and be developed in consultation with the member and member's chosen support network, as appropriate. The service plan is reviewed and revised at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

10.12. Conflict of Interest. The state shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The state also agrees that appropriate separation of service planning and service provision functions are incorporated into the state's conflict of interest policies.

10.13. CMS Approval of Managed Care Contracts. As part of the state's submission of associated Medicaid managed care plan contracts to implement HRSN services through managed care, the state must provide documentation including, but not limited to:

a. Beneficiary and plan protections, including but not limited to:

i. HRSN services must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid covered services.

ii. Medicaid beneficiaries always retain their right to receive the Medicaid covered service on the same terms as would apply if HRSN services were not an option.

iii. Medicaid beneficiaries who are offered or utilize an HRSN retain all rights and protections afforded under 42 CFR 438.

iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they are currently receiving HRSN services, have requested those services, or have received these services in the past.

v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.

b. Managed care plans must timely submit any related data requested by the state or CMS, including, but not limited to:

i. Data to evaluate the utilization and effectiveness of the HRSN services.

ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and/or supplemental reporting on health outcomes and any disparities. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.

iii. Any data necessary to monitor appeals and grievances for beneficiaries.

iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.

v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.

c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:

i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the state.

ii. Any additional information requested by CMS, the state or a legally authorized oversight body to aid in on-going evaluation of the HRSN services or any independent assessment or analysis conducted by the state, CMS, or a legally authorized independent entity.

iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on its progress in building and sustaining its partnership with existing housing and nutrition agencies to utilize their expertise and existing housing and nutrition resources and avoiding duplication of efforts.

iv. Any additional information determined reasonable, appropriate and necessary by CMS.

10.14. HRSN Rate Methodologies. All rate and/or payment methodologies for authorized HRSN services outlined in these STCs must be submitted to CMS for review and approval prior to implementation, including but not limited to FFS payment, as well as non-risk payments, state directed payment preprints, and capitation rates in managed care delivery systems, as part of the HRSN Implementation Plan (see STC 10.18) at least 60 days prior to implementation. The state must submit all documentation requested by CMS, including but not limited to the payment rate methodology (or methodologies) as well as other documentation and supporting information (e.g., state responses to Medicaid non-federal share financing questions). The state must also notify CMS if they intend to direct their managed care plans on how to pay for HRSN services at least 60 days prior to implementation. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting FFS payment rates.

10.15. Maintenance of Effort (MOE). The state must maintain a baseline level of state funding for ongoing social services related to the categories of housing transition supports and nutrition supports comparable to those authorized under this demonstration, for the populations authorized under this demonstration, and for the duration of this demonstration, not including one time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN Implementation Plan that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 15.5, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

10.16. Partnerships with State and Local Entities. The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care program, local housing authorities, Supplemental Nutrition Assistance Program (SNAP) state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the care plans as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and other supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 15.5, the state will provide the status of the state's fulfillment of its plan and progress relative to timeline, and whether and to what extent the non-Medicaid funded

supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented then the state may conclude its status updates in the Monitoring Reports.

10.17. Provider Rate Increase Expectations. As a condition of the HRSN expenditure authority, New Mexico must comply with the provider rate increase requirements in Section 12 of the STCs.

10.18. HRSN Implementation Plan.

a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The Implementation Plan can be updated as initiatives are changed or added. CMS will provide a template to support this reporting that the state will be required to use to help structure the information provided and prompt the state for information CMS would find helpful in approving the Implementation Plan.

b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent with one another.

i. The Implementation Plan must include information on, but not limited to, the following:

i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;

ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);

iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision;

iv. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in the SNAP, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries in the state;

v. An implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout, that can facilitate robust evaluation designs;

vi. Information as required per STC 10.14 (HRSN Rate Methodologies);

vii. Information as required per STC 10.15 (MOE); and

viii. Information as required per STC 10.16 (Partnerships with State and Local Entities).

ii. Failure to submit the Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and as such, would be grounds for termination or suspension of authority for the HRSN Infrastructure and HRSN Services, under this demonstration.

11. TRADITIONAL HEALTH CARE PRACTICES

11.1. Traditional Health Care Practices Program Overview. This component of the demonstration will provide FFP for state expenditures on traditional health care practices received through Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA) (here called Tribal facilities), and facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act (IHCIA) (here called urban Indian organization or UIO facilities) by Medicaid beneficiaries who are able to receive services by or through those facilities. Because some of the traditional health care practices covered under this demonstration may be considered religious or may contain elements of religious or spiritual practices, the state must attest, as a condition of receiving federal matching funds for its expenditures under Expenditure Authority 12, to: 1) providing adequate access to secular alternatives, including but not limited to preventive services, primary care, pharmacy services, mental health and substance use disorder services, as approved in its state plan, 1115 demonstration(s), or 1915 waiver(s), and in compliance with federal laws and regulations; 2) for any condition(s) addressed by and through covered traditional health care practices, ensuring beneficiaries have a genuine, independent choice to use other Medicaid- and CHIP-covered services; and 3) assuring that traditional health care practices may not be used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered under the state plan, 1115 demonstration(s), or 1915 waiver(s) and that the state will not deny access to services or settings on the basis that the beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. Provided that all other applicable requirements for claiming FFP have been met, the state may begin claiming FFP for its expenditures on traditional health care practices only after

submitting this attestation to CMS. The state must notify beneficiaries of their rights to file grievances, complaints, and appeals related to this attestation and take any needed actions or monitoring, consistent with federal laws and regulations regarding grievances, complaints, and appeals. As per STC 15.6.b the state must report any such grievances, complaints, and appeals to CMS in Monitoring Reports. CMS will review all reports and will follow up on credible concerns in those reports, as well as any credible concerns raised by members of the public. If the state is found to be out of compliance with the attestation and related STCs, CMS may: 1) require the state to submit a corrective action plan, 2) issue a deferral, or 3) withdraw authority for traditional health care practices.

11.2. Criteria for Receiving Coverage for Traditional Health Care Practices. To receive coverage for traditional health care practices under this component of the demonstration, a beneficiary must meet the following criteria:

a. Is a Medicaid beneficiary, and

b. Is able to receive services delivered by or through IHS, Tribal or UIO facilities, as determined by the facility.[1]

11.3. Scope of Traditional Health Care Practices. The state may claim FFP for its expenditures on any traditional health care practice that is delivered by or through an IHS, Tribal, or UIO facility to a beneficiary meeting the criteria in STC 11.2.

a. The state will be required to report traditional health care practices provided and utilization in the Annual Monitoring Report.

b. Consistent with CMS's longstanding interpretation of section 1905(b) of the Act, the state will receive a 100 percent federal medical assistance percentage (FMAP) for its expenditures on the services for which coverage is authorized under expenditure authority 12 when those services are received through IHS and Tribal facilities by Medicaid beneficiaries who are American Indians or Alaska Natives.[2] State expenditures for these services when delivered to Medicaid beneficiaries by UIO facilities and state expenditures on these services when provided by or through qualifying facilities to Medicaid beneficiaries who are not American Indians or Alaska Natives will be federally matched at the otherwise applicable state service match.

c. Excluded items, services, and activities that are not covered as part of the scope of traditional health care practices include, but are not limited to:

[1] Under IHS authorities, IHS and Tribal facilities serve Medicaid and CHIP beneficiaries who are eligible to receive services from the facility under IHS regulations at 42 CFR part 136, and also may serve other Medicaid and CHIP beneficiaries under 25 U.S.C. 1680c. Under IHS authorities, UIO facilities that receive funding from IHS are authorized to use the IHS funding to serve urban Indians (as defined in 25 U.S.C. 1603(28)), residing in the urban centers (as defined in 25 U.S.C. 1603(27)) in which such organizations are situated, including Medicaid and CHIP beneficiaries who also meet those definitions. UIO facilities may also serve other Medicaid and CHIP beneficiaries with non-IHS funds.

[2] Section 1905(b) of the Social Security Act (third sentence).

i. Construction costs (including building modification and building rehabilitation);

ii. Room and board;

iii. Costs for services in prisons or correctional facilities, or services for people who are civilly committed and unable to leave an institutional setting, except as described in expenditure authority 10;

iv. Services provided to individuals who are not lawfully present in the United States or are undocumented;

v. Capital investments; and

vi. Research grants and expenditures not related to monitoring and evaluation.

11.4. Participating Facilities. Traditional health care practices are covered only when received through IHS, Tribal, or UIO facilities.

11.5. Participating Providers. Practitioners or providers of traditional health care practices must be employed by or contracted with IHS, Tribal, or UIO facilities, which could include an urban Indian organization contracted with an IHS or Tribal facility. The qualifying facility is expected to make the following determinations and to provide documentation of these determinations to the state, upon request. Each qualifying facility is responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices 1) is qualified to provide traditional health care practices to the qualifying facility's patients; and 2) has the necessary experience and appropriate training. The qualifying facility also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional health care practices, 2) bill Medicaid or CHIP for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request.

11.6. Payment Methodology. The state must comply with the payment rate-setting requirements in 42 CFR Part 447, Subpart B, as though a state plan amendment were required, to establish a payment rate or methodology for traditional health care practices as approved through demonstration expenditure authority 12. The state must conduct state-level public notice under 42 CFR 447.205 prior to using the applicable payment methodologies to pay for traditional health care practices and must maintain documentation of the payment methodologies on its website described in 42 CFR 447.203. The state is encouraged to engage with CMS on the development of all new and modified fee-for-service or non-risk rate contract payment methodologies if the state is not using the IHS All-Inclusive Rate (AIR)[3] when paying for traditional health care practices. Provided that all other requirements for claiming FFP have been met (including submission of the attestation described in STC 11.1), the state may draw FFP for traditional health care practices after

[3] See https://www.ihs.gov/businessoffice/reimbursement-rates/.

using the payment methodologies to pay providers (and can use them to pay providers only subsequent to conducting notice under 42 CFR 447.205, as described above).

11.7. Implementation Expenditures. The state may claim FFP in its administrative and implementation expenditures to support the development and implementation of traditional health care practices:

a. This FFP will be available for state expenditures funding the following activities:

i. Technology: e.g., internal electronic referral systems, shared data platforms, electronic health record modifications or integrations, accounting and billing systems, data analytics and reporting;

ii. Development of business or operational practices to support delivery of traditional health care practices: e.g., procurement and planning, developing policies and workflows for managing referrals from other providers, privacy, evaluation, and beneficiary navigation;

iii. Workforce development: e.g., recruiting and training new staff, training staff on new policies and procedures; or

iv. Outreach, education, and community engagement: e.g., potential beneficiary engagement and coverage coordination, design and production of outreach and education materials, obtaining community input including through community convenings.

b. The state may claim FFP in traditional health care practices implementation expenditures for up to no more than the annual amounts outlined in Table 8. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period, and the state may claim the remaining amount in a subsequent demonstration year.

Table 8. Annual Limits of Total Computable Expenditures for Traditional Health Care Practices Implementation Expenditures

	DY 13	DY 14	DY 15	DY 16	DY 17
Total Computable Expenditures	$0	$250,000	$500,000	$250,000	$250,000

c. Traditional health care practices implementation expenditures must be claimed at the applicable administrative federal match rate.

d. Excluded items, services, and activities that are not covered as part of traditional health care practices implementation expenditures include, but are not limited to:

i. Construction costs (including building modification and building rehabilitation);

ii. Room and board;

iii. Costs for services in prisons or correctional facilities, or services for people who are civilly committed and unable to leave an institutional setting, except as described in expenditure authority 10;

iv. Services provided to individuals who are not lawfully present in the United States or are undocumented;

v. Capital investments; and

vi. Research grants and expenditures not related to monitoring and evaluation.

e. This implementation funding is separate and distinct from any payment to managed care plans for delivery of traditional health care practices. The state must ensure that traditional health care practice implementation expenditures are not factored into managed care payments for delivery of traditional health care practices and that there is no duplication of funds.

f. To the extent the state requests any additional implementation funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

12. PROVIDER PAYMENT RATE INCREASE REQUIREMENTS

12.1. The provider payment rate increase requirements described hereafter is a condition for HRSN expenditure authority as referenced in Expenditure Authorities 8 and 9.

12.2. As a condition of approval and ongoing provision of FFP in HRSN expenditures over this demonstration period of performance, DY 12 through DY 17, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid FFS provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for one of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent.

a. The state may not decrease provider payment rates for other Medicaid- or demonstration-covered services for the purpose of making state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).

b. The state will, for the purposes of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increase as

may be required under this STC, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

c. No later than 90 days of the demonstration effective date, and if the state makes fee for service payments, the state must establish and report to CMS the state's average Medicaid to Medicare FFS provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

    i. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:

        1. For primary care and obstetric care services, in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); and

        2. For behavioral health services, the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3); OR

    ii. Provide to CMS for approval for any of the three service categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

        1. Service codes must be representative of each service category as defined in STC 12.2(b).

        2. Medicaid and Medicare data must be from the same year and not older than 2019.

        3. The state's methodology for determining the year of data, the Medicaid code-level utilization, the service codes within the category, the geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

d. To establish the state's ratio for each service category identified in STC 12.2(b) as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

i. The average FFS ratio as provided in STC 12.2(c)(i), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the state pay providers based on state plan FFS payment rate schedules); or

ii. The data and methodology for any or all of the service categories as provided in STC 12.2(c)(i)(1) or 12.2(c)(i)(2) using Medicaid managed care provider payment rate and utilization data.

e. In determining the ratios required under STC 12.2(c)(i)(1) and 12.2(c)(i)(2), the state may not incorporate FFS supplemental payments that the state made or plans to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a) and 438.6(d).

f. If the state is required to increase provider payment rates for managed care plans per STC 12.2(d) and 12.2(e), the state must:

i. Comply with the requirements for state-directed payments in accordance with 42 CFR 438.6(c), as applicable; and

ii. Ensure that the entirety of a two-percentage point increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

g. For the entirety of DY 14 through DY 17, the provider payment rate increase for each service in the service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 12, and such rate will be in effect on the first day of DY 14. A required payment rate increase shall apply to all services in the service category as defined under STC 12.2(b).

h. If the state uses a managed care delivery system for any of the service categories defined in STC 12.2(b), for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 14 through DY 17 the managed care plans' provider payment rate increase for each service in the affected category will be no lower than the highest rate in DY 17 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment rate increase shall apply to all services in a service category as defined under STC 12.2(b).

i. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY 14 (or, as applicable, the first day of the first rating period that starts in DY 14), the state will provide an alternative effective date and rationale for CMS review and approval.

j. The state will provide the information to document the payment rate ratio required under STC 12.2(c)(i)(1) or 12.2(c)(i)(2), via submission to the Performance Metrics Database and Analytics (PDMA) portal for CMS review and approval.

k. For demonstration years following the first year of provider payment rate increases, the state will provide an annual attestation within the state's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, the previous year.

l. No later than 90 days following the demonstration's extension effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 12.2(c)(i)(1) or 12.2(c)(i)(2) for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment O:

New Mexico HRSN Related Provider Payment Increase Assessment – Attestation Table		
The reported data and attestations pertain to the HRSN related provider payment increase requirements for the demonstration period of performance DY 12 through DY 17.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	[*insert percent, or N/A if state does not make Medicaid fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories*]
	[*insert approach, either ratio derived under STC 12.2(c)(i)*]	[*insert approach, either ratio derived under STC 12.2(c)(i) and insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Obstetric Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories*]
	[*insert approach, either ratio derived under STC 12.2(c)(i)*]	[*insert approach, either ratio derived under STC 12.2(c)(i) insert data source and time*]

		period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Behavioral Health Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[*insert approach, either ratio derived under STC 12.2(c)(i)*]	[*insert approach, either ratio derived under STC 12.2(c)(i)*]; insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio

In accordance with STCs 12.1 through 12.2, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the one service category in each delivery system, as applicable to the state's Medicaid or demonstration service delivery model, if for that delivery system the ratio is both the lowest ratio amount the three and below 80 percent. Such provider payment increases for each service will be effective beginning on [*insert date*] and will not be lower than the highest rate for that service code in DY 12 plus a two-percentage point increase relative to the rate for the same or similar Medicare billing code through at least [*insert date*].

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 12.2(b) will be based on Medicaid managed care provider payment rate and utilization data.

[*Select the applicable effective date, must check either a. or b. below*]

☐a. The effective date of the rate increases is the first day of DY 14 and will be at least sustained, if not higher, through DY 16. ☐b. New Mexico has a biennial legislative session that requires provider payment approval and the timing of that session precludes the state from implementing the payment increase on the first day of DY 14. New Mexico will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY 16.
New Mexico [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and/or obstetric care. For any such payments, as necessary to comply with the HRSN STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*].
New Mexico [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, as necessary to comply with the HRSN STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 12.2(d)(ii). through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date*]
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 12.2(f)(ii), I attest that necessary arrangements will be made to assure that 100 percent of the two percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
New Mexico further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 12.
I, *[insert name of SMD or CFO (or equivalent position*] [*insert title*], attest that the above information is complete and accurate. [*Provide signature*_____] [*Provide date*_____] [*Provide printed name of signator*]

13. GENERAL FINANCIAL REQUIREMENTS

13.1. Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

13.2. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

13.3. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

13.4. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The FFP paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

13.5. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organizations, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

13.6. Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Act, 42 CFR 433.66, and 42 CFR 433.54.

13.7. State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 15.11. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

13.8. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in Section 14:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

13.9. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

13.10. Medicaid Expenditure Groups**.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 9: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
TANF and Related	Main	X		X	Eligible TANF and related individuals (STC 4.2).
SSI Medicaid Only	Main	X		X	Eligible SSI Medicaid Only individuals (STC 4.2).

Table 9: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
SSI Dual	Main	X		X	Eligible SSI Dual individuals (STC 4.2).
217-Like Medicaid	Hypo 6	X		X	Eligible 217-like Medicaid individuals (STC 4.2).
217-like group Dual	Hypo 6	X		X	Eligible 217-like group Dual eligible individuals (STC 4.2).
VIII Group	Hypo 2	X		X	Eligible VIII Group individuals (STC 4.2).
SUD/IMD	Hypo 1	X		X	All expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment (STC 4.2).
CHV	Hypo 3	X		X	Months of Medicaid eligibility for the CHV program eligible (STC 6.21).
Tenancy	Hypo 3	X		X	Months of Medicaid eligibility for individuals eligible to receive tenancy supports (STC 6.22).
SMI/SED IMD Managed Care	Hypo 3	X		X	All expenditures for medical assistance provided during an SMI/SED IMD month for managed care enrollees.
SMI/SED IMD FFS	Hypo 3	X		X	All expenditures for medical assistance provided during an SMI/SED IMD month for FFS enrollees.
Continuous Eligibility Children	Hypo 7	X		X	All expenditures for continued benefits for children who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination.
Reentry Services	Hypo 8	X		X	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating correctional facilities.

Table 9: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Reentry Non-Services	Hypo 8		X	X	Expenditures for planning and supporting the Reentry Demonstration Initiative.
HRSN Services	Hypo 9		X	X	Expenditures for approved HRSN initiatives.
HRSN Infrastructure	Hypo 9		X	X	Infrastructure expenditures for approved HRSN initiatives.
Traditional health care practices implementation expenditures	Main			X	See Expenditure Authority 13

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

13.11. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00285/6) Separate reports must be submitted by MEG (identified by Waiver Name) and DY (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

13.12. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

13.13. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against

expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

13.14. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

13.15. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in Section 14, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

13.16. Member Months. As part of the Quarterly and Annual Monitoring Reports described in Section 15, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

13.17. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 10: MEG Detail for Expenditure and Member Month Reporting

MEG	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expenditures are assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
TANF and Related	All expenditures for medical assistance provided to	N/A	Follow standard CMS-64.9 Category of Service	Date of service	MAP	Y	1/1/14	12/31/29

Table 10: MEG Detail for Expenditure and Member Month Reporting								
MEG	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expenditures are assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
	TANF and Related eligibles.		Definitions					
SSI Medicaid Only	All expenditures for medical assistance provided to SSI Medicaid Only eligible.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/14	12/31/29
SSI Dual	All expenditures for medical assistance provided to SSI Dual eligibles	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/14	12/31/29
217-like Medicaid	All expenditures for medical assistance provided to 217-like Medicaid eligibles.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/14	12/31/29
217-like group Dual	All expenditures for medical assistance provided to 217-like group Dual eligibles.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/14	12/31/29
VIII Group	All expenditures for medical assistance provided to VIII Group eligibles.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/14	12/31/29

Table 10: MEG Detail for Expenditure and Member Month Reporting								
MEG	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expenditures are assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD/IMD	All expenditures for medical assistance provided during a SUD/IMD month.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	5/21/19	12/31/29
MHV	All expenditures for MHV program described in STC 6.21.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/19	12/31/29
Tenancy	All expenditures for Peer Delivered Pre-Tenancy and Tenancy Services described in STC 6.22	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/19	12/31/29
SMI/SED IMD Managed Care	All expenditures for medical assistance provided during an SMI/SED IMD month for managed care enrollees.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	3/28/23	12/31/29
SMI/SED IMD FFS	All expenditures for medical assistance provided during an SMI/SED IMD month	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	3/28/23	12/31/29

Table 10: MEG Detail for Expenditure and Member Month Reporting								
MEG	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expenditures are assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
	for FFS enrollees.							
HFW FFS	All expenditures for HFW services provided during a month for FFS enrollees.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	3/28/23	12/31/29
CE Children	All expenditures for medical assistance provided to CE eligible children	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/24	12/31/29
Reentry Services	All expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating correctional facilities.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/25/24	12/31/29
Reentry Non-Services	Expenditures for planning and	N/A	Follow standard CMS-64.9	Date of payment	ADM	N	7/25/24	12/31/29

Table 10: MEG Detail for Expenditure and Member Month Reporting								
MEG	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expenditures are assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
	supporting the Reentry Demonstration Initiative		Category of Service Definitions					
HRSN Services	Report all expenditures state incurs on HSRN services	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	N	7/25/24	12/31/29
HRSN Infrastructure	Report all expenditures state incurs on HRSN Infrastructure	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	ADM	N	7/25/24	12/31/29
Traditional health care practices implementation expenditures	Implementation costs related to traditional health care practices	See STC 11.7d	Follow standard CMS-64.10 Category of Service Definition	Date of payment	ADM	N	10/16/24	12/31/29
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	ADM	N	1/1/14	12/31/29

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group.

13.18. Demonstration Years (DY). DYs for this demonstration are defined in the table below.

Table 11: Demonstration Years		
Demonstration Year 12	July 25, 2024 to December 31, 2024	6 months
Demonstration Year 13	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 14	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 15	January 1, 2027 to December 31, 2027	12 months
Demonstration Year 16	January 1, 2028 to December 31, 2028	12 months
Demonstration Year 17	January 1, 2029 to December 31, 2029	12 months

13.19. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the PMDA system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in Section 13. CMS will provide technical assistance, upon request.[5]

13.20. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

13.21. Future Adjustments to Budget Neutrality.
CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions

[5] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

13.22. Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. Contents of Request and Process. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 13.22.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. Types of Allowable Changes. Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments

for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. Budget Neutrality Update. The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

14. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

14.1. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, one or more Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, if applicable, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

14.2. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 9, Master MEG Chart and Table 10, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

14.3. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

14.4. Main Budget Neutrality Test. The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 12: Main Budget Neutrality Test

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
TANF and	PC	Both	4.7%	$469.61	$484.47	$499.79	$515.60	$531.90	$548.92

Related									
SSI and Related – Medicaid Only	PC	Both	5.4%	$2,428.87	$2,520.84	$2,616.28	$2,715.35	$2818.16	$2,925.25
SSI and Related – Dual	PC	Both	4.8%	$1,706.81	$1,771.45	$1838.54	$1,908.17	$1,980.43	$2,055.69
UPL Payments	Agg	WOW Only	n/a	$40,450,588	$80,901,176	$80,901,176	$80,901,176	$80,901,176	$80,901,176
Traditional health care practices implementation expenditures	Agg	WW Only	The state must have savings to offset these expenditures.						

*PC = Per Capita, Agg = Aggregate

14.5. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

14.6. Hypothetical Budget Neutrality Test 1: SUD/IMD. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 13: Hypothetical Budget Neutrality Test 1									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY12**	**DY 13**	**DY 14**	**DY 15**	**DY 16**	**DY 17**
SUD/IMD MC	PC	Both	5.1%	$1,010.03	$1,048.42	$1,101.89	$1,158.09	$1,217.15	$1,279.22
SUD/IMD FFS	PC	Both	5.1%	$1,010.03	$1,048.42	$1,101.89	$1,158.09	$1,217.15	$1,279.22

14.7. Hypothetical Budget Neutrality Test 2: VIII Group. Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in the budget neutrality. The state must not be allowed to obtain budget neutrality "savings" from this population. Therefore, a separate expenditure cap is established for this group, to be known as Hypothetical Test 2.

Table 14: Hypothetical Budget Neutrality Test 2							
MEG	**TREND**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
VIII Group	5.2%	$748.62	$777.63	$818.07	$860.61	$905.36	$952.44

14.8. Hypothetical Budget Neutrality Test 3: CHV and Tenancy. The state must not be allowed to obtain budget neutrality "savings" from this population. Therefore, a separate expenditure cap is established for this group, to be known as Hypothetical Test 3.

Table 15: Hypothetical Budget Neutrality Test 3							
MEG	**TREND**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
CHV	4.7%	$708.33	$741.62	$776.48	$812.97	$851.18	$891.19
Tenancy	6.4%	$450.00	$478.80	$509.44	$542.05	$576.74	$613.65

14.9. Hypothetical Budget Neutrality Test 4: SMI/SED IMD. The state must not be allowed to obtain budget neutrality "savings" from this population. Therefore, a separate expenditure cap is established for this group, to be known as Hypothetical Test 4.

Table 16: Hypothetical Budget Neutrality Test 4							
MEG	**TREND**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
SMI/SED FFS	5.1%	$16,690.71	$17,288.04	$18,169.73	$19,096.39	$20,070.30	$21,093.89
SMI/SED MC	5.1%	$1,001.20	$1,037.03	$1,089.92	$1,145.50	$1,203.93	$1,265.33

14.10. Hypothetical Test 5: HFW FFS Services: The state must not be allowed to obtain budget neutrality "savings" from these services. Therefore, a separate expenditure cap is established for these services, to be known as Hypothetical Test 5.

Table 17: Hypothetical Budget Neutrality Test 5							
MEG	**TREND**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
HFW FFS	4.9%	$2,293.03	$2,371.69	$2,487.90	$2,609.81	$2,737.69	$2,871.84

14.11. Hypothetical Test 6: Additional Hypothetical Groups: The budget neutrality test for this demonstration includes an allowance for hypothetical populations, which are optional populations that could have been added to the Medicaid program through the state plan, but instead will be covered in the demonstration only. The expected costs of hypothetical populations are reflected in the "without-waiver" budget neutrality expenditure limit. The state must not accrue budget neutrality "savings" from hypothetical populations. To accomplish these goals, a separate expenditure cap is established for the hypothetical groups, to be known as Hypothetical Test 6.

Table 18: Hypothetical Budget Neutrality Test 6							
MEG	**TREND**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
217- like Medicaid	5.4%	$4,031.35	$4,193.54	$4,419.99	$4,658.67	$4,910.24	$5,175.39
217-like Group - Dual	4.8%	$4161.63	$4,310.57	$4,517.48	$4,734.32	$4,961.57	$5,199.73

14.12. Hypothetical Test 7: Continuous Eligibility for Children: The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 7. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 7 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 19: Hypothetical Budget Neutrality Test 7							
MEG	**TREND**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
CE Children	4.9%	$546.14	$564.88	$592.56	$621.59	$652.05	$684.00

14.13. Hypothetical Budget Neutrality Test 8: Reentry. Reentry Demonstration Initiative Expenditures. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 8. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 8 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 20: Hypothetical Budget Neutrality Test 8									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**TREND**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
Reentry Services	PC	Both	5.0%	$0	$1,074	$1,127	$1,184	$1,243	$1,305
Reentry Non-Services	Agg	Both	$0	$20,007,032	$60,021,097	$60,021,097	60,021,097	$0	$0

14.14. Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives. When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in Section 10), CMS considers these expenditures to be "capped hypothetical" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this

demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

14.15. Capped Hypothetical Budget Neutrality Test: HRSN. The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 21: Capped Hypothetical Budget Neutrality Test 9

MEG	Agg	WOW only, WW Only, or Both	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
HRSN Services	Agg	Both	$40,241,844	$88,532,056	$144,870,637	$160,967,374	$177,064,112	$193,160,849
HRSN Infrastruc-ture	Agg	Both	$6,963,195	$49,737,110	$39,789,688	$2,984,277	$0	$0

14.16. **Monitoring Budget Neutrality for Traditional Health Care Practices.** As discussed earlier, the expenditure authority provided for the coverage of traditional health care practices is limited to practices that are delivered by or through certain facility types that are defined by the IHCIA and ISDEAA (laws that stem from the unique government-to-government relationship between the federal government and Indian Tribes). This expenditure authority is also limited to coverage for Medicaid beneficiaries who are able to receive services from those facilities. Further, traditional health care practices are being covered as a complement to services covered by Medicaid under existing authorities. This expenditure authority is not likely to increase overall expenditures beyond what those expenditures could have been without the demonstration. This expenditure authority will not expand the Medicaid-eligible populations, and CMS anticipates that the Medicaid

payment rate for most of these services will be the IHS AIR. CMS has therefore determined that this coverage of traditional health care practices is expected to be budget neutral and will not require a specific budget neutrality expenditure sub-limit. The state will be held to the general monitoring and reporting requirements, as per the STCs, and will continue to be held accountable to the overall budget neutrality expenditure limit of the demonstration. Failure to meet the monitoring and reporting requirements might result in CMS requiring the state to include these expenditures in the budget neutrality agreement for this demonstration, to ensure that CMS has sufficient information to support its initial determination that the approval of these expenditures is expected to be budget neutral. CMS reserves the right to request budget neutrality expenditures and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.7. This amendment includes the addition of a "with waiver" only expenditure authority for implementation expenditures which will be paid for with demonstration savings. The state must still report quarterly claims and report expenditures on the CMS 64.9 form.

14.17. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

14.18. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 07/25/2024 to 12/31/2029. If at the end of the demonstration approval period the Main Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

14.19. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

15. MONITORING AND REPORTING REQUIREMENTS

15.1. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be

consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable(s) were due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable(s) were not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable(s) into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay, the steps the state has taken to address such issue(s), and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b) above, and the state fails to comply with the corrective action plan or despite the corrective action plan, still fails to submit the overdue deliverable(s) that meet the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in MBES/CBES following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

iii. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

15.2. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be

deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

15.3. Submission of Post-Approval Deliverables. The state must submit deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

15.4. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

i. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

ii. Ensure all section 1115 demonstration, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

iii. Submit deliverables to the appropriate system as directed by CMS.

15.5. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment G. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

a. At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 15.6), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS, as applicable. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

b. The Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Disparities Sensitive Measure Set from CMS. This set of measures consists of metrics known to be important for addressing disparities in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

c. In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze relevant non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include but are not limited to data related to carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

d. In addition, the state must describe in the Monitoring Protocol methods and a timeline for collecting and analyzing non-Medicaid administrative data necessary to conduct comprehensive monitoring and evaluation of traditional health care practices. These sources may include but are not limited to data related to traditional health care practices provided by IHS, Tribal, or UIO facilities. Across data sources, in consultation with IHS, Tribal, and UIO facilities, the state must make efforts to collect data in ways that support subgroup analyses as appropriate.

e. For the qualitative elements (e.g., operational updates as described in STC 15.6), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

15.6. Monitoring Reports. The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each demonstration year (DY). The fourth quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth quarter information) is due no later than ninety (90) calendar days following the end of the DY.

The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by individuals; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's progress toward meeting the applicable program-specific goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable.

   Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on individuals' outcomes as well as outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. For the traditional health care practices demonstration component, Monitoring Reports must also include beneficiary grievances, complaints, and appeals related to the attestation described in STC 11.1.

   Specifically, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary participation in demonstration components, primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve

outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 9.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

The state's selection and reporting of metrics for traditional health care practices are expected to include, but not be limited to: the number of facilities and providers providing traditional health care practices under the demonstration, the number of each type of traditional health care practice provided under the demonstration, and the number of individuals receiving traditional health care practices under the demonstration. In addition, the state must provide narrative updates on activities undertaken regarding allowable traditional health care practices implementation expenditures.

For the HRSN component, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations. The state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs, such as, SNAP and WIC for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

Common SUD metrics include, but are not limited to, those that measure alignment with assessment of need and qualification for SUD treatment services and the

demonstration's six milestones as outlined in the State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMDL #17- 003).[6]

Common SMI metrics include, but are not limited to, screening of beneficiaries admitted to psychiatric hospitals or residential treatment facilities, mental health services utilization (inpatient and outpatient), and average length of stay in IMDs and the demonstration's four milestones as outlines in the SMDL dated November 13, 2018 (SMDL #18—011).[7]

In consultation with CMS, proposed HFW performance metrics should pertain to, but not be limited to, intensive care coordination, treatment planning, and staff trainings completed to meet the HFW requirements for HFW intensive care coordination.

In consultation with CMS, HCBS performance metrics should continue to be tracked as before but account for the expanded HCBS (Community Benefit) enrollment.

In addition to tracking enrollment and renewal metrics, systematic monitoring of the continuous eligibility policy must support—at a minimum—understanding the trends in preventive care services, including vaccination among populations of focus, and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and non-emergent use of emergency departments.

The state must also establish monitoring metrics to help track operational and implementation progress and performance of the demonstration's Home Visiting services. At a minimum, the metrics for these programs must capture the number of individuals eligible for these pilots, the counts of service utilization by type, and corresponding health outcomes, as applicable.

The required monitoring and performance metrics must be included in writing in the Monitoring Reports and must follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the Form CMS-64.

[6] SMDL #17-003, Strategies to Address the Opioid Epidemic. Available at: https://www medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[7] SMDL #18—011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. SUD and SMI/SED Health IT. The state will include a summary of progress made in regard to SUD and SMI/SED Health IT requirements outlined in STC 6.27.

15.7. Reentry Demonstration Initiative Mid-Point Assessment. The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. The report must be submitted to CMS by the end of the third year of the demonstration. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: provider participation in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval.

Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

e. CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

15.8. SUD and SMI/SED Mid-Point Assessment. For the SUD and SMI/SED components, the state must contract with an independent entity to conduct an independent Mid-Point Assessment by June 30, 2026. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and conduct of the Mid- Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, health care providers (including treatment providers), beneficiaries, community groups, and other key partners.

a. The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 calendar days after June 30, 2026. If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

b. For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the relevant Implementation Plan and Monitoring Protocol for ameliorating these risks. Modifications to the Implementation, Financing Plan, and Monitoring Protocol are subject to CMS approval.

c. Elements of the Mid-Point Assessment must include:

i. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plans and toward meeting the targets for performance measures as approved in the Monitoring Protocol;

ii. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

iv. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Implementation Plan, or to pertinent factors that the state can influence that will support improvement; and

v. An assessment of whether the state is on track to meet the budget neutrality requirements in these STCs.

15.9. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

15.10. Close-Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 16.7 and 16.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 15.1.

15.11. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations, to include but not limited to, any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, enrollment and access and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

15.12. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its Medicaid website. The state must also post the most recent Annual Monitoring Report on its Medicaid website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

16. EVALUATION OF THE DEMONSTRATION

16.1. Cooperation with Federal Evaluators and Learning Collaborative. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 15.1.

16.2. Independent Evaluator. The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement

to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved, Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

16.3. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with:

a. Attachment D (Developing the Evaluation Design) of these STCs, and

b. Any applicable CMS evaluation guidance and technical assistance specific to the demonstration's policy components.

16.4. The draft Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic), as these implementation strategies help create strong comparison groups and facilitate robust evaluation. The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 16.7 and 16.8.

a. For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amended Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

16.5. Evaluation Budget. A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

16.6. Evaluation Design Approval and Updates. The state must submit to CMS a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon

CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's Medicaid website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

a. Evaluation Questions and Hypotheses. Consistent with Attachments D and F (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals. The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by NQF.

   CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary individual understanding of and experience with and experience the various demonstration policy components, including but not limited to, beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

b. Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

c. The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

d. The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

e. Evaluation hypotheses for the HRSN initiatives in the demonstration must focus on assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include an analysis of how the initiatives (e.g., short-term pre/post-hospitalization services, nutrition services, and temporary housing services) affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the

initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level.

f. The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing, nutrition and any other type of allowable HRSN services change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiatives must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. It is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

g. In addition, in accordance with the approved Evaluation Design, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys).

h. Evaluation hypotheses for the SUD component of the demonstration must support an assessment of the demonstration's success in achieving the core goals of the program through addressing, among other outcomes, initiation and compliance with treatment, utilization of health services in appropriate care settings, and reductions in key outcomes such as deaths due to overdose.

i. Hypotheses for the SMI component must map to the SMI goals of the demonstration including reducing utilization and lengths of stay in EDs, reducing preventable readmissions to acute care hospitals and residential settings, improving the availability of crisis stabilization services, improving access to community-based services, and improving care coordination.

j. For expanded enrollment in HCBS for PCS, hypotheses must test the impact of the programs on all relevant populations focused on beneficiaries' experience of care, access to care, provision and utilization of care, the quality, efficiency, and coordination of care centered on rebalancing and community integration, and the costs of care.

k. The state must evaluate the impact of the continuous eligibility policy program on all relevant populations appropriately tailored for the specific time span of eligibility. For

example, the state must evaluate how the continuous eligibility policy affects coverage, enrollment and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled but then re-enroll within 12 months) as well as population-specific appropriate measures of service utilization and health outcomes.

l. The state must also evaluate the effectiveness of the continuous eligibility authority. For example, for the state's populations of focus under the demonstration's continuous eligibility policy, to the extent feasible, the state may collect and analyze data such as changes in beneficiary income at 12-month intervals to inform how a longer period of eligibility can potentially help streamline the state's administrative processes around enrollment and eligibility determinations. In addition, or alternatively, the state may conduct a comprehensive qualitative assessment involving beneficiary focus groups and interviews with key stakeholders to assess the merits of such policies.

f. The state must conduct comprehensive evaluation of its pilot programs and develop robust evaluation questions and hypotheses to examine the impacts on enrollment, health outcomes, and general effectiveness of the Medicaid Home Visiting Pilot Services in serving eligible pregnant individuals, postpartum individuals, infants, children and families.

g. Evaluation of the traditional health care practices demonstration initiative must be designed to examine whether the initiative increases access to culturally appropriate care for beneficiaries served by or through IHS, Tribal, or UIO facilities. In evaluating the effectiveness of the initiative, the state must capture the perspectives of IHS, Tribal, and UIO facilities through qualitative data collection efforts. The state is also strongly encouraged to consult with IHS, Tribal, and UIO facilities, participating providers, and beneficiaries in the development of the evaluation design. The evaluation must address topics that include but are not limited to: beneficiary awareness and understanding of traditional health care practices; reasons for individuals receiving the traditional health care practices; access to, utilization and costs of traditional health care practices; quality and experience of care; and physical and behavioral health outcomes. The state's evaluation efforts must facilitate understanding the extent to which the traditional health care practices initiative might support reducing existing disparities in access to and quality of care and health outcomes.

h. As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

i. Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data

analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes and help inform how the demonstration's various policies might support reducing such disparities.

16.7. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Interim Evaluation Report should be posted to the state's Medicaid website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for the extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses, and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

f. The Interim Evaluation Report must comply with Attachment F (Preparing the Interim and Summative Evaluation Report) of these STCs.

16.8. Summative Evaluation Report. The state must submit to CMS a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment F (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit the revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

16.9. Corrective Action Plan Related to Evaluation Data. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

16.10. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

16.11. Public Access. The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

16.12. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

17. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date – Specific	Deliverables	STC Reference
30 calendar days after demonstration approval	State acceptance of demonstration waiver/expenditure authorities and STCs	Approval letter
90 days after SMI/SED program approval date	SMI/SED Implementation Plan (including Health IT Plan)	STC 6.30
60 calendar days after receipt of CMS comments	Revised SMI/SED Implementation Plan (including Health IT Plan)	STC 6.30
90 days after approval of demonstration	HRSN Services and Infrastructure Protocol	STC 10.6
90 days after the approval of any amendment to the demonstration impacting HRSN Services or Infrastructure	Revised HRSN Services and Infrastructure Protocol	STC 10.6
9 months after approval of the demonstration	HRSN Implementation Plan	STC 10.14
90 days after the approval of the demonstration	HRSN MOE Information	STC 10.12
90 days after the approval of the demonstration	Provider Rate Ratio Analysis	STC 11.5
90 days after the approval of the demonstration	Provider Rate Increase Attestation Table	STC 11.14
Yearly, as part of Annual Demonstration Monitoring Report	Yearly Provider Rate Increase Attestation	STC 11.3
150 days after approval	Monitoring Protocol	STC 15.5
60 calendar days after receipt of CMS comments	Revised SMI/SED Monitoring Protocol	STC 15.5
No later than 60 calendar days after March 28, 2026	Mid-Point Assessments	STC 15.7, 15.8
60 calendar days after receipt of CMS comments	Revised Mid-Point Assessments	STC 15.7, 15.8
180 days after initial approval or amendment	Submit Draft Evaluation Design	STC 16.3
60 calendar days after receipt of CMS comments	Revised Evaluation Design	STC 16.6
One year prior to the end of the demonstration	Draft Interim Evaluation Report	STC 16.7
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 16.7

18 months prior to the end of the demonstration	Draft Summative Evaluation Report	STC 16.8
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 16.8
Monthly	Monitoring Calls	STC 15.10
60 after the end of each quarter	Quarterly Monitoring Report	STC 15.6
Quarterly	Quarterly Financial Report	STC 14.5
Annually	Annual Monitoring Report	STC 15.6
Six months before specific authority expires	Submit an Expiration Plan	STC 3.10
12 months before the demonstration termination	Submit an Extension Request or a Phase Out Plan and an Interim Evaluation Report	STC 3.10
120 days after the demonstration termination	Close-Out Report	STC 15.10

ATTACHMENT A: TURQUOISE CARE COMMUNITY BENEFITS DEFINITIONS AND LIMITS

I. Adult Day Health (ABCB)

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

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

II. Assisted Living (ABCB)

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

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

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

III. Behavior Support Consultation (ABCB and SDCB)

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

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

implementation based on a functional assessment; 4) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the member and his/her service and support providers. Based on the member's care plan, services are delivered in an integrated/natural setting or in a clinical setting.

IV. Community Transition Services (ABCB)

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

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

Limits or Exclusions: Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services are limited to $4,000 per person every five years. Deposits for Assisted Living Facilities are limited to a maximum of $500. In order to be eligible for this service, the person must have a NF stay of at least 90 days prior to transition to the community.

V. Customized Community Supports (SDCB)

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

VI. Emergency Response (ABCB and SDCB)

Emergency Response services provide an electronic device that enables a member to secure help in an emergency at home and avoid institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when a "help" button is activated. The response center is

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

VII. Employment Supports (ABCB and SDCB)

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

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

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

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

VIII. Environmental Modifications (ABCB and SDCB)

Environmental Modification services include the purchase and/or installation of equipment and/or making physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance his/her level of independence.

Adaptations include the installation of ramps and grab-bars; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing); turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light-activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices;

heating/cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems and/or signaling devices.

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

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

Limits or Exclusions: Environmental Modification services are limited to six thousand dollars ($6,000) every five (5) years. Additional services may be requested if a member's health and safety needs exceed the specified limit.

IX. Home Delivered Meals (ABCB and SDBC)

Services to provide and deliver home delivered meals on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Services are furnished consistent with the participant's person-centered service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

X. Home Health Aide (ABCB and SDCB)

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

registered nurse or other appropriate professional staff. Must make a supervisory visit to the member's residence at least every two weeks to observe and determine whether goals are being met. Home Health Aide Services must be provided by a state licensed Home Health Agency under the supervision of a registered nurse.

XI. Non-Medical Transportation (SDCB)

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

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

XII. Nutritional Counseling (ABCB and SDCB)

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

XIII. Personal Care Services (ABCB and SDCB)

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

Agency-Based Community Benefit:

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

Self-Directed Community Benefit:

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

XIV. Private Duty Nursing for Adults (ABCB and SDCB)

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

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

XV. Related Goods (SDCB)

Related goods are equipment, supplies or fees and memberships, not otherwise provided through under Medicaid. Related goods must address a need identified in the member's care plan (including improving and maintaining the member's opportunities for full membership in the community) and meet the following requirements: be responsive to the member's qualifying condition or disability; and/or accommodate the member in managing his/her household; and/or facilitate activities of daily living; and/or promote personal safety and health; and afford the member an accommodation for greater independence; and advance the desired outcomes in the member's care plan; and decrease the need for other Medicaid services. Related goods will be carefully monitored by health plans to avoid abuses or inappropriate use of the benefit.
The member receiving this service does not have the funds to purchase the related good(s) or the related good(s) is/are not available through another source. These items are purchased from the member's individual budget.

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

XVI. Respite (ABCB and SDCB)

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

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

XVII. Skilled Maintenance Therapy Services (ABCB and SDCB)

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

Physical Therapy

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

Occupational Therapy Services

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

Speech Language Therapy

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

Therapy services must be provided by a state licensed speech and language pathologist.

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

XVIII. Specialized Therapies (SDCB)

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

Acupuncture

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

Biofeedback

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

Chiropractic

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

Cognitive Rehabilitation Therapy
Cognitive rehabilitation therapy services are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome specific cognitive problems. Cognitive Rehabilitation Therapy providers must have a license or certification with the appropriate specialized training, clinical experience and supervision, and their scope of practice must include Cognitive Rehabilitation Therapy.

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

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

Naprapathy
Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle

treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function. Naprapathy providers must have a state license in Naprapathy.

Native American Healers
Native American Healers are a covered benefit under the self-directed community benefit. These services are subject to the $2000 annual specialized therapies limits. These services may also be a value-added service provided by the MCO, for which the MCO does not receive FFP for these services. There are twenty-two sovereign Tribes, Nations and Pueblos in New Mexico, as well as numerous Native American individuals who come from many other tribal backgrounds. Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support members in their communities by addressing their physical and emotional health. Treatments may include dance, song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel. This form of therapy may be provided by community-recognized medicine men and women and others as healers, mentors and advisors to members, and provides opportunities for members to remain connected with their communities. The communal support provided by this type of healing can reduce pain and stress and improve quality of life. This self-directed community benefit service will phase out of the demonstration by December 31, 2025.

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

ATTACHMENT B: MEDICAID HOME VISITING PILOT SERVICES

Table One: Description of Services

Evidence-Based Model	Description of Services
Nurse Family Partnership (NFP)	NFP is focused on first time mothers: First visit must be before mother is 28 weeks pregnant, and program ends when child is 2 years old. Prenatally, NFP is focused on preventive health and prenatal practices for the mother–helping her find appropriate prenatal care, improve her diet, and reduce her use of tobacco, alcohol, and illegal substances. Additionally, maternal and child health nurses help the mother prepare emotionally for the arrival of the baby. Post-birth, the model is focused on health and development education, including child development milestones and behaviors and teaching parents to use praise and other nonviolent techniques. They also focus on coaching the mothers and their families in planning for their future, staying in school, finding employment, and planning future pregnancies.
Parents as Teachers (PAT)	Parents as Teachers is an early childhood, parent education, and family support program serving families from pregnancy until their children enter kindergarten. Certified parent educators conduct home visits, using a curriculum with the latest neuroscience research findings to offer practical ideas on ways to enhance parenting knowledge. The educators provide age-appropriate information as the child develops. The educators also work with parents to increase the parents' skills as observers of their child. Parents also meet in groups to discuss topics such as positive discipline, sleep, sibling rivalry, and toilet learning and to promote parent–child interaction through activities such as story reading and play. During home visits, parent educators conduct periodic vision, hearing, and general developmental screenings. They also will refer parents to resources provided by their own agencies or others in the community.

Child First	Child First is a comprehensive, home-based, therapeutic intervention for high-risk families with children ages 6–36 months. The Child FIRST model includes the following two complementary core components: • Intensive care coordination: The model connects families with comprehensive, integrated, community-based services and supports through a system-of-care approach. These services are meant to stimulate growth and learning and decrease the stress experienced by the family. • Parent–child psychotherapy: A team of mental health practitioners provides parents and caregivers relationship-based psychotherapy to strengthen the learning environment and boost development. Instead of using a fixed curriculum, parents/caregivers are given guidance and parenting strategies based on their needs. The clinician and care coordinator develop a family plan of broad, integrated supports and services for all family members based on family priorities, strengths, culture, and needs. The care coordinator completes the therapeutic assessment and helps the family to become engaged in community services. While no curriculum is used, easy-to-read child development materials are often shared with the families, in English and Spanish. The clinician and parent study the child's behavior and attempt to interpret reasons (motivations and feelings) for the behavior and find ways parents might respond to their children. Play is used to promote parent–child interactions, handle challenges, and promote language development.

Healthy Families America	Families are eligible to begin between prenatally to 3 months old. Services are provided for a minimum of 3 years. Home visitors offer participating families long-term services (usually three to five years), beginning intensively (at least one visit per week), and use well-defined criteria for determining whether the intensity of service should be increased or decreased. Services are culturally sensitive. Comprehensive services support parents, parent–child interaction, and child development. Families are linked to a medical provider (for timely inoculations and well-childcare) and, if needed, financial assistance, food and housing assistance programs, school readiness programs, childcare, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.

Family Connects	The Family Connects model uses a triage model of care, providing one to three home visits to every family living within a defined service area, typically when the infant is 2 to 12 weeks old, and up to 6 months old. During the initial home visit, the nurse conducts a physical health assessment of the mother and newborn, provides supportive guidance on topics that are common to all families (such as infant feeding and safe sleeping practices), and conducts a systematic assessment of family risks and needs associated with the health and well-being of mothers and infants. If an assessment reveals a risk or need, nurses directly support families or connect them to community resources, typically through additional home visits and/or telephone contacts. In cases of mild risk, nurses may provide direct support, such as feeding assistance. If a family's risk is more significant, the nurse collaborates with the family to connect them to desired community services and supports. Supports may include intensive, targeted home visiting programs, mental health services, public assistance programs, or primary health care providers. Nurses use a searchable database of local agencies, created by local program staff, in making referrals. One month after case closure, a staff member (the nurse home visitor or another staff member) calls families to determine whether they connected with the referred agency(ies), are receiving services, have any additional needs, and were satisfied with the program.

SafeCare Augmented	SafeCare Augmented is an adapted version of the SafeCare model that that incorporates additional training for providers in Motivational Interviewing. This model targets families with children from birth to five years old. SafeCare includes three modules: (1) infant and child health, (2) home safety, and (3) parent-infant/parent-child interactions (Planned Activities Training). The health module trains parents to use health reference materials, record health information, use basic health supplies (such as a thermometer), prevent illness, identify symptoms of childhood illnesses or injuries, and provide or seek appropriate treatment. The safety module helps parents identify and eliminate safety and health hazards and teaches parents how to appropriately supervise their young children. The parent-infant/parent-child interactions (Planned Activities Training) module aims to teach parents how to provide engaging and stimulating activities, increase positive interactions, and prevent challenging child behaviors. Providers observe parents during daily routines and parent-infant/parent-child play. Providers reinforce positive behaviors with parents and address problematic ones. In addition, providers offer parents activity cards to encourage skill acquisition. The three SafeCare modules typically include a baseline assessment and observation of parents' knowledge and skills, followed by four parent training sessions, and conclude with a follow-up assessment to monitor change.

CMS Approved Models

The excerpt below provides descriptions of the of six home visiting models approved for use in New Mexico's Medicaid Home Visiting Pilot program, which all meet the criteria established by the Department of Health and Human Services (DHHS) as an "evidence based early childhood home visiting service delivery model."

The NFP program model is designed for first time, low-income mothers and their children, and is designed to improve 1) prenatal health and outcomes; 2) child health and development; and 3) families' economic self-sufficiency and/or maternal life course development. NFP home visitors use input from parents, nursing experience, nursing practice, and a variety of model-specific resources coupled with the principles of motivational interviewing to promote low-income, first-time mothers' health during pregnancy, care of their child, and own personal growth and

development. The NFP program model, therefore, may also address both teaching basic parenting skills, as well as training parents on how to manage a child's medical, behavioral, and/or developmental treatment needs.

The PAT program model features: 1) comprehensive assessment on maternal (prenatal and postpartum) and child health, parent-child interactions and early literacy; 2) family goal setting; and 3) personal visits and group connection practices that home visitors partner, facilitate and reflect with families to reach their goals. Parent educators use the PAT *Foundational Curriculum* in culturally sensitive ways to deliver services that emphasize parent-child interaction, development-centered parenting and family well-being. The Program's outcomes include increased healthy pregnancies and improved birth outcomes as well as improved child health and development, prevention of child abuse and neglect, increased school readiness and increased parent involvement in children's care and education.

The goal of the Child First model is to prevent and heal adverse effects of childhood trauma, such as developmental and learning issues, emotional and behavioral disturbance, and abuse and neglect and childhood trauma, especially amongst high-risk young children and families. Outcomes target wellbeing of parents and children including: 1) decreased child abuse and neglect and improved social-emotional development; 2) language and cognitive development and executive functioning amongst children; and 1) improved various mental wellbeing measures (i.e., depression, Post-Traumatic Stress Disorder); 2) decreased parental stress; 3) improved executive functioning; and 4) increased education and employment amongst parents. The Child First model assigns each family a team of licensed master's level clinicians and a care coordinator to develop an ecological approach that best supports each family's strengths and weaknesses, culture, and priorities. The model is flexible and dependent on the needs of each family. This model will be implemented in New Mexico in 2024.

The Healthy Families of America (HFA) model intends to focus its intervention on parents experiencing challenges such as single parenthood, being of low income, having childhood history of abuse or other adverse experiences, and previous or current substance abuse, mental health issues, and/or domestic violence. All parents must complete the parent survey which is used by individual HFA sites to determine the specific population they will serve. The model 1) screens and assesses families to determine those at risk for the challenges mentioned above; 2) provides home visiting services; and 3) involves routine screening for parent-child interactions, child development, and maternal depression. By using evidence-informed curriculum, HFA aims to strengthen nurturing parent-child relationships, promote health childhood growth and development, and enhance family functioning by reducing risk and building protective factors. This model will be implemented in New Mexico in 2024.

The Family Connects model uses nurse home visits to provide families who have newborns the resources they need to support the well-being of their child. Based off an assessment in the initial home visit, the nurse home visitor will provide general parenting guidance, but also connect the family with community resources specific to their needs. This model is primarily designed for families who have newborns between two to 12 weeks old. The model's outcomes include 1)

increased connection to community resources; 2) reduced child maltreatment; 3) reduced usage of emergency medical care; 4) safer home environments; 5) increased positive parenting behaviors; 6) less parental anxiety and depression; and 7) when non-parental childcare is desired, promotion of high quality child care. This model will be implemented in New Mexico in 2024.

The SafeCare Augmented model is designed to address behaviors that could lead to child neglect and abuse. The model targets families with risk factors for child maltreatment, including families with children who have developmental, behavioral, emotional, mental health, and/or physical disabilities. SafeCare is intended to supplement intervention services a family may be receiving from a different agency. The model is structured into three sections; each section provides training on general parenting knowledge and best practices. SafeCare is intended to be delivered within 18 home visits but varies based on how quickly a parent masters each skill that is taught with a four-step approach. This model will be implemented in New Mexico in 2024.

The provider qualifications for the services provided are described in Table Two: Provider Qualifications below.

Table Two: Provider Qualifications

Home Visitor Provider Qualifications – **Nurse Family Partnership (NFP)**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Nurse Home Visitors – Hired by approved NFP implementing agency	Registered nurse (RN) with Baccalaureate degree in nursing; may have additional degrees beyond BSN such as MSN or other related/advanced practitioner designations e.g., nurse practitioner, nurse midwife, current licensure.	At least five years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. Must have American Heart Association HealthCare provider CPR (Cardiopulmonary Resuscitation) and valid AED (automated External Defibrillator) certification. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	Technical skills: Providing care mgmt. and care coordination to high-risk pops; understanding and applying federal, state, local, and grant program regulations and policies in a public health environment; Leadership skills, interpersonal and relationship building; communication and quality improvement analysis skills.	Comprehensive training and preparation as required by NFP model, and the NM Home Visiting Pilot Program Standards.

Nurse Home Visitor Supervisor	RN with Baccalaureate degree in nursing. Preferred that nurse supervisors have additional degrees beyond BSN such as MSN or other related/advanced practitioner designations e.g., nurse practitioner, nurse midwife.	At least five years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. Must have American Heart Association HealthCare provider CPR and valid AED certification. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	Nurses must receive reflective supervision weekly to meet requirements of the evidence-based program. This nurse supervision is part of the direct services provided. Nurse supervisors may conduct home visits as required to support nurses and/or members LOC needs. For example, if a child or caregiver is ill for a month, a Nurse Home Visitor Supervisor may visit the home to re-assess the caregiver and child and offer an appropriate LOC.	Comprehensive training and preparation as required by NFP model, and the NM Home Visiting Pilot Program Standards.

Home Visitor Provider Qualifications – **Parents as Teachers (PAT)**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Home Visitors – Hired by approved PAT implementing agency	High School Diploma or GED	At least two years of experience working with children/families in a related field.	Certification in Family and Infant Studies; Bilingual Spanish and English	Comprehensive training and preparation as required by PAT model, and the NM Home Visiting Pilot Program Standards.
Clinical Manager	Licensed Master Social Worker	A Master's degree in a relevant discipline, one to three years in related program oversight experience.	Bilingual Spanish and English	Comprehensive training and preparation as required by PAT model, and the NM Home Visiting Pilot Program Standards.

Home Visitor Provider Qualifications – **Child First**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Mental Health/ Developmental Clinicians - Hired by approved Child First Affiliate Agency	Master's level or higher degree	Licensed or licensed-eligible (with approval) in a mental health specialty and three to five years of experience providing relationship-based psychotherapy with very young children. Must be culturally informed and sensitive, meet the language needs of the communities served.	All staff should be co-located at same organization to enhance relationship and team building.	Pre-service training in the form of distance learning modules which explain the fundamentals of the Child First model. Includes reading and community-based child observations. On-site, in-person Child First Learning Collaborative that is eight months and divided into four learning sessions of two to three days (Pre-service and in-service training). Also involves ongoing professional development.
Care Coordinator	Bachelor's degree	Knowledge about community resources and experience working in ethnically diverse young children and families.	Same as above	Same as above

Clinical Director/ Supervisor	Master's level or higher degree in Mental Health Training	Experience and training in mental health and child development, including at least five years in relationship-based psychotherapy for young children and families and knowledge of adult psychotherapy. Experience in providing clinical supervision. Experience working with ethnically diverse, low-income, high-risk families.	Same as above	In addition to the training listed above, must participate in biweekly, clinical, and reflective consultation with Child First state clinical director and weekly supervision from a senior clinician at the affiliate agency. Intensive four-day training on the Child First model.

Home Visitor Provider Qualifications – **Healthy Families of America (HFA)**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Family Direct Support Staff (Includes Family Support and Family Resource Staff) – Hired by each site	Minimum of high school diploma	Experience providing services to families and children, soft skills, experience working with culturally diverse communities representative of site's population.	Not Listed	Must have 1.5 to 2 hours of individual supervision a week and be shadowed by supervisors at least twice a year. Mandatory four day similar delivered by nationally certified HFA trainers.

Family Supervisor	Bachelor's degree	Must have either three years in a supervisory position or a master's degree with a clinical and reflective background.	Infant Mental Health Endorsement	Mandatory four day similar delivered by nationally certified HFA trainers, and an additional day focused on administrative, clinical, and reflective supervision.

Home Visitor Provider Qualifications – **Family Connects**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Nurse Home Visitor– Hired by site with consultation from local department of social services.	Registered Nurse with active license in New Mexico.	Not Listed	Recommendation that Nurse Home visitors hold a Bachelor's degree.	Pre-service training that is virtual and in-person. In-service training based on training and mentoring approach. Weekly case review and supervision from Nurse Supervisor.
Nurse Supervisor	Registered Nurse with active license in New Mexico.	Not Listed	Recommendation that Nurse Supervisors hold a Master's degree.	In addition to above, must partake in session specific to supervision.

Home Visitor Provider Qualifications – **SafeCare Augmented**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Provider; Delivers Home-Based Services – Chosen by a local implementing agency	No minimum education requirement.	Good communication and interpersonal skills, comfortable delivering interventions to families in home setting, responsive to constructive feedback, etc.	Not Listed	Multi-day provider workshop delivered by National SafeCare Training and Resource Center (NSTRC) specialists. Pre-service training in Motivational Interviewing from national trainers.
Coach; Monitors fidelity of implementation, coaching, and service delivery of model	No minimum education requirement.	Same as above	Not Listed	In addition to the above, must receive certification as a SafeCare Coach and complete two-day coaching workshop delivered by NSTRC.

ATTACHMENT C: SUBSTANCE USE DISORDER CONTINUUM OF CARE

I. ASAM Level 0.5 Early Intervention

Screening, Brief Intervention, and Referral to Treatment (SBIRT) – New Mexico was part of the first cohort of states selected to receive SBIRT funding. In August 2013, SAMHSA awarded NM with a new five-year, $10 million grant to implement SBIRT at selected locations. SBIRT services integrate BH within primary care and community health care settings. Each medical partner site universally screens adult patients 18 years old or over at least annually to identify those at-risk of or those having a substance use disorder and offers brief intervention, brief treatment, and appropriate referral as needed. The following are the seven NM SBIRT medical partner sites and locations: White Sands Family Medical Practice, Alamogordo; Aspen Medical Center, Santa Fe; Christus St. Vincent Entrada Contenta, Santa Fe; Christus St. Vincent Family Medicine Center, Santa Fe; First Nations Community Health Source Zuni Clinic, Albuquerque; Santa Fe Indian Hospital, Santa Fe; University of New Mexico Hospital, Albuquerque. As of September 2017, 37,536 screens were conducted with 34,092 individuals screened. Grant funding ends July 30, 2018.

II. ASAM Level 1 Outpatient

This is a covered Medicaid benefit, covering a wide range of services including assessment, treatment plan development, individual and group therapy, crisis intervention, pharmacological management, suboxone induction, and methadone maintenance.

III. ASAM Level 2.1 Intensive Outpatient

This is a covered Medicaid benefit. Intensive outpatient (IOP) services are provided through an integrated multi-disciplinary approach or through coordinated, concurrent services with MH providers. The intent is to not exclude consumers with co-occurring disorders. IOP is available for adults with SUD or COD that meet ASAM patient placement criteria for Level II Intensive Outpatient Treatment.

IV. ASAM Level 2.5 Partial Hospitalization Services

Defined in the ASAM criteria as 20 or more hours of clinically intensive programming per week for multidimensional instability not requiring 24-hour care. This is currently a covered benefit for MH but not SUD. The state is currently revising the rule on partial hospitalization to include SUD as a covered benefit.

V. ASAM Level 3 Adult Residential Treatment

This is currently not a covered Medicaid benefit. SUD services at 11 adult residential treatment centers (RTCs) are state-funded. $7.2 million was spent in CY16, with a projection of close to $8 million for CY17. A recent survey of eleven RTC providers showed 199 beds, with 126 for men and 73 for women, far less than what is needed. Nine of ten responding providers use ASAM admission criteria. Only two of ten are CARF accredited, but others are in process. The planned state plan amendment to include adult RTCs in the Medicaid program would enable important transitions of care within the SUD continuum to produce better outcomes for Medicaid members.

VI. Educational and Prevention Efforts

Naloxone Pharmacy Technical Assistance -New Mexico's Office of Substance Abuse Prevention (OSAP) has contracted with the Southwest CARE Center under the Opioid STR grant to provide technical assistance to NM pharmacies reimbursed by Medicaid to dispense naloxone for 100 pharmacy trainings over the two-year grant period, to be completed by September 2018.
Opioid treatment training – the Opioid STR grant supports training on MAT, including buprenorphine, to increase the availability of qualified staff and programs to address the needs of peoples with OUD and improve access to services.

Prescription drug monitoring – New Mexico's OSAP received SAMHSA's Strategic Prevention Framework for Prescription Drugs (SPF Rx), which provides $371,616 award per year for five years beginning September 1, 2016. The purpose of the grant is to raise awareness about the dangers of sharing medications, and promote collaboration between states, pharmaceutical and medical communities to understand the risks of over-prescribing to youth and adults; bring prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and users in a targeted community of high need; and promote increased incorporation of Prescription Monitoring Program (PMP) data into state and community level needs assessments and strategic plans.

Training on Medical Detoxification – Medically managed inpatient detoxification is a Medicaid reimbursable service if provided in general hospital settings. Standardized evidence-based protocols are available to systematically guide medically managed detoxification, but too often this has not been part of regular practice among general hospitalists and nurses in NM. To improve capacity, through CBHTR, New Mexico's Health Care Authority supports training in evidence-based, medically-managed detoxification in community hospitals throughout the state.

Underage Drinking and Prescription Drug Abuse - New Mexico's OSAP was awarded a SAMHSA grant of $1.68 annually for 5 years ($8 million total) beginning October 2015 to address underage drinking and youth prescription drug abuse through targeted strategic planning for selected New Mexico communities. Implementation of evidence-based strategies began August 2017.

PAX Good Behavior Game – PAX is an evidence-based practice that teaches students self-regulation, self-control, and self-management. Long-term outcomes include reduced need for special education services, reductions in drug and alcohol addictions, serious violent crime, suicide contemplations and attempts, and initiation of sexual activity; and increases in high school graduation rates and college attendance. The Health Care Authority, Behavioral Health Services Division, funded a pilot project in 2016 to train 172 teachers in PAX, reaching 3,329 students. A 2017 RFA is expected to extend the reach to an additional 139 elementary school teachers. The STR will build on SGF efforts to expand PAX to 12 tribal schools.

VII. Opioid Treatment Services

Defined as daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder. OTS is a Medicaid funded service. New Mexico's Health Care Authority approves licensing of Opioid Treatment Programs (OTPs). Currently there are 19 OTP, serving approximately 5,800 patients. There is a high concentration of OTPs in Albuquerque, NM's largest population center; thus, the Opioid STR grant (above) is providing training to expand OTC capacity throughout the state.

VIII. Utilization of Buprenorphine

State direction to MCOs to cover buprenorphine in any formulation for the treatment of OUD without requiring a prior authorization.

IX. Behavioral Health Investment Zones

The state has developed and funded two Investment Zones in counties with high rates of OUD: Rio Arriba County has implemented county-wide Pathways care coordination system; McKinley County has renovated the Gallup Detox center, converted an old hospital into a SUD RTC.

X. Programs for Justice-Involved Individuals

Through state general funds, New Mexico supports a range of programs for adult substance abuse offenders and their families, from jail diversion to treatment to reentry, aftercare and recovery planning. Funding supports district courts, county alternative sentencing programs, and other community providers of services for justice-involved individuals.

XI. Recovery Support Services

New Mexico's Office of Peer Recovery and Engagement (OPRE) is developing and delivering trainings with a special focus on OUD for certified peer support specialists who can work in regional hubs to provide recovery services. One of our peer-run recovery agencies will have dedicated staff trained to support local agencies and providers in implementing MAT for OUD. In addition, Medicaid covers the following recovery services: Comprehensive Community Support Services, Behavioral Management Skills Development, Adaptive Skills Building, Psychosocial Rehab, Family Support Services, Recovery Services, and BH Respite Services.

XII. Supportive Housing

NM has a number of supportive housing programs (Crisis Housing, Move-in Assistance and Eviction Prevention, Oxford House, Linkages Permanent Supportive Housing, Special Needs Housing, SAMHSA Permanent Supportive Housing Grant) that provide a continuum of support for individuals with behavioral health issues (SUD, SMI, and COD), from Crisis Housing to Transitional Housing to Permanent Supportive Housing. Some programs allow a primary SUD diagnosis, while others require primary SMI diagnosis. A combination of state funds and federal grants supports these housing programs. Medicaid covers certain supportive housing services through CCSS.

XIII. Collaborative Efforts

The state continues to have strong collaboration and partnership with Counties & Municipalities to provide better coordinated behavioral health services: The January 2017 New Mexico Association of Counties (NMAC) Conference showcased BH innovations in the counties of McKinley, Rio Arriba, Bernalillo, and Dona Ana; June 2017 conference: Opioid crisis & increased access to naloxone in detention centers; 2018: Crisis triage and Emergency Department Information Exchange (EDIE). In addition, Bernalillo County approved 1/8 GRT ($16 million) to fund behavioral health services in Albuquerque and Bernalillo County.

ATTACHMENT D
Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

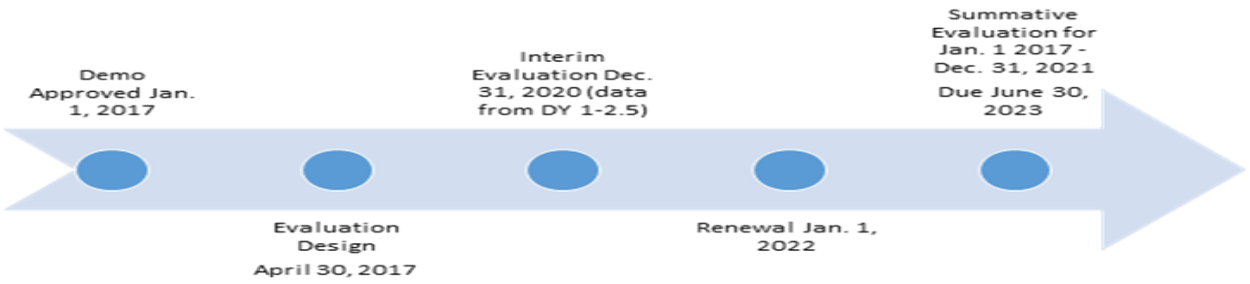
Expectations for Evaluation Designs

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals**.**

The format for the Evaluation Design is as follows:
General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2) Include a Driver Diagram to visually aid readers in understanding the rationale behind

the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration;

4) Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;

5) Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (member, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.

    b. Qualitative analysis methods may be used, and must be described in detail.

    c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

    d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

    f. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).

    g. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

    If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

    b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison

groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).

d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid members -Members with diabetes diagnosis	Medicaid fee-for-service and encounter claims records	Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	Sample, e.g., PPS administrators	Key informants	Qualitative analysis of interview material

D Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

1) When the state demonstration is:
   a. Long-standing, non-complex, unchanged, or
   b. Has previously been rigorously evaluated and found to be successful, or
   c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT E
Evaluation Design (Reserved)

ATTACHMENT F
Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid members for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

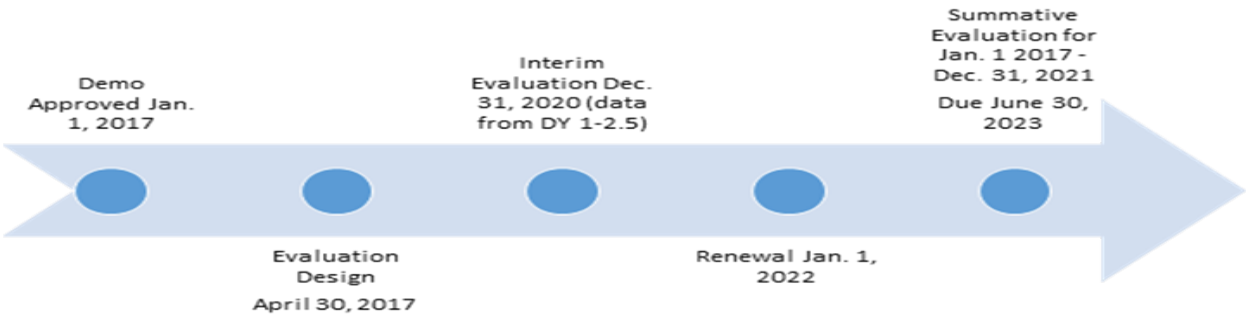
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS , pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports
The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve member health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and

c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected
4. *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6. *Analytic methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.
    A. **Methodological Limitations** - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.
    B. **Results** – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

    C. **Conclusions** – In this section, the state will present the conclusions about the

evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
    a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

D. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

E. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

Attachment G
Monitoring Protocol (Reserved)

Attachment H
SUD Implementation Plan Protocol

Introduction

The prevalence of Substance Use Disorders (SUDs) in the United States occurs in 5-6 percent of the population (Ritchie, H. & Roser M, (2018), Substance Use, *Institute of Health Metrics and Evaluation*), with alcohol substantially outweighing other substances. In New Mexico, the statistics exceed those of the nation:

- Alcohol related injury deaths are 1.6 times the national average;
- In the reporting period 2012-2016, drug overdoses surpassed alcohol related motor vehicle traffic crashes;
- Unintentional drug overdoses account for almost 86% of drug overdose deaths with the most common drugs accounting for deaths in descending order being prescription opioids, benzodiazepines, cocaine, and methamphetamines;
- New Mexico records 1.9 times the national average for deaths from suicide;
- The negative consequences of excessive alcohol use in New Mexico are not limited to death but also include domestic violence, crime, poverty, and unemployment as well as chronic liver disease, motor vehicle crash and other injuries, mental illness, and a variety of other medical problems.

New Mexico has made significant advances in recent years in our services to both combat and treat OUD and SUD. We halted the increasing overdose trend from the highest rate among states to 13th. We must consider, however, that the upward trends of other states also impact this. However, New Mexico continues to be the top state in alcohol-related deaths and 3rd in suicides. We still have much work to do. The following link represents NM OUD/SUD statistics: https://www.nmpharmacy.org/resources/2018%2006%2023%20-%20NMPhA%20Law%20Update.pdf.

Research reported by Ritchie and Roser suggests that "the transition from intermittent or regular use toward addiction and relapse are most strongly influenced by a mixture of stress response, environmental factors, genetic predisposition to addiction and importantly the drug-induced effects which often create a cycle of addiction and relapse." The Ritchie/Rose article also relates mental health as a risk factor for SUD postulating that a person with a mental health condition is 1.1 to 6.3 times more likely to develop a SUD. ADHD, bipolar disorder, intermittent explosive disorder, and PTSD are among the top diagnoses signaling risk.

For these reasons New Mexico's continuum of SUD services and its implementation plan also includes:

- Treatment of co-occurring mental health conditions with a primary diagnosis of SUD;
- A focus on the integration of SUD screening in physical health provider locations;
- The introduction of behavioral health counselors in primary care agencies, and primary care practitioners in behavioral health agencies; and
- Interdisciplinary teaming with the Medicaid beneficiary and his/her natural supports to treat not only the person with the SUD, but also the family or natural support system.

New Mexico's 1115 demonstration application supports and focuses its SUD evaluation on the six goals developed by CMS:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUD;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmission is preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

This implementation plan will describe services currently in place, and put forward our plans to implement new services, i.e. our gaps in service options. It is based upon American Society of Addiction Medicine (ASAM) levels of care for the continuum of care, and is organized by CMS's SUD milestones:

1. Access to critical levels of care for OUD and other SUDs
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including Medication Assisted Treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Milestone 1: Access to critical levels of care for OUD and other SUDs

0.5 – Early Intervention: Screening & prevention

Current State:
Screening, Brief Intervention, and Referral for Treatment*:* New Mexico is in the final year of a SAMHSA grant to promulgate Screening, Brief Intervention and Referral for Treatment (SBIRT) for adults. NM SBIRT services are intended to identify individuals with risky alcohol and drug behavior and provide a brief intervention or a referral to treatment, if necessary. NM SBIRT has provided services to emergency rooms, health clinics, and primary care offices in targeted areas, and in an Indian Health clinic.

Both the NM Managed Care organizations and the CareLink New Mexico Health Homes (CLNM) promote prevention through their disease management programs to manage chronic illnesses and prevent risk factors such as SUD.

NM State Plan does not support all screening and prevention activities in the categorically needy:

Screening & prevention	3.1-A	Pg 5

Future State Implementation Plan:

Strategic importance: Early detection of SUD and concomitant behavioral health conditions in a physical health environment at which an individual is more likely to visit has not been a focus. Moving this service and a behavioral health practitioner into an environment that is more natural for an individual can offset what may be an escalating behavioral health condition.

1) Expand SBIRT to include adolescents.
2) Include SBIRT in other physical health settings beyond the targeted areas identified in the discretionary grant. This will include eligible providers and practitioners.
   A) Providers:
      - Primary care offices including FQHCs, IHS and 638 tribal facilities;
      - Patient centered medical homes;
      - Urgent care centers;
      - Hospital outpatient facilities;
      - Emergency departments;
      - Rural health clinics;
      - Specialty physical health clinics; and
      - School based health centers.

   B) Practitioners, who must be trained in SBIRT, may include:
      - Licensed nurse;
      - Licensed certified nurse practitioner or licensed clinical nurse specialist;
      - Behavioral health practitioner;
      - Certified peer support worker;
      - Certified family peer support worker;
      - Certified community health worker;
      - Licensed physician assistant;
      - Physician;
      - Medical assistant; and
      - Community health representative in tribal clinics.
3) Staff training and/or certification requirements for SBIRT approved practitioners:
   A) General requirements (can be in person or webinar based):
      - Attest to all agency/clinic mandatory trainings and clearances;
      - Evidence of current professional licensure;
      - Peer and family Peer Support Workers - evidence of current CPSW/CFPSW certification or enrollment in classes to receive certification; and
      - Evidence of annual HIPAA training.
      - Harm Reduction 101;
      - SBIRT 101 including a warm handoff process;
      - Training in the scoring of the screening tools utilized;
      - 42 CFR part 2; and
      - Naloxone/Overdose prevention.

   B) Specific training for the clinician delivering the BI (all required):
      - Motivational Interviewing (by a MINT trainer);

- QPR (Suicide Prevention);
- Community Reinforcement Approach (CRA); and
- Reviews of Audit-10; GAD-7; PCL-C; PHQ-9 and DAST-10

C) Suggested for Behavioral Health Counselors/Therapists

- Seeking Safety
- IMPACT

Subject to Approval of 1115 Demonstration and State Plan Amendment Summary of Actions Needed – Early Intervention

Action	Timeline	Responsible entity
Submit to CMS the SUD State Plan Amendment including screening, prevention, and SBIRT services	3/1/19 – 3/31/19	MAD
Solicitation of interested providers for SBIRT	1/01/19 – 3/31/19 (ongoing)	BHSD
Provider Staff Training and University clinical student training for SBIRT	1/01/19 – 12/31/20 by groups	BHSD, LifeLink, UNM
Implementation of SBIRT in provider agencies	4/01/19 – 12/31/20 by groups	BHSD, UNM, LifeLink
Complete BH rule promulgation	1/01/19 – 12/31/19	Program Policy Bureau
Add SUD to beneficiary eligibility criteria for CLNM health homes through SPA and rule - which includes all OUD/ SUD screening	6/31/19 – 12/31/19	Medicaid BH Manager & BHSD HH Program Manager
Update and Publish CLNM policy Manual	7/01/19 – 12/31/19	HH Program Manager
Continue the statewide education of naloxone use and availability of the kits	1/01/19 – 12/31/20	HCA

1.0 – Outpatient Services: Less than 9 hours of services/week for adults, and less than 6 hours of services/week for youth.

Current State:

Outpatient Treatment: Medicaid enrolled providers currently deliver outpatient services to New Mexicans throughout each region of the State. Outpatient programs include individual, group and family counseling and provide services specific to elders, adolescents, youth, men and women both within managed care and fee-for-service which is primarily our Native American population. Tele-medicine is also available for many services to accommodate frontier regions with few resident practitioners.

Specialized OP services targeting SUD are available in some areas and are inclusive ~~comprised~~ of:

- Comprehensive Community Support Services to promote recovery, rehabilitation and resiliency for SUD, SED and SMI – all ages. This culturally sensitive service coordinates and provides services and resources to an eligible recipient and his or her family necessary to promote recovery, rehabilitation and resiliency. CCSS identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the eligible recipient's community, as well as strengths that may aid the eligible recipient and family in the recovery or resiliency process
- Crisis intervention services for BH crises – all ages, beneficiaries
- Family Support Services to enhance the family's strengths, capacities and resources to promote recovery and resiliency, and the behavioral health goals of the beneficiary – all ages
- Medication assisted treatment (MAT) for opioid use disorders – any age with OUD: MAD pays for coverage for medication assisted treatment (MAT) for opioid use disorder to an eligible recipient as defined in the Drug Addiction Treatment Act of 2000 (DATA 2000) and subsequent Comprehensive Addiction and Recovery Act (CARA) 114-198. Services include 1) an assessment and diagnosis by the prescribing practitioner as to whether the recipient has an opioid abuse diagnosis and their readiness for change; 2) an assessment for concurrent medical or behavioral health illnesses; 3) an assessment for co-occurring substance abuse disorders; 4) educating the recipient as to differing treatment options prior to starting treatment; 5) a service plan that prescribes either in house counseling or therapy, or referral to outside services; and 6) skills building and recovery and resiliency support. Multi-systemic therapy for SED, SUD, justice involved, and at risk for out of home placement – 10 to 18 years of age
- Opioid Treatment Program in methadone clinics for withdrawal treatment - adults
- Recovery Services with peer-to-peer support to develop and enhance wellness and health care practices for chronic SUD, SMI and SED – all ages
- Legislation is in place to facilitate the use of telehealth to expand access to clinical services and telehealth is a reimbursable service through NM Medicaid.

Recent initiatives currently in place:

- Expanded access to counseling and therapy beyond normal business hours to include evening and weekend hours through rate differential.
- Expanded access to recovery services, peer and family support services through additional training and reimbursable codes.
- Updated NMAC regulation to cover peer support workers for individual and group skill building work, particularly for SUD beneficiaries.
- Added community-based crisis stabilization centers for less than 24 hours of triage, de-escalation, and stabilization services with trained behavioral health and physical health practitioners. This is available for ages 14 and over. It serves as an alternative to emergency department use, or incarceration, and will target overdose and threatened suicidal events.

- Added family peer support workers to the workforce to emphasize not only "person centered" service, but "family-centered" service, as recovery and resiliency rests on not only individual efficacy, but on a strong and educated support system.
- Increased rate for mobile crisis teams to incentivize more teams; particularly in frontier areas where there is limited access to services.

Opiate Treatment Program (OTP): Daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opioid use.

New Mexico has a system for development of OTPs and process for expanding throughout the state. The OTPs offer medication assisted treatment using methadone or buprenorphine and counseling. They are regulated and approved through the state opioid treatment authority (SOTA). Appendix M, Attachment A outlines the process for adding new OTPs.

NM State Plan supports OP and OTP services:

Crisis services	State Supplement A to attachment 3.1A	Page 21
Medication Assisted Treatment	State Supplement A to attachment 3.1A	Page 21d
CCSS	State Supplement A to attachment 3.1A	Page 21b
MST	State Supplement A to attachment 3.1A	Page 21c
OP hospital	State Supplement A to attachment 3.1A	Pages 1,2
FQHC, CMHC	State Supplement A to attachment 3.1A	Pages 5b, 5c
Behavioral Health	State Supplement A to attachment 3.1A	Pages 9 – 10a
EPSDT	State Supplement A to attachment 3.1A	Pages 5a – 5g

Implementation Plan for Future State of 1.0 Outpatient Medicaid covered services:

1) Include the ability to expand treatment services for OTPs. Previously, our methadone clinics did not provide many outpatient services except for the mandated one hour of counseling per month, and the initial physical exam and prescribing and administering methadone. We are now adding other forms of MAT, additional counseling and therapy, intensive outpatient services, recovery support services, and comprehensive community support services. This will facilitate a recipient receiving services in one location, particularly the one within which they are most comfortable. Additional medical treatments may also be added to serve the individuals in an integrated care model.

2) Add Behavioral Health Agencies to the provider types that can deliver Comprehensive Community Support Services (CCSS) to expand this highly needed service for SUD beneficiaries in more areas of the state. CCSS builds the skills necessary for an individual to live more successfully in the community, offers recovery and resiliency support, and links the recipient with other services to meet their needs such as housing, nutrition and employment supports. Most of the work is accomplished in the community rather than in a clinic with the certified peer support worker often accompanying the recipient until the recipient becomes more self-sufficient. Because the providers are most often peer support workers under supervision, they have demonstrated maximum effectiveness.

3) Add SUD as admission criteria for CCSS; it was previously restricted to those with a serious mental illness (adults) or severe emotional disturbance for children/adolescents. This service is focused on surrounding individuals/families with the services and resources necessary to promote recovery, rehabilitation and resiliency. Community support activities address goals specifically in the following functional domains: independent living, learning, working, socializing and recreation.

4) Further the "Treat First Clinical Model" which allows treatment of presenting conditions without requiring a full comprehensive assessment or diagnostic evaluation before attending to the reason for which the recipient presented. A provisional diagnosis is utilized for billing purposes. It also allows for immediate referral to CCSS services often rendered by a peer. This has already been shown to decrease the "no show" rate, particularly in the SUD and homeless population. Providers already certified in Treat First, have also significantly increased their open access hours to immediately capture individuals when their need presents without being placed on a "wait list" for an appointment.

5) Add coverage for interdisciplinary teaming to incentivize the collaboration of physical health, mental health, and social determinants of health, as many of the NM population with substance use disorders also have significant mental health and physical health disorders and navigating all concerns is difficult for these beneficiaries. Interdisciplinary teaming requires the recipient be present with the differing practitioner disciplines at significant times in their rehabilitative journey.

6) Expand training in best practices for substance use detoxification by UNM/CBHTR

7) Ambulatory withdrawal management: via administrative code add as a service in crisis stabilization centers

8) Add crisis intervention services that are community-based crisis intervention services which are immediate, crisis-oriented services designed to ameliorate or minimize an acute crisis episode or to prevent inpatient psychiatric hospitalization or medical detoxification. Services include four types of crisis services: telephone crisis services; face-to-face crisis intervention in a clinic setting; mobile crisis services; and outpatient crisis stabilization services. Crisis stabilization services are outpatient services for up to 24-hour stabilization of crisis conditions which may, but do not necessarily, include ASAM level two withdrawal management, and can also serve as an alternative to the emergency department or police department. Eligible population is 14 years and older or adult only.

9) BHSD has disseminated the HHS guidance for prescribing MAT via telehealth to all opioid treatment programs which is attached. This guidance is included in the NM Medicaid Behavioral Health Policy Manual.

All STR and SOR funded trainings related to Medication Assisted Treatment include specific information and guidance to attendees about the use of telehealth when setting up buprenorphine initiatives. This new guidance provides a hands-on mentorship experience for providers in rural areas who are considering applying their own DEA waiver to prescribe buprenorphine and is consistent with New Mexico's goal of increasing capacity for Medication Assisted Treatment throughout the state.

Summary of Actions Needed – LOC 1.0

Action	Timeline	Responsible entity
Schedule further trainings such as MAT, DATA waiver 2000, to expand access to buprenorphine.	Ongoing	HCA, UNM
Alert Behavioral Health providers to the additional benefits effective 1/01/19: additional counseling in an OTP, MAT through telehealth, crisis stabilization, additional access after-hours and weekends, reimbursable interdisciplinary teaming with the recipient; peer support; family peer support the use of non-independent practitioners in more agency types; and CADCs which are now reimbursable.	1/01/19 – 6/31/19	HCA, CYFD, Primary Care Assoc., NM Hospital Assoc., NM BH Provider Association
Complete promulgation of BH rule which adds the above listed benefits	1/01/19 – 12/31/19	MAD
Complete the publication of the BH Billing and Policy manual which clarifies many benefits intended to encourage provider participation: the reimbursement of masters level behavioral health interns, the addition of agency types that can utilize non-independent licensed practitioners and peer support workers, i.e. opioid treatment programs, behavioral health agencies, political subdivision of the state such as court systems, counties, cities once they are enrolled in Medicaid, and crisis stabilization and triage centers.	1/01/19 – 3/31/19	MAD
Expand the learning communities for the treat first model, and the	On-going	BHSD

Treat First University to continue exploring new initiatives to expand access to BH services;		
Explore collaborative opportunities with County organizations for crisis services.	4/01/19 – 12/31/22	HCA, NM Assoc. of Counties
Work with opioid treatment programs to expand services with additional counseling, peer support, and buprenorphine in addition to methadone.	4/01/19 – 12/31/19	BHSD
Process and add 2 new OTPs that have applied and are pending	1/01/19 – 6/31/19	BHSD
Process and add 4 new OTPs that are in process	7/01/19 – 12/31/19	BHSD
Process and add new OTPs as they apply	Ongoing	BHSD
Conduct an analysis for results on CY 1 activities related to availability of providers for OP services in all regions of the state, including MAT, tele-medicine, and after-hours access	10/01/19 – 12/31/19	HCA

2.1– Intensive Outpatient Services: Adult: 9 or more hours of services/week; youth: 6 or more hours of services per week to treat multi-dimensional instability

Current State:
Certified Medicaid enrolled providers offer intensive outpatient (IOP) services for SUD to New Mexicans throughout each region of the State. IOP programs offer treatment activities weekly based on individual needs and the evidence-based practice that the providers use. These activities consist of a combination of psycho-educational groups, individual, group, and/or family therapy sessions.

NM State Plan supports intensive outpatient services:

Behavioral Health	State Supplement A to attachment 3.1A	Pages 9 – 10a

Future State Implementation:

Strategic importance: IOP, through the weekly hours of engagement, offers the support for both recovery and developing the resiliency necessary to change the habits that have adversely affected an individual's life. Both through education based on the reasons why, and the effects on the brain, body and behaviors, and the support of group activities with individuals with similar struggles, positive changes are more likely to occur. In offering evidence-based models and groups specific to the range of ages of enrollees, success is more likely.

Expand this level of service to Opioid Treatment Programs. This will enhance the continuity of care and provide more access to this service in an environment in which the individuals are comfortable.

Continue to add more evidence-based models for specific ages or distinct groups, for example drug court individuals through moral reconation therapy to decrease recidivism.

There is no waiver request.

Summary of Actions Needed:

Action	Timetable	Responsible entity
Complete the promulgation of the BH rule	1/01/19 -12/31/19	MAD
Support the OTPs in the application and training process for adding IOP as a service.	4/01/19 – 12/31/19	BHSD
Complete the publication of the BH Billing and Policy manual which clarifies many benefits intended to encourage provider participation: the reimbursement of licensed substance abuse associates for some services; the use of interns, the addition of agency types that can utilize non-independent licensed practitioners and peer support workers, i.e. for 2.1 level of care such as behavioral health agencies, political subdivision of the state such as court systems, counties, and cities once they are enrolled in Medicaid.	1/01/19 – 3/31/19	HCA
Continue to investigate and add more EBPs to the approved list of proven models for recovery	1/01/19 - ongoing	HCA
Conduct an analysis of available programs for all applicable age levels across the state.	10/01/19 – 12/31/19	HCA & CYFD

2.5 - Partial Hospitalization: 20 hours or more per week of clinically intensive programming with direct access to psychiatric, medical and lab services.

Current State:
Partial hospitalization is a covered service for youth as part of EPSTD in a psychiatric hospital.

NM State Plan supports partial hospitalization services:

OP hospital	State Supplement A to attachment 3.1A	Pages 1,2
EPSDT services	State Supplement A to attachment 3.1A	Page 5a

Future State Implementation:
No waiver request; through SPA and administrative code

Strategic importance: This service is particularly important because it is designed to stabilize deteriorating conditions in a supportive medical and behavioral environment and avert inpatient hospitalization. It can also be a step-down strategy for supportive transitions for individuals with SUD, SMI, or SED who have required inpatient hospitalization, and are not yet ready for complete community existence. It keeps them in a structured environment with intensive services, while preparing for community living by having them return home in the evening. The program works with the family as well as the individual to enhance success at home and avert additional hospitalizations.

1) Expand partial hospitalization to cover adults, youth and children with SMI/SED/SUD, and
2) Expand partial hospitalizations to acute care hospitals with a psychiatric unit.
3) Increase reimbursement rate for partial hospitalization to encourage greater service delivery.

Summary of Actions Needed:

Action	Timetable	Responsible entity
Complete the promulgation of the BH rule which re-drafts regulation and reimbursement for partial hospitalization to encourage hospitals to add this service.	1/01/19 - 12/31/19	MAD
Include in State Plan Amendment for SUD continuum of care	1/01/19 – 3/31/19	MAD
Work with hospitals to add this service	1/01/19 – 12/31/19	HCA

2.0 withdrawal management: Ambulatory withdrawal management with exended on-site monitoring

3.1 Clinically managed low-intensity residential services: 24 hour structure; at least 5 hours of clinical service/week

3.2 withdrawal management (WM) – clinically managed residential withdrawal management: 24 hour structure

3.3 – Clinically managed population specific residential services: 24-hour structure, high intensity clinical services with a less intense milieu and group treatment for those with cognitive or other impairments

3.5 – Clinically managed high intensity residential services: 24 hour care, high intensity services for persons who cannot be treated in less intensive levels to stabilize mult-dimensional needs and/or safety issues

3.7 – Medically Monitored intensive residential services: 24 hour nursing care with physician availability for significant problems with acute intoxication and/or withdrawal potential, biomedical conditions and complications, or emotional, behavioral, or cognitive conditions and complications with 16 hour/day counselor availability.

3.7 withdrawal management (WM) – medically monitored residential withdrawal management with 24 hour care with physician availability.

Current State:
Not currently available for adult Medicaid population

NM State Plan supports hospitalization and residential treatment for youth through EPSDT services:

EPSDT Services not otherwise in the State Plan	State Supplement A to attachment 3.1A	Page 5a

Future State Implementation subject to 1115 demonstration and State Plan Amendment approval:

Strategic importance: When a less restrictive setting is not sufficient to engender change, residential care is often medically necessary.

1) Include 2 WM, 3.2, 3.5, and 3.7 WM in crisis triage centers for adults and adolescents;
2) Include 3.1 in step down accredited residential treatment centers for SUD and co-occurring conditions to prepare beneficiaries for community-based services and living;
3) Include 3.2, 3.3, and 3.5 in adult accredited residential settings for individuals with SUD and co-occurring conditions; and
4) Include 3.7 and 3.7 WM in shorter term accredited residential settings with enhanced clinical support for beneficiaries with SUD.

Summary of Actions Needed:

Action	Timetable	Responsible entity
Develop & submit State Plan Amendment which delineates new services at every level of care for both MCO members and fee-for-service recipients. The new services are SBIRT and other screening tools (ASAM 0.5); peer support and family peer support services, ambulatory withdrawal management in crisis stabilization centers (ASAM 1.0); IOP for SUD in an OTP (ASAM 2.1); partial hospitalization for SUD from ages 14 and over (ASAM 2.5); accredited residential treatment centers for adults with SUD (ASAM 3), and	1/01/19 – 4/01/19	HCA

SUD treatment in an inpatient IMD (ASAM 3.7 & 4.0).		
Align Department of Health standards for crisis triage centers with behavioral health certification and with BH rule;	1/01/19 – 6/31/19	HCA
Complete promulgation of the behavioral health rule that includes crisis triage centers;	1/01/19 – 12/31/19	HCA
Provide technical support to residential providers to become accredited;	1/01/19 – ongoing	HCA
Schedule trainings on best practices for withdrawal management through UNM/CBHTR;	1/01/19 – 12/31/19	UNM

3.7 - Medically Monitored Inpatient Withdrawal Management: 24-hour nursing care with physician availability for significant problems with acute intoxication and/or withdrawal potential, biomedical conditions and complications, or emotional, behavioral, or cognitive conditions and complications. 16 hour/day counselor availability.

4.0 - Medically Managed Intensive Inpatient: 24-hour nursing care and daily physician care for severe unstable problems with acute intoxication and/or withdrawal potential, biomedical conditions and complications, or emotional, behavioral, or cognitive conditions and complications. Counseling available to engage patient in detox treatment.

Current State:
New Mexico funds inpatient services through acute care hospitals. At present this service is underutilized for withdrawal management (de-toxification).

IMDs currently have a 15-day limit for ages 21 through 64 for MCO coverage only as an "in lieu of service" and restricts services to withdrawal management. There is no coverage for the over 65 age range.

NM State Plan supports IP services in acute care and limited IMD services:

Inpatient	Supplement A to attachment 3.1A	Page 1
EPSDT IP and residential for psychiatric/SUD	Supplement A to attachment 3.1A	Page 5a
IMD – over 65	Attachment 3.1A	Page 6
IMD – under 22	Attachment 3.1A	Page 7

Future State Implementation subject to 1115 demonstration and SPA approval:

Strategic importance: Emergency rescue education for overdose through naloxone must be made increasingly pervasive, and then follow-up de-toxification in a hospital if medically necessary must be available. There is much encouragement to hospitals still needed.

1) No regulatory changes are expected for acute care hospitals; continue educational opportunities.
2) Delete the 15-day time restriction in IMDs, and add coverage for over 65 age range, but continue SUD specificity.

Summary of Actions Needed:

Action	Date	Responsible entity
Schedule trainings for acute care hospitals on best practices for withdrawal management	10/01/19 – 12/31/19	UNM
Complete the promulgation of NM Administrative code for behavioral health;	1/01/19 – 12/31/19	MAD
Offer directive to MCOs and IMDs to re-negotiate contracts related to reimbursement for IMDs;	1/01/19 – 6/31/19	MAD
Develop and submit to CMS the State Plan Amendment for SUD which includes coverage for adults with SUD from ages 18 and above, and adults over 65 for SUD and mental illness.	1/01/19 – 4/01/19	MAD
Develop a report that shows the average length of stay for adult ARTCs across the state. LOS will be specific for each of the 3 levels of care within an ARTC.	7/01/19 – 12/31/19	HCA

Milestone 2: Widespread use of evidence-based, SUD-specific patient placement criteria

Strategic importance: One size does not fit all. The medical necessity for residential care is very specific for differing stages and intensity of illness, and for different age groups, and for individuals with different cognitive abilities and readiness for change and are perfectly articulated through the ASAM placement criteria. That is why New Mexico's placement criteria will be based on ASAM criteria, and why we will require all accredited residential centers and MCOs that will be providing prior approval to have the same training so that consistency across all entities can be the expectation. To assure the most effective placement for the individual, we will also not require authorization until five days into a stay so that appropriate assessment as to level of care needed has been determined. Prior authorization will also be required between transitioning to a different level of residency and care.

Current state:
New Mexico relies on evidence-based practices and clinical practice guidelines for all aspects of provider development, treatment authorization and recovery. The State developed level of care guidelines for some services and will utilize ASAM level of care guidelines for SUD services. The NM Health Care Authority has created a BH policy manual that informs providers of expectations for specific placement, staffing and treatment guidelines for SUD treatment services.

Future State Implementation:

Schedule trainings on ASAM	1/01/19 – 12/31/19	CYFD, HCA
The state is developing the standards for prior authorization for the MCO and the review tools for appropriate placement and utilization, together the instruments will ensure proper placement aligned with ASAM criteria.	1/01/19 – 6/31/19	
Edit current report #41 (attached as C: Utilization Management Review Tool) to specify each ASAM level of care	7/01/19 – 9/30/19	HCA
Train and standardize prior authorization procedures for all MCO and FFS authorization staff in ASAM placement criteria to assure beneficiaries are placed in the correct LOC, i.e., extended partial hospitalization, accredited residential treatment centers, and inpatient admissions.	1/01/19 – 6/31/19	BHSD
Conduct an independent evaluation of placement criteria and utilization management for all levels of ARTCs	10/01/21 – 12/31/21	HCA

Milestone 3: Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications

Current State: NM Medicaid does not cover adult residential treatment centers.

Future State Implementation subject to 1115 demonstration and State Plan Amendment CMS approval:

- Standards: Because all residential treatment centers must be accredited by Joint Commission (JC), or Commission on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA) our regulation states that "all MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Follow up auditing is done by the accrediting agency per their standards". A composite of their standards includes:
- Leadership
- Governance
- Workforce Development and Management
- Financial Planning and Management
- Information Management

- Legal Requirements
- Rights of Persons Served
- National Patient Safety Goals
- Infection Prevention and Control
- Care, Treatment and Services including record keeping of same
- Screening and Access to Services
- Assessment
- Service Planning and Monitoring
- Emergency Management
- Risk Management
- Medication Management
- Medical Care and Clinical Support Team
- Detoxification Treatment
- Promoting Non-Violent Practices
- Transition/Discharge
- After Care and Follow-Up
- Performance Improvement

In addition, HCA will certify each ARTC before they are enrolled in Medicaid to assure compliance with ASAM standards of care for each level, staffing plans, and hours of service, and types of service. Below are the proposed sections of the HCA ARTC certification, to be completed in the first quarter.
Recommended requirements:

- Review of Policies and Procedures
    - Listing of specific policies and procedures to be submitted are in development.
- Documentation of staff ASAM training
- Copies of clinical staff licensure, also DEA# (for physician)
- Table of Organization demonstrating staffing appropriate to ASAM Level(s) of Care and appropriate oversight
- Copy of service schedule
- Attestation showing that required clinical staff are available at the required times per ASAM Level(s) of Care (attest to understanding of requirements and standards, bullet

pointing the requirements for the specific ASAM Level of Care). Attestations shall be signed by the CEO/ED or designee and notarized.

- Copy of Assessment Template (including ASAM assessment for each domain, summary, and placement recommendations)
- Copy of Treatment Plan Template (to include ASAM
- Copy of Current Accreditation Certificate (JC, CARF, COA)
- Electronic submission of application materials is acceptable.
- Site visit: Chart review ASAM Risk matches ASAM Level of Care Provided, services provided match schedule provided and meet agencies chosen ASAM Level(s) of Care
    - Review Tool in development.
- Review all ARTCs for inclusion of MAT either on-site or through referral relationships.

Notes:

- No provisional certification.
- Cost Analysis/Rate Setting application submitted, reviewed, approved, and sent to MCO's (rate for each of the Levels of Care). Cost Analysis based on state fiscal year.
- Interim rate might be available through Myers and Stauffer through January 2019.
- If nationally recognized accreditation body (JC, CARF, COA) and ASAM develop a Level Three specific certification that exceeds these proposed review standards, BHSD may reconsider state deemed status for certified programs.

1) Train all current residential treatment centers that are not covered by Medicaid and not accredited in ASAM placement and treatment standards to prepare them for becoming accredited and, therefore, covered by Medicaid.
2) Train all potential crisis triage centers in ASAM standards of care
3) Assure JC or CARF or COA service and quality standards are incorporated into ARTC policy and procedures for NM tiered ARTCs: a) 3.1 in step down accredited residential treatment centers for SUD and co-occurring conditions; b) 3.2, 3.3, and 3.5 in adult accredited residential settings mid-level services, and c) 3.7 and 3.7 WM in shorter term accredited residential settings with enhanced clinical support for beneficiaries with SUD.

Summary of Actions Needed:

Action	Timetable	Responsible entity
Complete promulgation of the behavioral health rule that includes accredited residential treatment centers	1/01/19 – 12/31/19	HCA
Provide technical support to residential providers to become accredited;	1/01/19 – ongoing	HCA
Notify and educate providers and authorization centers on ASAM requirements;	1/01/19 – 6/31/19	HCACA
Schedule trainings on ASAM criteria	1/01/19 – 12/31/19	CYFD HSD

Research state and national staffing ratios and provider types; and include in BHSD's certification process for ARTCs	4/01/19 – 6/31/19	HCA
Compare to The Joint Commission, CARF and COA standards.	7/01/19 – 9/30/19	HCA
Set standards for NM ARTCs	10/01/19 – 12/31/19	HCA, CYFD, DOH
Work with accrediting agencies and ARTCs to access evaluation results of standards of care at each ASAM level, and institute corrective action if needed	4/01/20 – 6/30/20	HCA
Develop certification criteria for new ARTCs	1/01/19 – 6/31/19	BHSD
Develop on-site audit tool for ARTCs to assure placement, staffing, service standards, and placement criteria meet ASAM criteria. This will be conducted every two years	1/01/19 – 9/31/19	BHSD
Review all ARTCs for inclusion of MAT either on-site or through referral relationships.	annually	HCA

Milestone 4: Sufficient provider capacity at each level of care, including Medication Assisted Treatment

Strategic importance: Adequate workforce is the precursor to access of care throughout the state. Workforce is the primary issue within New Mexico as this is a frontier state where areas of the state are without behavioral health providers, and access is a problem. Also, the majority of the population are enrolled in Medicaid where reimbursement isn't adequate to afford competitive salaries.

Rates have been increased in several areas to assist providers in these efforts. Below is a summary of rate increases:

- Treatment foster care – 20% increase
- ARTC for youth from $270/day to $350/day
- Supportive housing - $450/month
- Preventive education in an OTP - $40.05/30 min or $32.50 for groups
- Interdisciplinary teaming from $70,00 to $280 dependent on # of participants
- SBIRT - $27.00 for screen; $54.00 for brief intervention
- BH screening $16.36
- BH brief intervention $22.79
- Partial hospitalization - $875 for full day
- Group homes for youth - $112/day to $150/day
- Peer support individual - $12.00/15 min – group $7.20

The New Mexico Behavioral Health Collaborative, which includes all State Departments, developed a strategic plan with one arm of it being devoted to workforce. The work of this group continues with the second CY summit having just occurred. It included students interested in health-related careers and accentuated the need to reach out to students through internship programs and relationships with existing providers.

The new Behavioral Health Gaps Analysis is attached as Appendix M, Attachment D Behavioral health system barriers begin on page 19 of the New Mexico Health Gaps Analysis. The conclusion and recommendations begin on page 30.

- A range of behavioral health evidence-based practices (EBPs) are available in agencies throughout New Mexico. These EBPs include Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI). However, counties are also lacking important services, such as detox services and crisis mobile outreach services. With the high rates of overdose related to substance use in New Mexico, funding for these types of services should be prioritized.
    - Through the STR and SOR grants the state has been able to increase provider training on EBPs such as Motivational Interviewing, Seeking Safety Community Reinforcement Approach, American Society of Addiction Medicine criteria, Nurtured Heart, Medication Assisted Treatment, multiple trainings regarding opioid use disorder through the ECHO model.
- Given the racial and ethnic diversity of our state, it was encouraging to learn that many behavioral health agencies in NM have adapted or created behavioral health services for Hispanic and Native American populations. However, with this being the case for less than 50% of the agencies, more work needs to be done with respect to developing culturally appropriate services. Noteworthy is the need to extend this work to other cultures, including LGBTQ and people with developmental disabilities.
    - The state is currently offering LGBTQ 101 to all community BH providers (8-10) trainings across the state and delivered the same amount last FY.
- Less than 30% of behavioral health agencies consistently develop psychiatric advance directives. Psychiatric advance directives promote autonomy and empowerment, enhance communications between providers and consumers, and help prevent crisis situations. Training should be provided to agencies to encourage the use of this recovery-oriented practice.
    - BHSD has been in on-going communications to develop an electronic platform for Advanced Directives with Trilogy. Trilogy designs the state's Network of Care on-line resource and information site for BHSD.
- More agencies in urban counties (33%), compared to those in rural counties (22%) utilize telehealth/telemedicine to ensure consumers have access to treatment services. While this is a growth area for agencies throughout NM, this is especially true for those in rural counties.

    - BHSD has disseminated the HHS guidance for prescribing MAT via telehealth to all opioid treatment programs which is attached. This guidance is included in the NM Medicaid Behavioral Health Policy Manual.
    - All STR and SOR funded trainings related to Medication Assisted Treatment include specific information and guidance to attendees about the use of telehealth when setting up buprenorphine initiatives. This new guidance provides a hands-on mentorship experience for providers in rural areas who are considering applying their own DEA waiver to prescribe buprenorphine and is consistent with New Mexico's goal of increasing capacity for Medication Assisted Treatment throughout the state. Current research from UNM led by Dr. Salvador confirms that clinicians are looking for opportunities to observe experienced clinicians when prescribing buprenorphine including induction. The presence of a clinician at the originating site with a patient who is receiving buprenorphine by telehealth is an important component of learning new skills.
    - New Mexico already legislation in place to facilitate the use of telehealth to expand access to clinical services and telehealth is a reimbursable service through NM Medicaid.
- Another area of growth is the integration of electronic health systems into an information exchange to increase the sharing of information between providers. This integration of information is only available in about 26% of agencies in urban counties and 20% of agencies in rural counties.
- With only 50% of agencies having a process for using data to impact services, training and possibly even incentives need to be provided to agencies to make this a standard practice.
- While we know access to medication assisted treatment (MAT) has increased throughout NM since these data were collected, especially through initiatives such as the SAMHSA-funded State Targeted Response (STR) grants, the number of MAT providers needs to increase throughout NM. At the time these data were collected approximately 30% of agencies had providers who could prescribe and manage medications used to treat substance use disorders. For agencies where this is not possible, agreements or relationships with agencies who can provide these necessary services need to be developed.
    - Through efforts established in NM's Hub and Spoke model and the use of ECHO.
    - In addition, the State's Opioid Treatment Authority works to expand the opioid treatment programs (OTP). Currently there are three new providers working on completing the numerous licensing steps through SAMHSA, accreditation, the Drug Enforcement agency and the Board of Pharmacy. The state will offer CARF 101 training and ASAM training open to all potential OTPs. In addition, there are monies in the SOR to give OTP financial assistance for accreditation.
- Lack of reimbursement for trainees/interns was the most commonly cited barrier to independent licensure for both rural and urban clinical directors. In order to alleviate this barrier, funds should be made available to compensate a higher number of supervised trainees in NM. Funds should also be made available to compensate the clinical supervision

of master's level social work and counseling professionals to facilitate independent licensure either through stipends/salaries or changes to existing Medicaid reimbursement laws. In response to this feedback from providers,

- NM Medicaid issued a new proposed rule change that allows community behavioral health agencies to bill Medicaid for services provided by trainees as long as supervisory requirements are met. This new rule change takes effect January 1, 2019.

Summary of Actions Needed:

Action	Date	Responsible entity
Expand allowable agencies to include political subdivisions and other behavioral health agencies	1/01/19 – 3/31/19	HCA
Expand practitioners who can deliver SUD services, e.g., trainees under supervision, certified peer support workers, certified family support workers, and other qualified paraprofessionals	1/01/19 – 3/31/19	HCA, CYFD
Develop trainings focused on SUD for certified peer support workers, licensed clinicians, and prescribers	10/01/19 – 12/31/19	HCA, UNM and CYFD
Schedule further trainings such as MAT, DATA waiver 2000, to expand access to buprenorphine.	On-going	HCA, UNM
Expand statewide behavioral health workforce coalition	On-going	HCA, UNM, CYFD
Collaborate with professional licensing boards to review scopes of practice for all licensed professionals	1/01/2021 – 3/31/2021	HCA, CYFD
Edit the HSD network adequacy report to include BH services for all ASAM levels and incorporate composite into annual CMS reporting - identifying the types of services that are challenging to access and also identifying where in the state there are access challenges for those types of services.	4/01/19 – 6/31/19	HCA

Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

Current State:

Recovery Supports:
New Mexico's Office of Peer Recovery and Engagement (OPRE) is developing and delivering trainings with a special focus on OUD for certified peer support specialists who can work in regional hubs to provide recovery services. One of our peer-run recovery agencies will have dedicated staff trained to support local agencies and providers in implementing MAT for OUD.

In addition, Medicaid covers the following recovery services:

- Comprehensive Community Support Services;
- Behavioral Management Skills Development;
- Adaptive Skills Building;
- Psychosocial Rehabilitation;
- Family Support Services;
- Recovery Services; and
- BH Respite Services.

PAX Good Behavior Game
PAX Good Behavior Game® is a powerful evidence-based practice, consisting of proven instructional and behavioral health strategies used daily by teachers and students in the classroom. This universal preventive approach provides lifetime of benefits for every child by improving self-regulation and co-regulation with peers.

Prescription Monitoring Program (PMP):
16.19.29 NMAC, the rule regulating the PMP recently underwent a major rewrite addressing issues such as registration requirements to the PMP, restrictions on the disclosure of PMP information and mandatory reporting to one (1) business day.

State legislation and each healthcare professional licensing board enacted legislation/rules that mandate PMP utilization. The NM Board of Pharmacy has partnered with the NM Department of Health to analyze practitioner utilization compared to the controlled substances that were dispensed using their credentials. This analysis is then disseminated by the NM Board of Pharmacy to each of those healthcare licensing boards who have oversight of their licensees, and the licensing board can use this information to develop communication or initiate an investigation.

To help practitioners and pharmacists query PMP patient reports, medical staff (licensed and unlicensed) have the ability to query PMP patient reports for their supervising practitioners, and licensed pharmacy technicians and pharmacy interns also have the ability to query PMP patient reports on behalf of their pharmacists. Although a practitioner or pharmacist can only have four (4) delegates, a delegate can act in this role for an unlimited number of practitioners and pharmacists. As previously mentioned, the delegate usage and association to the practitioner's

profile allows for the data analysis to link the delegate's query to the practitioner's PMP utilization.

The NM Board of Pharmacy is now requiring dispensers (i.e., pharmacies and dispensing physicians) to report both prescription records or zero reports (i.e. no prescription-controlled substances dispensed during the reporting period) within one business day. While the PMP Director sends courtesy reminders and will work with data submitters experiencing temporary issues with reporting, 16.19.29 NMAC states very clearly that this is a requirement of dispensers dispensing controlled substances. If necessary, the NM Board of Pharmacy will open a case on those pharmacies who do not meet compliance needs. Ensuring that dispensers report daily ensures that the PMP is a valuable clinical tool to all authorized users with the most up-to-date prescription record data.

The NM Board of Pharmacy and the NM Department of Health developed a feature called a Prescriber Feedback Report (PFR), which provides a summary to the individual practitioner regarding the controlled substance dispensed using their credentials as reflected in the PMP. This report is informational which includes a comparison of prescribing measures to the average prescriber in the practitioner's specialty and graphical representation. It also includes information on several factors shown to increase the risk of overdose death involving prescription-controlled substances.

This link shows the NM statistics published at the 2018 Pharmacy Convention: https://www.nmpharmacy.org/resources/2018%2006%2023%20-%20NMPhA%20Law%20Update.pdf

Future State Implementation:

Strategic importance: Treatment of existing SUD has been part of New Mexico's array of services; however, prevention has not had enough focus. SUD is often a means of self-medication for those with serious mental illness (SMI) or severe emotional disturbances (SED) for adolescents. If this risk factor becomes part of the consciousness of all providers, the individual, and the natural support systems for individuals with a SMI or SED, and psycho-education and other preventive measures become common practice we can, hopefully, diminish the on-set of SUD.

There are no planned enhancements to the PMP at this time.

Opioid Prescribing Guidelines

The state has developed best practice protocols for opioid prescribing that are in keeping with the CDC guidelines. DOH and STR have contracted with Dr. Robert Rhyne to deliver trainings and follow up on these guidelines.

NM Medicaid ensures that best practices are followed by limiting the following opioid prescriptions through a soft edit process within the MCOs and FFS:

- Total daily doses above 90 MME of opioids

- Maximum of 7 days for all new opioid prescriptions for all patients who are new to opioids
- Refill threshold of 90% before opioid prescriptions can be filled

1) Centennial Care MCOs will monitor the use of controlled substances retrospectively to detect potential abuse or overuse and to assure the appropriate use of the drugs items with diversion potential. In addition, the Centennial Care MCOs will work together on the drug utilization review committee (DUR) to develop a standard monitoring program for controlled substance utilization. The program, at a minimum, must include how monitoring will be conducted; the frequency of monitoring; indicators and thresholds for suspicious utilization and suspicious prescribing patterns; actions that will be taken when suspicious utilization and prescribing patterns are identified; and plans for the DUR oversight group to report regularly to HCA and the Behavioral Health Collaborative, as requested. The MCOs shall notify the appropriate providers in their networks regarding this initiative and shall inform providers that utilization and prescribing patterns will be monitored.

2) Continue and expand PAX Good Behavior Games in early childhood education through the New Mexico public school system for early development of self-regulation and co-regulation with peers.

3) Add SUD to the admission criteria for individuals with SMI or SED in the NM CareLink health home program and enhance the risk factor education for SUD with all SMI/SED participants. The Health Home Steering committee will oversee the CLNM community providers in creating and implementing a health education program that informs participants with SMI/SED about the increased risk factors for SUD.

4) Overdose Prevention Education Coordinator (OPEC) whose task is to implement and coordinate trainings, technical assistance, and distribution of naloxone. The OPEC implements a Train the Trainer model, prioritized based on local need, local capacity, and overdose data, focused on increasing training access throughout 29 of the 33 New Mexico counties. This model focuses on providing overdose education and naloxone distribution (OEND) training to local individuals to serve as a county-based trainer for all OEND training needs. In addition, the SOR OPEC utilizes stipends as a mechanism to support the establishment of local trainers within the community. This will increase the ability of local providers to allot the necessary time needed to become trainers within their counties. The SOR OPEC also provides training and naloxone to special populations who are often underserved and at high risk of overdosing. These populations include adults age 55 and older, lesbian, gay, bisexual, and transgender community members, and youth under age 18. To assist with statewide capacity building, special population trainings, and fidelity checks with new trainers, the OPEC subcontracts with two statewide Overdose Prevention Educators and one Tribal Liaison. These individuals work regionally to orchestrate trainings, fidelity checks, and other local community needs identified by the SOR OPEC.

   A continued commitment must be established in order to effectively serve special and high need populations and the agencies that serve these populations. For example, law enforcement often serves as the first professional on the scene of an overdose. Due to turnover with law

enforcement officers, there must be a continued emphasis on training and educating law enforcement agencies to be best equipped to recognize and respond in cases of an overdose. For entities like corrections and treatment programs or homeless shelters, these individuals also experience turnover at the staff level as well as turnover with clientele. This requires a focus on a continuous relationship around training and distribution to these populations and encourages OSAP to coordinate activities across grants.

- To date, the STR OPEC has distributed 6,009 kits with 1,975 people being trained.
- To date, the Community-based Organizations funded through STR have distributed 953 kits with 814 people being trained.
- The Santa Fe Mountain Center (SFMC), who will expand opioid overdose prevention education/outreach and naloxone distribution specifically targeting youth, outpatient programs, LGBT, and community agencies, is anticipated to conduct 15 trainings reaching approximately 225 people.
- 32 reversals have been reported to date.
- An upcoming February 2019 purchase of Narcan will provide approximately 5,300 additional kits for distribution.
- The SOR OPEC is anticipated to conduct 120 trainings over the next 12-month period.
- The Law Enforcement Training Institute (LETI), who trains law enforcement agencies throughout the state, is anticipated to conduct 150 trainings to approximately 3000-5000 law enforcement officers over the next 12-month period.
- OSAP will purchase approximately 6,000 additional kits for distribution in 2020.

5) New Mexico has invested a great deal to implement and sustain a health IT infrastructure that supports Medicaid recipients. Like many states, substance use disorders (SUD) plague the health care system in New Mexico. The state will pull together stakeholders across the health care system to refine existing health IT plans or to develop a new plan that will detail the necessary health IT capabilities that will be implemented to support Medicaid recipient health outcomes to address the SUD goals of the demonstration. Stakeholder engagement and plan development will occur in first year of the demonstration. Applicable standards and best practices will be incorporated into the plan. During the first year of the demonstration, New Mexico will look for opportunities to leverage the Medicaid Management Information System (MMIS) replacement project to achieve the goals that will be developed in the plan.

   In years 2 and 3 of the demonstration, New Mexico will enhance its existing master client index (MCI) to support the state's MMIS replacement. The enhanced MCI is part of a broader master data management strategy and will function as a shared service to a variety of stakeholders within the health care system in New Mexico.

   Years two through five of the demonstration will see execution and monitoring of the plan. New Mexico will utilize existing governance structures and processes in place to monitor the execution and success of the plan.

Summary of Actions Needed:

Action	Timetable	Responsible Entity
Expand reimbursable services under home visiting initiatives to improve early identification and engagement in treatment for parents with SUD	4/01/19 - ongoing	HCA, DOH, CYFD, UNM
Continue and expand PAX Good Behavior Game	ongoing	HCA
Add SUD to CLNM admission criteria and expand risk factor education for members with SMI, SED	1/01/21 – 4/01/21	HCA
Drug utilization review committee to continually adjust monitoring guidelines (see IT Plan – Appendix M, Attachment F)	Ongoing	HCA & MCOs
Leverage the Medicaid Management Information System (MMIS) replacement project to achieve the SUD goals that will be developed in the plan.	1/01/19 – 12/31/19	HCA
Enhance the existing master client index (MCI) to support the state's MMIS replacement.	1/01/20 – 12/31/22	HCA
Execution and monitoring of the MMIS replacement plan	1/01/20 – 12/31/24	HCA

Milestone 6: Improved care coordination and transitions between levels of care

Current state:

Care coordination is currently provided by the four MCOs and is inclusive of transitions between levels of care, including a new transition between correctional facilities and the community. Care Coordination can include face to face contact during transitions, warm hand-offs to appropriate community providers such as the CLNM health homes, and/or information and referral to community resources.

In addition, they have delegated care coordination to the existing 9 health homes for our highest need chronically ill recipients with behavioral health conditions categorized as serious mental illness (SMI) or severe emotional disturbances (SED) for children. These recipients most often have multiple co-morbidities. They must agree to becoming a CLNM health home member (opt-in). The 9 health homes, in 11 counties, are providing

services to individuals with SMI/SED and all co-occurring conditions. There will be 13 counties targeted across the state for expansion. Approximately 1/3 of the counties are currently open for health homes, and the rest will be implemented in 2 future phases. In Appendix M, Attachment E on page 3 the potential population is calculated. However, it should be understood that these numbers are not unique to the diagnosis, meaning that a person that has an SMI/SED diagnosis and a SUD could potentially be counted in both.

Six services include:

1) Comprehensive care management
2) Care coordination
3) Health promotion
4) Comprehensive transitional care and follow-up
5) Individual and family support
6) Referral to community and social support services

NM State Plan supports CLNM Health Homes and transitions between levels of care:

CareLink NM Health Home	NM-15-0014 Attachment 3.1 - H	
CareLink NM Health Home	NM-18-0002 6A.1	
Discharge Planning & QA Review	Attachment 3.1-C	Page 1F

Future state implementation:

Strategic importance: For this high need population, comprehensive care coordination has proven to be more effective in the community in which the recipient lives, and in the behavioral health agency where he or she can receive multiple behavioral health or integrated services. Support of an individual between levels of care, which is one of the six core services, particularly from IP or residential or correctional facilities to the community, is most frequently the time for relapse and eventual recidivism. This is a crucial time for support to ensure the individual is well situated with the care and social determinants needed for a successful life.

1) Move some care coordination services to the beneficiaries' community through:
   a. The expansion of health homes into more counties;
   b. Expansion of delegated or partially delegated care coordination to other providers such as: PCMHs, FQHCs, etc. These will usually operate under value-based purchasing agreements with targeted populations.
2) Develop transition protocols for most at-risk populations;
3) Under State Plan Amendment authority, CLNM expansion for health homes will incorporate the addition of SUD to the eligible population. It has been the intention to add moderate to

severe substance use disorder to the qualifying conditions for Health Homes, and this intention was included in the first SPA. SUD can be added to the existing HHs and will be included in the new SPA for the 2020 roll out. Table one of Appendix M, Attachment E identifies the number of Medicaid beneficiaries with this diagnosis. In addition to having the highest numbers of beneficiaries with SMI, SED, and SUD claims, the recommended counties also have several providers that could serve as Health Homes or participate as part of the provider network. Please see Appendix M, Attachment E for an executive summary of plans.

Summary of actions needed:

Action	Date	Responsible entity
MCOs delegate care coordination to community agencies	1/01/19 - ongoing	HCA, MCOs
CLNM Steering committee to establish new requirements for SUD addition to CLNM HHs	1/01/19 – 6/31/19	HCA, CYFD, MCOs
Submit health home SPA to CMS	7/01/19 – 7/01/20	HCA
Solicit potential providers in 13 targeted counties (see Appendix M, Attachment E for the targeted expansion counties)	TBD	HCA
Evaluate potential health home applications	TBD	HCA, CYFD, MCOs,
Educate applicants on health home requirements and provision of additional services expected.	TBD	HCA, CYFD, MCOs
Develop reimbursement per facility	TBD	HCA
Activate HH in 13 counties	1/01/2021	HCA, CYFD
Repeat above steps and activate all remaining counties for Health Homes	1/01/2022	HCA, CYFD

Attachment A: Opioid Treatment Program Initiation Process

Attachment B: Best practices for substance use detoxification by UNM/CBHTR

Attachment C: Utilization Management Review Tool

Attachment D: New Mexico Gaps Analysis

Attachment E: CareLink New Mexico Health Home Expansion Plan

Attachment F: Information Technology Plan

ATTACHMENT H.
SUD Implementation Plan Protocol
SUD Health Information Technology (Health IT)

SUD Health Information Technology (Health IT). The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, will be included as a section of the state's "Implementation Plan" (see STC 6.26) to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support member health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

a. The SUD Health IT section of the Implementation plan will include implementation milestones and dates for achieving them.
b. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.
c. The SUD Health IT Plan will describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP)[1]
d. The SUD Health IT Plan will address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
e. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[3]
g. In developing the Health IT Plan, states shall use the following resources.
    i. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."
    ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and

Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

h. The state will include in its Monitoring Protocol (see STC 14.5) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or state defined metrics to be approved in advance by CMS.

i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 14.5).

j. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable state procurements (e.g., including managed care contracts) that are associated with this demonstration.

i. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

ii. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

ATTACHMENT I
Pre-Tenancy/Tenancy Services

Pre-Tenancy Services
• Assisting the member with identifying preferences related to housing (e.g., type, location, living along or with someone else, identifying a roommate, accommodations needed, or other important preferences). • Assisting the member to develop a housing support plan based on the functional needs assessment, including establishing measurable goals(s) as part of the overall person-centered plan. • Developing a crisis plan, which must identify prevention and early intervention services if housing is jeopardized. • Assisting the member with housing application and selection process, including filling out housing applications and obtaining and submitting appropriate documentation. • The CPSW will provide members tenancy orientation training including assistance in budgeting for housing/living expenses, assistance in establishing credit and in understanding, assistance in the process of securing necessary household supplies, ensuring a safe living environment, and meeting obligations of tenancy. • Supporting members in the development of independent living skills, such as skills coaching, financial counseling and communication.
Tenancy Services
• Assisting the member with early identification of issues that undermine housing stability, including member behaviors and housing safety. • Coaching to the member about relationship with neighbors and property owners and tenancy compliance. • Connecting the member to education and training on tenant and property owner roles, rights and responsibilities. • Assisting the member in resolving tenancy issues that help the member improve his or her conflict resolution skills, coaching, role-playing communication strategies targeted towards resolving disputes with property owners and neighbors, address biopsychosocial behaviors that put housing at risk, and provide ongoing support with activities related to household management. • Assisting the member to review, update and modify his or her housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. • Assisting the member in linking to available community resources responsible for maintaining housing.

ATTACHMENT J
Reserved for SMI/SED Implementation Plan

ATTACHMENT K
Reentry Demonstration Initiative Implementation Plan (Reserved)

ATTACHMENT L
Reentry Demonstration Initiative Reinvestment Plan (Reserved)

ATTACHMENT M
HRSN Implementation Plan (Reserved)

ATTACHMENT N
Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services Protocol (Reserved)

ATTACHMENT O
Provider Rate Increase Attestation Table (Reserved)