CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11W 00285/6

TITLE: Centennial Care 2.0 Medicaid 1115 Demonstration

AWARDEE: New Mexico Human Services Department

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Centennial Care 2.0 Medicaid 1115 Demonstration (hereinafter "demonstration") to enable the New Mexico Human Services Department (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 will begin January 1, 2019 and expire December 31, 2023, unless otherwise specified. Implementation of the demonstration may begin January 1, 2019 unless otherwise specified. This demonstration is approved through December 31, 2023.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. Native American Participation and Protection
VI. Demonstration Programs and Benefits
VII. Member Engagement and Cost Sharing
VIII. Delivery System
IX. Safety Net Care Pool
X. General Financial Requirements
XI. Monitoring Budget Neutrality for the Demonstration
XII. General Reporting Requirements
XIII. Evaluation of the Demonstration
XIV. 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.	Quarterly Report Content and Format
Attachment B.	Centennial Care 2.0 Community Benefit Definitions and Limits
Attachment C.	Centennial Home Visiting Pilot Services
Attachment D.	SUD Continuum of Care
Attachment E.	Hospitals Eligible for the Safety Net Care Pool (SNCP) Payments and Initial Allocation of Uncompensated Care (UC) Funding for UC pool
Attachment F.	UC Payment Application Template
Attachment G.	Measures for the Hospital Quality Improvement Incentive (HQII) Pool
Attachment H.	HQII Allocation and Payment Methodology
Attachment I.	UCC Pool Payment Tool
Attachment J.	Developing the Evaluation Design
Attachment K.	Preparing the Interim and Summative Evaluation Reports
Attachment L.	SUD Health Information Technology (Health IT)
Attachment M.	SUD Implementation Plan Protocol
Attachment N.	SUD Monitoring Protocol
Attachment O.	Pre-Tenancy/Tenancy Services
Attachment P.	HQII Transition Plan

II. PROGRAM DESCRIPTION AND OBJECTIVES

In the extension of this demonstration for New Mexico's Medicaid managed care program, known as Centennial Care 2.0, 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 2.0 features an integrated, comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care (including pharmacy), behavioral health services, institutional services and home and community-based services (HCBS).

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) expand 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.

III. GENERAL PROGRAM REQUIREMENTS

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, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Section 1557 of the Patient Protection and Affordable Care Act (ACA).

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in 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. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program 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 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.

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. 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.
    b. If mandated changes in the federal law require state legislation, 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.

5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments 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 may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs, but may work in conjunction with the demonstration; however, these STCs may define or articulate limitations that are not identified in the Medicaid state plan.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, 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. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

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 reports and other deliverables in a timely fashion according to the deadlines specified herein. 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 9, 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 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. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, if necessary; and
    e. Updates to existing demonstration reporting and quality and evaluation plans, including 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.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, if the state intends to request a demonstration extension under section 1115(a) of the Act, the state must submit the extension application no later than 12 months prior to the expiration date of the demonstration. The Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at CFR section 431.412(c) or a phase-out plan consistent with the requirements of STC 10.

9. **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.

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

10. **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 phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

       The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 calendar days after CMS approval of the phase-out plan.

b. 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 administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

13. **Withdrawal of 1115(a) Authority.** CMS reserves the right to withdraw waiver 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. 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' 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 and administrative costs of disenrolling participants.

14. **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.

15. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the list of waiver or expenditure authorities.

16. **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.

17. **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 Medicaid program – including public benefit or service programs; procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to those 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).

IV. ELIGIBILITY AND ENROLLMENT

18. **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 Centennial Care 2.0. Table 2 describes the optional state plan populations included in Centennial Care 2.0. 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 Centennial Care 2.0 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 79).

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 Centennial Care 2.0, and Column E describes the budget neutrality MEG under which expenditures for the population will be reported (as described further in STC 79).

Table 1: Mandatory State Plan Populations

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

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
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)(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 Centennial Care 2.0?	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)
	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)

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
	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 1619(b)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
	Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard 1902(a)(10)(A)(ii)(V) 1905(a) 42 CFR 435.236	NF LOC: Included PACE: Excluded ICF/IID: Excluded	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 Centennial Care 2.0?	D. MEG for Budget Neutrality
Optional Targeted Low Income Children	Optional group for uninsured children under age 6 1902(a)(10)(A)(ii)(XIV) 42 CFR 435.229 Note: If sufficient Title XXI allotment is available as described under STC 89, uninsured individuals in this eligibility group are funded through the Title XXI allotment. Insured individuals in this eligibility group are funded through Title XIX, and if Title XXI funds are exhausted as described in STC 90, then all individuals in	No	If Title XIX: TANF and Related If Title XXI: MCHIP Children

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on Centennial Care 2.0?	D. MEG for Budget Neutrality
	this eligibility group are funded through Title XIX.		
Optional Reasonable Classification of Children	Optional group for children under age 19 not eligible for a mandatory group §§1902(a)(10)(A)(ii)(I) and (IV) 42 CFR 435.222	No	TANF and Related
Independent Foster Care Adolescents	Individuals under age 21 who were in foster care on their 18th birthday 1902(a)(10)(A)(ii)(XVII) 42 CFR 435.226	No	TANF and Related
Out-of-State Former Foster Care Children	Individuals under age 26 who were in foster care in a state other than New Mexico or tribe in such other state when they aged out of foster care 1902(a)(10)(A)(ii)(XX) 42 CFR 435.218	No	TANF and Related
Aged, Blind, and Disabled	Working disabled Individuals 1902(A)(10)(A)(ii)(XIII)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Institutionalized Individuals	Individuals who would be eligible for SSI cash if not in an institution 1902(a)(10)(A)(ii)(IV) 1905(a) 42 CFR 435.211	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Breast and Cervical Cancer Program	Uninsured individuals under 65 screened and found to need treatment for breast or cervical cancer	No	TANF and Related

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on Centennial Care 2.0?	D. MEG for Budget Neutrality
	1902(a)(10)(A)(ii)(XVIII) 42 CFR 435.213		
Home and Community Based 1915(c) Waivers that are continuing outside the demonstration (217 group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Act, through the state's 1915(c) Developmentally Disabled waiver	1915(c) waiver services are not provided through Centennial Care 2.0	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Act, through the state's 1915(c) Medically Fragile waiver.	1915(c) waiver services are not provided through Centennial Care 2.0	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Home and Community Based 1915(c) Waivers that were transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who would only be eligible in an institution in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Social	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

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

Table 3: Demonstration Expansion Populations

A. Expansion Medicaid Eligibility Group	B. Description Statutory/ Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care 2.0?	E. MEG for Budget Neutrality
Home and Community Based 1915(c) Waivers that were transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who would only be eligible in an institution in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Social Security Act, if the state had not eliminated its 1915(c) AIDS, Colts, and Mi Via-NF waivers	Income test: 300% of Federal Benefit Rate with Nursing Facility Level of Care determination. Resource test: $2000	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Expansion Medicaid Eligibility Group	B. Description Statutory/ Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care 2.0?	E. MEG for Budget Neutrality
	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.2276 and section 1924 of the Act	Income test: 300% of Federal Benefit Rate with Nursing Facility Level of Care determination. Resource test: $2000	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

19. **Populations Excluded from Centennial Care 2.0.** 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); 1905(p)
    c. Qualified Individuals (QIs) – 1902(a)(10)(E)(iv); 1905(p)
    d. Qualified Disabled Working Individuals (QDWIs)– 1902(a)(10)(E)(iii); 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. DD waiver participants for HCBS[1]
    i. Medically fragile waiver participants for HCBS[2]
    j. Except as provided in STC 58, individuals receiving family planning-only benefits through the Family Planning category of eligibility

20. **Eligibility and Post Eligibility Treatment of Income for Centennial Care 2.0 Members who are Institutionalized.** Except as specified in STC 19 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.

21. **Regular and Post-Eligibility Treatment of Income for Centennial Care 2.0 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.

    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.

22. **Eligibility for Out of State Former Foster Care Youth.** Individuals eligible as "former foster care youth" are defined as individuals under age 26 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 federal 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.

23. **Retroactive Eligibility.** The state will phase out the retroactive period of eligibility by

[1] Acute care and behavioral health services will be received through Centennial Care 2.0 managed care
[2] Acute care and behavioral health services will be received through Centennial Care 2.0 managed care

reducing it from three months to one month in calendar year 2019 (such that medical assistance can be available starting in the month before the month in which the member applies), for all members covered under the managed care demonstration program, with the exception of individuals eligible for Institutional Care (IC) categories of eligibility, pregnant women (including during the 60-day postpartum period beginning on the last day of the pregnancy), infants under age 1, and individuals under age 19 will continue to be eligible for retroactive coverage starting as early as the third month before the month in which the member applies.

The waiver of retroactive eligibility will expire no later than February 7, 2020. Beginning February 8, 2020, New Mexico must again provide three months of retroactive eligibility for all members in the demonstration, as required under section 1902(a)(34) of the Act and 42 CFR § 435.915.

24. **Mandatory Enrollment.** With the exception of American Indian/Alaska Native (AI/AN) individuals described in STC 32, the state may mandatorily enroll members served through this demonstration in MCOs to receive benefits pursuant to Section V 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.

25. **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**.**

26. **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 and who must select a new MCO under Centennial Care 2.0 because their prior MCO is not providing coverage under Centennial Care 2.0, as well any individuals receiving benefits under fee for service (FFS), must have 60 days to enroll in a Centennial Care 2.0 MCO.
    b. AI/AN individuals. Consistent with STC 32, the state must not require AI/AN individuals to enroll with a Centennial Care 2.0 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 Centennial Care 2.0 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 Centennial Care 2.0 MCOs, and have an existing care plan, the state must require each outgoing MCO (the sending plan) to share the following information with the new Centennial Care 2.0 MCO (the

receiving plan) no less than 20 days prior to the initial transition to allow sufficient time for transition planning:

1. Transfer the care plan to the receiving plan (as applicable).
2. Send a report to the receiving plan for each enrollee who is expected to be using inpatient care and/or prenatal care at the time of initial transition.
3. Send the name of the NF in which the member is a resident, or is expected to be a resident, as well as service plan information for all members using HCBS, at the time of initial transition to the receiving plan, where applicable to the member.

27. 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.

28. 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.

29. 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).

V. NATIVE AMERICAN PARTICIPATION AND CONSULTATION PROCESS

30. 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 Centennial Care 2.0.

31. 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 Centennial 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 Centennial Care 2.0 MCOs on issues related to program service delivery and operations. The state must require MCOs to solicit advice and guidance from the (NAAB) regarding Centennial Care 2.0 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 114.
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 114.

32. **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 a 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.

33. **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.

34. **Expand Opportunities.** The state must continue to engage the Tribes, Tribal providers and Centennial Care 2.0 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.

35. **Ongoing evaluation and continuous improvement.** The state must closely monitor and evaluate the experience of AI/AN who are enrolled in Centennial Care 2.0 as part of the demonstration evaluation and demonstration annual reports, described in STC 114.

VI. DEMONSTRATION PROGRAM AND BENEFITS

36. **Centennial Care 2.0 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.

37. **Home and Community-Based Services.** Under Centennial Care 2.0, enrollees who meet the NF LOC criteria will be eligible for the CB in Centennial Care 2.0. Enrollees who are eligible for Medicaid under the state plan (i.e., described as a mandatory or optional state plan population in STC 18) 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 18.

    The CB service categories (and applicable limits) are listed below and further defined in Attachment B. 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 Centennial Care 2.0

Community Benefit Services Included Under Centennial Care 2.0			
	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 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
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 after December 31, 2018.

38. **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 38). 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.

39. **Community Benefit Service Planning Transition.** The state must require the MCOs, through contract requirements, prioritize the care planning process for those individuals whose care plans expire in the first 90 days of Centennial Care 2.0 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.

40. **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 Centennial Care 2.0 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 grievance and appeals process and the state's fair hearing process. The MCO's NF LOC assessment function will be performed by a 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.

41. **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.

42. **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 5,789.

43. **Integration of Section 1915(c) Waiver Assurances and Program Requirements into Centennial Care 2.0.** The state must implement Centennial Care 2.0 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. For HCBS, the state must have an approved Quality Improvement Strategy and is required to develop and measure performance indicators for the following waiver assurances:

        1. Administrative Authority: A performance measure must be developed and tracked for any authority that the State Medicaid Agency (SMA) delegates to another agency, unless already captured in another performance measure.

        2. LOC: The state must demonstrate and provide a performance measure for the following:
            i. 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.

        3. 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.

iii. The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to providers in accordance with the waiver.

4. Service Plan: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for
   i. Choice of waiver services and providers,
   ii. Service plans address all assessed needs and personal goals, and
   iii. Services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

5. 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 that, on an ongoing basis, seeks to prevent, identify, track, and address instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, 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 waiver.

b. Financial Accountability: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the HCBS program. The state must report on performance measures verifying the tracking of claims are coded and paid for in accordance for services rendered. In addition, the state must verify that rates remain consistent with the approved rate methodology during the life of the demonstration.

c. 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.

   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.

d. 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.
   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.

e. 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.

f. The state will submit a report to CMS which includes evidence on the status of the HCBS quality assurances and measures 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. This information can be captured in the 1115 Annual Report detailed in STC 108.

g. The state must also report annually the deficiencies found during the monitoring and evaluation of the HCBS waiver 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 (STC 114). Submission is due no later than 6 months following the end of the demonstration year (DY).

h. The state must report annually the actual number of unduplicated individuals served and

the estimated number of individuals for the following year. Submission due on December 31st of the DY.

i. Conflict of Interest: The state assures that the entity that authorizes the services is external to the agency or agencies that provide the HCB 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.

j. 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).

k. The state must assure compliance with the characteristics of HCBS settings as described in 1915(c) regulations in accordance with implementation/effective dates as published in the Federal Register.

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

44. Conflict of Interest. The SMA must ensure: a) there are clear guidelines for avoiding conflicts of interest for contracted entities participating in the service planning process so that these entities offer choices to the participant regarding the services and supports they receive and from available alternatives; b) a process exists for the participant to request changes to the participant's comprehensive care plan; and c) each participant has freedom of choice between alternative home and community-based services and settings.

45. Option for Participant Direction. Centennial Care 2.0 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.
    1. *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.
    2. *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.
e. Members transitioning from ABCB to SDCB may receive one-time funding of up to $2000.00 to be used for items that are identified in the CCP as essential for successful management of self-directed services, as outlined in Attachment B.
f. Existing SDCB members who, at implementation of Centennial Care 2.0, have budgets that exceed the service limits applicable under Centennial Care 2.0 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 Centennial Care service limits. Members newly receiving SDCB will be subject to the Centennial Care 2.0 service limitations beginning on January 1, 2019. See Attachment B for details regarding service limits.
g. 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.

h. 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.

46. **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 and 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 pre-tenancy and tenancy referred to in STC 49.

47. **Community Interveners.** Deaf and blind individuals enrolled in Centennial Care 2.0 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 Centennial Care 2.0 MCOs and the costs associated with the Community Interveners may be included in capitation payments from the state to the Centennial Care 2.0 MCO. The state will continue supporting and encouraging the use of Community Interveners.

48. **Centennial Home Visiting Pilot Program: Evidenced-based Home Visiting Services Pilot Program.** In collaboration with New Mexico Children, Youth and Families Department (CYFD) and New Mexico Department of Health (DOH), the state must require the Centennial Care 2.0 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 women 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 Centennial Care 2.0 MCOs. Additional program details, including services and provider qualifications, are in Attachment C. The state will be developing pilot program criteria for screening of potential individuals and submit these criteria for CMS' review and approval 60 calendar days prior to implementation of the pilot program.

The Centennial Home Visiting (CHV) pilot program will align with two CMS approved evidence-based early childhood home visiting delivery models focused on the health of pregnant women and their infants and promote parenting skills and child development. The two programs are:

a. Nurse Family Partnership (NFP): The NFP is designed to reinforce maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. The pilot program will adhere to the NFP national program standards in services delivery to eligible pregnant women. The home visiting services will end once the child reaches two (2) years of age.
b. Parents as Teachers (PAT): The goals of the PAT program are to provide parents with child development knowledge and parenting support, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness. The PAT pilot program will adhere to the PAT national model and curriculum and serve families beginning during pregnancy and up to when the child reaches five (5) years of age or enters kindergarten, whichever is earlier.

If the state chooses to incorporate additional evidence-based models into the demonstration, the state will have to submit a demonstration amendment as per STC 7.

49. Peer Delivered Pre-Tenancy and Tenancy Services. The aim of 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 O. The state will use its existing program infrastructure and network of provider agencies associated with the Linkages Supportive Housing Program to deliver pre-tenancy and tenancy services. Linkages providers will be expected to utilize certified peer support workers (CPSWs), who have similar lived experience, are on a solid footing in their recovery, and are employed by Linkages providers 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.

a. Pre-Tenancy and Tenancy Services will be made available to a range of 180 to 250 of demonstration members with Serious Mental Illness (SMI) annually.

b. Pre-Tenancy and Tenancy Services will be limited to areas where the Linkages Supportive Housing Program operates.
c. As a part of its approved Quality Improvement Strategy, the state must develop performance measures to address the following requirements of the pre-tenancy and tenancy Services:
    1. Service plans that:
        i. address assessed needs of participants;
        ii. are updated annually; and
        iii. document choice of services and providers.
    2. Eligibility Requirements: The state will ensure that:
        i. 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. 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.
    3. Providers meet required qualifications.
    4. The SMA retains authority and responsibility for program operations and oversight by MCOs as required in the MCO contract.
    5. The SMA maintains financial accountability through payment of claims by MCOs for services that are authorized and furnished to participants by qualified providers.
d. The state must report annually the actual number of unduplicated individuals served and the estimated number of individuals for the following year. Submission due at the end of the DY.
e. To the extent housing services are available and accessible by a beneficiary under other programs, those services that might otherwise be available through this demonstration will not be authorized for that particular beneficiary. The pre-tenancy and tenancy services authorized under this demonstration, however, could cover connecting the member to such program and helping them secure housing through that program.

50. Medicaid Authorities Transition. During the demonstration period, the state must conduct an evaluation to assess if portions of the demonstration could be transitioned to 1915(c) and 1915(i) authorities and how such transitions are consistent with the states program goals including consideration for the impact to services, members, waiver allocation process and budget implications. Pending the outcome of the evaluation, there will be a five-year transition plan as follows:

a. **January 2019 through December 2021** – CMS and the state conduct joint transition planning activities in order to identify which portions can be transferred.
b. **January 2022 through December 2022** – The state must develop and submit 1915(c) and 1915(i) authorities for the portions to be transitioned.
c. **January 2023 through December 2023** – Applications are under review.
d. **January 2024**: 1915(c) waivers and 1915(i) state plan in effect.

51. 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 Institution for Mental Diseases (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 53 below, 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 while also improving care coordination and care for comorbid physical and mental health conditions.

The coverage of OUD/SUD treatment services and withdrawal management during short-term residential and inpatient stays in IMDs will expand the state's current 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

* New Mexico is developing a SPA to cover Table 5 services marked with an asterisk under Medicaid state plan authority. The services will have a January 1, 2019 effective date contingent

on CMS SPA approval. When indicated as being covered under the state plan, such services are also included as part of the Alternative Benefit Plan (ABP) for the Adult Group, and are incorporated into the ABP state plan.

52. SUD Implementation Plan Protocol. The state must submit an OUD/SUD Implementation Plan Protocol within 90 calendar days after approval of the SUD program under this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the SUD Implementation Plan Protocol. Once approved, the SUD Implementation Plan Protocol will be incorporated into the STCs, as Attachment M, and once incorporated, may be altered only with CMS approval. After approval of the SUD Implementation Plan Protocol, FFP will be available prospectively, not retrospectively. Failure to submit a SUD Implementation Plan Protocol 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 OUD/SUD 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. At a minimum, the SUD Implementation Plan Protocol must describe the strategic approach and 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 an accredited and state certified organization, pursuant to the residential service provider qualifications described in NMAC 8.321.2 and the Behavioral Health Policy and Billing Manual. The state must establish residential treatment provider qualifications in a pre-enrollment certification by the state based upon meeting accrediting body qualifications and ASAM standards for staffing credentials, hours of clinical care and types of clinical service established in the regulations in NMAC 8.321.2 referred to above within 12-24 months of OUD/SUD program demonstration approval. The managed care contracts and credentialing policies along with prior authorization practices offers further guidance and monitoring of adherence to SUD specific program standards.

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 SUD program 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 SUD program demonstration approval;
g. **Sufficient Provider Capacity at each LOC including MAT for OUD:** An assessment of the availability of providers in the key 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 SUD program demonstration approval;
h. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and 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;
i. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 57 or Attachment L; and
j. **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.

53. SUD Monitoring Protocol. The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of the SUD component of this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment N. At a minimum, the SUD Monitoring Protocol will include reporting relevant to each of the program implementation areas listed in STC 53. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 53 of the demonstration. In addition, the SUD Monitoring Protocol will identify a baseline and a target to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the Monitoring Protocol will be reported via the quarterly and annual monitoring reports.

54. Mid-Point Assessment. The state must conduct an independent mid-point assessment by June 1, 2022. The state must require that the assessor collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, members, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan Protocol, and toward meeting the targets for performance measures as

approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The mid-point assessment will also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a 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. A copy of the report will be provided to CMS. CMS will be briefed on the report. For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Plan Protocol and SUD Monitoring Plan Protocols for ameliorating these risks subject to CMS approval.

55. **SUD Evaluation.** The OUD/SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as listed in sections XII General Reporting Requirements and XIII Evaluation of the Demonstration of the STCs.

56. **SUD Evaluation Design.** The draft Evaluation Design must be developed in accordance with Attachment J (Developing the Evaluation Design) of these STCs. The state must submit, for CMS's comment and approval, a revision to the Evaluation Design to include the SUD program with implementation timeline, no later than one hundred eighty (180) days after the effective date of these amended STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state must use an independent evaluator to develop the draft Evaluation Design.
    a. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. 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 within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. 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.
    b. **Evaluation Questions and Hypotheses Specific to OUD/SUD Program.** Consistent with Attachments J and K (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets 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).

57. 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 "SUD Implementation Plan Protocol" (see STC 52) 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 SUD Health IT Plan will also be used to identify areas of SUD health IT ecosystem improvement.

a. The SUD Health IT section of the SUD Implementation Plan Protocol will include implementation milestones and dates for achieving them (see Attachment L).
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)[3]
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.[4] 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.[5]
g. In developing the Health IT Plan, states should use the following resources.
    1. 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."

[3] 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.
[4] *Ibid*.
[5] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

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. 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 Plan (see STC 53) an approach to monitoring its SUD Health IT Plan which will include performance 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 114).

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.
   1. 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.
   2. 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.

58. Family Planning Services. The Family Planning benefit package is limited to reproductive health care, contraceptives and related services. Beginning on January 1, 2019, the state limits family planning-only eligibility to otherwise eligible men and women 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.

VII. MEMBER ENGAGEMENT

59. Member Rewards Program Defined. The Centennial 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 Centennial Rewards account, which is managed by the MCO. Earned credits may be used for health-related expenditures as approved under the Centennial Rewards Program. Additional details regarding the rewards program not found in these STCs, may be found the Centennial Rewards Guide.

a. **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 (Centennial 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 Centennial Rewards catalog must specify the cost (in credits) of each item. The credit amount available to participating members in their Centennial 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 Centennial Rewards program and will receive applicable credits in his or her Centennial Rewards account. The state must require the MCO to timely post earned credits into the Centennial 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.

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

   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.

b. **Participants Earning Member Rewards.** The state must ensure that all enrollees in a Centennial Care 2.0 plan must be eligible to voluntarily participate in activities to earn Centennial Rewards points, and to redeem such points for qualifying health-related items, for the duration of their enrollment.

Member Access to Credits. The state must require the MCO provide access to an individual's earned credits in his or her Centennial Rewards account for one year from the date of last enrollment, for an individual who is no longer enrolled in Centennial Care 2.0 (either due to loss of eligibility or change of eligibility to an eligibility group not authorized to participate in Centennial Care 2.0) but who had a positive balance in his or her account when most recently enrolled, unless the demonstration and/or the Centennial Rewards program is sooner terminated. If an individual regains eligibility to participate in Centennial Care 2.0 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.

VIII. DELIVERY SYSTEM

Centennial Care 2.0 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.

60. 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.

61. Managed Care Benefit Package. Individuals enrolled in Centennial Care 2.0 MCOs must receive the benefits as identified in Section VI of the STCs.

62. 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.

63. 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).

64. Care Coordination in Centennial Care 2.0.

a. The state must require MCO contracts provide comprehensive care coordination to members who are assessed to need either state-defined Level 2 or Level 3 care coordination and in accordance with 42 CFR 438.208. The state must ensure that MCOs assesses new members using a standardized health risk assessment, and if a member is identified as needing care coordination, conducts a comprehensive needs assessment and assigns a care coordinator who must conduct care coordination activities at specific intervals as defined in the MCO contract. Such comprehensive care coordination is continuous and must include at least the following:
    1. Assessing the member's comprehensive physical, behavioral, functional, psychosocial, and LTC needs;
    2. Identifying the medical, behavioral and LTC services and other social support services and assistance (e.g., housing, transportation or income assistance) necessary to meet identified needs;
    3. Ensuring members receive services and supports that address their needs and preferences as identified through a comprehensive needs assessment;
    4. Ensuring timely access to, and provision of, ongoing coordination and monitoring of services needed, in accordance with the person-centered service plan, to help each member maintain or improve his or her health status, functional abilities and maximize independence; Facilitating access to other social support services and assistance needed in order to promote each member's health, safety and welfare;

5. Ensuring adequate support for participants who choose to self-direct the CB;
6. Developing and facilitating transition plans for participants who are candidates to transition from an institutional facility to the community; and
7. Ensuring members receive integrated behavioral health, physical health and long-term care services.

b. **Targeted Care Coordination for High Needs Populations.** The state must ensure the MCOs assign dedicated care coordinators that are able to meet the special needs of members in each of the following populations:
   1. Traumatic Brain Injury Members;
   2. Medically Fragile Members receiving case management services through the University of New Mexico;
   3. Individuals with Intellectual Disabilities;
   4. Children and adults with Special Health Care Needs (members having or at risk for chronic physical, developmental, behavioral, or emotional conditions who also require health and health related services);
   5. Members with housing insecurity needs; and
   6. Members with complex behavioral health needs.

c. **Transitions of Care for High-Need Populations.** The state must ensure that the MCOs develop and implement a transition plan that must remain in place for a minimum of 60 days for members transitioning from a higher LOC to a community setting.

d. The state must ensure the following members must receive an additional assessment within seventy-five (75) calendar days of transition to determine if the transition was successful and identify any remaining needs:
   1. Member transitioning from a NF to the community;
   2. Member(s) with special circumstances (including persons not fitting within the criteria listed, but who may have special circumstances such as a patient who is being discharged from hospice services but continues to have home health needs);
   3. Member(s) moving from a higher LOC to a lower LOC;
   4. Member(s) turning twenty-one (21) years of age;
   5. Member(s) changing MCOs while hospitalized;
   6. Member(s) changing MCOs during major organ and tissue transplantation services;
   7. Member(s) changing MCOs while receiving outpatient treatment for significant medical conditions; and/or
   8. Member(s) changing MCOs;
   9. Member(s) moving from a residential placement or institutional facility to a community placement;
   10. Children returning home from a foster care placement;
   11. Member(s) released from incarceration or detention facilities;
   12. Member(s) discharging from a hospital;
   13. Member(s) discharging from out-of-home placements (Accredited residential treatment centers (ARTC), Residential non-accredited Treatment Centers (RTC), Group Homes (GH), Treatment Foster Care (TFC)) and crisis centers related to Behavioral Health treatment; and/or
   14. Member(s) who are preparing to receive out-of-state treatment.

65. **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 Social Security Act.

66. **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 114, the state must also provide CMS with annual reports on the implementation and effectiveness of their Quality Strategy impacting the demonstration.

67. **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 113.

68. **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.

69. **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.

70. **State Operated Call Center.** The state must operate a call center independent of the MCOs for the duration of the demonstration. This can be achieved either by providing the call center directly or through other state contracted entities (e.g. Aging and Disability Resource Centers (ADRCs), Fiscal Intermediary). This entity should be able to help enrollees in making independent decisions about MCO choice, provide access to other state resources and enable enrollees to voice complaints about each of the MCOs independent of the MCOs.

71. **Call Center Response Statistics.** The state must review all statistics at least weekly for the first 180 days of implementation. Data and information regarding call center statistics, including member questions and concerns, must be made available to CMS upon request.

IX. SAFETY NET CARE POOL

The terms and conditions in Section IX apply to the operation of the state's safety net care pools (SNCP), as authorized by Expenditure Authorities 6 and 7.

72. Terms and Conditions Applying to Pools Generally.

a. The non-federal share of pool payments to providers may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. All payments must remain with the provider, and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this STC have not been followed.
b. The state must inform CMS of the funding of all payments from the pools to hospitals through a quarterly payment report, in coordination with the quarterly operational report required by STC 114, to be submitted to CMS within 60 days after the end of each quarter. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-federal share (including health care related taxes, certified public expenditures, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.
c. The state must ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.
d. Each quarter the state makes a pool payment for either pool described in STC 73 and 74 below and claims FFP for such payment, appropriate supporting documentation must be made available for CMS to determine the allowability of the payments. Supporting documentation must include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments must also identify all other funds transferred to such fund making the payment.

73. Uncompensated Care (UC) Pool. The UC Pool itemized in the STC 73(b) table is available in DY 6 to defray the actual uncompensated cost of inpatient and outpatient hospital services provided to Medicaid eligible or uninsured individuals (defined as individuals who have no source of third party coverage). In DYs 7 through 10, the new UC amount will be based on S-10 data using charity care. The UC Pool is available in DYs 7 through 10 to defray the actual uncompensated cost of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to uninsured individuals as charity care by hospitals, as specified at STC 73(c) below, including uninsured full or partial discounts, that provide all or a portion of services free of charge to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association.[6] Expenditures must be claimed in accordance with the methodology described in STC 73(c) below.

[6] Available at http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589.

a. Eligible hospitals. Eligibility for UC pool payments is limited to sole community provider (SCP) hospitals and the state teaching hospital. A full list of eligible hospitals and their number of beds is included in Attachment E.

Eligible hospitals must be divided into groups based on their size, as defined by the number of hospital beds. Total available funding from the UC pool must be divided among the hospital groups, with larger proportions available to the smallest hospitals. The hospital groups and division of funding is included in Attachment E.

b. Annual UC Payment Limits. The state may claim FFP for UC Payments in each DY up to the limits (total computable) described in the table. Any amount not claimed from the UC pool at the end of DY may be allocated to the Hospital Quality Improvement Incentive Pool (HQII) in the next DY.

Demonstration Year	UC Pool (total computable)
DY 6	$68,889,323
DY 7	$0/TBD/S-10
DY 8	$0/TBD/S-10
DY 9	$0/TBD/S-10
DY 10	$0/TBD/S-10

c. UC Payment Methodology

1. All UC payments for DY 7 through 10 are based on uncompensated care costs calculated in accordance with the General DSH Audit and Reporting Protocol, CMS-2198-F. Payments are made each calendar quarter based on a UC Payment Application that contains information reported by each hospital from its Medicare hospital cost report associated with the state's most recent disproportionate share hospital (DSH) audit collection tool, net of any DSH payments received in that fiscal year. Nothing in this STC must require that a hospital not receiving a DSH payment be subject to a DSH audit of its cost report.
2. If the total allocation to any hospital group, as described in STC 73(a) and further defined in Attachment I, exceeds the total amount of UC costs for that group, the balance of funding must be made available to the next group of larger hospitals. Among the hospitals of any specified group UC payments will be distributed in proportion to the UC costs incurred by that group. UC payments must not exceed the amounts specified in STC 75(b).

d. UC Payment Application. To qualify for a UC Payment, a hospital must submit to the state an annual UC Payment Application that will collect cost and payment data on services eligible for reimbursement under the UC Pool. The state may continue using its current UC Payment Application for DY 6; however, in DY 7, if there is any additional S-10 analysis to support a positive increase in UC, the state must submit a revised UC Payment application. The state must submit a revised UC Payment Application template to CMS for review by January 31, 2020 for DY 6. Data collected from the application will form the basis for UC Payments made to individual hospitals, based on expected

unreimbursed uninsured charity care cost, starting with DY 7. The UC Payment Application template must be approved by CMS prior to use, and will become Attachment F upon approval. Data collected from the application will form the basis for UC Payments made to individual hospitals. The state must require hospitals to report data in a manner that is consistent with the Medicare 2552-10 cost report.

1. Hospitals are required to submit their UC Payment Applications to the state by December 31st of each year, in order to qualify for a UC Payment for the DY that begins on January 1st of the following year.
2. Cost and payment data included on the application must be based on schedule S-10 of Medicaid 2552-10 cost report. The state must trend the data to model costs incurred in the year in which payments are to be made. Subsequent DY application will be used to reconcile estimates for prior years. For example, uncompensated care costs data from a DY 8 application will be used to determine the actual uncompensated care for DY 6 UC Payments for a qualifying hospital. Any overpayments identified in the reconciliation process that occurred in a prior year must be recouped from the provider. The state must reallocate the recouped funds to hospitals that received UC pool payments that were less than their uncompensated costs in the same time period. If the recouped amounts are not reallocated, the state must return the associated FFP to CMS.
3. The state must not claim FFP for UC payments to a hospital until it has received a completed UC Application from that hospital, using the CMS approved Application Template.

e. All applicable inpatient and outpatient hospital UC payments received by a hospital count as title XIX revenue, and must be included as offsetting revenue in the state's annual DSH audit reports. Providers receiving both DSH and UC Payments cannot receive total payments under the state plan, DSH, and the UC Pool (related to inpatient and outpatient hospital services) that exceed the hospital's total eligible uncompensated costs. All reimbursement must be made in accordance with CMS approved cost claiming protocols that are consistent with the Medicare 2552-10 cost report. If a DSH audit reveals that a hospital has received Medicaid payments (inclusive of UC Payments) that exceeded its allowable uncompensated cost, the excess payment must be reclaimed from the hospital. The state may reallocate the recouped funds to hospitals that received UC pool or DSH payments that were less than their uncompensated costs in the same time period. If the recouped amounts are not reallocated, the state must return the associated FFP to CMS.

f. UC Payment Protocol**.** The UC Payment Protocol, also known as the funding and reimbursement protocol, establishes rules and guidelines for the state to claim FFP for UC Payments. The approved UC Payment Protocol is appended into these STCs as Attachment F. By January 31, 2020, the state must submit for CMS approval an addendum to the funding and reimbursement protocol that will establish rules and guidelines for the State to claim FFP for UC payments beginning in DY 7. CMS and the state will work collaboratively with the expectation of CMS approval of the protocol within 90 calendar days after it receives the addendum. The state must not claim FFP for any UC Payments for DY 7 or later until a UC Protocol addendum has been submitted to and approved by CMS. The UC Payment Protocol addendum must include precise definitions of eligible uncompensated care costs (consistent with the Medicare cost

reporting principles and revenues that must be included in the calculation of uncompensated care cost for the purpose of reconciling UC payments to unreimbursed uninsured charity care cost). The protocol must also identify the allowable source documents to support costs; it must include detailed instructions regarding the calculation and documentation of eligible costs, the tool used by the state and hospitals to apply for UC Payments, and a timetable and reconciliation of payments against actual care cost documentation. This process must align the application process (based on prior cost periods) to the reconciliation process (using the application costs from subsequent years to reconcile earlier payments). The protocol must contain not only allowable costs and revenues; it must also indicate the twelve (12) month period for which the costs will apply.

g. Reporting Requirements for UC Payments. The state must submit to CMS two reports related to the amount of UC Payments made from the UC Pool per DY. The reporting requirements are as follows:
   1. By March 31st of each DY, beginning in DY 6, the state must provide the following information to CMS:
      a. The UC payment applications submitted by eligible providers; and
      b. A chart of estimated UC Payments to each provider for a DY.
   2. Within ninety (90) days after the end of each DY, the state must provide the following information to CMS:
      a. The UC Payment applications submitted by eligible providers; and
      b. A chart of actual UC payments to each provider for the previous DY.

74. Hospital Quality Improvement Incentive (HQII) Pool. The HQII Pool is available in DY 6 through 8 to incentivize hospitals' efforts to meaningfully improve the health and quality of care of the Medicaid and uninsured individuals that they serve. Each hospital's HQII activities must be consistent with the state's quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without harm to individuals, families or communities).

The requirements for the HQII pool are outlined below and additional information is provided in Attachment E (Hospitals Eligible for Safety Net Care Pool (SNCP) Payments and Initial Allocation of Uncompensated Care (UC) Funding for UC Pool), Attachment G (HQII Outcome Measures), and Attachment H (HQII Allocation and Payment Methodology).

a. Eligible hospitals. Hospitals that may receive HQII pool payments are those listed in Attachment E.
b. Outcome measures: The outcome measures for HQII must be nationally validated measures of patients' clinical events or health status that reflect areas of high need for the state Medicaid and uninsured population. Process measures or subjective measures on patient experience are not permitted if there are more appropriate clinical outcome measures available. The complete list of outcome measures is described in Attachment G.

The outcome measures are divided into two domains:

1. *Domain 1 - Urgent Improvements in Care.* Critical patient safety and quality measures for areas of widespread need where there are opportunities to achieve better care for individuals within 5 years and "raise the floor" for all participating hospitals.
2. *Domain 2 - Population-focused Improvements.* Measures of prevention and improved care delivery for the highest burden conditions in the Medicaid and uninsured population where there are opportunities to achieve better health for the population and lower cost through improvement at select hospitals that elect to "raise the bar" by selecting additional HQII outcome measures.

Incentive payments from hospitals' initial HQII allocations must be directed towards outcome measures in domain 1 and incentive payments from any reallocation of unused HQII funding (as described in STC 74(d)(i) below) must be directed towards outcomes measures in domain 2.

c. Performance levels. By no later than April 1, 2019, the state must identify high performance levels (HPL) and minimum performance levels (MPL) for each outcome measure, which must be used by hospitals to help set targets for improvement. HPLs and MPLs must be based on the higher of state and national benchmarks according to a methodology agreed to by the state and CMS. In general, HPLs must be set to the 90th percentile of the state or national performance (whichever is greater) and MPLs must be set to the 25th percentile of state or national aggregate performance (whichever is greater).

   On or before April 1, 2019, the state must propose technical modifications to the standard measures described in Attachment G that are necessary for the state to set appropriate targets and the addition or removal of measures in order to better align with community needs identified by stakeholders. Specifically, the state will review available data about the current performance of the HQII hospitals to ensure that the HQII measures reflect areas of high need in the state and that the hospitals' current performance on the measures does not exceed the high performance level.

d. HQII Allocation and Payment Methodology. By July 1, 2019, the state must submit an Allocation and Payment Methodology (APM) document that describes the method for allocating HQII pool funds between eligible hospitals, the standard target setting methodology for all hospitals, the monitoring and oversight of the achievement of HQII milestones, a data collection and analysis strategy that supports accurate measurement, calculation and assessment, and any additional operational requirements needed in order to monitor and evaluate the demonstration and make HQII payments. Upon CMS approval, this APM document must become Attachment H of the STCs.
   1. *Allocations.* The HQII funds available for allocation to providers is the sum of the initial pool amount (described in STC 75) plus any additional UC funds made available as described in STC 74(b) above. The APM document must describe a methodology to distribute the initial allocation for each provider opting to participate in the HQII pool. The allocation methodology must be based primarily on the hospital's volume of Medicaid and uninsured patients and not based on the state's

historic levels of supplemental payments.

All eligible providers must be given one opportunity in DY 6 to use their initial allocation to participate in HQII. All participating hospitals must report, and have their payments be based on their performance on all measures listed in domain 1 (Urgent Improvements in Care) of Attachment G. If a hospital elects not to participate, the state must reallocate the hospital's HQII allocation to participating hospitals to receive additional incentive payments for reporting and achieving improvement on all measures listed in domain 2 (Population-focused Improvements) of Attachment G.

2. *Improvement targets*. For each outcome measure, improvement targets must be set in DY 6, 7, and 8 that progressively close at least 10 percent of the gap between the provider's current performance and the high performance level (as defined in STC 74(c) above).

   The state must consider any adjustments to the target setting methodology that are appropriate for smaller hospitals, as defined by the number of beds, including but not limited to the possibility of an aggregate performance target for some or all hospitals in order to stabilize the sample size. Any adjustments to the target setting methodology must be proposed in the APM document and approved by CMS.
3. *Incentive payment amount*. The total amount of funding over DY 6-8 for each outcome measure must be described in the APM document and must be set at a level commensurate with the community need and the level of effort required to achieve the target goal. HQII funding for each outcome measure must be divided among DYs in the same proportion as the initial HQII allocation.
4. *Payment oversight.* The APM document must describe the process for making payments based on achievement of milestones, including the option for partial payment for partial achievement of an improvement target.

   The state must review achievement of HQII milestones before making HQII payments and must share HQII reporting results on its state website. Hospitals' reports must contain sufficient data and documentation to allow the state and CMS to determine if the hospital has fully met the specified metric, and hospitals must have available for review by the state or CMS, upon request, all supporting data and back-up documentation.

   FFP must be available only for payments related to achievement on outcome measures, as defined by the APM document. Hospitals must submit sufficient documentation to allow the state and CMS to determine if it has fully met the specified metric, and the state must provide sufficient documentation to support claims made for FFP on the CMS-64.9 Waiver forms.
5. *Annual reporting template.* The state must develop a standard annual reporting template for all HQII hospitals that includes information about hospital interventions, their challenges, mid-course corrections and successes, along with a data strategy for aggregating reporting from hospitals into reports that will be used for oversight by CMS and shared learning among all hospitals.

e. HQII Mid-Course Review. Prior to the start of DY 8, the state and CMS will jointly conduct a Mid-Point Review, to examine the hospitals' progress in meeting their improvement targets, and to assess the impact of the project to date on achievement of the Three Part Aim. If a hospital's performance on an outcome measure in DY 8 is found to exceed the high performance level (as described in STC 74(c) above), the state must require the hospital to report on an additional outcome measure for DY 9 and achieve improvements on that measure in DY 10. The additional outcome measures must be nationally validated, in accordance with the requirements of STC 74(b) above.

Based on the results of the mid-course review, the state or CMS may propose adjustments to the hospital interventions, or other aspects of the demonstration including but not limited to the HQII Allocation and Payment Methodology or technical modifications to the list of HQII outcome measures.

f. HQII Transition
   1. The state must draft a transition plan to CMS by October 1, 2020 for CMS review and approval, describing how the state will further develop its delivery system reform efforts without HQII funding and/or phase out HQII in DY9. The final transition plan will become Attachment P of the demonstration STCs. The transition plan must be finalized within 6 months of submission to CMS. The state's HQII is a time-limited federal investment that must conclude by no later than December 31, 2021.
   2. Portions of the overall FFP for HQII will be at-risk for the state's achievement on achievement milestones, as specified below. If the state fails to submit a complete transition plan by October 1, 2020, CMS will defer 10 percent of FFP for HQII funding beginning in the next quarter, and an amount to be determined and specified in Attachment P in all subsequent quarters indefinitely until the state comes into compliance. Accountability for performance on milestones to be defined in Attachment P will be as follows: an additional 15 percent for FFP for HQII will be at-risk in DY 8 (CY2021) for failure to meet the milestones. The state will not be able to recoup this 15 percent except, as outlined in Attachment P.

g. **HQII Payments Transitioned to State Directed Payments.**
   1. **Transition of DSRIP to State Directed Payment Arrangements**. Expenditures for HQII payment arrangements that are based on the delivery of Medicaid covered services to members enrolled in a managed care delivery system, or health outcomes from the delivery of those covered services, must be transitioned to state directed payment arrangements authorized under 42 CFR 438.6(c).
   2. **Prior Approval of State Directed Payment Arrangements**. CMS approval, prior to implementation, is required for all state directed payment arrangements authorized under 42 CFR 438.6(c), including any state directed payment arrangement used to transition HQII payment arrangements into managed care contracts and capitation rates.
   3. **Technical Assistance**. The state must request technical assistance from CMS at least 6 months prior to an expected implementation date of any new state directed payment arrangement authorized under 42 CFR 438.6(c) and intended to transition HQII payment arrangements into managed care contracts and capitation rates.

75. Limits on Payments. The state may claim FFP for the Safety Net Care Pools (UC Pool and HQII Pool) in each DY up to the limits on total computable listed in the table below.

a. Reassessment of Hospitals' Uncompensated Charity Care. CMS and the state agree that UC Pool limits for DY 7 and beyond may be revised based on a reassessment of the amount of uncompensated charity care cost provided by the state's hospitals, to take place by December 31, 2021. The state and CMS must collaborate on the reassessment, which must be based on information reported by hospitals on schedule S-10 of the CMS 2552-10 hospital cost report for the most recent year available, with adjustment to ensure that demonstration pool payments do not enter the calculation, following a methodology approved by CMS. For non-S-10 hospitals, costs must be based on the CMS-approved cost reports for the most recent available year. The results of the reassessment must be used to revise the UC Pool limits for DY 7 and beyond. The UC pool limits may be revised based on the reassessment without requiring a demonstration amendment under STCs 6 and 7.

b. If the reassessment discussed in (a) is not completed to produce an updated UC Pool limit by December 31, 2021, the place-holder amounts shown in the table below ($0) will be the UC Pool limits for DY 7 through 10.

	DY 6 (CY 2019)	DY 7 (CY 2020)	DY 8 (CY 2021)	DY 9 (CY 2022)	DY 10 (CY 2023)
UC Pool	$68,889,323	$0 or TBD/S-10	$0 or TBD/S-10	$0 or TBD/S-10	$0 or TBD/S-10
HQII Pool	$12,000,000	$12,000,000	$12,000,000		

76. Assurance of Budget Neutrality.

a. By October 1st of each year, the state must submit an assessment of budget neutrality to CMS, including a summation of all expenditures and member months already reported to CMS, estimates of expenditures already incurred but not reported, and projections of future expenditures and member months to the end of the demonstration, broken out by DY and MEG or other spending category.

b. Should the report in (a) indicate that the budget neutrality Annual Target for any DY has been exceeded, or is projected to be exceeded, the state must propose adjustments to the limits on UC Pool and HQII Pool limits, such that the demonstration will again be budget neutral on an annual basis, and over the lifetime of the demonstration. The new limits must be incorporated through an amendment to the demonstration.

77. Changes to the Safety Net Care Pool. Any changes to the SNCP (UC Pool or HQII Pool), unless otherwise specified, are subject to the amendment process described in STC 7. SNCP

amendments must be approved by CMS prior to implementation.

X. GENERAL FINANCIAL REQUIREMENTS

This project is approved for Title XIX and Title XXI expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures

78. Quarterly Financial Reports. The state must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in Section X of the STCs

The state must provide quarterly Title XXI expenditure reports using the Form CMS-64.21U/64.21UP and CMS-21 to report total Title XXI expenditures for services provided under the approved CHIP plan and those provided through Centennial Care 2.0 under the section 1115 authority. CMS will provide FFP only for allowable the state's Title XXI demonstration expenditures that do not exceed the state's available title XXI funding.

79. Reporting Expenditures Under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures: In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and section 2115 of the state Medicaid Manual. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Lines 6, 7, or 10B, in lieu of Lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments must be reported on lines 6, 7, and 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in Section XI.

b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9 Waiver) for the Summary Sheet Lines 6, 7, or 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments must be reported as otherwise instructed in the State Medicaid Manual.

c. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet

line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) must also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations must be offset against expenditures. These section 1115 premium collections must be included as a manual adjustment (decrease) to the demonstration's actual expenditures on the Budget Neutrality Monitoring Tool, Total Adjustments tab, a quarterly basis.

d. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.

e. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (described in Section XI of these STCs). The state must complete separate waiver forms for the following Medicaid eligibility groups or expenditure categories, using the Waiver Names in "quotes":

1. "TANF and Related": All expenditures for medical assistance provided to TANF and Related eligibles, excluding medical assistance provided during a SUD/IMD month. [MEG1-TANF & Related]
2. "SSI Medicaid Only": All expenditures for medical assistance provided to SSI Medicaid Only eligibles, excluding medical assistance provided during a SUD/IMD month. [MEG2-SSI Medicaid Only]
3. "SSI Dual": All expenditures for medical assistance provided to SSI Dual eligibles, excluding medical assistance provided during a SUD/IMD month. [MEG3-SSI Dual]
4. "217-like Medicaid": All expenditures for medical assistance provided to 217-like Medicaid eligibles, excluding medical assistance provided during a SUD/IMD month. [MEG4-217]
5. "217-like group Dual": All expenditures for medical assistance provided to 217-like group Dual eligibles, excluding medical assistance provided during a SUD/IMD month. [MEG5-217 Dual]
6. "VIII Group": All expenditures for medical assistance provided to VIII Group eligibles, excluding medical assistance provided during a SUD/IMD month. [MEG6-VIII Group]
7. "UC" [MEG7-UHC-Uncompensated Care]
8. "HQII" [MEG8-HQII-Hospital Quality Improvement Incentive]
9. "IMD/SUD": All expenditures for medical assistance provided during a SUD/IMD month. [MEG9-IMD/SUD]
10. "CHV": All expenditures for CHV pilot program. [MEG10-CHV]
11. "Tenancy": All expenditures for Peer Delivered Pre-Tenancy And Tenancy Services. [MEG11-Tenancy]

f. Use of Waiver Forms for CHIP.

1. As outlined in STC 18, uninsured children above 185 percent through 235 percent of the FPL are funded with Title XXI funds. Insured children above 185 percent through 200 percent of the FPL are funded with Title XIX funds. The state is eligible to receive title XXI funds for expenditures for these uninsured children meeting the

definition specified in section 2110(b)(1) of the Act, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or 64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual.

2. Title XIX funds for these uninsured children meeting the definition specified in section 2110(b)(1) of the Act are available under this demonstration if the state exhausts its title XXI allotment once timely notification as described in STC 79(f)(iii) has been provided.
3. If the state exhausts its title XXI allotment prior to the end of a federal fiscal year, title XIX federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver. To initiate this:
   i. The state must provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for this demonstration population;
   ii. The state must submit:
      a. An updated budget neutrality assessment that includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure cap. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension 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 result of the proposed change which isolates (by Eligibility Group) the impact of the change;
      b. An updated CHIP allotment neutrality worksheet.
4. If the state exhausts its title XXI allotment prior to the end of a federal fiscal year, the expenditures attributable to this demonstration population must count toward the budget neutrality expenditure cap calculated under STC 79, using the per member per month (PMPM) amounts for TANF Children described in STC 18, and must be considered expenditures subject to the budget neutrality cap as defined in STC 96, so that the state is not at risk for claiming title XIX federal matching funds when title XXI funds are exhausted.

g. The DYs for this demonstration are defined as follows:

DY 6	January 1, 2019 to December 31, 2019	12 months
DY 7	January 1, 2020 to December 31, 2020	12 months
DY 8	January 1, 2021 to December 31, 2021	12 months
DY 9	January 1, 2022 to December 31, 2022	12 months
DY 10	January 1, 2023 to December 31, 2023	12 months

h. **Budget Neutrality Specifications Manual.** The state must create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state compiles data on actual expenditures and member months 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 and in member-month reports, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual must be made available to CMS on request.

80. Administrative Costs. Administrative costs must not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name "ADM", and CMS-21.

81. Payment for HCBS or Managed Long Term Services and Supports. The state must use the portion of the capitated payment rate that is attributable to the CB as the "dollar" amount of HCBS/PC services that the individual is liable for since the capitated portion of the rate that is attributable to the CB is the actual amount the state pays to the MCO/entity for these services.

82. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

83. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the as part of the BN Monitoring Tool required under STC 104, the actual number of eligible member months for each MEG described in STC 83(c) below. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals

who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

c. The state must report member months according to the MEGs defined below.
   1. "TANF and Related": Months of Medicaid eligibility for TANF and Related eligibles, excluding SUD/IMD months. [MEG1-TANF & Related]
   2. "SSI Medicaid Only": Months of Medicaid eligibility for SSI Medicaid Only eligibles, excluding SUD/IMD months. [MEG2-SSI Medicaid Only]
   3. "SSI Dual": Months of Medicaid eligibility for SSI Dual eligibles, excluding SUD/IMD months. [MEG3-SSI dual]
   4. "217-like Medicaid": Months of Medicaid eligibility for 217-like Medicaid eligibles, excluding SUD/IMD months. [MEG4-217]
   5. "217-like group Dual": Months of Medicaid eligibility for 217-like group Dual eligibles, excluding SUD/IMD months. [MEG5-217 dual]
   6. "VIII Group": Months of Medicaid eligibility for VIII Group eligibles, excluding SUD/IMD months. [MEG6-VIII group]
   7. "IMD/SUD": Months of Medicaid eligibility during SUD/IMD months, which are months in which a member received SUD inpatient care in an IMD for any day of the month. [MEG7-IMD/SUD]
   8. "CHV": Months of Medicaid eligibility for the Centennial Home Visiting program eligible. [MEG8-CHV]
   9. "Tenancy": Months of Medicaid eligibility for individuals eligible to receive tenancy supports. [MEG9-Tenancy]

84. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap 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 will 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 must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

85. Standard CHIP Funding Process. The standard CHIP funding process must be used during the demonstration. The state must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. As a footnote to the CMS 21B, the state must provide updated estimates of expenditures for the demonstration populations. CMS will 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 must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

86. Extent of FFP 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 demonstration as a whole as outlined below, subject to the limits described in Section XI below.

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 state plan.
c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

87. Sources of Non-Federal Share. The state must certify that the matching non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.
c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

88. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, must certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) must exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. 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, and 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.

89. Title XXI Limits. The state must be subject to a limit on the amount of federal title XXI funding that the state may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including currently available reallocated funds. Should the state expend its available title XXI federal funds for the claiming period, no further enhanced federal matching funds will be available for costs of the approved title XXI child health program or demonstration until the next allotment becomes available.

90. Exhaustion of Title XXI Funds. After the state has exhausted title XXI funds, expenditures for optional targeted low income children within CHIP State plan-approved income levels, must be claimed as title XIX expenditures as approved in the Medicaid State plan. The state must report expenditures for these children as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with STC 36**.**

91. Exhaustion of Title XXI Funds Notification. The state must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures. The state must follow Medicaid State plan criteria for the members unless specific waiver and expenditure authorities are granted through this Demonstration.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

92. Limit on Title XIX Funding. The state must be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the state using the procedures described in Section XI. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance

with these annual limits will be done using the Schedule C report from the CMS-64.

93. Risk. The state will be at risk for the per capita cost for demonstration populations as defined in STC 18, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

94. Budget Neutrality for Family Planning and for Out of State Former Foster Youth Expenditures. CMS has determined that the waivers to enable the state to limit the provision of medical assistance (and treatment as eligible) for individuals described in the eligibility groups under sections 1902(a)(10)(A)(ii)(XX) of the Act (for out-of-state former foster care youth) and 1902(a)(10)(A)(ii)(XXI) of the Act (for family planning benefits) will not result in an increase in federal Medicaid spending, and deems these waivers to be budget neutral. The demonstration will not include a budget neutrality expenditure limit for these waivers, and no further test of budget neutrality will be required. Accordingly, the state cannot obtain budget neutrality "savings" from provision of medical assistance to these populations. Expenditures for persons whose medical assistance is limited to family planning services and supplies or who are out-of-state former foster care youth will be reported on the CMS-64 base form(s) for Medicaid State Plan populations in accordance with section 2500 of the State Medicaid Manual.

95. Calculation of the Primary Budget Neutrality Limit: For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits must be calculated for each DY on a total computable basis, as described in STC 96 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit must 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 of this limit must be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share 1, which is defined in STC 102 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names: TANF and Related, SSI Medicaid Only, SSI Dual, UC, HQII, plus any excess spending from the Hypothetical Tests described in STCs 98, 99, 100 and 101.

The state may not subsequently amend its Medicaid state plan to authorize lower payments for hospitals without making a corresponding reduction in the demonstration's budget neutrality limit.

96. Capita Budget Neutrality Limit and Aggregate Adjustment. For each DY, separate annual budget limits of demonstration service expenditures will be calculated. Each annual budget limit will have per capita and aggregate components.

a. The per capita component is determined as the sum of the products of the trended

monthly per person cost times the actual number of eligible/member months, as reported to CMS by the state under the guidelines set forth in the following STCs. The trend rates and per capita cost estimates for each MEG for each year of the demonstration are listed in the table below.

MEG	TREND	DY 6 - PMPM	DY 7 – PMPM	DY 8 – PMPM	DY 9 – PMPM	DY 10 – PMPM
TANF and Related	3.8%	$460.00	$477.48	$495.62	$514.45	$534.00
SSI and Related – Medicaid Only	4.1%	$2158.77	$2247.28	$2339.42	$2435.34	$2535.19
SSI and Related — Dual	4.1%	$2057.62	$2141.98	$2229.80	$2321.22	$2416.39

b. The aggregate component for each DY is shown on the table below, and represents the amount of supplemental payments to hospitals that the state could have continued making in the absence of the demonstration.

	TREND	DY 6 – Total	DY 7 – Total	DY 8 – Total	DY 9 – Total	–DY 10 – Total
UPL Payments	0%	$80,901,176	$80,901,176	$80,901,176	$80,901,176	$80,901,176

97. Savings Phase-out. Each DY, the net variance between the without-waiver cost and actual with-waiver cost must be reduced for selected Medicaid population-based MEGs. The reduced variance will be calculated as a percentage of the total variance, which must then be substituted for the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) The formula for calculating the reduced variance is: reduced variance equals total variance times applicable percentage. The percentages for each MEG and DY are determined based on the amount of time the associated population has been enrolled in managed care subject to this demonstration; lower percentages are for longer established managed care populations will have lower percentages applied to them. The MEGs affected by this provision and the applicable percentages are shown in the table below, except that if the total variance for an MEG in a DY is negative, the applicable percentage is 100 percent.

MEG	DY 6	DY 7	DY 8	DY 9	DY 10
TANF and Related	25%	25%	25%	25%	25%
SSI and Related – Medicaid Only	25%	25%	25%	25%	25%
SSI and Related – Dual	25%	25%	25%	25%	25%

98. Hypothetical Test 1: 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 1.

a. The MEGs listed in the table below are for the Supplemental Budget Neutrality Test 1.

MEG	TREND	DY 6 – PMPM	DY 7 – PMPM	DY 8 – PMPM	DY 9 – PMPM	DY 10 PMPM
217-like Medicaid	3.1%	$5747.30	$5926.04	$6110.34	$6300.37	$6496.31
217-like Group- Dual	4.1%	$3661.18	$3811.29	$3967.56	$4130.23	$4299.57

b. The Supplemental Cap 1 is calculated by taking the PMPM cost projection for each group in the above table in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of Supplemental Cap 1 is obtained by multiplying the total computable Supplemental Cap 1 by Composite Federal Share 2.

c. Hypothetical Test 1 is a comparison between the federal share of Supplemental Cap 1 and total FFP reported by the state for hypothetical groups under the following Waiver Names: 217-like Medicaid, 217-like Group- Dual.

d. If total FFP for hypothetical groups should exceed the federal share of Supplemental Cap 1, the difference must be reported as a cost against the budget neutrality limit described in STC 104.

99. Hypothetical 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.

a. The MEG listed in the table below is included in Supplemental Budget Neutrality Test 2.

MEG	TREND	DY 6 – PMPM	DY 7 – PMPM	DY8 – PMPM	DY9 – PMPM	DY10 – PMPM
VIII Group	4.7%	$738.22	$772.92	$809.24	$847.28	$887.10

b. The Supplemental Cap 2 is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that

group and DY, and adding the products together across groups and DYs. The federal share of the Supplemental Cap 2 is obtained by multiplying total computable Supplemental Cap 2 by the Composite Federal Share 3.

c. Hypothetical Test 2 is a comparison between the federal share of the Supplemental Cap 2 and total FFP reported by the state for VIII Group.

d. If total FFP for VIII Group should exceed the federal share of Supplemental Cap 2, the difference must be reported as a cost against the budget neutrality limit described in STC 104.

100. Hypothetical Test 3: SUD/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 3.

a. The MEG listed in the table below is included in Hypothetical Test 3.

MEG	TREND	DY 6 – PMPM	DY 7 – PMPM	DY8 – PMPM	DY9 – PMPM	DY10 – PMPM
SUD/IMD	4.1%	$808.21	$841.35	$875.85	$911.76	$949.14

b. The cap for Hypothetical Test 3 is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the Supplemental Cap 3 is obtained by multiplying total computable Supplemental Cap 3 by the Composite Federal Share 4.

c. Hypothetical Test 3 is a comparison between the federal share of the Supplemental Cap 3 and total FFP reported by the state for SUD/IMD.

d. If total FFP for SUD/IMD should exceed the federal share of Supplemental Cap 3, the difference must be reported as a cost against the budget neutrality limit described in STC 104.

101. Hypothetical Test 4: CHV. 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.

a. The MEG listed in the table below is included in Hypothetical Test 3.

MEG	TREND	DY 6 – PMPM	DY 7 – PMPM	DY8 – PMPM	DY9 – PMPM	DY10 – PMPM
CHV	0%	-	$708.33	$708.33	$708.33	$708.33
Tenancy	0%	-	$450.00	$450.00	$450.00	$450.00

b. The cap for Hypothetical Test 4 is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member moths for that group and DY, and adding the products together across groups and DY. The federal share of the Supplemental Cap 4 is obtained by multiplying total computable Supplemental Cap 4 by the Composite Federal Share 5.

c. Hypothetical Test 4 is a comparison between the federal share of the Supplemental Cap 4 and total FFP reported by the state for CHV pilot program and Tenancy.
d. If total FFP for CHV pilot and Tenancy should exceed the federal share of Supplemental Cap 4, the difference must be reported as a cost against the budget neutrality limit described in STC 104.

102. Composite Federal Share Ratios. 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, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There are five Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures reported under Waiver Names TANF and Related, SSI Medicaid Only, and SSI Dual; Composite Federal Share 2, based on the expenditures reported under Waiver Names 217-like Medicaid and 217-like Group- Dual; Composite Federal Share 3, based on the expenditures reported under Waiver Name VIII Group; Composite Federal Share 4, based on the expenditures reported under Waiver Name SUD/IMD, and Composite Federal Share 5, based on the expenditures reported under Waiver Names CHV and Tenancy. Should the demonstration be terminated prior to the end of the extension approval period (see STC 8), the Composite federal Share will be determined based on actual expenditures for the period in which the demonstration was active. 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 upon method.

103. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration. 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 of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

104. 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 Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section XI. CMS will provide technical assistance, upon request.

105. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration extension, which for this purpose will be from January 1, 2019 through

December 31, 2023 (DY 6 through DY 10). The budget neutrality test for the demonstration extension must incorporate net savings from the immediately prior demonstration period consisting of DY 1 through DY 5. If the state's cumulative expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the DYs, the state must submit a corrective action plan to CMS for approval. The state must subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 6	Cumulative budget neutrality limit plus:	2.0 percent
DY 7	Cumulative budget neutrality limit plus:	1.5 percent
DY 8	Cumulative budget neutrality limit plus:	1.0 percent
DY 9	Cumulative budget neutrality limit plus:	0.5 percent
DY 10	Cumulative budget neutrality limit plus:	0 percent

106. Exceeding Budget Neutrality. The state agrees, as a condition for accepting this demonstration award, that if at the end of the demonstration extension period the cumulative budget neutrality limit has been exceeded, it must return the excess federal funds to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision must be based on the time elapsed through the termination date.

XII. GENERAL REPORTING REQUIREMENTS

107. General Financial Requirements. The state must comply with all general financial requirements under title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section XI of these STCs.

108. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

109. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, 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 singly 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 share of expenditures for the currently approved 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) Thirty (30) days after the deliverable was 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) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable 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 and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.
c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (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.

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.

110. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state must work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
c. Submit deliverables to the appropriate system as directed by CMS.

111. Cooperation with Federal Evaluators. 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. 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 109.

112. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XI of these STCs.

113. Monthly Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, 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, 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.
d. Other possible areas to be addressed include, but are not limited to: transition and implementation activities, stakeholder concerns raised at the Native American Advisory Board and the Native American Technical Advisory Subcommittee, MCO operations and performance, enrollment, cost sharing, quality of care, network provider access by plan and service type, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the state is considering submitting.

114. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The information for the fourth quarter should be reported as distinct information within the Annual Report. The reports are due no later than sixty (60 calendar days) following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90 calendar days) following the end of the DY. The reports must 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 must be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework 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 challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion must also include any issues or complaints identified by members; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report must also include a summary of all public comments received through post-award public forums regarding the progress of the

demonstration.

b. Performance Metrics. Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to members and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This must also include the results of member satisfaction surveys, if conducted, grievances and appeals. 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 CMS-64.

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 must 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 Health IT. The state must include a summary of progress made in regards to SUD Health IT requirements outlined in STC 57.

115. Corrective Action. If federal monitoring indicates that demonstration features may not be operating as intended, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 13.

116. Close-Out Operational Report. Within 120 calendar days prior to the expiration of the demonstration, the state must submit a Draft Close-Out Report to CMS for comments.

a. The draft final report must comply with the most current Guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the Close-Out report.

c. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.

d. The Final Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 109.

117. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) 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 website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

118. **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 SUD Implementation Plan Protocol 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.

XIII. EVALUATION OF THE DEMONSTRATION

119. **Evaluation Goals and Objectives.** The evaluation must include a discussion of the goals and objectives of the demonstration aligned with proposed research questions and hypotheses that the state intends to test. If the demonstration is extended beyond the current demonstration period, the evaluation design must include a summary of the previous evaluation findings and a discussion of how the evaluation design will build and expand on earlier findings.

120. **Independent Evaluator.** Upon approval of the demonstration extension, the state must begin arrangements with 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 accord with the CMS-approved, draft 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.

121. **Draft Evaluation Design.** The draft Evaluation Design must be developed in accordance with Attachment J (Developing the Evaluation Design) of these STCs. The state may choose to submit one evaluation design inclusive of the demonstration and SUD, or a separate evaluation design focused on SUD. If the state chooses to submit two evaluation designs, the SUD evaluation design is subject to the same terms and conditions listed below which apply to the overall demonstration evaluation. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state must use an independent evaluator to develop the draft Evaluation Design.

122. 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.

123. Evaluation Questions and Hypotheses. Consistent with Attachments J and K (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets 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). CMS requires states waiving retroactive eligibility to evaluate the impact of the waiver. The state will collaborate with CMS to identify hypotheses and research questions tailored to the state's provisions which align with CMS' guidance on evaluating retroactive eligibility, family planning, home visiting and pre-tenancy and tenancy support services, including the impact of peer supports. Possible areas of focus for hypotheses include the effect of the waiver on 1) enrollment and enrollment continuity (including for different types of enrollees such as applicants and existing members, and for individuals who are healthy and those with complex medical needs); 2) health outcomes, including but not limited to, increased transitions of individuals from nursing facilities to home and community-based settings as a result of nursing facilities submitting Medicaid applications more timely and reduced rates of potentially preventable hospital events as a result of hospitals submitting Medicaid applications more timely~~,~~ and 3) the financial impact on members and providers.

124. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. 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 website within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in theses STCs. 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.

125. 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 a renewal process when associated with the state's Interim Evaluation Report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 13.

126. 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 renewal, the Evaluation Report should be posted to the state's 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 that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) 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 final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
e. The Interim Evaluation Report must comply with Attachment K of these STCs.

127. Public Access. The state must post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

128. Electronic Submission of Reports. The state must submit all required plans and reports using the process stipulated by CMS, if applicable.

129. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment K of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period, January 1, 2019 – December 31, 2023, no more than 18 months after the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

130. 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, and/or the summative evaluation.

131. 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. 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 ten (10) business 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.

XIV. 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
90 days after approval	Submit quality strategy	STC 66
90 days after SUD program approval date	SUD Implementation Plan Protocol	STC 52
180 days after approval	Submit draft evaluation plan	STC 121
150 days after approval	Submit SUD Monitoring Plan Protocol	STC 53
180 days after approval date	SUD Draft Evaluation Design	STC 56
60 days after receipt of CMS comments	SUD Revised Draft Evaluation Design	STC 56
30 days after CMS Approval	SUD Approved Evaluation Design published to state's website	STC 55
June 1, 2022	SUD Mid-Point Assessment	STC 54
One year prior to the end of the demonstration, or	Draft Interim Evaluation Report	STC 126
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 126
18 months of the end of the demonstration	Draft Summative Evaluation Report	STC 129
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 129
90 days after middle of DY4 (September 30, 2020)	Submit Draft SUD Mid-point Assessment	STC 54
60 calendar days after receipt of CMS comments	Submit Final SUD Mid-point assessment	STC 54

Monthly	Monitoring calls	STC 113
60 days after the end of each quarter	Quarterly progress report	STC 114
Quarterly	Quarterly financial report	STC 78
Annually	Annual report	STC 114
6 months before specific authority expires	Submit an expiration plan	STC 10
12 months before the termination of the	Submit an extension request or a phase out plan and an interim evaluation report	STC 8
120 days after the termination of the demonstration	Close-Out Operational Report	STC 116

ATTACHMENT A. QUARTERLY REPORT CONTENT AND FORMAT

Pursuant to STC 114 *(Quarterly Progress Report)* of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One –Centennial Care 2.0 Demonstration Title
Line Two – Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
Example: Demonstration Year: 1 (1/1/2019–12/31/2019) Federal Fiscal Quarter:
Footer: Date on the approval letter through December 31, 20xx

III. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

IV. Enrollment and Benefits Information

Discuss the following:

Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.

Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.

Information about the member rewards program, including the number of people participating, credits earned, and credits redeemed.

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

V. Enrollment Counts for Quarter and Year to Date

Note: Enrollment counts should be unique enrollee counts, not member months

Demonstration Populations	Total Number of Demonstration participants Quarter Ending – MM/YY	Current Enrollees (year to date)	Disenrolled in Current Quarter
Population 1 – TANF and Related			
Population 2 – SSI and Related – Medicaid Only			
Population 3 -- SSI and Related -			
Population 4 – 217-like Group – Medicaid only			
Population 5 – 217-like Group – Dual			
Population 6 – VIII Group			

IV. Outreach/Innovative Activities to Assure Access
Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data
Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

VI. Operational/Policy/Systems/Fiscal Developments/Issues
A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

VI. HCBS Reporting

1. A status update that includes the type and number of issues identified and resolved through the Consumer Support Program,
2. Identification of critical incidents reported during the quarter, and
3. Systemic CB issues or problems identified through monitoring and reporting processes and how they are being addressed. Issues include but are not limited to: participant access and eligibility, participant-centered planning and service delivery, provider credentialing and/or verification, and health and welfare.
4. Information regarding self-direction of benefits

VII. AI/AN Reporting

Summarize the implementation of Centennial Care 2.0 for AI/AN members including:

1. Access to care, especially in frontier areas;
2. Status of contracting between MCOs and I/T/U providers.
3. Status of ensuring timely payment for all I/T/U providers and include complaints by such providers; and
4. A summary of issues identified and recommendations made by the Native American Advisory Board and the Native American Technical Advisory Subcommittee;

VIII. Action Plans for Addressing Any Issues Identified

Summarize the development, implementation, and administration of any action plans for addressing issues related to the demonstration. Include a discussion of the status of action plans implemented in previous periods until resolved.

IX. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

X. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations[7]

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Population 1 – TANF and				
Population 2 – SSI and Related – Medicaid Only				
Population 3 – SSI and Related – – Dual				
Population 4 – 217-like Group – Medicaid only				
Population 5 – 217-like Group-				
Population 6 – VIII Group				

XI. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

XII. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XIII. Managed Care Reporting Requirements

Address network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of MCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation. The state must include additional reporting requirements within the annual report as outlined in STC 114.

XIV. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XV. Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XVI. State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

XVII. Date Submitted to CMS

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[7] Allotment neutrality information for Title XXI is reported separately.

ATTACHMENT B: CENTENNIAL CARE 2.0 COMMUNITY BENEFITS AND LIMITS

I. Adult Day Health (ABCB)

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

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

II. Assisted Living (ABCB)

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

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

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

III. Behavior Support Consultation (ABCB and SDCB)

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

Behavior Support Consultation: 1) informs and guides the member's providers with the services and supports as they relate to the member's behavior and his/her medically fragile condition; 2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to

interfering behavior and potentially reducing interfering behavior(s); 3) supports effective implementation based on a functional assessment; 4) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the member and his/her service and support providers. Based on the member's care plan, services are delivered in an integrated/natural setting or in a clinical setting.

IV. Community Transition Services (ABCB)

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

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

Limits or Exclusions: Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services are limited to $3,500 per person every five years. Deposits for Assisted Living Facilities are limited to a maximum of $500. In order to be eligible for this service, the person must have a 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 five thousand dollars ($5,000) every five (5) years. Additional services may be requested if a member's health and safety needs exceed the specified limit.

IX. Home Health Aide (ABCB and SDCB)

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

X. Non-Medical Transportation (SDCB)

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

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

XI. Nutritional Counseling (ABCB and SDCB)

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

XII. Personal Care Services (ABCB and SDCB)

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

Agency-Based Community Benefit:

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

Self-Directed Community Benefit:

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

XIII. Private Duty Nursing for Adults (ABCB and SDCB)

Private Duty Nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for members who are twenty-one (21) years of age or older with intermittent or extended direct nursing care in the member's home. Services include medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance.

Limits or Exclusions*:* All services provided under Private Duty nursing require the skills of a Licensed Registered Nurse or a Licensed Practical Nurse under written physician's order in accordance with the New Mexico Nurse Practice Act, Code of federal Regulation for Skilled Nursing.

XIV. Related Goods (SDCB)

Related goods are equipment, supplies or fees and memberships, not otherwise provided through under Medicaid. Related goods must address a need identified in the member's care plan (including improving and maintaining the member's opportunities for full membership in the community) and meet the following requirements: be responsive to the member's qualifying condition or disability; and/or accommodate the member in managing his/her household; and/or facilitate activities of daily living; and/or promote personal safety and health; and afford the member an accommodation for greater independence; and advance the desired outcomes in the member's care plan; and decrease the need for other Medicaid services. Related goods will be carefully monitored by health plans to avoid abuses or inappropriate use of the benefit.
The member receiving this service does not have the funds to purchase the related good(s) or the related good(s) is/are not available through another source. These items are purchased from the member's individual budget.

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

XV. Respite (ABCB and SDCB)

Respite services are provided to members unable to care for themselves that are furnished on a short-term basis to allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite care is furnished at home, in a private residence of a respite care provider, in a specialized foster care home, in a hospital or 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.

XVI. Skilled Maintenance Therapy Services (ABCB and SDCB)

Skilled maintenance therapy services include Physical Therapy (PT), Occupational Therapy (OT) or Speech and Language Therapy (SLT) for individuals twenty-one years and older. These services are an extension of therapy services provided for acute and temporary conditions that are provided with the expectation that the individual will improve significantly in a reasonable and generally predictable period of time. Skilled Maintenance Therapy services are provided to adults

with a focus on maintenance, community integration, socialization and exercise, or enhance support and normalization of family relationships. Services in this category include:

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

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

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

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

XVII. Specialized Therapies (SDCB)

Specialized Therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A member may include specialized therapies in his/her care plan when the services enhance opportunities to achieve inclusion in community activities and avoid institutionalization. Services must be related to the member's disability or condition, ensure the member's health and welfare in the community, supplement rather than replace the member's natural supports and other community services for which the member may be eligible, and prevent the member's admission to institutional services. Experimental or investigational procedures, technologies or therapies and those services covered as a Medicaid state plan benefit are excluded. Services in this category include:

Acupuncture

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

Biofeedback

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

Chiropractic

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

Cognitive Rehabilitation Therapy

Cognitive rehabilitation therapy services are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or

establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome specific cognitive problems. Cognitive Rehabilitation Therapy providers must have a license or certification with the appropriate specialized training, clinical experience and supervision, and their scope of practice must include Cognitive Rehabilitation Therapy.

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

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

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

function. Naprapathy providers must have a state license in Naprapathy.

Native American Healers
Native American Healers are a covered benefit under the self-directed community benefit. These services are subject to the $2000 annual specialized therapies limits. These services may also be a value added service provided by the MCO, for which the MCO does not receive FFP for these services. There are twenty-two sovereign Tribes, Nations and Pueblos in New Mexico, as well as numerous Native American individuals who come from many other tribal backgrounds. Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support members in their communities by addressing their physical and emotional health. Treatments may include dance, song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel. This form of therapy may be provided by community-recognized medicine men and women and others as healers, mentors and advisors to members, and provides opportunities for members to remain connected with their communities. The communal support provided by this type of healing can reduce pain and stress and improve quality of life.

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

ATTACHMENT C: CENTENNIAL HOME VISITING PILOT SERVICES

Table One: Description of Services

Service	Description of Service
Prenatal Home Visit	The CHV Pilot Project will provide home visit services to expectant mothers during their pregnancy. The prenatal home visit services will provide: • Monitoring for high blood pressure or other complications of pregnancy (NFP only); • Diet and nutritional education; • Stress management; • Sexually Transmitted Diseases (STD) prevention education; • Tobacco use screening and cessation education; • Alcohol and other substance misuse screening and counseling; • Depression screening; and • Domestic and intimate partner violence screening and education.
Postpartum Home Visits	The CHV Pilot Project will provide home visit services to Medicaid eligible mothers during their sixty (60) day postpartum period. • Diet and nutritional education; • Stress management; • STD prevention education; • Tobacco use screening and cessation education; • Alcohol and other substance misuse screening and counseling; • Depression screening; • Domestic and intimate partner violence screening and education; • Breastfeeding support and education (NFP may refer members out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service); • Guidance and education with regard to well woman visits to obtain recommended preventive services; • Nursing assessment of the postpartum mother and infant (NFP only); • Maternal-infant safety assessment and education e.g. safe sleep education for Sudden Infant Death Syndrome (SIDS) prevention • Counseling regarding postpartum recovery, family planning, needs of a newborn; • Assistance for the family in establishing a primary source of care and a primary care provider (i.e. ensure that the mother/ infant has a postpartum/ newborn visit scheduled); • Parenting skills and confidence building.

Infant Home Visits	The CHV Pilot Project will provide home visit services to newborn infants born to CHV Pilot Project members until the child reaches two (2) years of age for NFP and five (5) years of age or kindergarten entry for PAT. • Breastfeeding support and education (NFP may refer members out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service); and • Child developmental screening at major developmental milestones from birth to age two (2) for NFP according to model standard practice and age five (5)/kindergarten entry for PAT; • Parenting skills and confidence building.

The NFP program model meets the criteria established by the Department of Health and Human Services (DHHS) for an "evidence-based early childhood home visiting service delivery model." The 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 model also meets the criteria established by DHHS for an "evidence-based early childhood home visiting delivery model." The 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 provider qualifications for the services provided are described in Table Two: Provider Qualifications below.

Table Two: Provider Qualifications

Home Visitor Provider Qualifications				
Home Visitors	Education (typical)	Experience (typical)	Skills (preferred)	Training
Nurse Family Partnership (NFP) 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 5 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 Program Standards.

Home Visitor Provider Qualifications				
Home Visitors	Education (typical)	Experience (typical)	Skills (preferred)	Training
NFP Nurse Home Visitor Supervisor – Hired by approved NFP implementing agency	RN with Baccalaureate degree in nursing. Preferred that nurse supervisors have	At least 5 years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. Must have	Nurses must receive reflective supervision weekly to meet requirements of the evidence based program. This nurse	Comprehensive training and preparation as required by NFP model, and the NM Home Visiting

	additional degrees beyond BSN such as MSN or other related/advanced practitioner designations e.g., nurse practitioner, nurse midwife.	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.	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.	Program Standards.
Parents as Teachers (PAT) Home Visitors – Hired by approved PAT implementing agency	High School Diploma or GED	At least 2-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 Program Standards.
PAT Clinical Manager – Hired by approved PAT implementing agency	Licensed Master Social Worker	A Master's degree in a relevant discipline, 1-3 years in related program oversight experience.	Bilingual Spanish and English	Comprehensive training and preparation as required by PAT model, and the NM Home Visiting Program Standards.

ATTACHMENT D: 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 Office of Substance Abuse Prevention (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 Human Services Department supports training in evidence-based, medically-managed detoxification in community hospitals throughout the state.

Underage Drinking and Prescription Drug Abuse - New Mexico's Office of Substance Abuse Prevention (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 Human Services Department, 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 Human Services Department approves licensing of Opioid Treatment Programs (OTPs). Currently there are 19 Opioid Treatment Programs, 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 E: Hospitals Eligible for Safety Net Care Pool (SNCP) payments and Initial Allocation of Uncompensated Care (UC) Funding for UC pool

HOSPITAL NAME	COUNTY	# OF BEDS
Alta Vista Regional Medical Center	San Miguel	54
Artesia General Hospital	Eddy	49
Carlsbad Medical Center	Eddy	115
Cibola General Hospital	Cibola	25
Dan C. Trigg	Quay	31
Eastern New Mexico Medical Center	Chaves	162
Espanola Hospital	Rio Arriba	70
Gerald Champion Medical Center	Otero	123
Gila Regional Medical Center	Grant	68
Guadalupe Hospital	Guadalupe	10
Holy Cross Hospital	Taos	25
Lea Regional Hospital	Lea	186
Lincoln County Medical Center	Lincoln	25
Los Alamos Medical Center	Los Alamos	47
Memorial Medical Center	Dona Ana	298
Mimbres Memorial Hospital	Luna	25
Miners Colfax Medical Center	Colfax	25
Mountain View Regional Medical Center	Dona Ana	168
Nor-Lea General Hospital	Lea	25
Plains Regional Medical Center	Curry	100
Rehoboth McKinley Christian Hospital	McKinley	60
Roosevelt General Hospital	Roosevelt	24
Roswell Regional Hospital	Chaves	26
San Juan Regional Medical Center	San	194*
Sierra Vista Hospital	Sierra	15
Socorro General Hospital	Socorro	24
CHRISTUS St. Vincent Regional Med.	Santa Fe	248
Union County General Hospital	Union	25

TEACHING HOSPITAL	COUNTY	# OF BEDS	RESIDENTS
The University of New Mexico Hospital	Bernalillo	527	

*as of August 27, 2014

As described in paragraph II.82.a of the demonstration's special terms and conditions (STCs), eligible hospitals shall be divided into groups based on their size, as defined by the number of hospital beds. The total available funding from the UC pool shall be divided among the hospital groups, with larger proportions available to the smallest hospitals.

Hospitals eligible for UC payments are divided into the following groups; Available funding is allocated as indicated.

1. Smallest hospitals (30 or fewer hospital beds); 60% of available funding

2. Small hospitals (31-100 hospital beds); 30% of available funding
3. Medium hospitals (101-200 hospital beds); 10% of available funding
4. Large hospitals (201-300 hospital beds); 0%
5. Largest hospitals (more than 301 hospital beds); 0%

As described in paragraph II.82.c of the STCs, if the total allocation to any hospital group defined above exceeds the total amount of UC costs for that group, the balance of funding shall be made available to the next group of larger hospitals. Among the hospitals of any specified group, UC payments will be distributed in proportion to the UC costs incurred by that group. UC payments shall not exceed the amounts specified in paragraph II.82.b of the STCs.

ATTACHMENT F: UC PAYMENT APPLICATION TEMPLATE

SECTIONS A - C INSTRUCTIONS

A. General Instructions and Identification of Cost Reports that Cover the UC Payment Year:

1. Select the "Sec. A-C Application Info" tab in Excel workbook. In row 1, select your facility from the drop-down menu provided. When your facility is selected, the following fields will be populated: in-state Medicaid provider number and Medicare provider number. Review information and indicate whether it is correct or incorrect. If incorrect, provide correct information.
2. Provide your cost reporting periods that are needed to completely cover the UC Payment Year. If the end date for cost report period 1 is before the end date of the UC Payment year, report your next cost reporting period (cost report 2). If this cost report ends prior to the end of the UC Payment year, report your next cost reporting period (cost report 3). The cost reporting periods must cover the entire UC Payment year.
    i. NOTE: For the 20*XX* UC Application, if your hospital completed the UC Application for 20*XX*, the first cost report year should follow the last cost report year reported on the 20*XX* UC Application. The last cost report year on the 20*XX* UC Application must end on or after the end of the 20*XX* UC Payment year. If your hospital did not complete the 20*XX* UC Application, your cost reports for 20*XX* must cover the entire 20*XX* UC Payment year.
3. Supporting documentation for all data elements provided within the UC Payment Application must be maintained for a minimum of five years.

B. (Intentionally left blank)

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid supplemental payments should include GME, IME, In-State DSH and Out-of-State DSH (if applicable) payment.

Certification:

1. The hospital CEO or CFO must certify the accuracy of the survey responses. Provide hospital and outside preparer contacts who can respond to requests for additional information and answer questions related to the hospital's responses.

EXHIBITS 1 AND 2; SECTIONS D - K INSTRUCTIONS

General Instructions and Identification of Cost Reports that cover the UC Payment Year:

1. Select the "UC Application - Sec. D, E, F CR Data" tab in the Excel workbook. Line 1, is linked to section A. When your facility is selected, the following Lines will be populated with your facility specific information: Line 2 - applicable cost report years, Line 4 - Hospital Name, Line 5 - in-state Medicaid provider number, Line 6 - Medicaid Sub provider Number 1 (Psychiatric or Rehab), Line 7 - Medicaid Provider Number 2 (Psychiatric or Rehab), and Line 8 - Medicare provider number. The provider must manually select the appropriate option from the drop down menu for Line 3 - Status of Cost Report Used for the Survey. Review the information and indicate whether it is correct or incorrect. If incorrect, provide correct information in the provided space and submit supporting

documentation when you submit your survey.

2. You must complete a separate UC Application Excel workbook for each cost report year needed to cover the State UC Payment year and not previously submitted for a UC Payment application. To indicate the proper time period for the current survey select an "X" from the drop down menu on the appropriate box of Line 2 of the "Survey - Sec. D, E, F CR Data" tab in this Excel workbook. If two cost report years are selected at the same time the survey will generate an error message as only one cost report year may be selected per Excel workbook.
    a. NOTE: For the 20*XX* UC Application, if your hospital completed the UC Application for 20*XX*, the first cost report year should follow the last cost report year reported on the 20*ZZ* UC Application. The last cost report year on the 20*XX* UC Application must end on or after the end of the 20*XX* UC Application year. If your hospital did not complete the 20*ZZ* UC Application, you must report data for each cost report year that covers the 20*XX* UC Payment year.
3. Supporting documentation for all data elements provided within the UC Payment Application must be maintained for a minimum of five years.

Exhibit 1 - Support of Uninsured I/P and O/P Hospital Services: (DO NOT SUBMIT)

1. See "Exhibit 1 - Uninsured" tab for an example format of the information that needs to be available to support the data reported in Section H of the UC Application related to uninsured services provided in each cost reporting year needed to completely cover the UC Payment year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. (DO NOT SUBMIT THIS INFORMATION WITH THE UC APPLICATION).
2. Complete Exhibit 1 based on your individual state Medicaid hospital reimbursement methodology (if your state reimburses based on discharge date then only include claims in Exhibit 1 that were discharged during the cost reporting period for which you are pulling the data).
3. Exhibit 1 population should include all uninsured patients whose dates of service (see above) fall within the cost report period.
4. The total inpatient and outpatient hospital (excluding professional fees, and other non-hospital items) charges from Exhibit 1, column N should tie to Section H, line 103 of the UC Application.

Exhibit 2 - Support for Self-Pay I/P and O/P Hospital Payments Received: (DO NOT SUBMIT)

1. See Exhibit 2 for an example format of the information that needs to be available to support the data reported in Section E and H of the UC Application related to ALL patient payments received during each cost reporting year needed to completely cover the UC Payment year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Create a separate Exhibit 2 for each cost reporting period included in the UC Application.
    a. Note: Include Section 1011 payments received related to undocumented aliens if they are applied at a patient level.
2. Exhibit 2 population should include all payments **received** from patients **during the cost**

report year regardless of dates of service and insurance status (report on the CASH BASIS).

3. Only the payments received from uninsured patients should be included on Section H of the UC Application, line 115. Payments from both the uninsured and insured patients should be reported on Section E of the UC Application, lines 9 and 10, respectively. The total payments from Section H, line 115 should reconcile to Section E, line 9.

Section D - General Cost Report Year Information

1. For Lines 1 through 8 of Section D, please refer to the instructions listed above in the "General Information and Identification of Cost Reports that Cover the UC Payment Year section.
2. For Lines 9 through 15, provide the name and Medicaid provider number for each state (other than your home state) where you had a current Medicaid provider agreement during the term of the UC Payment year. Per federal regulation, the DSH examination must review both in-state Medicaid services as well as out-of-state Medicaid services when determining the Medicaid shortfall or longfall. The same standard is being applied for the New Mexico UC Payment calculation.

Section E - Disclosure of Medicaid / Uninsured Payments Received

1. Please read "Note 1" located at the bottom of Section E before entering information for Lines 1 through 7. After reading through Note 1, please provide the applicable Section 1011 payment information as indicated.
2. Please read "Note 2" located at the bottom of Section E before entering information for Line 8. After reading through Note 2, please provide the total Out-of-State DSH payments as indicated.
3. Lines 9 and 10 should reconcile to the Exhibit B information provided by the facility.

Section G - CR Data

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

1. The provider should enter all applicable Routine and Ancillary Cost Centers not currently provided in Section G. Once the Routine and Ancillary Cost Centers have been entered into Section G of the UC Application, they will populate the Routine and Ancillary Cost Centers on UC Application "Sec. H - In-State", "Sec. I - Out-of-State".
2. If your teaching hospital removed intern and resident costs in Column 25 of Worksheet B, Part I, you will need to enter those amounts in the column provided so the amounts can be added back to your total cost per diems and CCRs for Medicaid/Uninsured. If intern and resident cost was not removed in Column 25 of Worksheet B, Part I then no entry is needed. Teaching costs should be included in the final cost per diems and CCRs.
3. After the Routine and Ancillary Cost Centers have been identified, it will be necessary for the provider to fill in the remaining information required by Section G. The location of the specific cost report information required by Schedule G for both Routine and Ancillary Cost Centers is identified in each column heading. The provider will NOT need to enter data into the "Net Cost", or "Medicaid Per Diem/Cost-to-Charge Ratios"

columns as these are calculated columns.

4. Once the "Medicaid Per Diem/Cost-to-Charge Ratios" column has been calculated, the values will also populate on UC Application "Sec. H - In-State", and "Sec. I - Out-of-State".

Section H - Calculation of In-State Medicaid and Uninsured I/P and O/P Costs:

1. This section of the survey is used to collect information to calculate the hospital's Medicaid shortfall or longfall. By federal Medicaid DSH regulations, the shortfall/longfall must be calculated using Medicare cost report costing methodologies. The same standard is being applied for the New Mexico UC Payment Application.
2. The routine per diem cost per day for each hospital routine cost center present on the Medicaid cost report will automatically populate in Section H after UC Application "Sec. G - CR Data" has been completed. These amounts are calculated on Worksheet D-1 of the cost report. The ancillary cost-to-charge ratio for each ancillary cost center on your cost report will also automatically be populated in Section H after UC Payment Application "Sec. G - CR Data" has been completed.
3. Record routine days of care, routine charges and I/P and O/P ancillary charges in the next several columns. This information, when combined with cost information from the cost report, will calculate the total cost of hospital services provided to Medicaid and uninsured individuals.
    a. **In-State Medicaid FFS Primary -** *Traditional Medicaid Primary (should exclude non-Title XIX programs such as CHIP/SCHIP)***.** In these two columns, record your in-state Medicaid fee-for-services days and charges. The days and charges should reconcile to your Medicaid provider statistics and reimbursement (PS&R) report, or your state version generated from the MMIS (Tab Run). Record in the box labeled "Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)," the total (gross) payments, prior to reductions for third party liability (TPL), your hospital received for these services. Reconcile your responses on the survey with the PS&R (Tab Run) total at the bottom of each column. Provide an explanation for any unreconciled amounts.
    b. **In-State Medicaid Managed Care Primary** - *Managed Care Medicaid Primary (should exclude non Title XIX programs such as CHIP/SCHIP)*. Same requirements as above. If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient).
    c. **In-State Medicare FFS Cross-Overs (with Medicaid Secondary)** - *Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary.* Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.
    d. **In-State Other Medicaid Eligibles (not included elsewhere)** - *In-State Other Medicaid Eligibles (not included elsewhere) (should exclude non-Title XIX programs as CHIP/SCHIP).* Enter claim charges, days and payments for any

other Medicaid-eligible patients that have not been reported anywhere else in the application. The patients must be Medicaid-eligible for the dates of service and they must be supported by Exhibit 3, including the patient's Medicaid ID number. This would include Medicare Part C cross-overs not reported elsewhere on the application.

e. **Uninsured -** Federal requirements mandate the uninsured services must be costed using Medicare cost reporting methodologies. As such, a hospital will need to report the uninsured days of care they provided each cost reporting period, by routine cost center, as well as inpatient and outpatient ancillary service revenue by cost report cost center. Exhibits 1, 2, 2.1 and 3 have been prepared in the UC Application template as examples to assist hospitals in developing the data needed to support responses on the application. This data must be maintained in a reviewable format. It must also only include charges for inpatient and outpatient hospital services, excluding physician charges and other non-hospital charges. Per federal guidelines uninsured patients are individuals with no source of third party healthcare coverage (insurance).

4. Federal requirements mandate the hospital cost of providing services to the uninsured during the DSH year must be reduced by uninsured self-pay payments received during the DSH year. The same standard is being applied for the New Mexico UC Payment Application. Exhibit 2 will assist hospitals in developing the data necessary to support uninsured payments received during each cost reporting period. The data must be maintained in a reviewable format and made available upon request.

Section I - Calculation of Out-of-State Medicaid Costs:

1. This schedule is formatted similar to Schedule H. It should be prepared to capture all out-of-state Medicaid FFS, managed care, FFS cross-over and managed care cross-over services the hospital provided during the cost reporting year. Like Schedule H, a separate schedule is required for each cost reporting period needed to completely cover the UC Payment year. Amounts reported on this schedule should reconcile to the out-of-state PS&R (or equivalent schedule Tab Run) produced by the Medicaid program or managed care entity.
    a. **Out-of-State Medicaid FFS Primary** - *Traditional Medicaid Primary (should exclude non-Title XIX programs such as CHIP/SCHIP).*
    b. **Out-of-State Medicaid Managed Care Primary** - *Managed Care Medicaid Primary (should exclude non-Title XIX programs such as CHIP/SCHIP).*
    c. **Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)** - *Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary.*
    d. **Out-of-State Other Medicaid Eligibles (not included elsewhere)** - *Out-of-State Other Medicaid Eligibles (not included elsewhere) (should exclude non-Title XIX programs such as CHIP/SCHIP).*

Section J - Calculation of In-State Medicaid and Uninsured Organ Acquisition Costs:

1. This section is to be completed by hospitals that have incurred in-state Medicaid or uninsured organ acquisition costs only. Information is collected in a format similar to Section H.
2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of

Medicaid and uninsured useable organs to total organs.

Section K - Calculation of Out-of-State Medicaid Organ Acquisition Costs:

1. This section is to be completed by hospitals that have incurred out-of-state Medicaid organ acquisition costs only. Information is collected in a format similar to Section I.
2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.
3. The following columns will NOT need to be entered by the provider as they will automatically populate after Section J has been completed: "Total Organ Acquisition Cost", "Revenue for Medicaid/Uninsured Organs Sold", and "Total Useable Organs (Count)".

Adjustments to Uncompensated Care

General Instructions: The Department is interested in obtaining the most accurate cost estimates in this application in order to make Safety Net Care Pool payments that will need to undergo minimal adjustments during future reconciliation. Deductions and increases in this section should be used to provide the clearest possible picture of true uncompensated care for the payment year.

1. **Deductions to Payments:** Include any payments or revenue present in the application that are not expected in the application payment year. This might include lump sum payments such as those made by the MCOs as part of the transition to Centennial Care 2.0.
2. **Increase to Payments:** Include the estimated impact of any expected increase to payment rates such as the state's proposed increase to the base rate for qualified hospitals. (A reasonable methodology here would be the application of the percentage increase to the base rate multiplied by the total expected Medicaid payment at the current rate). This should equal your inpatient payments from FFS and MCO in the application multiplied by the percentage increase supplied by the Department. If your estimate differs from this amount, please provide a justification and methodology.
3. **Increase to Payments:** Include the estimated impact of Medicaid payments received for patients estimated to be covered by the Medicaid expansion. This would include payments received for newly eligible individuals who did not have insurance coverage prior to January 1, 2014. The state must provide hospital specific estimates, with a description of its methodology. (An increase to patient costs is not considered necessary because patients eligible for the expansion are similar to patients in the uninsured population reported on Section H of the application). If your estimate differs from this amount, please provide a justification and methodology.

Reconciliations

Uncompensated Care Cost Data from DY 3 application will be used to determine the actual uncompensated care for DY 1 UC Payments for each qualifying hospital. Any overpayments identified through this reconciliation process that occurred in a prior year will be recouped from the provider. The state may reallocate the recouped funds to hospitals that received UC pool payments that were less than their uncompensated care in the same time periods. If the recouped amounts are not reallocated, the state shall return the associated FFP to CMS.

UNINSURED DEFINITIONS

Include In Hospital Uninsured Charges:

To the extent hospital charges pertain to services that are medically necessary under applicable Medicaid standards and the services are defined as inpatient or outpatient hospital services under the Medicaid state plan the following charges are generally considered to be "uninsured":

Hospital inpatient and outpatient charges for services to patients who did not have any hospital health insurance or other legally liable third party coverage in effect at the time the services were rendered (reported based on date of service). (42 CFR 447.299 (14) / Creditable coverage is further defined in the 45 CFR 146.113)

- Include facility fee charges generated for hospital provider based sub-provider services to uninsured patients. Such services are identified as psychiatric or rehabilitation services, as identified on the facility cost report, Worksheet S-2, Line 3. The costs of these services are included on the provider's cost report.
- Include hospital charges for undocumented aliens with no source of third party coverage for hospital services. (73 FR dated 12/19/08, page 77916 / 42 CFR 447.299 (13))
- Include lab and therapy outpatient hospital services.
- Include services paid for by religious charities with no legal obligation to pay.

Include In Hospital Uninsured Payments:

Include all payments received for hospital patients that met the uninsured definition at the time of the service. The payments must be reported on a cash basis (report in the year received, regardless of the year of service). (73 FR dated 12/19/08, pages 77913 & 77927)

- Include uninsured liens and uninsured accounts sold, when the cash is collected. (73 FR dated 12/19/08, pages 77942 & 77927)
- Include Section 1011 payments for hospital services without insurance or other third party coverage (undocumented aliens). (42 CFR 447.299 (13))
- Include other waiver payments for uninsured such as Hurricane Katrina/Rita payments. (73 FR dated 12/19/08, pages 77942 & 77927)

Do NOT Include In Hospital Uninsured Charges:

Exclude charges for patients who had hospital health insurance or other legally liable third party coverage in effect at the time the services were rendered. Exclude charges for all non-hospital services. (42 CFR 447.299 (14) / Creditable coverage is further defined in the 45 CFR Section 146.113)

- Exclude professional fees for hospital services to uninsured patients, such as Emergency Room (ER) physician charges and provider-based outpatient services.

  Exclude all physician professional services fees and CRNA charges. (42 CFR 447.299 (15) / 73 FR dated 12/19/08, pages 77924-77926)
- Exclude bad debts and charity care associated with patients that have insurance or other third party coverage (have coverage). (42 CFR 447.299 (15))
- Exclude claims denied by an active health insurance carrier (have coverage). (73 FR dated 12/19/08, pages 77910-77911, 77913)
- Exclude uninsured charges for services that are not medically necessary (including elective procedures), under applicable Medicaid standards (if the service does not meet definition of a hospital service covered under the Medicaid state plan). (42

CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77930)

- Exclude charges for services to prisoners (wards of the state). (73 FR dated 12/19/08, page 77915 / State Medicaid Director letter dated August 16, 2002)
- Exclude Medicaid eligible patient charges (even if claim was not paid or denied). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77916)
- Exclude patient charges covered under an automobile or liability policy that actually covers the hospital service (insured). (45 CFR 146.113, 45 CFR 146.145, 73 FR dated 12/19/08, pages 77911 & 77916)
- Exclude contractual adjustments required by law or contract with respect to services provided to patients covered by Medicare, Medicaid or other government or private third party payers (insured). (42 CFR 447.299 (15), 73 FR dated 12/19/08, page 77922)
- Exclude charges for services to patients where coverage has been denied by the patient's public or private payer on the basis of lack of medical necessity, regardless as to whether they met Medicaid's medical necessity and coverage criteria (still insured). (73 FR dated 12/19/08, page 77916)
- Exclude charges related to accounts with unpaid Medicaid or Medicare deductible or co-payment amounts (patient has coverage). (42 CFR 447.299 (15))
- Exclude charges associated with the provision of durable medical equipment (DME) or prescribed drugs that are for "at home use", because the goods or services upon which these charges are based are not hospital services. (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)
- Exclude charges associated with services not billed under the hospital's provider numbers, as identified on the facility cost report, Worksheet S-2, Lines 2 and 3. These include non-hospital services offered by provider owned or provider based nursing facilities (SNF) and home health agencies (HHA). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)
- Exclude facility fees generated in provider based rural health clinic outpatient facilities (not a hospital service in state plan). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77926)
- Exclude charges for provider's swing bed SNF services (not a hospital service in state plan). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)
- Exclude non-Title XIX charges including stand-alone Supplemental Children's Hospital Insurance Programs (SCHIP / CHIP).
- Exclude Independent Clinical ("Reference") Laboratory Charges (not a hospital service). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)

Do NOT Include In Hospital Uninsured Payments:

- Exclude State, county or other municipal subsidy payments made to hospitals for indigent care. (42 CFR 447.299 (12))
- Exclude any individual payments or third party payments on deductibles and co-insurance on Commercial and Medicare accounts (cost not included so neither is payment). (42 CFR 447.299 (15))
- Exclude collections for non-hospital services: Skilled Nursing Facility, Nursing Facility, Rural Health Clinic, Federally Qualified Health Clinic, and non-hospital clinics (i.e. clinics not reported on Worksheet "C" Part I) (not hospital services).

(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)

ATTACHMENT G: LIST OF MEASURES FOR THE HOSPITAL QUALITY IMPROVEMENT INCENTIVE (HQII) POOL

Outcome Domain 1: Urgent Improvements in Care

The following are measures of safer care that align with the CMS Partnership for Patients initiative.[8]

1. Adverse Drug Events*
2. Catheter-Associated Urinary Tract Infections(CAUTI)*
3. Central Line Associated Blood Stream Infections (CLABSI)
4. Injuries from Falls and Immobility*
5. Obstetrical Adverse Events
6. Pressure Ulcers*
7. Surgical Site Infections (SSIs) (NQF Measure 0753)
8. Venous Thromboembolism (VTE)*
9. Ventilator-Associated Events
10. All Cause (Preventable) Readmissions*

*Required measures for hospitals with <100 beds

Outcome Domain 2: Population-focused Improvements

The following are measures of preventive care that align with the Agency for Healthcare Research and Quality's Prevention Quality Indicators.[9]

- PQI 01 Diabetes Short-term Complications Admissions Rate
- PQI 02 Perforated Appendix Admission Rate
- PQI 03 Diabetes Long-term Complications Admission Rate
- PQI 05 COPD or Asthma in Older Adults Admission Rate
- PQI 07 Hypertension Admission Rate
- PQI 08 Heart Failure Admission Rate
- PQI 09 Low Birth Weight Rate
- PQI 10 Dehydration Admission Rate
- PQI 11 Bacterial Pneumonia Admission Rate
- PQI 12 Urinary Tract Infection Admission Rate
- PQI 13 Angina without Procedure Admission Rate
- PQI 14 Uncontrolled Diabetes Admission Rate
- PQI 15 Asthma in Younger Adults Admission Rate
- PQI 16 Rate of Lower-Extremity Amputation Diabetes
- Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions

[8] http://partnershipforpatients.cms.gov/about-the-partnership/what-is-the-partnership-about/lpwhat-the-partnership- is-about.html

[9] http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx; the state may use a subset of these.

ATTACHMENT H: HOSPITAL QUALITY IMPROVEMENT INCENTIVE (HQII) ALLOCATION AND PAYMENT METHODOLOGY

Hospital Quality Improvement Incentive (HQII) Pool
Allocation and Payment Methodology (APM)

Intent to Participate
Each qualifying hospital (see list of qualifying hospitals in Attachment E of the Special Terms and Conditions) must declare to the Human Services Department (HSD) their intent to participate in the HQII no later than October 31, 2014.

Initial Calculation Formulae
The HQII Pool will be primarily allocated based on Medicaid volume but a portion of it will be allocated in equal portions to all participating hospitals.

- 25% of Pool will be divided equally among all qualifying hospitals (APM#1). The formula is: APM#1 Allocation = (Total Pool X .25) / # of participating hospitals.
- 75% of Pool will be allocated based on the volume of Medicaid patients at the specific hospital (APM#2). The volume of Medicaid patients will be based on Medicaid "adjusted patient days" (APDs) and each hospital will be allocated a portion of APM#2 based on their percentage of the total APDs. The formula is: APM#2 Allocation = (Total Pool X .75) X (Hospital's APDs/Total APDs of all participating hospitals).

Total Funding = (1/29 X APM pool#1) + (Hospital's APDs/Total APDs) X APM pool#2

For DY 2 (DY2 or CY2015), the total expected HQII Pool amount is $2,824,462. Therefore, $706,115.50 (25%) will be in APM#1 and $2,118,346.50 (75%) will be in APM#2.

Assuming all 29 qualifying hospitals participate, each would have an initial DY2 allocation of $24,348.81 from APM#1 plus their portion of APM#2 as defined above. The table below shows anticipated funding levels for DY3 through DY5.

Demonstration Year	TOTAL	APM#1	APM#2
DY3 (2016)	$5,764,727	$1,441,182	$4,323,545
DY4 (2017)	$8,825,544	$2,206,386	$6,619,158
DY5 (2018)	$12,011,853	$3,002,964	$9,008,889

Possible Stratification Plan
The state is considering the stratification of hospitals for purposes of setting benchmarks. In this case, there would be two strata for purposes of calculating baseline and performance: <100 beds; and 100+ beds. However, funding allocation would not be stratified (i.e., The state does not intend to first allocate the total Pool funding by these strata prior to allocation based on the methodology above).

Allocation Plan by Demonstration Year (DY1=calendar year 2014)

- In DY2, all participating hospitals will receive full allocation as long as they follow program rules, including submitting necessary performance measure data to establish a baseline and an average performance (50^{th} percentile) for all hospitals, by stratum. Baseline will be established for both Domain 1 and Domain 2 measures.
- In DY3, allocation will be based on meeting minimum state performance levels (MPL) for each Domain 1 performance measure. This will be the 25^{th} percentile based on hospital (or stratum) average established during DY2. Unearned money (i.e., for hospitals not meeting one or more of the benchmarks) will return to the Pool and be re-allocated using the methodology outlined below.
- Beginning in DY3, hospitals must also set improvement targets that close the gap between their current performance and the state High Performance Level (HPL). The HPL will be the 90^{th} percentile. Targets can be no lower than the MPL (25^{th} percentile) and must increase each year until the HPL is reached.
    - Example 1: A hospital that performed at the 30^{th} percentile must set a target that is greater than the 30^{th} percentile (improved performance).
    - Example 2: A hospital performing at the 10^{th} percentile would need to set a target of at least the 25^{th} percentile (the MPL).
    - Example 3: A hospital performing at the 90^{th} percentile could set a target that sustains performance at the 90^{th} percentile (the HPL).
- In DY4 and DY5, allocation will be based on hospitals' meeting their individual improvement targets for each Domain 1 performance measure. Unearned money (i.e., for hospitals not meeting one or more of the benchmarks) will return to the Pool and be re-allocated. Additionally, hospitals must set new targets in DY4 and DY5 for the following years that adhere to the rules outlined above.

NOTE: For any year, all measures for which performance is at or above the High Performance Level (HPL) will be considered met.

Exclusion of Measures with Low Numbers

For a given hospital, a performance measure will be excluded from the allocation process if the denominator is too low to ensure a minimal level of validity. It is anticipated that the minimum level will be 10 cases.

Pool Re-Allocation

In order to receive full allocation, a qualifying hospital would need to meet the benchmark (MPL or individual target) for each Domain 1 measure. Each measure will be equally weighted such that it would be worth 1/X of total allocation. (E.g., for hospitals with <100 beds and no excluded measures, each measure would be worth 1/6 of initial allocation amount; for hospitals with 100+ beds and no excluded measures, each measure would be worth 1/10 of initial allocation amount.)

Any portion of the initial allocation amount that is not earned by a hospital (i.e., for measures on which they failed to meet the benchmark) will be returned to a Re-Allocation Pool (RAP).

After all initial allocations are settled, the RAP will be allocated using the APM#2 methodology (based on Medicaid volume [APDs]).

For DY3, funds will be (re)allocated to hospitals for each measure on which they reached at least the 75th percentile (using the baseline information from above) on any Domain 1 measure.

For DY4 and DY5, funds will be (re)allocated to hospitals for each Domain 2 measure on which they reached at least the 50th percentile (using the baseline information from above).

Example for a Hospital with 5% of total APDs in Demonstration Year 2 (numbers are rounded)

- INITIAL and FINAL Allocation: $24,349 (from APM#1) + $105,917 (from APM#2) = $130,266 total initial allocation.

Example for a Hospital with 5% of total APDs in Demonstration Year 3 (Total Pool in DY3 = $5,764,727; numbers are rounded)

- INITIAL Allocation: $49,696 (from APM#1) + $216,177 (from APM#2) = $265,873 total initial allocation.
- If this hospital has fewer than 100 beds, each of its six required measures would be worth $44,312 (total initial allocation divided by 6).
- If one of the six measures is excluded due to low numbers, each of the remaining five measures would be worth $53,175 (total initial allocation divided by 5).
- If the hospital meets only 3 of these 5 measures' benchmarks, they would receive $159,524 ($53,175 X 3) and $106,349 would be returned to the RAP.

Example of Reallocation in Demonstration Year 3 (Total Pool in DY3 = $5,764,727; numbers are rounded)

- In the example above, the hospital received only $159,524 of its potential allocation of $265,873. The remaining $106,349 was placed into the RAP. To illustrate how reallocation would work, we can assume that 20% of the total funding was not captured in the initial allocation. A total of $1,152,945 goes into the RAP.
- Reallocation will be made to hospitals for each *Domain 1* measure on which they achieved the 75th percentile, or higher. If 10 hospitals had a total of 25 measures on which they achieved the 75th percentile, the total RAP would be equally divided across those 25 measures ($46,118 per measure) and the reallocation would look like that in the table below.

Hospital	**Measures at 75th percentile**	**Total Reallocation (# X $46,118)**
A	3	$138,353
B	2	$92,236
C	1	$46,118
D	3	$138,353
E	5	$230,589
F	1	$46,118

G	1	$46,118
H	4	$184,471
I	3	$138,353
J	2	$92,236
TOTAL	**25**	**$1,152,945**

Example of Reallocation in Demonstration Years 4 and 5
Reallocation in Years 4 and 5 would work essentially as described above for DY3, but the RAP would be divided among *Domain 2* measures on which hospitals achieved at least the 50th percentile.

Data Collection and Analysis
The state is working with the New Mexico Department of Health/Epidemiology and Response Division (DOH/ERD) to collect data related to hospital performance. All New Mexico hospitals are required by statute to submit Hospital Inpatient Discharge Data (HIDD) on a quarterly basis. The state believes that HIDD data will allow for the calculation of performance, by hospital, on all HQII measures without further reporting requirements for the participating hospitals.

Monitoring and Oversight
The state has been working closely with the New Mexico Hospital Association (NMHA), individual hospitals, and other quality experts in the state on the development of the HQII program. The state will continue to communicate programmatic policies and procedures through these channels, providing guidance, training or technical assistance, as necessary.

The state will follow the Special Terms and Conditions (STCs) applicable to the HQII program and all applicable regulations regarding monitoring, oversight, and audits to ensure fidelity in the HQII program. The state may use its contracted agents, Myers & Stauffer, to assist in performing necessary monitoring activities. This may include such activities as desk and field audits.

Reserved for Attachment I: UCC Pool Payment Tool

ATTACHMENT J
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.

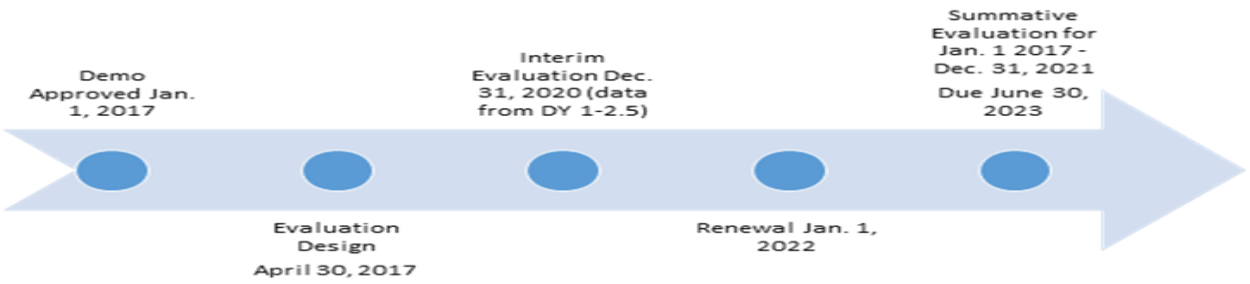
Expectations for Evaluation Designs

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 K
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

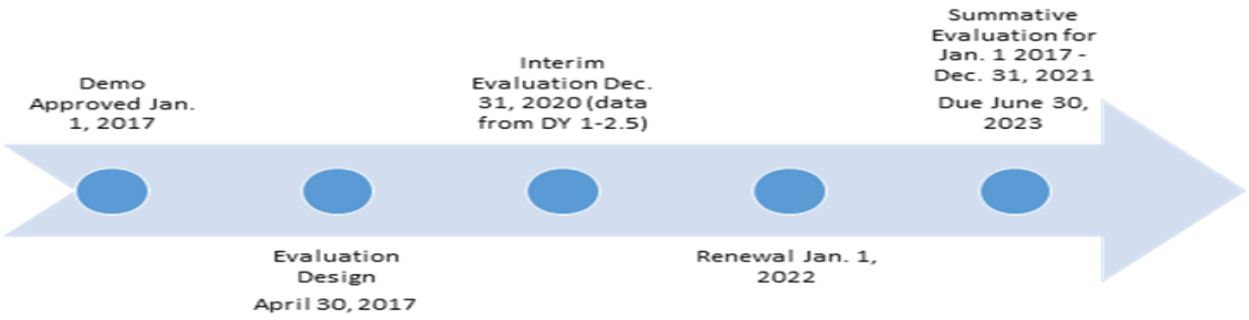
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved 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 L
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 52) 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)[7]
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.[8] 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.[9]
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

[7] 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.
[8] *Ibid*.
[9] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

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 53) 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 114).

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.

Centennial Care 2.0 Medicaid 1115 Demonstration
Appendix M
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 waiver 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	HSD

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 (see Appendix M, Attachment B)

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	HSD, 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 week-ends, 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	HSD, 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	1/01/19 – 3/31/19	MAD

state such as court systems, counties, cities once they are enrolled in Medicaid, and crisis stabilization and triage centers.		
Expand the learning communities for the treat first model, and the Treat First University to continue exploring new initiatives to expand access to BH services;	On-going	BHSD
Explore collaborative opportunities with County organizations for crisis services.	4/01/19 – 12/31/22	HSD, 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	HSD

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	HSD
Continue to investigate and add more EBPs to the approved list of proven models for recovery	1/01/19 - ongoing	HSD
Conduct an analysis of available programs for all applicable age levels across the state.	10/01/19 – 12/31/19	HSD & 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	HSD

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 waiver 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	1/01/19 – 4/01/19	HSD

(ASAM 2.5); accredited residential treatment centers for adults with SUD (ASAM 3), and 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	HSD
Complete promulgation of the behavioral health rule that includes crisis triage centers;	1/01/19 – 12/31/19	HSD
Provide technical support to residential providers to become accredited;	1/01/19 – ongoing	HSD
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	HSD

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 Human Services Department 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, HSD
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 Mgmt Review Tool) to specify each ASAM level of care	7/01/19 – 9/30/19	HSD
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	HSD

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 waiver 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, HSD 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 HSD 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	HSD
Provide technical support to residential providers to become accredited;	1/01/19 – ongoing	HSD
Notify and educate providers and authorization centers on ASAM requirements;	1/01/19 – 6/31/19	HSD,
Schedule trainings on ASAM criteria	1/01/19 – 12/31/19	CYFD HSD
	4/01/19 – 6/31/19	HSD

Research state and national staffing ratios and provider types; and include in BHSD's certification process for ARTCs		
Compare to The Joint Commission, CARF and COA standards.	7/01/19 – 9/30/19	HSD
Set standards for NM ARTCs	10/01/19 – 12/31/19	HSD, 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	HSD
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	HSD

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	HSD
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	HSD, CYFD
Develop trainings focused on SUD for certified peer support workers, licensed clinicians, and prescribers	10/01/19 – 12/31/19	HSD, UNM and CYFD
Schedule further trainings such as MAT, DATA waiver 2000, to expand access to buprenorphine.	On-going	HSD, UNM
Expand statewide behavioral health workforce coalition	On-going	HSD, UNM, CYFD
Collaborate with professional licensing boards to review scopes of practice for all licensed professionals	1/01/2021 – 3/31/2021	HSD, 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	HSD

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.

7. 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 HSD 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	HSD, DOH, CYFD, UNM
Continue and expand PAX Good Behavior Game	ongoing	HSD
Add SUD to CLNM admission criteria and expand risk factor education for members with SMI, SED	1/01/21 – 4/01/21	HSD
Drug utilization review committee to continually adjust monitoring guidelines (see IT Plan – Appendix M, Attachment F)	Ongoing	HSD & 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	HSD
Enhance the existing master client index (MCI) to support the state's MMIS replacement.	1/01/20 – 12/31/22	HSD
Execution and monitoring of the MMIS replacement plan	1/01/20 – 12/31/24	HSD

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 diagnosis and an 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	HSD, MCOs
CLNM Steering committee to establish new requirements for SUD addition to CLNM HHs	1/01/19 – 6/31/19	HSD, CYFD, MCOs
Submit health home SPA to CMS	7/01/19 – 7/01/20	HSD
Solicit potential providers in 13 targeted counties (see Appendix M, Attachment E for the targeted expansion counties)	TBD	HSD
Evaluate potential health home applications	TBD	HSD, CYFD, MCOs,
Educate applicants on health home requirements and provision of additional services expected.	TBD	HSD, CYFD, MCOs
Develop reimbursement per facility	TBD	HSD
Activate HH in 13 counties	1/01/2021	HSD, CYFD
Repeat above steps and activate all remaining counties for Health Homes	1/01/2022	HSD, 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 N:
Reserved for SUD Monitoring Protocol

Attachment O: 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 P:
Reserved for HQII Transition Plan